CONCEPTUAL AND CONTEXTUAL DESCRIPTIONS OF THE BIPOLAR MOOD DISORDER SPECTRUM: COMMENTARIES ON THE STATE OF PSYCHOLOGY AS REFLECTED THROUGH POLARISED EPISTEMOLOGIES

by

LEANNE MANDIM

submitted in accordance with the requirements
for the degree of

DOCTOR OF LITERATURE AND PHILOSOPHY

in the subject

PSYCHOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

PROMOTER: DR V J RAPMUND

JOINT PROMOTER: PROF F J A SNYDERS

JUNE 2007

I declare that **Conceptual and Contextual Descriptions of the Bipolar Mood Disorder Spectrum: Commentaries on the State of Psychology as Reflected through Polarised Epistemologies** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

_____   _____

Ms L Mandim   Date

ACKNOWLEDGEMENTS

I would like to thank the following people for accompanying me on this journey:

My family – Mom, Pops, Avó, Craig, Melissa and Annie. Thank you for all of your love, support, encouragement and strength. You have all shown me that the ups and the downs are part of life. I am very lucky to have such a colourful and inspiring family, thank you.

Val, I thank you for being a brilliant guide and mentor. Your patience, compassion and hope have helped me so much in catching a dream. Thank you for allowing me to be heard, helping with translating my voice, and for giving me a space to share my thinking. You have been a guiding light for me, thank you. Above all, thank you for the time that you have given to me over the past few years which has been priceless in my process of growth.

Ricky, you pushed me out of all known comforts and certainties. Thank you for challenging my taken-for-granted beliefs, and for respecting the fact that they were mine. Thank you for being the interpersonal artist that you are, I have learned many a lesson through the perturbations.

I would also like to thank the people who participated in this research. They were all dedicated to furthering understanding of human behaviour, and I thank them for trusting that I may be able to actualise that.

To my friends and colleagues, thank you for supporting me in this process.

SUMMARY

Bipolar mood disorder has been traditionally researched, explored, and explained from a modernistic, psychiatric perspective. The purpose of this study is to explicate an alternative description for bipolar mood disorder, from a postmodern perspective. The widely accepted psychiatric knowledge focuses on the signs and symptoms of the disorder, pharmacological treatments, and manualised psychotherapies. This thesis shifts the focus from an intrapsychic, deficit perspective towards one which is inclusive of surrounding discourses and patterned relationships.

The social constructionist research approach is followed, utilising vignette and thematic analyses for textual deconstruction and reconstruction. In addition to these data analyses, discourses were analysed using the actual text of the co-researchers. This allowed for a thorough explication of the ways in which discourses shape the construct bipolar mood disorder. From these analyses, emergent themes were then distilled and compared to the existing body of literature in the bipolar mood spectrum field of study. Process models were generated to depict the various pertinent aspects of the social construction of bipolar mood disorder.

This research has value for the treating professional, allowing for a broader, more inclusive discourse perspective to add to the already established medical model view. Further, this research gives credence to the voice of the person who has been diagnosed with the illness. This research may also contribute to the epistemological debates within modernist and postmodernist paradigms.

Key words: Bipolar mood disorder, medical model, pharmacology, mania, depression, psychiatry, psychotherapy, titrating power relations, expert, problem determined systems, belonging, problems of therapy and therapeutic problems, vignette analysis, people as meaning generating beings, context, reflexivity, self-reflection, multiple realities, positivism, social constructionist epistemology, qualitative research, process model.

TABLE OF CONTENTS

Tables

Figures

CHAPTER ONE

Introduction

General Introduction

Incessantly cast in this empty role of unknown visitor, and challenged in everything that can be known about him, drawn to the surface of himself by a social personality silently imposed by observation, by form and mask, the madman is obliged to objectify himself in the eyes of reason as the perfect stranger, that is, as the man whose strangeness does not reveal itself. The city of reason welcomes him only with this qualification and at the price of this surrender to anonymity

M. Foucault (1961, p. 237)

This quote offers a description of what it may feel like to be marginalised by society because of being and feeling different to the normative population. Modern society strives towards mental health and well-being, and makes great scientific attempts to eradicate what is viewed as abnormal and dysfunctional. Bipolar mood disorder, paradoxically, is a co-constructed diagnosis, brought about so that people who exhibit such behaviours can be cured of their ailments. This research will show how the naming of the disorder is reflexively informed by the construction of it. The thesis extrapolates stories and information which provides explanations for how these problem systems come about and how they are maintained by overarching discourses, which in turn construct the diagnosis.

The psychiatric classification of bipolar mood disorder has been chosen as a field of study for several reasons. Bipolar mood disorder has been extensively researched and discussed from a traditional psychiatric perspective (Scott, 2001) which is congruent with an overarching medical model and the scientific paradigm of empiricism. The predominant areas of focus in clinical research have been on

categorising the signs and symptoms that define individual behaviour as disordered, that is, the development of an effective nosology (Miklowitz, 2002); effective treatment consisting of pharmacological interventions and hospitalisation if necessary (Maj, Tortorella & Bartoli, 2000; Moller & Grunze, 2000; Tohen, 2000); neuropsychological disturbances associated with the disorder (Clark, Iversen & Goodwin, 2002; Ferrier, Stanton, Kelly, & Scott, 1999; Murphy & Sahakian, 2001) and the cost effects on the medical health system due to the diagnosis and the subsequent effects on the economy because of a reduction in work performance (Gupta & Guest, 2002; Keck, McElroy, Arnold, Dewan & Bennett, 2000). This implies that bipolar mood disorder has been approached from an individual, medical and political-medical management systems perspective. The systems of the family, psychotherapeutic and psychiatric relationships, societal expectations, and cultural and historical discourses have largely been left un-researched.

The researcher has previously had an aversion to the traditional diagnosis of mood disorders. This stems back to undergraduate years where the researcher would adopt a critical stance of diagnosis and refute the labelling of people and their behaviours. For academic achievement purposes, the researcher finally accepted the need to be able to define reality in a way that allowed for a common language to develop among those who work in the psychiatric/psychological field. The researcher now sees an opportunity to delve into the critical side of diagnosis and explore the dominant and marginalised discourses surrounding the field of diagnosis. As a qualified clinical psychologist, there is a requirement to speak the language of diagnosis and the researcher believes that there is a great incongruence between her fundamental epistemological assumptions and the language that is required to be spoken.

On one level then, this research study is a platform for the researcher to voice her dissatisfaction with what she perceives to be the stagnation of psychology in a transient world. Therefore, a more integrated world-view is sought. According to Hoshmand (1994, p. 5), the "self-understanding as a profession requires a reflexive study of the nature of the discipline and the foundations of its claims to knowledge and scientific practice". Reflexivity is defined as a process of reflecting back on oneself or referring one's experience to oneself (Gergen, 1994). Further, reflexivity

requires that psychotherapists step aside from the system in which they are functioning to study and reflect on their own involvement in it (Hoshmand, 1994).

The definitions of bipolar mood disorders are currently vast and intricately differentiated (for example in the research conducted by Akiskal & Pinto, 1999). The researcher believes that the majority of people function adequately in a balance between polarities and are able to integrate the polarised positions through a meaning-making process. A motivation would then be to understand how a person may become stuck in one side of a polarity and then move towards the opposite extreme, and once again, experience a pattern of stuckness (Marneros, 2000). One can see how the metaphor of bipolar mood disorders is applicable and apparent in the way in which the researcher received her academic training as well, initially beginning with the focus on the medical model and then being trained to work in a more ecosystemic, postmodern disposition. Integration is required for balance to exist and from which to further question and develop understandings of human behaviour.

The researcher is also motivated to understand the personal narratives of the diagnosed patient. From extensive readings in the literature field, the intricate details of the person's life, relationships, and social ecologies are largely ignored in favour of structured categorisation of common behaviours. The researcher believes that each person has a unique story to tell, perhaps sharing commonalities with other people with the same diagnosis. From a therapeutic perspective, the researcher is interested in understanding how the individual person makes sense of the diagnosis, and integrates this information into his/her life-worlds.

The time-lag between initial diagnosis and prospective treatments (Miklowitz, 2002) has motivated the researcher to question what might be effective ways of bettering the quality of life for people who have this diagnosis. There is the possibility at the outset of the study that an eclectic treatment approach may be the most beneficial, but this researcher would have to find a way of working that provides congruence between a philosophical understanding of mood disorders and a way of practising these beliefs.

In summary, **the research questions** that are emerging at the outset of this study are the following:

- What are the common understandings and treatments of bipolar mood disorders?
- What are my understandings of the philosophical foundations of the modernist and postmodernist paradigms?
- What are the conceptual and methodological implications of these paradigms?
- What are the types of problems or questions these paradigms are best suited to address?
- What are the benefits and limitations of having this diagnosis?
- What are the common and different historical patterns of interacting among those diagnosed with bipolar mood disorders?
- How do life stories impact on the diagnosis and vice versa?
- How is creativity and madness balanced in this diagnosis?
- Are psychotherapeutic and psychiatric models aligned and complementary, or oppositional and mutually defiant?

The medical model is helpful in understanding the bipolar mood disorder spectrum because of its neat structure. It has provided clear-cut definitions, signs and symptoms, and recommends thoroughly researched treatment strategies. But, the experiences of the person diagnosed with the disorder are largely left untapped. The postmodern paradigm is thought to be useful when broadening the understanding of what it means to have such a diagnosis (Dickerson & Zimmerman, 1995).

For the purposes of this study, the diagnosis of bipolar mood disorder will be challenged from a postmodern, social constructionist stance. Postmodernism can be understood as a grouping of theories that share certain assumptions about the nature of reality (Burr, 1995). The commonly held view is that reality has many variations and explanations, rather than just one fixed truth. From this perspective, the focus is on meanings and how they come to be generated through conversational dialogue (Downing, 2000). Further, diagnostic categories in the DSM-IV are seen to be influential discourses that shape the client's problem (Gorman, 2001).

Explaining the Title

The terms used in this title: **Conceptual and contextual descriptions of the bipolar disorder spectrum: Commentaries on the state of psychology as reflected through polarised epistemologies** will now be briefly explained. Conceptual and contextual descriptions make reference to the realist position of knowledge acquisition as well as contextual constructionism. The realist position assumes that there is a truth to be known, it can be discovered, reified, and generalised to wide populations regardless of cultural and social backgrounds. The contextual approach differs somewhat and proposes that knowledge is local, situation dependent, and co-created. Bipolar mood disorder is a realist construction, brought into existence to categorise human behaviour as abnormal and rectifiable through scientifically proven treatment protocols. From a postmodern, contextual approach, bipolar mood disorder is a linguistically co-created meaning system, to which people give importance and value. Many systems and discourses form around this shared problem meaning system, giving it power and legitimacy. The psychiatric discourse is one particular possibility, among many others. Within the realist paradigm, dominant discourses of psychiatry and the medical model overpower and subjugate other possible discourses, such as the social, cultural and historical. This research will aim to explore the multiple discourses which form and in-form the diagnosis known as bipolar mood disorder. The inclusion of the medical model classification system as one possibility (rather than truth) will also be entertained. The research interviews will also be written up from both a conceptual and a contextual approach.

Psychology and the psychotherapy have been closely linked with psychiatry. Psychiatry has promulgated itself as a science of human behaviour. Therefore, it makes sense that psychology has attempted to align itself with psychiatry over the years, thereby also attaining a scientific stamp of approval. However, as postmodern theories point out, human interactions and behaviours cannot be reduced to cause and effect functioning. People are linguistic beings, sharing and co-creating meaningful lives. Scientific principles of objectivity, linear causality, and reductionism are ill-fitting within a psychotherapeutic context which is built upon premises of

subjectivity, value-inclusion, complexity, context-dependency, and idiosyncrasy. Yet, there are many schools and models of psychotherapy that strive towards gaining scientific stature thereby aligning themselves with the psychiatric paradigm. These models will be discussed in this research, highlighting the benefits and difficulties within this approach to reifying human behaviour. The alternative option, of moving away from singular diagnoses towards complexifying behaviour does not easily collate with a scientific perspective. It will be shown that there is value for the treating professionals (the psy-fraternity) as well as the patients, by including wider influences of discourse dynamics, problem-determined systems, and collaborative relationships.

Psychology, for the researcher, has polarised into modernist and postmodernist positions. Each pole has valid suppositions about knowledge, human behaviour, problems and solutions. But, it would seem that each has developed an intolerance for the other. This thesis will aim to create a language through which both positions can make sense for the researcher. It is assumed from the outset that this will involve a both/and position, being mutually inclusive, and respectful of diverse opinions. The way in which psychotherapy is practised, with demands of the managed health care system, is pushing psychologists towards a more realist position of working, whereby change is dictated to by the number of allocated and paid for sessions. The postmodern values and premises need to also align with this evolving paradigm so that the tenets of this theoretical bracketing can continue to add significance to the people who require psychological services, as well as those who practise psychotherapy.

Aim and Rationale of the Study

The research aims have been demarcated according to several areas of interest, which are still open for change and remain permeable for contextual factors that may arise.

The researcher will begin with a traditional explication of bipolar mood disorder, entailing a write-up of scientific disclosures and theoretical hypotheses on the causes, treatments, and maintenance factors of this disorder. This will also include

a discussion of prominent psychological models that have been documented in the existing body of literature. This section will begin with a list of commonly used terms associated with bipolar mood disorder providing the reader and the researcher with a shared understanding of conceptual languaging. This aspect of the research will provide a platform from which a critical analysis can be carried out. This will also be the conceptual framing of bipolar mood disorder from a psychiatric and scientific perspective.

The next aim of the researcher is to provide a postmodern description of bipolar mood disorder. This implies that the researcher will be enacting the principles of postmodern tenets through collaborative research interviews. As bipolar mood disorder has not yet been addressed from a postmodern perspective, this aim of the researcher will be shaped by the intentions of the researcher, along with the psychiatric culture, psychotherapeutic inferences, and experiences of those that have been diagnosed as bipolar. This postmodern inquiry will hopefully complement that of the medical model described in the first aim, and build upon what is already taken-for-granted knowledge.

This leads to a subsequent aim of the researcher which is to explore the possibility of a **synergy** between the two epistemologies. This is where the bipolar mood disorder diagnosis serves as a metaphor for polarised epistemologies. Just as mania and depression are viewed as separate categories of behavioural expression, with their individualised treatments and different forms of representation, so too are modernism and postmodernism separated accordingly. The researcher feels that it would be beneficial if the two epistemologies could be integrated, albeit on differing logical levels. This will largely be explored on a process level, documented in sections of memoing.

Finally, the researcher will aim towards providing conceptual models which will shape the rich text and thick descriptions, into dynamic diagrammatic ecological maps. This could have benefits for understanding the ways in which bipolar mood disorder can be conceptualised and contextualised from contesting paradigmatic perspectives. These models could also assist in areas of deconstruction and de-reification of other constructs which impact on the lived experiences of people.

The aims and intentions of the researcher are co-ordinated responses to doubts and uncertainties when faced with the possibility that the field of psychology is being steered towards a realist position, complying with modern society's need for absolute normalcy and reduction in deficits, such as those of 'mental illnesses'. The use of single quotation marks are frequently included by postmodernists and are used to "undermine the common or conventional understanding of those words" (Held, 2000, p. 37), which displays the postmodernist's support for multiple truths. Held (2000, p. 37) also commented that these quotation marks are called "scare or sneer quotes" by anti-postmodernists. Throughout this thesis, the single quotation marks will be used when making reference to the multiple possibilities of the words, instead of letting them be considered as absolute truths.

The exploration of bipolar mood disorder from a postmodern lens could contribute to a more in-depth experiential process for both patients and psy-complex role players. This research could also provide legitimacy for a voice other than the dominant psychiatric paradigm with regards to critical thinking, analysis, and explanations for bipolar mood disorder

Design of the Study

Contextualist analysis accepts the inevitability of bringing one's personal and cultural perspectives to bear on research projects. In fact, the empathy provided by a shared humanity and common cultural understanding can be an important bridge between researcher and participant and a valuable analytic resource (Madill et al., 2000 p. 10).

This study will be designed to create a context in which people can share their experiences of living and working with bipolar mood disorder. To do this, several research methods will be combined for such a collaborative event. This research is aiming towards knowledge production, through the active process of open-ended interviews. Pidgeon and Henwood (1997) have identified four levels which can effect such a knowledge production. They are:

- Co-researchers personal understandings.
- The researcher's interpretations.
- The cultural discourses which shape both the co-researcher and researcher's interpretations, and
- The consumer of the researcher who ultimately decides upon the value of the research.

In this research design, 'objectivity' will be replaced with the construct of permeability as advocated by Stiles (1993). This is consistent with a postmodern epistemology, and infers that the aims, intentions, and theories generated by this research are open to re-negotiation. Research viewed as such is not a fixed entity, but rather a fluid process, allowing for feedback and feed-forward interactions. Bipolar mood disorder, from a realist position, is created from a so-called objective stance, where the observer remains devoid of subjective influence, and is therefore able to make deductions based on objective observations. A postmodern position advocates the opposite and suggests that this objective position is un-attainable because of the nature of researcher reflexivity and inclusion (Snyman & Fasser, 2004).

Reliability of the research data, that is the trustworthiness of the interview transcriptions are context-dependent in this research, and will rest upon thorough explications of the contextual backgrounds for each vignette used. The researcher is disclosing her intentions, aims, theoretical underpinnings, and epistemological orientation, or what Stiles (1993, p. 602) calls "forestructure", in an effort to allow the consumers of the research the opportunity of understanding how the researcher's interpretations are shaped by the researcher's background, which impacts on the outcome of the research inferences. With regards to validity, meaning trustworthiness of the interpretations (Stiles, 1993), the researcher will make efforts to provide completeness of interpretations (Madill et al., 2000) rather than convergence. This research will be focusing on multi-disciplinary fields within the mental health framework, including that of the patient's experiences. It is therefore fitting that this research exemplifies emergent differences, rather than acquiring knowledge through consensus. As this research design has been uniquely created for the purposes of this particular research, there is no previous design to follow, potential pitfalls are expected to arise, and the necessary adjustments will be made.

This research design is constructed for the purposes of exploring the ways in which bipolar mood disorder is understood and experienced by those who live and work with the diagnosis. This approach respects both modern and postmodern epistemological paradigms. It should be kept in mind, that the interpretations of the researcher and the emergent discourses and themes of this research will be dependent on the way in which the research interviews are conducted, including place, time of interview, and general phase of mood (for the patient) and patient load (for the psy-fraternity).

Following Parker et al. (1995) the consumers of the research are actually the most valid standard of appreciation as it is this group of people who will ultimately decide if the research generated has any impact on their understanding of bipolar mood disorder. It is hoped that this critical analysis will provoke taken-for-granted beliefs about the nature of this diagnosis, as well as expand upon previously held meaning systems of psychiatric nomenclature.

Sampling and Selection

For the purposes of this research, sampling will be purposive, and convenience selection will be used (Lincoln & Guba, 2000). Participants will be selected if they are willing to speak about their experience of bipolar mood disorder, and if they agree to the demands of the process such as, interviews, and follow-up discussions. It is suggested that rich descriptions of their stories will be gleaned from open ended conversations about processes that come to shape their experiences of living and working with bipolar mood disorder.

Data Collection

The unstructured interview, or conversation, will be the method used to obtain information (verbal and non-verbal) (Mishler, 1986). Co-researchers will be encouraged to tell their stories as they wish to, starting where they want to. The nature of questions asked will be open-ended and modified according to the co-researcher's unique story. The researcher will be an active participant by guiding the story through

questions asked, checking her understandings, and reformulating presuppositions according to the demands of each conversation. Each interview will be recorded and transcribed. The researcher's careful analysis of the transcriptions will allow for further questioning, and the enrichment of bipolar mood disorder stories by continuously unfolding and refolding co-constructions of meanings. The analysis of the content of the interviews, combined with the observation of the ensuing processes, will be utilised to demarcate pertinent idiosyncratic and common themes. These themes will be reflected on by the researcher, and once again, thematically arranged, and commented on.

Data Analysis

The intention of this research is to explain bipolar mood disorder from a wide variety of role-players, and not to predict the determinants of such a diagnosis. This is therefore a reflexive process and requires on-going analysis of data, from the literature review, tacit knowledge, research interviews, peer and promoter conversations, and comparative literature reviews. The data analysis has therefore been constructed in an effort to draw out these experiences on an on-going basis from inception of the research proposal, up until the conclusions chapter.

As previously stated, open-ended unstructured interviews will be used to elicit information about the experiences of living and working with bipolar mood disorder. Once the interviews have been carefully and thoroughly transcribed, vignette analysis as described by Miller et al. (1997) will be used to convey the richness of the research interviews. This will entail a write-up including both modernist psychiatric stories, and postmodernist contextual accounts. These vignettes will be further explored using the coding process described by Pidgeon and Henwood (1997) and the discourse analysis outline provided by Parker et al. (1995), using the language and words of the co-researchers. This will then be thematically analysed according to the framework provided by Hayes (1997) which will assist in clarifying themes of difference and similarity. This process of data analysis will require a back and forth process, as the themes will be harvested from within and across the interviews.

Lastly, the data analysis will make use of matrices, as set out by Miles and Huberman (2001) to assist the researcher in noting patterns, themes, contrasts and comparisons. These matrices will be constructed to analyse direct text of the co-researchers, generate pertinent themes, diagrammatically present the discourse analysis, and track the emergent discourses when compared with the existing body of literature. In addition to these matrices, process models will be used to highlight the premises of this research.

Format of the Study

This study will comprise a literature review or survey, as well as a theoretical, and a practical component.

Chapter 2 provides an overview of the existing literature relating to the psychiatric diagnosis of bipolar mood disorder. Although this chapter cannot be all-inclusive, it will highlight areas of importance as portrayed through a psychiatric lens. A list of common terms used to describe bipolar mood disorder is given to establish a common ground of shared knowledge for the reader. The various aspects of bipolar mood disorder are discussed from: a historical perspective; a modern day psychiatric description; a clear demarcation of the signs and symptoms of manic and depressive episodes; criteria for classification of the diagnosis; a thorough explication of the various medications and their physiological interactions; a more holistic based nutritional approach to medication; and an exploration of the manual evidence based psychotherapies highlighting treatment protocols, techniques and interventions.

Chapter 3 will outline the philosophical polarities of modernism and postmodernism. The focus of this chapter will be on distilling the pertinent assumptions which underlie these theoretical paradigms. This includes a discussion of the branch of philosophy known as epistemology, a medical model overview, and an in-depth exposition of postmodern theories detailing their assumptions. The link between epistemology and practice is then discussed in a section highlighting 'psychiatric diagnosis denial syndrome', entailing accounts of problems, solutions, the client and change. This is then followed by criticisms of the postmodern paradigm.

Chapter 4 will describe the method of research and the conceptualisation of the research design. In this, distinctions will be drawn between traditional quantitative and evolving qualitative approaches to research.

Chapters 5, 6, 7, and 8 will contain the vignette analyses of the four stories shared with the researcher. Each research participant is given a pseudonym reflecting the way in which she presented herself in the interviews, and the stories are reconstructed using the data collection and analysis methods described above. Each story is written up in a similar format, allowing for the differences between interviews with patients and that of the psychiatrist and psychologist.

Chapter 9 describes the deconstruction of the stories and reviews thematic disclosures. This chapter outlines nine areas of thematic and discourse description.

Chapter 10 provides the comparative analysis of the deconstructed themes with that of existing literature. Similarities and differences among the five themes that emerged are highlighted, and critically discussed.

Chapter 11 discusses and displays the process models which diagrammatically depict the way in which stories of bipolar mood disorder are created, shaped, and perpetuated.

Chapter 12 concludes this study with an overview of this research, a discussion of the limitations and strengths of the study, as well as providing recommendations for future research.

Appendix A will contain the letter of consent as agreed to by all of the research participants.

Appendix B will house some of the memoing and journaling examples made by the researcher throughout this research process.

Conclusion

This study will explore the construct of bipolar mood disorder from the experiences of those that live and work with the diagnosis, as well as through the existing body of literature. A qualitative approach that is grounded in the theoretical principles of social constructionism will be utilised. Attention will be given to the idiosyncratic conceptualisation of the diagnosis, revealing the dominant and non-dominant stories. This research therefore adds to the field of psychology by contextualising bipolar mood disorder from a postmodern perspective and a realist conception.

CHAPTER TWO

The Psychiatric Perspective

Introduction

This chapter will review the mainstream psychiatric literature available on the topic of bipolar mood disorder. This will include the historical and theoretical developments of the bipolar mood disorder spectrum; contextualisation of bipolar mood disorder within the mood disorder grouping as stipulated in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) (1994a); traditional paradigms for conceptualising and managing the bipolar mood disorder; and current treatments available in both the psychiatric and psychological fields of expertise (that is, published research).

An attempt will be made to provide an all-inclusive overview of the literature available on bipolar mood disorder. However, this is probably not attainable. Therefore, the departure point of this chapter will be in creating a shared understanding of what the bipolar mood disorder spectrum of behaviours entails. Once this has been achieved, the chapters that follow will be grounded in the terminology explicated here. After completing the reading of the chapter, one should be familiar with the terms and definitions associated with bipolar mood disorder, manic-depression, mood disorders in general, diagnosis, treatment and prognosis, therapeutic approaches to this mental illness, and pharmacological innovations.

A Common Grounding of Terminology

The psychiatric perspective consists of specific terminology that is defined and widely used by the researchers, physicians, theoreticians and clinicians within this field of expertise. For purposes of clarity, certain terms commonly associated with bipolar mood disorder discussions will be defined at the outset. The more common terms used are defined below, and this list should not be considered to be exclusive.

Akathisia: this is a distressing feeling of restlessness that may result in an inability to sit still. It may also be a noted side-effect of some anti-psychotic or anti-depressant medication.

Anhedonia: this is the feeling of not being able to experience pleasure from previously enjoyable activities. It is a noted sign of a depressive episode (Stoudemire, 1994).

Anosognosia: this is the unawareness of recognising one's own dysfunction or condition. People with the diagnosis of bipolar mood disorder often deny the diagnosis and play-down the behaviours exhibited, especially if in a manic phase (American Psychiatric Association, 2000).

Anti-depressants: the medications used to treat major depression, anxiety, and panic disorders (Stoudemire, 1994).

Bipolar mood disorder: mood disturbances that include the symptoms of euphoric, grandiose, manic highs followed by symptoms of depression. There is also a suggested hereditary link and caution should be observed if there is bipolar mood disorder in the family, especially in first degree relatives, such as mother, father, brother or sister (American Psychiatric Association, 2000).

Depression: this has been described as a general mood that sits like a black, dark cloud that will not lift (Duke & Hochman, 1992). There are specific behavioural and psychological identifiers of this mood state, and they will be explicated in detail under the psychiatric discussion of mood disorders. Depression is also referred to as unipolar depression. Depression is the gloomy pole of bipolar mood disorder and is thought to generally follow a manic episode (Jamison, 1995).

Diagnosis: the use of an examination and analysis to determine the patient's illness. The diagnosis has a direct impact on the treatment of the disorder.

Drug names: lithium carbonate (Lithium); fluoxetine (Prozac); divalproex sodium (Valproate); carbamazepine (Tegretol)

DSM-IV: the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994a).

Episodes: of mania and depression are defined in terms of the type of episode, the frequency of occurrence, the length of time that symptoms persist, and the actual symptoms experienced (Bourgeois & Marneros, 2000).

Hypomania: a period in which a person experiences less than pure manic outbursts. It is characterised by mild euphoria, an increase in self-belief and/or confidence, and increased energy. The person that is hypomanic does not become psychotic and does not require hospitalisation for the mania. The episode lasts for two to ten days (Duke & Hochman, 1992). Hypomanics do experience recurrent depressions, and recurrent hypomanic episodes, but not full blown mania.

Insanity: "Insanity works a change in the mental personality, that sum of characteristics which, to our minds, represents a man's real being in a far higher degree than his physical peculiarities. Hence, our patient's whole relation to the outside world is affected in the most comprehensive way" (Kraepelin, in Wolpert 1977, p. 10).

Manic-depression: this is the traditional and older term used to describe the mood disorder defined by the swinging behaviour between manic and depressive episodes.

Manic behaviour/mania: behaviour characterised by out of the ordinary activities pursued, for example spending sprees, and a feeling of personal invincibility. Energy levels increase during this episode and the need for sleep decreases or is characterised by insomnia. This energy can be misdirected and applied with poor judgement, for example, driving recklessly, engaging in sexual promiscuity, and making poor financial investments. The time frame for a manic episode varies for each person (Schou, 1983).

Mixed states: this particular mood state involves the complexity of bipolar mood disorder in its fullest expression. A person may experience feelings of elation and euphoria with being irritable and feeling an anger that may explode into a destructive rage and rampage. This person is typically noted to be hypercritical and manipulative, uncaring towards others and self-absorbed with life-complaints. It is also a common pattern that the

person may be consumed with sadness and may threaten or attempt suicide (Duke & Hochman, 1992; Schou, 1983).

Mood disorders: a mood disorder generally involves varying degrees of depression, elation and/or irritability. An alternative term for a mood disorder is an affective disorder. A formal psychiatric diagnosis of a mood disorder can only be made if a defined set of observable signs and symptoms occur for a specified period of time, and produce a degree of disability in everyday functioning (Stoudemire, 1994).

Outcome: with reference to the course of the bipolar mood disorder, outcome is the description of the biological and the psychological status of the disorder over time, as well as mortality and morbidity (Bourgeois & Marneros, 2000).

Prophylaxis: in medicine this term means the prevention of a disease. In the case of psychiatric illness the term prophylaxis refers to the prevention of attacks that are severe enough to warrant a period of hospitalisation (Shopsin, Georgotas, & Kane, 1979).

Psychiatrist: a registered medical physician who specialises in the diagnosis, treatment, and prevention of mental and emotional disorders (Schou, 1983).

Psychopharmacology: the study of the effects of psychoactive drugs on both animals and people (Schou, 1983).

Psychotherapy: this form of interviewing is associated with behaviour and thought change, personality restructuring, and the development of a relationship between a therapist and a client. It is generally assumed that psychotherapy is concerned with abnormal behaviour and strives towards mental well-being. Psychotherapy can be seen as a process whereby a psychotherapist provides and a patient receives talk therapy for the purpose of alleviating symptoms, or for resolving problems (Ivey, Ivey & Simek-Downing, 1987).

Racing thoughts: this is one of the identifying features of a manic episode. It is generally known to be the speeding up of mental functions. Flight of ideas is the verbal expression of these racing thoughts. Both are indicative of a manic episode (American Psychiatric Association, 1994b).

Rapid cycling: this mood state is characterised by fast fluctuating between a manic and a depressive episode. The two mood states run together in an almost simultaneous manner, for example, one day being suicidal and the next day, becoming completely energised and acting strangely, and so on. It is also demarcated by the occurrence of four or more episodes in one year. This behavioural pattern is notably treatment resistant (Duke & Hochman, 1992; Kilzieh & Akiskal, 1999).

Relapse: a relapse occurs when the symptoms return enabling a diagnosis according to the criteria of episodic behaviour. A relapse occurs during a remission, but before a recovery (Bourgeois & Marneros, 2000).

Recovery: recovery refers to the alleviation of symptoms from an episode and not necessarily from the illness itself. It is considered to be a full remission if symptoms disappear for an indeterminable period of time (Bourgeois & Marneros, 2000).

Recurrence: this is the reappearance of the signs and symptoms that define the disorder, and can therefore only occur during a recovery (Bourgeois & Marneros, 2000).

Remission: can occur because of treatment or in a spontaneous manner. A person is considered to be in a full remission if a-symptomatic (Bourgeois & Marneros, 2000).

Research: according to Ivey et al. (1987), research is a means through which to test the accuracy and meaningfulness of our theories.

Signs and symptoms: these are observable criteria that together describe the disorder as it is commonly known. The person supposedly expresses these signs and symptoms which then allow the treating professional to cluster the behaviours into that which is dysfunctional. From this point, treatment can be implemented, whether it be psychological, biological, or a combination of both. A disorder is the cluster of symptoms that relate to an identifiable or diagnosable condition (Kaplan et al., 1994).

Current Research on Bipolar Mood Disorder

A current biblio-metric study conducted by Clement, Singh and Burns (2003) has found that there is more research into schizophrenia and the effects of this disorder rather than bipolar mood disorder. They conducted this research by comparing computerised data-bases by searching for both disorders (schizophrenia and bipolar mood disorder) and comparing the quantities of research available. These researchers have postulated several factors to account for the paucity in research on this particular disorder of mood.

To begin with, the pharmacological drug that has proven to be most effective in the treatment of bipolar mood disorder is lithium. This is a natural substance that cannot be patented and as such holds very little interest on behalf of the pharmaceutical companies who often fund research projects (Clement et al., 2003). Schizophrenia, on the other hand, has a wide variety of treatments available in terms of drugs and there is always a need to improve treatment by continuously researching the disorder. Therefore, one of the factors contributing to the lesser research on bipolar mood disorder is because of **commercial interests and financial gain**. Schizophrenia research has been shown to continuously shape the treatment of the disorder and as such, offers scientific achievement for the researchers. Bipolar mood disorder, on the other hand does not allow for consistent outcome evidence-based studies (Clement et al., 2003; Perugi et al., 1999).

Another factor that has minimised the focus on bipolar mood disorder is the very **nature of the disorder** itself. When a person is in the depressed phase, minimal information can be gathered due to the low functioning of the person. And similarly, when the person enters the phase of mania he or she may not have the want, nor see the need, to participate in a research project. The recruitment difficulties are directly caused by the cyclicity of the disorder, and this effects the research design itself (Calabrese et al., 2001; Jamison, 1995; Miklowitz, 2002; NIMH, 2003; Simoneau et al., 1999). Schizophrenia presents itself in a more consistent, albeit psychotic manner. It is therefore more troublesome for researchers to ascertain when a participant should enter a research schedule and the uniformity of bipolar patients is inherently more difficult to attain. The type of research conducted is largely

quantitative and outcome based, making research designs an extremely important aspect so that replicability can be attained (Simoneau et al., 1999; Stoll et al., 1999).

On a societal level, little interest has been given to bipolar mood disorder especially in comparison to schizophrenia. Clement et al. (2003) suggest that this may be due to clinical neglect. Another factor may be attributed to the unfashionable nature of bipolar mood disorder, in other words, it simply is not the trend of the day. Bipolar mood disorder is a part of the larger group of mood disorders and unipolar depression seems to attract higher interest than the swinging behaviour patterns of depression and mania (Scott, 1996). Schizophrenia, on the other hand, is part of the psychotic disorders, and as such it stands alone and merits unique research appraisals. It has also been suggested by Clement et al. (2003) that mania and depression can be looked at as being extensions of normal every day living, whereas the psychotic nature of schizophrenia holds more of an academic and scientific challenge in understanding.

Lastly, the researchers claim that the development of neuroimaging as a research tool into mental disorders has yielded inconsistent results with regards to bipolarity while it is the opposite with schizophrenia. Therefore, neuroimaging research is used less frequently with bipolar mood disorder (Clement et al., 2003). Within the area of neuropsychiatric research, there is a definite tendency to focus on schizophrenia rather than bipolar mood disorder. This includes areas such as aetiology, genetics, diagnosis, metabolism, pathology and physiopathology, blood group, drug therapy, complications, rehabilitation, and psychology and psychotherapy (Clement et al., 2003). These findings are consistent over time. The disparity between research conducted on bipolar mood disorder and schizophrenia can also be understood by seeing the global context of mental illness. It is a societal generalised perception that schizophrenia causes more harm, economic damage and dysfunctional behaviour than the bipolar mood disorder (Clement et al., 2003).

Research on bipolar mood disorder is seriously lacking (Scott, 1996). This is even more evident when compared with the other major mental illnesses (Perugi et al., 1999). Further, qualitative research projects are even scarcer. There have been several narrated stories of the experience of having the diagnosis of bipolar mood disorder and these tales provide crucial literature when attempting to understand the nature of the bipolar mood disorder (Duke & Hochman, 1993; Jamison, 1995). Since modern research is aimed more

towards the financial gain and pharmaceutical marketing, bipolar mood disorder can best be understood and explained in terms of its' psychiatric development and history. The psychiatric aspects of bipolar mood disorder have remained relatively unchanged over the years. The developments have mostly been in the arena of psychotherapy, and even there, the theoreticians are beginning to repeat old theories made to look sellable in revamped language and words (Ford & Urban, 1998). This literature exposition will aim towards explicating the development of the disorder, the available treatments, and the future avenues for change and development.

According to the NIMH (2003), (the NIMH stands for the National Institute of Mental Health, which is part of the United States Department of Health and Human Services) the best way to understand bipolar mood disorder is through research. This organisation has dedicated time, money, and resources to researching bipolar mood disorder. Their research approach investigates areas such as neuroscientific studies, scientific approaches to the brain and behaviour, genetic speculations, epidemiological studies, and clinical research (NIMH, 2003). The clinical trials are directed at determining which treatments are effective, and which treatment combinations yield the best results. The NIMH is a scientific mental health biomedical research organisation that is directed towards scientific excellence. The underlying premise of this organisation is that the results of bipolar mood disorder **investigations can be effectively researched, quantified and generalised**. The personal narratives of the patient are not accounted for. Similarities and differences among large groups of people are noted and from this, causal explanations are deduced and disseminated to the treating professionals.

A Brief Historical Overview

The historical development of bipolar mood disorders dates back to the Greek physicians of the classical period. Hippocrates (460-337BC) is thought to be the first person to describe the states of melancholia and mania systematically. In the 1st century AD Aretaeus of Cappadocia initiated the idea of bipolar disorders by describing mania and melancholia as two different stages of the same illness. In 1899 Emil Kraepelin (a professor of psychiatry) termed a certain constellation of behaviours manic-depressive insanity (Marneros & Angst,

2000) and accordingly researched and documented prognosis and outcome. In 1966, the term bipolar disorder took shape and has since remained in use.

The categorisation and simplification of a very complex spectrum of behaviours has served to help medical professionals deal effectively with this type of illness. Rivas-Vazquez et al., (2002) state that despite the severity and chronicity of this disorder, it is still frequently undetected or misdiagnosed. Typically, after an individual has received a diagnosis of bipolar disorder, medication (depending on the mood phase, either a mood stabiliser or anti-depressant, or both) is prescribed and if necessary hospitalisation occurs (in the case of Bipolar I diagnosis). Current treatments may include the family in terms of psycho-education as bipolar patients are notorious for altering their medications on the basis of their perceived improvement, which often leads to relapses of either mania, depression, or both (Rivas-Vazquez et al., 2002).

Kraepelin's Distinction of Manic-Depressive Insanity

Emil Kraepelin (1856-1926), a psychiatrist from Edinburgh, best described the disease known today as bipolar mood disorder. He authentically termed the illness maniacal-depressive insanity. His methodology was phenomenological and he systematically recorded his own, and fellow clinicians observations of patient behaviour. From this point he attempted to confirm his findings through experimental psychophysiological research. With regards to bipolar mood disorder his two main assertions were that firstly the disorder was brought about by permanent internal structural changes, of which the causes were unknown; and secondly, that symptoms were caused by the external triggers of events, but can only manifest as symptoms if the person is able and ready to allow for the presence of these symptoms (Wolpert, 1977).

The Role of the Psychiatrist: Then

According to Kraepelin (1904), psychiatrists were compelled to focus on disturbances of comprehension, memory and judgement, illusions and hallucinations, depression, and any drastic changes in the activity of the will. Kraepelin's reference to mental illness was called insanity and included the above mentioned mental changes. Mood itself was of little importance to Kraepelin (Bourgeois & Marneros, 2000). The world of insanity challenged

Kraepelin because he could not find physiological explanations for the disruptions observed in behaviour easily. Therefore, he postulated that the treating physician be educated into his systematic observations and follow his guidelines for the assessment of a deranged person. His suggested treatment approach outlined the following:

- ✥ The physician should have knowledge to recognise the signs and symptoms of the illness early on.
- ✥ The physician should be able to prevent suicides and accidents through proactive measures and sound knowledge of the disease.
- ✥ The physician was required to educate those who have the disease about the course of the illness.
- ✥ The physician could help prevent the marriage of two mentally insane people.
- ✥ The physician should communicate with the family of the diagnosed patient. In the case of the patient's children, the physician should initiate effective career assessments accounting for the possibility of future limitations on the basis of the disease being hereditary (Kraepelin, in Wolpert, 1977).

In 1921 Kraepelin documented the complexity of manic-depressive insanity. In his write-ups, he carefully and studiously documented each and every observable psychic and physiological indicator of both manic and depressive episodes. His descriptions were complete, encompassing the whole existence of the individual, from physiological manifestations to emotional expressions. In addition, he used a very rich and varied vocabulary so that any reader could not mistake what his thoughts were. His thoroughness and commitment to understanding laid a wonderful foundation from which modern day researchers – from multiple disciplines – could continue. In essence, the current basic framework of causation of bipolar mood disorder has remained very similar to the initial speculations and observations made by Kraepelin (Kraepelin, in Wolpert, 1977).

The Role of the Psychiatrist: Now

There has been a vast development in the field of psychiatry in terms of describing the role of the psychiatrist. This is linked to the biological developments that have occurred and the focus on prophylactic treatment protocols (Scott, 1996). The American Psychiatric Association (1994b) has differentiated the tasks of the psychiatrist according to identifying

cross-sectional and longitudinal factors. The **cross-sectional factors** are those features that are currently or recently affecting the individual's behaviour. **Longitudinal factors** are those features that have occurred in the past and are consistently present throughout the course of the disorder. The first task of the psychiatrist is to determine if the individual meets the DSM-IV criteria for episodes of mania, depression, hypomania and/or a mixed state. The cross-sectional and longitudinal factors allow the psychiatrist to fully explore the nature of the mood disorder as it is presenting, and thereby make the correct psychiatric diagnosis, or an accurate differential diagnosis.

The assessment of **cross-sectional** factors includes,

assessment for the presence of psychotic features, cognitive impairment, risk of suicide, risk of violence to persons or property, risk-taking behavior (including financial extravagance), sexually inappropriate behavior, and substance abuse, as well as the DSM-IV specifiers for current or most recent episode. Assessment of the individual's ability to care for himself or herself, childbearing status or plans, and supports, including family and friends, housing, and financial resources, is important. The degree of distress and disability is also important. Careful attention to these factors will enable the psychiatrist to make a recommendation as to the site of treatment (e.g., inpatient, outpatient, partial hospitalisation) and to formulate well-reasoned and appropriate clinical approaches to the patient and family (American Psychiatric Association, 1994b, p. 2).

The assessment of **longitudinal factors** includes,

the number of prior episodes, the average length of episodes and average interepisode duration, the interval since the last episode of mania or depression, the level of psychosocial and symptomatic functioning between episodes of illness, and the response to prior treatment (American Psychiatric Association, 1994b, p. 2).

and further,

the psychiatrist needs to ask explicitly about such prior manic episodes because knowledge of their presence can influence treatment recommendations and decisions. The psychiatrist should also ask about a family history of mood disorders, including mania and hypomania. Consultation with family members and significant others may be extremely useful in establishing family history. DSM-IV specifiers describing the course of recurrent episodes include rapid cycling, seasonal patterns, and longitudinal course (with or without interepisode recovery). Some patients switch rapidly and frequently between manic and depressive symptoms without experiencing an intervening period of euthymia (American Psychiatric Association, 1994b, p. 2).

From a thorough assessment of both the cross-sectional and the longitudinal factors, the psychiatrist should have adequate information from which to determine an effective treatment plan. Once all information has been gathered, the psychiatrist initiates a treatment plan with clearly formulated goals. The **psychiatric management** of the disorder involves both general and specific goals as tabulated below (as adapted from the American Psychiatric Association, 1994b, p. 4).

Table 1: The psychiatric management of bipolar mood disorder

General management goals	Specific management goals
To assess and treat acute episodes.	Monitoring the patient's psychiatric status.
To prevent recurrent episodes.	Early identification of new episodes.
To improve inter-episode functioning.	Providing education about the disorder.
To provide education, support and assistance to both the patient and the family.	Promoting regular sleep/wakefulness patterns.
	Enhancing compliance.
	Providing an understanding of the psychosocial effects of the disorder.
	Establishing and maintaining a therapeutic relationship.
	Reducing the morbidity and mortality rate for bipolar mood disorder.

The role of the modern day specialist psychiatrist has differentiated towards implementing a treatment plan that accounts for bio-psychosocial factors. The psychiatrist gives a diagnosis, devises a treatment plan, and remains a part of the treatment phase ensuring patient compliance. Gabbard and Kay (2001) have called for the re-entrance of the bio-psychosocial psychiatrist who participates in both the medical management of the patient, and offering psychotherapy that is disease specific. They claim that "the one-person treatment model demands that the psychiatrist must think both in terms of a dysfunctional brain and a psychologically distressed human being" (Gabbard & Kay, 2001, p. 1959). In the case of bipolar mood disorder there are high levels of denial of the illness and hence patient non-compliance. Gabbard and Kay (2001) as well as Basco and Rush (1996) believe that non-compliance factors can be confronted and thwarted through a trusting relationship that is built between the psychiatrist and the patient. The psychiatrist is therefore expected to deal with cognitive, individual, familial, and interpersonal variables that may impede a good prognosis (Gabbard & Kay, 2001).

The DSM-IV Diagnosis of Bipolar Mood Disorder: Definitions, Signs and Symptoms

Bipolar mood disorder has been extensively researched and discussed from a traditional psychiatric perspective (Scott, 2001) which is congruent with an overarching medical model and the scientific paradigm of empiricism. Bipolar disorder I is traditionally understood to be the presence of at least one manic episode, and further, the patient would require hospitalisation for the episode to be brought under control. In addition, there may be the presence of hypomanic (Bipolar II) and/or mixed episodes, as well as the presence of mood lability occurring between episodes disallowing a complete stabilisation period (euthymia). According to the American Psychiatric Association, (1994b), the hallmark features of a bipolar mood disorder are the episodic, long-term nature of the disorder, having a variable and cyclic course. Psychiatrists are very concerned with identifying signs and symptoms of the disorder as well as being aware of the course and outcomes. These factors are considered to influence any treatment plan.

The medical model is helpful in understanding the bipolar mood disorder spectrum because of its neat structure. It has provided clear-cut definitions, signs and symptoms of the

disorder, and recommends thoroughly researched treatment strategies, such as the practice guidelines for psychiatric illnesses published by the American Psychiatric Association (1994b; 2000).

The psychological theories that fall under the umbrella of modernism are aligned with these practice guidelines and are known as manual based therapies for working with bipolar mood disorders (Miklowitz, 2002; Rivas-Vazquez et al., 2002). These theories, such as that of the cognitive behavioural therapies (Scott, 2001) and the psychodynamic approaches (Ginsberg, 1979), share assumptions with the framework of the DSM-IV (American Psychiatric Association, 1994a). For example, "the aims of therapy for bipolar disorder are to alleviate acute symptoms, restore psychosocial functioning, and prevent relapse and recurrence" (Scott, 2001, p. 164). This assumption of cause and effect ties in neatly with the aims of the DSM-IV. According to this nosology, psychiatric treatment would advocate pharmacotherapy with these above-mentioned therapies as an adjunct to medication (Fava, Bartolucci, Rafanelli & Mangelli, 2001).

In a psychiatric context, the Mental Status Exam (MSE) is utilised to help provide the treating physician with a guideline to gather descriptions of as many behavioural symptoms that manifest, as well as any collateral information confirming the severity of the observations. The MSE as outlined by Kaplan, Sadock & Grebb (1994) covers the following descriptors in an interview setting: general description of the patient; mood, affect, and feelings; speech; perceptual disturbances; thought patterns; cognitions; impulse control; judgement and insight; and reliability of the information as it is described by the patient (Kaplan et al., 1994). This interview schedule elicits information for both depressive and manic episodes. According to Kaplan et al. (1994, p. 535), "manic patients are notoriously unreliable in their information. Lying and deceit are common in mania, often causing inexperienced clinicians to treat manic patients with inappropriate disdain". Whereas, the authors comment that information gathered from depressed patients,

> overemphasizes the bad and minimizes the good. A common clinical mistake is to unquestioningly believe a depressed patient who states that a previous trial of anti-depressant medications did not work. …The psychiatrist should not view the patient's misinformation as an intentional fabrication, since the admission of any hopeful information may be

impossible for a person in a depressed state of mind (Kaplan et al., 1994. p. 535).

In both cases, it is interesting to note that the patient is considered to be unbelievable and dishonest in giving forth information. This idea is supported by the American Psychiatric Association (1994b) who claimed that patients who have had manic episodes in the past rarely report on it, as a manic episode is perceived to be a better position than that of being depressed. Therefore, it is stressed that the treating professional must gather collateral information from caregivers to verify or disqualify what the patient has said. This would hopefully give a more accurate account of the patient's condition.

The DSM-IV has specific lists of signs and symptoms of behaviour that allow the psychiatrist to categorise a person's behaviour into the form of a diagnosis. There are also course specifiers and other distinguishing features that must be accounted for or ruled out when making a diagnosis. The two main mood features looked for when diagnosing bipolar disorder, are signs of depression and that of mania. For a more in-depth and expansive description of the variants of mood disorders see the DSM-IV (American Psychiatric Association, 1994a).

Akiskal and Pinto (1999) have outlined the current bipolar disorder spectrum as follows:

Bipolar ½:	schizobipolar disorder
Bipolar I:	manic-depressive illness
Bipolar I½:	depression with protracted hypomania
Bipolar II:	depression with spontaneous discrete hypomanic episodes
Bipolar II½:	depression superimposed on cyclothymic temperament
Bipolar III:	depression plus hypomania occurring solely in association with anti-depressant or other somatic treatment
Bipolar III½:	marked mood swings in the context of substance and/or alcohol ab(use)
Bipolar IV:	depression superimposed on a hyperthymic temperament

One can see that most of the co-morbid disorders (**see pages 19-21**) that align themselves with bipolar mood disorder have been included in this neat description (excepting for the personality disorders).

<u>Symptoms of Mania</u>

> Comprehension occurs quickly, ideas spring up unhindered, though soon driven out by something new. The spirits are cheerful, actions run untrammelled and without obstacles, without even those which act as a restraint in normal life. The combination of symptoms of disease, which we frequently meet with the same form, we designate by the name of *Mania*, or, if the individual disturbances are only slightly developed, as in the present case, by that of *Hypomania* (Kraepelin, in Wolpert, 1977, p. 26).

There are a wide array of symptoms that define a mood episode as manic. The symptoms and signs are generally agreed upon from the time of Kraepelin up until modern day observations. The criteria for a manic episode as stipulated by the DSM-IV (American Psychiatric Association, 1994a) are based upon the observable signs and symptoms as they manifest during a manic episode. A manic episode may last for up to three months if it is not treated properly. This can have devastating effects on the social surrounds of the patient, hence the importance of an early diagnosis as a preventative measure (American Psychiatric Association, 2000). The following is a description of the various signs and symptoms, clustered together for the sake of convenience purposes for this literature review;

- ✥ **Mood**: During a manic phase, the mood is generally excessively good, euphoric, expansive, or irritable. The overwhelming happiness can quickly shift into anger. The mood is notably out of the person's normal range of happy behaviour and is normally inappropriate for the context (American Psychiatric Association, 2000).

- ✥ **Self-confidence**: During a manic phase, the feeling of self-worth increases dramatically, and invites unwarranted optimism and with this a lack of judgement. The person acts upon feelings of grandeur and does not recognise the consequences of the actions. The person normally feels invincible and has the perception that he or she can accomplish any task at hand, even the work of the president. This inflated concept

of self-worth may endanger the person to perform reckless activities, such as stepping off a building thinking that he or she will not fall, or dancing naked in a snowstorm believing that he or she will not get sick (American Psychiatric Association, 2000).

✤ **Excessive energy**: During a manic episode a person feels a dramatic increase in energy levels (noted by some to be similar to hyperactive behaviour). This bodily change allows the person to engage in many different plans and activities simultaneously, not necessarily finishing any project that is started. Again, the results or consequences of the behaviours are not recognised. The need of urgency to complete as many activities as possible interferes with the person's sleep-wake cycle, and the person has a decreased need for sleep based on the will to complete activities. The person may engage in unusual sexual activities, foolish business investments, and uncontrolled spending of money purchasing all sorts of items from clothes to a house. The excessive energy is markedly abnormal for that person (American Psychiatric Association, 2000).

✤ **Flight of ideas**: During a manic episode a person's thoughts race about in an uncontrolled manner. Typically, the person does not have a complete conversation, but switches quickly between ideas without completing anything. The speech of the person is rapid and oblivious to the feedback of other people indicating their interest or disinterest. The person is easily distracted and shows fluctuating attention and concentration. The thought processes of the person are thought to be disorganised and incoherent when having these racing thoughts (American Psychiatric Association, 2000; Kaplan et al., 1994).

✤ **Sleep patterns**: During a manic episode, the need for sleep seriously decreases. The person may go for days without any sleep. This is highly distressing for family members. The person does not acquire a feeling of tiredness during a manic phase (American Psychiatric Association, 2000; Jamison, 1995).

✤ **Rage**: During a manic episode, a person may shift into fits of rage and uncontrolled anger. This may occur, for example, when plans may be hampered or sexual advances made by the person are rejected. The person shows extreme mood lability (Stoudemire, 1994).

<u>Symptoms of Depression</u>

Depression has been used to denote a variety of conditions, including (i) a normal mood state – for example, grief; (ii) a symptom synonymous with a sadness that is seen in many psychiatric disorders; and (iii) a syndrome characterized by psychomotor retardation or agitation, dejection, hopelessness, self-derogation, suicidal preoccupations, insomnia, loss of appetite (anorexia), and loss of libido (Akiskal & McKiney, Jr, in Wolpert, 1977, p. 511).

Symptoms of depression may precede or follow a manic episode. In the case of mixed episodes, both manic and depressive symptoms are shown. Generally speaking, the symptoms of depression in bipolar mood disorder are similar to those of a unipolar episode or major depression (American Psychiatric Association, 2000). They are the following:

✤ **Feelings**: During a depressed episode, a person experiences feelings of worthlessness, total indifference, guilt, extreme and long-lasting sadness, unexplained crying spells, loss of interest in pleasurable activities, irritability, loss of interest in activities, such as work, sex or socialising with friends (American Psychiatric Association, 1994a; American Psychiatric Association, 2000).

✤ **Concentration**: During a depressed episode a person finds it difficult to concentrate and may experience problems with memory. There is difficulty in remembering details of events. This hinders the person's interactional contexts (Stoudemire, 1994).

✤ **Thoughts**: During a depressed episode, a person thinks very negatively and tends to see the negative aspects of life, frequently resulting in thoughts of death and committing suicide. Attempts to end one's life are often carried out due to the pessimistic thought pattern (Kaplan et al., 1994).

✤ **Decreased energy**: During a depressed episode, a person feels lower energy levels and is less productive in terms of output of activities. There is also a noticeable change in either an increase or decrease in appetite, persistent feelings of being

fatigued, and either insomnia (too little sleep) or hypersomnia (too much sleep) (American Psychiatric Association, 2000).

✧ **Bodily changes**: During a depressed episode, a person may experience physical pain in the form of aches and pains for which there is no physiological explanation present. There may also be a marked increase in weight gain or weight loss. The person may also show signs of psychomotor agitation or retardation (American Psychiatric Association, 2000).

A person that presents with the signs and symptoms described above, along with other course specifiers (such as the length of time of an episode, and the severity of the episode), would probably warrant a treatment protocol that included pharmacology. The medication is an integral part of the treatment process. The medications for psycho-pharmacotherapy include mood stabilisers, anti-depressants, anti-psychotics and anti-convulsants. Before medication is advocated, the psychiatrist needs to arrive at a clear diagnosis. The problems associated with diagnosing a mood disorder are largely due to the co-morbid presentation of behavioural dysfunctions mimicking other disorders.

Co-morbidity

Co-morbidity refers to the co-occurrence of two or more psychiatric disorders in the same person, within a given period of time. More often than not, the treating psychiatrist will give a differential diagnosis, because of the manifestation of multiple symptoms, and also because of not knowing which box to categorise a person into. This has implications for pharmacological treatment. If the multi-symptoms are effectively recognised, proper medication can be given to alleviate the dysfunctional behaviour. Common disorders that co-present with bipolar mood disorder are: anxiety based disorders; attention deficit disorder, or hyperactivity disorder; borderline personality disorder; anti-social behaviour; cyclothymic disorder; schizophrenia, or schizoaffective disorder (a combination of bipolar and schizophrenic symptoms); recurrent episodes of major depression; recklessness and impulse control problems; substance abuse; and substance induced mood disorder (American Psychiatric Association, 1994b; Miklowitz, 2002; Perugi et al., 1999).

Bipolar mood disorder sufferers have a 60% association with substance abuse disorders, such as alcohol and drug use (Miklowitz, 2002). This is believed to be common because of the cyclical nature of the disorder which involves the craving for drugs and/or alcohol and self-medication.

Bipolar mood disorder is also strongly linked to the anxiety disorders (such as panic-agoraphobia, social phobia, post traumatic stress disorder and obsessive compulsive disorder). Gordon and Rasmussen (1986) reported that patients diagnosed with obsessive compulsive disorder had shown manic or hypomanic behaviour when treated with SSRI's (selective serotonin reuptake inhibitors). The SSRI's are the most effective medication for the treatment of this anxiety disorder and as such it presents a problem for effective treatment (Gordon & Rasmussen, 1986; Van Scheyen & Van Kammen, 1979). Conversely, the treatment for reducing manic episodes, for example, classic neuroleptics, actually increases the level of anxiety, phobias, and symptoms of OCD. The mood stabilisers have not shown to have any effect on the reduction of anxiety associated with OCD and therefore a combination of various medications is prescribed to reduce the effects of cyclicity of the mood disorder (Van Putten & Marder, 1987). Further, the co-existence of a substance abuse and an anxiety and mood disorder has shown to increase the likelihood of suicide (American Psychiatric Association, 1994b).

Patients with bipolar mood disorder often present with high levels of anxiety and often use ineffective coping mechanisms to reduce the anxiety. Examples of poor coping skills are: alcohol and drug use and abuse; excessive self-monitoring to the point of becoming obsessional; and the implementation of extreme restrictions on their lifestyles, leading to phobic conditions and social avoidance (Scott, 1995).

Perugi et al. (1999) have cited the following reasons for the lack of research into co-morbid disorders: firstly they purport that bipolar II (hypomanic features) disorder is under diagnosed and miscalculated to be a personality disorder or symptomatic of unipolar depression; and secondly, there is a failure to utilise a structured interview in diagnosing hypomanic patients with underlying anxiety, and vice versa, patients with anxiety and hypomanic features. The under diagnosis of bipolar II disorder is of great concern to many researchers and clinicians alike. Again, the greatest outcome of incorrectly diagnosing a patient is in the misapplication of medication, whereby the anti-depressant/anti-anxiety

tablets may trigger further manic episodes, preventing a positive prognosis. Further, cognitive behavioural therapy (CBT) has shown to be ineffective in the treatment of this co-morbid presentation of both an anxiety and a bipolar mood disorder. CBT has traditionally been shown to be effective in the isolated treatment of OCD and unipolar depression, but not in a situation involving the co-morbidity of bipolarity and OCD. Those patients that are diagnosed with a personality disorder, such as borderline, narcissistic or histrionic, are believed to be robbed of effective pharmacological treatment (Perugi et al., 1999). More research is needed to establish further causal links.

Medication: Pharmacotherapy

Before psychiatrists came on the scene, the violent inmate of an insane asylum was confined in a padded cell or a straight jacket. If that did not prove beneficial, then he was likely to be beaten or immersed in cold water – what might now be considered 'aversive therapy' of an unacceptably brutal nature. Even after the specialty took form, until the 1930s psychiatrists could only do their best to prevent the patient from destroying himself, to isolate him, use warm baths or wet packs, or employ various chemical agents that were far from specific, and wait for spontaneous remissions (Shopsin et al., 1979, p. 177).

With regards to the treatment of bipolar mood disorder, pharmacotherapy has been the most widely advocated curative measure (Callahan & Bauer, 1999). This is consistent with research which has focused primarily on understanding the role of biological and genetic factors in inducing and maintaining bipolar mood disorder. The hypothesis of biological mood instability is best matched with pharmacotherapy treatment.

Bipolar mood disorder presents with difficulties to the treating psychiatrist. The depressive phase can be successfully medicated with anti-depressants. However, the anti-depressants are known to increase the risk of switching into a manic or hypomanic phase, or of developing rapid cycling (Kilzieh & Akiskal, 1999). Therefore, it is generally suggested that pharmacological interventions make use of both an anti-depressant and a mood stabiliser (American Psychiatric Association, 2000).

Current Pharmacological Therapies

Bipolar mood disorder has been successfully managed with the use of mood stabilisers, anti-psychotics, anti-convulsants, and anti-depressants. Depending on the person, these medication groups may be given alone, or in conjunction with one another. The treating professional, usually the psychiatrist, will monitor the progress and reaction of the patient and adjust the treatment regime when and if appropriate. As such, it is imperative that the patient has a good, trusting and respectful relationship with the psychiatrist.

Mood stabilisers have received the most attention in the research and treatment of bipolar mood disorder and will therefore be discussed in depth. The other pharmacotherapy agents will also be outlined and defined. One can see that medication should be an integral part of the treatment protocol of bipolar mood disorder once a diagnosis has been made.

Mood stabilisers

Mood stabilisers are prescribed in situations where the mood is fluctuating (between phases of depression and mania, or in the presence of a mixed episode). A mood stabiliser is considered to be effective when it **firstly** stabilises the mood fluctuations, and **secondly**, prevents the onset of new episodes of mood fluctuation in the long-term maintenance of the disorder. Further, the medication should not worsen the mood stability nor cause the onset of rapid cycling (Miklowitz, 2002). Anti-depressants, on the other hand, only manage the depressive symptoms but do not treat the manic outbursts, and in fact, the anti-depressant may trigger a manic episode (for example using fluoxetine alone).

Some of the greatest concerns with prophylactic (preventative) treatment include a lack of patient compliance, extreme side-effects from the tablets, forgetting to take the medication as prescribed, a denial of the diagnosis of bipolar mood disorder, a feeling of being controlled by the medication, and the social discourses surrounding the meaning of being dependant on mood stabilisers for effective functioning (Miklowitz, 2002). These factors greatly influence the medical treatment and management of the physiological effects of bipolar mood disorder. There are evidently complications associated with medicating a person who has been diagnosed with bipolar mood disorder. Once the psychiatrist has made the diagnosis, which can be considered a fairly straightforward activity, an attempt is made to

begin medical treatment. This often involves convincing the patient that she or he has a problem that can be rectified with the use of medication and psychotherapy as well as life-style changes. Since it is not a common occurrence that the patient self-refers for treatment, there is very little intrinsic desire to change. This is the disturbing contradiction that accompanies the mood disorder in that the very hand that helps (in this case, the medical fraternity) is also the one that can take away all that is perceived by the patient to be good and useful (Jamison, 1993). This causes great resistance in terms of patient treatment. Essentially a mood stabiliser can only be of benefit to the person if she or he has the desire or want to actively change the situation (Gabbard & Kay, 2001).

Bipolar mood disorder involves a long-term treatment approach and as such the effects of the medication are most beneficial when administered over a long period of time. Research has shown that people who take lithium consistently over time, have a decreased suicide rate (Jamison, 1995; Miklowitz, 2002). This is a very positive finding and it shows the benefit of using medication. It must be remembered that the ultimate aim of the mental health professions is to prolong life while simultaneously making life as emotionally satisfying and pain-free as possible.

Overall, a mood stabiliser (such as lithium) has three main practice-guidelines: **Firstly**, it should control the current episode and help bring the mood to a point of stability. **Secondly**, it should prevent the onset of future episodes and if episodes do occur again, then the medication should decrease the severity of that episode. **Lastly**, the symptoms experienced between episodes should also be lessened. If these three practice protocols are adhered to, then the person should (according to research) show improvement and lessen mood fluctuating disturbances (American Psychiatric Association, 2000; Miklowitz, 2002). Mood stabilisers are not addictive nor habit-forming. Many people remain uneducated about the effects of the medication that they are taking and fear an addiction and dependence on the drug. It has never been proven that mood stabilisers are habit-forming. The implication of this is that the person will not feel withdrawal symptoms when being weaned off the treatment regime. Much of the hesitance to initiate prophylactic treatment is due to misinformation and ignorance on both the psychiatrist's and patient's behalf (Clement et al., 2003; Scott, 1996).

Examples of mood stabilisers are lithium (a naturally occurring element), divalproex sodium, and carbamazepine.

Lithium

Lithium was initially discovered by a Swedish chemist named August Arfwedson in 1818. He gave this metallic substance the name lithium derived from the Greek word lithos, which means stone, as the mineral was found in the stone (Schou, 1983). The stabilising effects of lithium were first noted by John Cade (1949). Originally lithium was used for the treatment of gout in the form of lithia tablets (Cade, 1949). Cade initially tested the benefits of lithium on guinea pigs. The animals were injected intraperitoneally with large doses of lithium carbonate. The result was that after about two hours, the animals became extremely lethargic and unresponsive to stimuli for approximately another two hours. They remained fully conscious. Lithium was therefore applied to the treatment of mania and seizure disorders because of its noted sedative effect (Cade, 1949). Cade also observed that the visible over-dosage effects include abdominal pain, anorexia, nausea and vomiting, as well as twitching, slurring speech, dizziness, and depression (Cade, 1949).

Lithium is most effective in the treatment of manic episodes and helps to prevent the **relapse** of both manic and depressive episodes. Lithium cannot be used to prevent the *onset* of bipolar mood disorder. Lithium was initially introduced for the treatment of manic-depression in 1959 by Hartigan and Baastrup, an English and a Dutch psychiatrist respectively (Schou, 1983). Studies were then conducted in Denmark by Baastrup and Schou and they found that the administration of lithium prevented relapses and in some cases led to a complete disappearance of symptoms (Schou, 1983). Lithium has been in general use since the 1960's with positive effect. The dosage of lithium is dependant on a person's physiological make-up and the grounding rule is that it is effective when the person's blood level reaches therapeutic range (the blood level that stabilises a person's mood). Lithium's anti-manic effects may take up to two weeks to have a significant effect (Kaplan et al., 1994; Schou, 1983).

Lithium is noted to have disturbing side effects such as: thirst, water retention, fatigue, frequent urination, diarrhoea, a metallic taste in the mouth, problems with memory, shaking hands, gastrointestinal pain, weight gain, and an activation of pre-existing skin conditions (such as psoriasis or acne). Physiologically, it has been noted that lithium can have an effect on the thyroid whereby it does not produce enough hormones (in the case of

women), and it can also effect kidney functioning with long-term use (American Psychiatric Association, 1994b; Cade, 1949; Kaplan et al., 1994; Maj et al., 1998; Miklowitz, 2002; Schou, 1983).

Long-term use of lithium and the incorrect dosage could result in lithium toxicity. This means that the body accumulates lithium at very high levels. The signs of toxicity are commonly described as experiencing problems with balance and co-ordination of movement, severe diarrhoea, blurred vision, slurring of speech, extreme shaking of the hands, severe nausea and vomiting, and feeling disorientated and being mentally slowed down. These factors imply that lithium levels need to be acutely observed through the use of blood tests at regular intervals. Miklowitz (2002) has suggested that blood should be drawn every week for the first one to two months of treatment, followed by blood testing once a month for three to four months. This can pre-empt any unnecessary discomfort associated with lithium intake. Unfortunately not many treating professionals adhere to this medicating protocol. The responsibility is believed to lie in the hands of the patient who should be able to observe changes in physiological make-up and act on the discomfort. Again, a contradiction is that the person may not want to comply with the treatment approach and may be negative in attitude towards self-monitoring (Kaplan et al., 1994).

Divalproex Sodium

This mood stabiliser is also known as valproate or valproic acid. Divalproex is a fatty acid that is commonly found in animal fats and vegetable oils. This is traditionally an anticonvulsant medication which is used effectively in the treatment of epilepsy. Again, the reasons for why this drug works as a mood stabiliser is not entirely clear to scientists. Pharmacologists have suggested that it may work in one or many of the following ways: enhancing the action of the inhibitory neurotransmitter GABA, and reducing the activity of the protein kinase C pathway (Goldberg, 2000). The effectiveness of divalproex in preventing future episodes of manic outbursts are suggestive and speculative rather than proven by outcome research of a long-term nature. Many practioners have found the drug to be just as effective as lithium (Bowden et al., 1994).

There have been three noted reasons as to why a person would be given divalproex rather than lithium. First, research has shown that if a person has rapid cycling or mixed

episodes, the treatment effect may be better taking the anticonvulsant (Bowden et al., 1994). Secondly, the divalproex has a faster reaction time and can decrease the impact of a manic episode within three to five days following an episode. The dosage of the drug can also be increased without noticing an increase in side-effects as is common with lithium increase. Lastly, the side effects of divalproex are notably less severe than lithium. This is a very swaying point when considering to medicate a person as patient compliance is part and parcel of medication side-effects (Bowden, 1996).

Side-effects of this drug include effects on an increase in liver enzymes and a decrease in the production of blood platelets. For this reason, blood tests should be taken at regular intervals, as is suggested with lithium treatment (Miklowitz, 2002). Other noted side-effects include a rapid weight gain, hair loss or thinning, nausea and stomach pain (often treated with ant-acids), fatigue and sedation upon initial intake, headaches and dizziness and hand tremors (American Psychiatric Association, 2000).

Carbamazepine

This medication is more commonly known as tegretol and is also an anticonvulsant used to control seizure and mood disorders. This is the least popular of the three mood stabilisers because of the noted side-effects and difficulty in ascertaining the most beneficial therapeutic levels. This drug has been successfully applied to people with acute mania, rapid cycling, mixed episodes and psychotic manias (Post et al., 1986). It is assumed that carbamazepine affects the transmission of sodium and calcium ions across the membranes of the nerve cells. The messages transmitted across the nerve cells are therefore controlled by the drug. The drug acts by slowing down the rate at which the cells fire and therefore decreases the rate of the activity occurring in nerve pathways (Post et al., 1986).

There are no blood tests that can reveal the optimum dose required for mood stabilisation so this is mostly attained through the patient's subjective experience related to the treating physician. The treatment is usually monitored according to side-effects and not blood levels. Carbamazepine does have an effect on liver enzymes and blood platelets as described with divalproex. This can be monitored with blood level tests and should be as there is the risk of developing a disease known as agranulocytosis involving a dramatic drop

in white blood cells. This is a relatively rare disease and the onset should be prevented at all costs.

In terms of side-effects, there is a less noted weight gain with this medication hence people prefer taking it. Other effects include fatigue and sedation, mild memory problems, blurry vision, nausea and dizziness, constipation and loss of muscle coordination. The medication is usually started at a minimum dosage and increased gradually (Miklowitz, 2002).

More often than not, a mood stabiliser is used in conjunction with an anti-depressant. Lithium and valproate are the most commonly used mood stabilisers.

The Anti-depressants

Anti-depressant medication is given by the treating physician in order to alleviate the following symptoms: sadness, loss of interest, sleep disturbances (either too little or too much sleep), fatigue, loss or gain of appetite and suicidal ideation. This medication is targeted at lifting the mood, that is, the depressed pole of the bipolar mood disorder. So, where a mood stabiliser is used to control the over excess of thought and energy, the anti-depressant is indicated to increase the thought processing.

Traditionally there are three groups or classes of anti-depressants: the selective serotonin reuptake inhibitors (SSRI's), such as prozac (fluoxetine); the tricyclics, such as tofranil (imipramine); and the monamine oxidase inhibitors (MAOI's), for example nardil (phenelzine). There is also a newer class of drugs used to rid of the unpleasant mood affects of bipolar mood disorder such as Efexor (venlafaxine) and Remeron (mirtazapine). The SSRI's are a newer class of drugs and have noted lesser side-effects in comparison to the older tricyclics and MAOI's. Tricyclics are known to have the worst side-effects. All of these drugs help in alleviating signs and symptoms of depressive episodes (Kaplan et al., 1994; Stoudemire, 1994; Miklowitz, 2002).

Unfortunately, a great concern of using anti-depressant medication within the bipolar mood disorder treatment protocol is that they all have a major side-effect of bringing on a hypomanic, manic, or mixed affective state, and can bring about rapid cycling (Miklowitz,

2002; Perugi et al., 1999; Van Scheyen & Van Kammen, 1979). Due to this reason, a mood stabiliser is essential when giving an anti-depressant. If an anti-depressant is required, then both medications are normally given together. It logically follows that the anti-depressant will lift the mood, and with the added instability of bipolar mood disorder the chances of having a manic episode or increased mood cycling increase. Side-effects of anti-depressants include loss of sexual drive, fatigue, weight gain, insomnia, headaches and dry mouths. It is ironic how the side-effects of the treatment regime mimic the signs and symptoms of depression. A side-effect can most notably be identified by the change in behaviour experienced. This subjective experience of changes (physiologically and psychologically) should be reported to the treating professional.

The Anti-psychotics

An anti-psychotic is traditionally given to people who have severe delusions and hallucinations, as in the case of a psychotic episode. These medications can be helpful in the treatment of bipolar mood disorder when a person has severe disturbances in thought processing and perception. The newer range of anti-psychotics, known as the atypical anti-psychotics have specific anti-manic properties. Anti-psychotics can also be used to decrease anxiety and sleep problems, that is, they act with tranquillising effects. One can see that the applicability of anti-psychotics is broad including reducing manic episodes, and decreasing excessive anxiety, as well as enabling better thought and perceptual processing (American Psychiatric Association, 1994b; Miklowitz, 2002).

The side effects of the anti-psychotics are quite extensive and can have long-term effects such as tardive dyskinesia (a serious motor movement disorder). The other symptoms include the typically noted weight gain and a feeling of being sedated as well as over-sleeping.

A recent NIMH funded study investigated the use of an anti-psychotic (clozapine) for use in treatment-resistant bipolar mood disorder and found it to be effcetive. A treatment-resistant disorder is one for which the symptoms do not decrease regardless of the mode of treatment. Other anti-psychotics that have proved to be effective are olanzapine (for acute mania) and risperidone (NIMH, 2003; Suppes et al., 1999; Tohen et al., 1999)

Electro-convulsive Therapy (ECT)

ECT is known to be a very quick and effective method for treating depression, and has also shown to improve manic episodes (American Psychiatric Association, 2000; Miklowitz, 2002; Mukherjee et al., 1994). ECT is administered by the placement of electrodes on the skin allowing for certain parts of the brain to be stimulated. The person is normally under anaesthetic during this time, and the effects of the electric shocks are seen as twitching behaviours. Miklowitz (2002) suggested that a person should stop taking the prophylaxes and wait for these treatments to exit the body (this can take up to two weeks) before embarking on an ECT treatment protocol.

According to Schou (1983), ECT induces a mild seizure, but not a supposedly harmful one but rather one that stimulates brain functioning or production of neurotransmitters. ECT is considered to be an extremely safe treatment when administered with correct and current anaesthesia practice, altering the delivery of electrical stimuli, and with the use of advanced cardio-pulmonary monitoring. ECT can be administered on an outpatient or inpatient basis, depending on the severity of the symptoms experienced by the person. It is generally agreed that ECT is administered up to three times a week for a month, or between four and twelve treatments are given, person dependant. After the ECT treatments, the person is placed back on medication as ECT is an acute form of treatment and medication is considered to be a long-term stabilising and maintenance treatment (American Psychiatric Association, 2000; Kaplan et al., 1994; Schou, 1983).

ECT is considered to be a first line treatment over above prophylaxes if a person is pregnant, or has general medical conditions that do not allow for medications. ECT is also used as a primary intervention if the person's situation requires a rapid response, such as in the case of a person having extreme suicidal ideation (Miklowitz, 2002).

The biggest draw-back of having ECT is known to be the side-effect of memory loss. People have experienced memory loss for the duration of the treatment and often have difficulty recalling information from short-term storage. Patients are known to improve memory functioning as time passes following the batch of ECT treatments. Another complication of ECT treatment is that it may induce manic episodes as is reported in the case

of administering some of the anti-depressants. This is obviously not a desired outcome of treatment (Miklowitz, 2002; Schou, 1983).

A Nutritional Approach

This is a newer approach to medicating bipolar mood disorder on a long-term basis, in conjunction with traditional medications, such as lithium. Investigations by Stoll et al. (1999) have found that bipolar mood disorder maintenance treatment can benefit from the involvement of omega-3 fatty acids commonly found in fish oils. Research is suggesting that a combination of the two main omega-3 fatty acids may be effective in combination with conventional drug treatment. Together, the combination of drugs avoids an acute illness episode (a relapse) and improves a variety of symptoms. The goal of the study was to assess the underlying mood stabilising potential properties of omega-3 fatty acids. The assumption of the study was that "overactive cell-signaling pathways may be involved in the pathophysiological mechanisms underlying bipolar disorder" (Stoll et al., 1999, p. 407). The ingestion of large amounts of omega-3 fatty acids, found in plant and marine sources, are believed to dampen signal transduction pathways. Obviously, more research is needed in ascertaining the safety of this drug combination when treating bipolar mood disorder (Stoll et al., 1999).

The results of the pilot study indicated that patients who received large doses of omega-3 fatty acids showed significant symptom reduction and fewer episodic relapses when compared to the patient group who received a placebo (olive oil). The research showed that the "mechanism of action of mood stabilizers in bipolar disorder is the suppression of aberrant signal transduction pathways" (Stoll et al., 1999, p. 411). This pilot study offers hope into understanding the mechanisms of pathway transmissions in bipolar mood disorder. It should be noted that the main side-effects noted were a fishy taste in the mouths of the patients taking the omega-3 capsules, and gastro-intestinal upsets. This study remains promising for further development because a naturally occurring dietary component was evaluated and shown to have positive effects on the mood stabilisation of patients with bipolar mood disorder (Stoll et al., 1999).

Brain Imaging

Scientists are making use of brain imaging technology to understand how the brain produces a neuropsychiatric illness. Imaging research focuses on the identification and categorising of neural circuits. These neural circuits are thought to be the networks of interconnected nerve cells in the brain. The interactions among these circuits are thought to be responsible for the production of normal and abnormal behaviours. It has been hypothesised that bipolar mood disorder can be accounted for by understanding the abnormalities in the *structure* and *function* of these brain circuits. It is the belief of scientific researchers that a thorough understanding of the neural circuits involved with regulating mood states will have a direct influence on improving current treatments, assessment and diagnosis of unstable mood states (Miklowitz, 2002).

Structural imaging through the use of magnetic resonance imaging (MRI) has been used to examine the brain tissue in people with bipolar mood disorder, amongst other mental disorders. An MRI scan is a technique used for imaging anatomical structures employing the use of a strong magnetic field to produce an image of internal body parts. This type of research is aimed at identifying what specific areas of the brain are responsible for separating a person with bipolar mood disorder from a healthy functioning individual. Findings as reported by Soares and Mann (1997a), have consistently indicated that there are lesions (specific abnormalities) found in the white matter of the brain with people diagnosed with bipolar mood disorder. It has been asserted that this particular area of the brain is responsible for emotional processing. The researchers Soares and Mann (1997a) have speculated a causal link between the white matter abnormalities in the brain and the presence of the disorder of bipolarity. This proposed causal link has been discredited on two accounts. Firstly, some of the people with bipolar mood disorder do not have the lesions, and secondly, many healthy individuals, free of mental illness, also have the lesions. This research is still in its infancy and more research is required to understand the significance of the brain lesions and how this information can be useful for diagnosis, assessment and treatment (Soares & Mann, 1997a).

Functional imaging involves the use of the technique known as positron emission tomography (PET). This technique measures brain functioning in terms of blood flow or glucose metabolism. The researchers investigated brain functioning during both manic and

depressive episodes and found the following: abnormal activity in specific brain areas including the prefrontal cortex, basal ganglia, and the temporal lobes. The researchers have not yet determined if these functional changes are caused by the presence of bipolar mood disorder, or if they cause bipolar mood disorder (Soares & Mann, 1997b). Further, the PET scan allows researchers and scientists to study changes in brain chemistry directly and activity of neurotransmitters in people with bipolar mood disorder and those who are considered to be healthy.

Psychology within the Field of Psychiatric Knowledge

Obviously, this research endeavour is aimed at increasing valuable knowledge in the treatment and understanding of bipolar mood disorder, from a psychotherapy point of view. Manic-depression was traditionally discussed in terms of its initial psychiatric formulation. Since then, a multiplicity of treatment approaches has been developed, many still undergoing research to determine effectiveness and efficacy (studies conducted under controlled circumstances, with limited criteria for participant selection). The earlier assertions made by Kraeplin and Freud did not have to endure such research measures. Their works were more directed at understanding mood disorders. Modern day research is more tilted towards identifying what works to alleviate mental illness rather than focusing on establishing an understanding of the complexity of the disorder. This could be accounted for by the increased economic burden and financial costs of bipolar mood disorder (Scott, 1996).

The repetitive and relapsing nature of the bipolar cycle can be reduced effectively and can simultaneously maintain stability through an application of a psychosocial understanding. Whereas the DSM-IV and other psychiatric measures are most useful in identifying behaviour patterns, and initiating treatment, they do not solely prevent a **relapse** from occurring and re-occurring. The disorder would require treatment approaches that track the nature of the disorder as it presents itself (American Psychiatric Association, 1994b).

This research review will outline the documented and suggested psychotherapeutic treatment strategies when dealing with bipolar mood disorder. Even though the majority of research in this field has been on biological and genetic causative factors (Scott, 1996), there is evidence that indicates that psychosocial factors have great, if not equal, influence on the

maintenance of the mood variance experienced by the individual (Callahan & Bauer, 1999; Miklowitz et al., 1988; Scott, 1996). In addition to this point, the nature of the disorder has a severe impact on a person's social, work and family life. It is within these contexts that the diagnosed person functions and in many cases, the contexts need to change to accommodate the individual (Miklowitz, 2002). The recognition of this viewpoint has promulgated the development of psychosocial interventions in the treatment of bipolar mood disorder. The clinical psychologist should be aware of all the contributing factors that maintain a person's well being and mental health. The bio-psychosocial approaches should be seen as complementary to each other and should encourage the treating professional to utilise a wide scope of practice (American Psychiatric Association, 1994b).

The American Psychiatric Association (1994b, p. 15) has outlined the suggested benefits of psychotherapeutic treatments when applied to the following areas. This includes the psychiatric management of the disorder as described on **page 26**. In brief the issues to be confronted in a therapeutic environment are:

- The emotional consequences of having periods of a major mood disorder, and accepting the implications of being diagnosed with a chronic mental illness.
- The effects of developmental deviations and delays caused by past episodes.
- Problems arising from stigmatisation of having a mental illness.
- Problems with maintaining a consistent belief in oneself and self-esteem.
- Fears of recurrent episodes and the implications thereof on psychosocial functioning.
- Interpersonal difficulties and conflict management.
- Issues pertaining to family, marriage, child-bearing, and parental matters.
- Academic and occupational problems.
- Any other social, legal, economic, and emotional problems that may arise due to the reckless, violent, or peculiar behaviour that may occur during manic and depressive episodes.

This section will firstly be a general discussion of psychosocial intervention research, including discussions of psychosocial stressors, chrono-biological effects, and compliance with pharmacotherapy. This will be followed by the four specific manual-based psychotherapy approaches that are known to be effective with bipolar mood disorder treatment. These psychotherapies can be seen as the application of the theory of psychosocial

interventions into practice. The therapeutic approaches are: the psycho-education programme, family focused therapy, interpersonal and social rhythm therapy, and the life goals programme.

Psychosocial Intervention Research

Research conducted by Coryell et al. (1993) showed that 50% of patient's in their particular study continued to manifest significant functional deficits after a five year recovery period in which there was an absence of mood symptoms. This study was pivotal in asserting that social, occupational, and familial settings need to be included as part of the treatment protocol of bipolar mood disorder. Scott (1995) raised the concern that due to limited research in this area there was an inadequate catalogue of psychosocial factors that do indeed contribute to the course maintenance of the disorder. For example, four of the greatest hindrances on the positive outcome of treatment have been noted to be, non-compliance; inadequate doses of medication resulting in mood fluctuations; psychosocial stressors; and patho-physiologic progression of the illness (Scott, 1995). These factors contribute to the relapse of manic and depressive episodes. Therefore, it is suggested by these researchers that psychosocial factors be accounted for and addressed if a symptom-free condition is sought after.

Callahan and Bauer (1999), suggested that a number of psychosocial factors have a direct influence on the prognosis of the course of the bipolar mood disorder. These are: psychosocial stressors; chrono-biological factors; and medication compliance (or rather, lack thereof). According to these authors, the combination of these factors may render a person vulnerable to having an effective relapse. They therefore explicated these three factors in some detail, so that heed could be taken when attempting to apply a uniquely medical approach.

Psychosocial Stressors

Psychosocial stressors are described as being the events that trigger a negative response in an individual, for example, experiencing a loss of income. Research conducted by Ellicott et al. (1990) showed that people who are exposed to negative life events were four times more likely to relapse than those not exposed (Ellicott et al., 1990).

There are *individual* factors that may contribute to bipolar mood disorder related problems which may be treated effectively with a psychosocial therapy (Scott, 1995). Some of the issues that may be addressed on an individual level (which have an impact on overall psychosocial functioning) are: the reaction to the initial diagnosis as determined by pre-morbid personality characteristics; the availability of effective coping skills; the differences between actual and anticipated losses; and the nature and severity of the illness itself and the implications of this on relationships (Scott, 1995). According to Goodwin and Jamison (1990) typical reactions to a diagnosis include denial, anger, anxiety and ambivalence. These feelings and thoughts should be addressed. Further, resentment and frustration may have a negative impact on family relationships, social networks and the therapeutic relationship (Goodwin & Jamison, 1990; Scott, 1995)

Difficult and confrontational *familial interactions* have also shown to be a good predictor of the bipolar mood disorder course. Miklowitz et al. (1988) researched the effects of family dysfunction on the rates of relapsing episodes. Their findings indicate that a family interactional style that comprised of open hostility, and/or over involvement in the patient's life, contributed to the recurrence of episodic mood swings. In particular, they found that after experiencing a manic attack, patients who returned into families with these above-mentioned characteristics, were five times more likely to relapse over a time period of nine to twelve months compared to patients who returned to relatively stable family settings (little hostility, and boundary differentiation) (Miklowitz et al., 1988).

The presence of *social supports* has also been shown to have a positive effect on the decreasing of affective symptoms. An hypothesis for this outcome is that social supports buffer the effects of negative stress responses, such as adverse effects to physiological responses (McPherson, Herbison & Romans, 1993).

It has also been shown that *during* an affective episode, the experience of negativity strongly affected the long-term prognosis of recovery in that it took patients up to three years longer to go into a remission than those with no exposure to negative life events (Callahan & Bauer, 1999).

Chrono-biologic Factors

Chronicity is noted to be very important in an understanding of the cycling nature of bipolar mood disorder. Time factors have an influence on many aspects of this disorder, namely, from categorising diagnoses according to durations of episodes, to a lack of sleep, and the effects of insomnia on the development of a manic episode.

The literature on the implications of time factors on mood swings is long-standing and is a diagnostic criteria that should be met when making a diagnosis of this nature. Specifically, the effects of time frames on biological fluctuations (chrono-biology) have been intensely researched, primarily in the domain of depression. Research has been done on circannual rhythms (seasonal affective disorder being a sub category/diagnosis of depression), and circadian rhythms. Circannual rhythms affected by seasonal variations are thought to precipitate affective episodes (Callahan & Bauer, 1999). Goodwin and Jamison (1990) documented the correlation between episodic onsets of mood swings and the spring and autumn months of the year. People diagnosed with bipolar II disorder (hypomania with depressive episodes) commonly suffer from depression during the colder months of the year (Goodwin & Jamison, 1990). The importance of recognising the circannual effects on bipolar mood disorder comes into play when attempting to develop a psychosocial intervention. If one does not consider the seasonal effects on mood and behaviour, an intervention may become null and void. It is more a preventative measure to be aware of the possible seasonal effects, than to ignore them and take chances on the possibility of there being a null effect.

Circadian effects are most noted during the manic episodes. Disruptions in circadian rhythms may precipitate an affective relapse due to sleep deprivation. Circadian rhythms are understood to be the psychological and biochemical variations over a 24-hour period. Ehlers et al. (1988) hypothesised that disturbances in social routine rhythms, such as sleeping, eating, exercise and working, can cause a disruption of circadian rhythms and from that precipitate an affective episode (Ehlers et al., 1988). This study was further supported by research conducted by Malkoff-Schwartz et al. (1998) who found that stressful live events had a direct and negative effect on the onset of manic episodes. These stressful live events were particularly comprised of disruptions in social rhythms and disturbances in the sleep/wake cycle.

Compliance with Pharmacotherapy

As discussed under the pharmacotherapy section (**page 35**), patient compliance is one of the greatest hindrances to the effective biological treatment of bipolar mood disorder. This factor often results in poor outcome and affective relapses (Goodwin & Jamison, 1990; Maj et al., 1998). The non-compliant attitude increases the frequency with which patients stop taking their medication and often leads to further psychosocial complications. The mood fluctuations re-occur (a relapse) and place strain on the significant others and caregivers. According to Goodwin and Jamison (1990) compliance with prophylactic treatment is increased when a patient has a stable social network, and when the patient perceives the disorder to be severe and treatment to be beneficial for symptom reduction. Lastly, patients showing obsessional personality traits are normally more compliant than those without these personality traits (Goodwin & Jamison, 1990).

Scott (1995) asserted that patients are compliant to reduce the effects of depression rather than the symptoms of manic episodes. Jamison and Akiskal (1983) noted that there is a discrepancy between the clinician's and the patient's experiences of non-compliance with regards to side-effects. They found that clinicians attributed non-compliance to the somatic presentation of side-effects (such as psychomotor agitation and excessive thirst), whereas patients experienced the changes in thought processes (for example, memory problems and confusion) to be the most limiting (Jamison & Akiskal, 1983). According to Scott (1995) this difference in opinion comments on the relationship between the clinician and the patient and raises great concerns in terms of compliance, treatment commitment, and the patient-psychiatrist relationship. The American Association's practice guidelines for the treatment of psychiatric disorders emphasise the importance of the therapeutic relationship as the grounding framework from which to build a trusting treatment relationship. If this is not a solid relationship, it is suspected that non-compliance rates will be higher (American Psychiatric Association, 2000).

Callahan and Bauer (1999) have identified and distinguished three aspects that complicate the issue of compliance. They are, disease aspects; patient related aspects; and treatment related aspects (Callahan & Bauer, 1999).

The *disease aspects* include the chronicity of bipolar mood disorder, that is, the length of time in which the patient is observed to be a-symptomatic, and the extent of the disability accrued by the patient. These factors affect compliance in that the patient may become frustrated with the lengthy treatment and simply give up any hope of change. The patient would have to continue with medication up until he or she is a-symptomatic (euthymic), or remain on medication as a life-long intervention. A patient may have incurred irreparable damage to him or herself and require a long-term intervention. This factor promotes non-compliance as a patient may not want to continue consulting the treating professional on a long term basis (Callahan & Bauer, 1999; Goodwin & Jamison, 1990; Miklowitz, 2002; Scott, 1995).

The *patient related aspects* include the patient's perception and understanding of the treatment, and the nature of the illness itself in terms of mood cycling. The patient's views on the efficacy of treatment also affects compliance in that the patient should believe in the treatment that he or she is receiving. Further, social supports, or lack thereof, can complicate compliance. The family or significant others are not always enthusiastic about supporting the patient with constant pharmacotherapy. Further, patients are often thought to be in denial about the diagnosis and underscore the presence of a previous episode, the nature of their behaviour, and the consequences of their behaviour (American Psychiatric Association, 2002; Callahan & Bauer, 1999; Miklowitz & Goldstein, 1990; Scott, 1995).

Jamison (1995) and Jamison and Akiskal (1983) found that the fundamental explanations for non-compliance were that people with bipolar mood disorder did not like being controlled by medication (this implies a perception of being controlled); missed their highs, increased self-esteem, and increased energy experienced during manic phases; missed the creativity associated with manic highs; did not appreciate the seriousness of the illness; did not accept the longevity of bipolar mood disorder; and lastly, patients experienced the additive feeling of being depressed if the manic episodes are managed appropriately. These factors can be seen to fall under patient aspects as the compliance dynamic is effected by the perceptions of both the illness and the self, by the person. If a person believes that treatment will be helpful, in both the short and long term time frames, then he or she will be more accepting and adaptable to the course of treatment. Unfortunately, there is no known cure or set time frame within which treatment can occur, and this problem breeds uncertainty with

regards to the outcome and the prognosis of bipolar mood disorder (American Psychiatric Association, 2000; Jamison, 1995).

Treatment related aspects involve the cost of the actual treatment, the ease with which the treatment is given, for example, the distance the patient has to travel to consult with the doctor, and lastly, the attitude of the physician (Manning et al., 1999). It is essential that the patient has a good working relationship with the treating professional. A trusting relationship is thought to inspire confidence in the process of treatment, thereby enhancing compliance (Miklowitz, 2002; Scott, 1995). Jamison (1993) has indicated that in her medical practice, she modifies her treatment approach with each individual, for example, acknowledging the needs of those who are affected by circannual rhythms and symptoms, and adjusting the medication accordingly (Jamison, 1993).

The concerns of patient compliance with pharmacotherapy treatment, chrono-biological affects, and psychosocial stressors, are integrative and separated for the purposes of this discussion. The treating professional would need to take heed of all of the above-mentioned factors in the planning of therapeutic interventions (American Psychiatric Association, 2000). The spin-off psychotherapies that have been developed can be aligned with these three psychosocial factors. Psycho-education has been developed to primarily assist in the aspects of personal deterrents of treatment. The interpersonal and social rhythm therapy helps in alleviating the impact of chrono-biological factors, and lastly, family-focused therapy and cognitive behaviour therapies address the integration of all the above mentioned concerns. These therapeutic interventions focusing on psychosocial aspects will now be discussed further. All the psychotherapy treatment approaches for bipolar mood disorder have in common that they primarily advocate a biological approach (medication), followed by the belief that the environment plays a role in the maintaining of the course of bipolar mood disorder (Scott, 1995). Hence the therapies are largely focused on causative factors in the environment of the patient.

The Psychotherapeutic Manual-Based Approaches

According to the American Psychiatric Association (1994b), psychotherapy is an important additive to the psychiatric and pharmacological therapies. Psychotherapy is advocated for the treatment of various psychosocial factors, addressing the concerns (patient and treating professionals) for future episodes, and confronting the implications of having a long-term illness and the effects thereof on all spheres of living. The psychotherapies that have been developed for use in bipolar mood disorder are **goal-oriented**, **structured**, and focused on **symptom reduction** and eventual eradication. The approaches to be discussed in this section support the biological hypothesis and are tailored accordingly. They are, an underlying psycho-educational approach (this approach can be used as part of the many other therapies, or as an approach on its own); family-focused therapy; cognitive therapy; interpersonal and social rhythm therapy; and the life goals programme. It appears in the literature that the cognitive behavioural therapies and the family focused approaches have embarked on the most outcome studies, and the other therapies, such as the life goals programme adhere to the common grounding assumptions of cognitive behavioural therapy, albeit with their own point of focus.

Psycho-education

This is an all encompassing approach that is included in many of the more specific manual-based psychotherapy treatments. Examples of psycho-education include: knowing the signs and symptoms of the disorder; early warning signs that are individual-specific; learning about stress triggers; self-management tools; illness management tools; sleep-wake cycles; the affects of depression and loss; family and interpersonal conflict; accepting the illness; the recurring nature of the illness; behavioural and physiological management; and medication compliance (Miklowitz, 2002). The emphasis is on recognising early warning signs of a relapse so that the person can seek appropriate medical and psychological care before the recurrence of a full-blown episode (either manic, depressive, or both).

Psycho-education is reliant on the full participation of the patient as well as from the caregivers and the support giving structures. To activate personal responsibility, the construct of *illness management skills* is used (Bauer & McBride, 1996; Callahan & Bauer, 1999).

Illness management skills are defined as the abilities of the patient to cope with the effects of the illness and to participate fully in the advocated treatment modalities (Bauer & McBride, 1996). The illness management skills are believed to be of great importance for determining the way that the patient presents him or herself for treatment, and also in terms of how the clinician will approach the treatment process based on the patient's commitment and need for change. Illness management skills are determined by: individual functional capabilities, such as cognitive style and locus of control; individual attitudes and preferences; cultural factors, for example, religious and ethnic backgrounds; and socio-economic factors (Bauer & McBride, 1996).

Psycho-education utilises the basics of a patient's illness management skills and works towards improving them through the mutual sharing of information between the patient and the clinician. Therefore, the patient is taught about the illness, and a professional relationship is built with the patient to ascertain where development needs to occur. Jamison's (1993) approach to treatment may be considered to be psycho-educational within a wider biological framework. Patty Duke commended the style of her psychiatrist in helping her to understand her illness and in also being encouraged to be an active participant in the treatment phases of her recovery process (Duke & Hochman, 1992). According to Bauer and McBride (1996) psycho-educational interventions primarily address the following goals:

- To reduce an affective relapse.
- To decrease inter-episode symptoms.
- To increase functional outcome.

Psycho-education is used for all people, regardless of individual characteristics. The approach includes family members and other primary caregivers or significant others. It is applied at all stages of the illness and is not specific to either a manic or a depressive episode. However, the way the programme is applied takes the individual into account. In summary, the programme first assesses the factors that can impact on the patient's illness (such as, past and present experiences of the patient); once a thorough assessment has been conducted, the implementation phase begins which consists of three dimensions. These are: setting the stage (providing a description of the ground rules of the programme); analysing personal cost-benefits with regards to treatment options (deconstructing the pros and cons of various treatment modalities); and lastly follow-up which involves an assessment of the overall

programme once constructed and also allows for the patient, and the family, to contract in to the process and in that way, commit to a decided upon treatment. In this follow-up phase any changes or adjustments that need to be made can be agreed on (Bauer & McBride, 1996). Studies done by Peet and Harvey (1991) and Harvey and Peet (1991) showed that patients who received an educational approach to lithium management as a part of their illness had greater therapeutic success than those who did not participate in the programme. These studies show the benefits of utilising education in conjunction with a more medical treatment approach.

Family Focused Therapy (FFT)

FFT is a manual-based therapy implying that the therapist is required to be structured and to adhere strictly to the instructions given. FFT is normally administered under supervision ensuring that the approach is disseminated in a structured manner (Simoneau et al., 1999). The underlying premise of FFT is to confront and reduce the stress experienced within the family that may be adversely affecting the course of the bipolar mood disorder. There is an assumption that there are family factors that influence the outcome of mood disorders. The disturbances in the family are believed to be reflected in the emotional and communication styles of the key family members (Callahan & Bauer, 1999; Simoneau et al., 1999). This approach is aimed at rectifying the factors that contribute to, or result from, the diagnosed person's array of symptoms (Miklowitz, 2002; Miklowitz & Goldstein, 1990).

FFT is primarily a psycho-educational tool aimed towards communication enhancement and problem-skills training. This is implemented in conjunction with a pharmacological approach. The combination of the two fields (biological and psychotherapy) has yielded consistent results with regards to prevention of relapsing mood episodes (Miklowitz et al., 1988).

FFT Structure and Implementation

FFT occurs over twenty-one outpatient sessions. The sessions begin when the person is experiencing an acute manic, depressed, or mixed state. The sessions are constructed as follows:

- ✍ 12 sessions weekly

- ✥ 6 sessions bi-weekly
- ✥ 3 sessions monthly.

FFT (Callahan & Bauer, 1999; Simoneau et al., 1999) consists of the following four treatment topics that are covered during this time frame. They are:

- ✥ **Assessment** of the family and marital setting, including an evaluation of the problem-solving style of the family.
- ✥ **Psycho-education** for the family and the patient about the nature and course of bipolar mood disorder, symptoms of relapse, prognosis, aetiology and current treatments. This phase begins after the patient has been stabilised on medication.
- ✥ **Communication enhancement** training includes training in active listening; being observant of non-verbal communication such as eye contact and communicating with facial gestures; teaching of both positive and negative verbal feedback indicators; and increasing observational skills in noticing changes occurring in the behaviour of family members.
- ✥ Training in **problem-solving skills** addresses the identification and defining of problematic behaviour within the family, creating solutions for these problems, developing problem-evaluation skills, and the implementation of solutions.

This style of therapy involves both the patient and the family, or significant others. In order to anchor the behavioural changes due to the educational process, role-plays and homework tasks are utilised. These behavioural techniques also ensure that behavioural changes are transposed to the home setting as well. The approach aims to educate the family system about the nature of the disorder and helps aid in communication (verbal and non-verbal) and problem-solving skills. Simoneau et al. (1999) found that there was a direct relationship between a reduction in patient symptomatology and an increase in the patient's non-verbal ability to give and receive expression. This result supports the premise of FFT that the behavioural manifestations of bipolar mood disorder are dependent on family interactions, and vice versa (Callahan & Bauer, 1999; Miklowitz, 2002; NIMH, 2003; Simoneau et al., 1999).

FFT is researched on an ongoing basis, and to date, it has proven to be effective in reducing the number of bipolar relapses following discharge from a hospital setting

(Miklowitz et al., 1988; Miklowitz et al., 1995). The study conducted by Simoneau et al. (1999) compared FFT with a crisis management approach (supportive problem solving). They consistently found that FFT significantly improved the non-verbal behaviours of the family with a bipolar member. However, many of the bipolar mood disorder patients were estranged from their families and they found a need for the development of an individual focused treatment addressing similar issues. It was the researchers' contention that individual psycho-education would be just as effectual, and obviously suggested further research to legitimise this assertion (Simoneau et al., 1999).

A Cognitive Behavioural Therapy (CBT) Approach to Rectifying Abnormal Behaviour

Beck et al., (1979), developed the use of CBT in the treatment of unipolar depression. It has been empirically researched over the years and has shown to be consistently effective in reducing the symptomatic pattern of behaviours associated with clinical depression (Scott, 1995). According to Scott (1996), Beck et al.'s (1979) model of CBT can be easily applied to bipolar mood disorder, personality disorders, and anxiety disorders. The importance of this overlap is that bipolar mood disorder usually presents itself in a co-morbid fashion. Further, Scott (1996) has used the CBT approach in multiple settings (individual, family, in- and out-patient facilities) with positive outcomes. Patients receiving lithium treatment and CBT have had lower relapse rates than those solely receiving lithium (Simoneau et al., 1999).

The core functions of CBT are to help the patient modify inappropriate and destructive thought patterns, and behavioural patterns that are commonly associated with this disorder (Scott, 1996). Briefly stated, the thinking patterns that are targeted for restructuring are negative cognitions associated with depression and the optimistic, often unrealistic, cognitions associated with mania. Often, the manic patient overestimates the benefits of impulsive action and underestimates the risks of carrying out the impulse (American Psychiatric Association, 1994b). For example, going on a spending spree. This may be done to bring about good luck with the added belief that bad luck will continue if it is not done immediately.

Scott (1996) asserted that the main aims of a CBT treatment of bipolar mood disorder would have the following goals in mind:

- To alleviate acute symptoms of mania and depression.
- To restore psychosocial functioning.
- To prevent future episodes from occurring through schema changes.
- To improve individual compensatory skills for promoting behaviour changes.
- To increase individual understanding of locus of control and assuming of personal responsibility.

A CBT therapist is generally focused on attaining the following with reference to bipolar mood disorder:

> To increase or enhance non-pharmacological coping skills, to enhance adherence to treatment, to help the individual recognize and manage psychosocial stressors, and to teach CBT strategies to deal with cognitive and behavioural problems (Scott, 1996, p. 199).

Scott (1996) asserts that on a more specific level, the bipolar mood disorder needs to be understood in terms of its impact on the patient, including a description of all areas of the person's functioning. This would cover cognitions, including thoughts, images and beliefs (Rachman, 2003), problematic and effective behaviours, emotional responses, biological explanations, and complicating environmental factors. CBT is implemented in a very structured, collaborative and educational way. The structured nature of the approach is thought to help provide boundaries to the effects of fluctuating moods. Miklowitz et al. (1988) found that novice therapists were caught up in the mood changes and believed that great improvement was occurring, when in fact, a patient was cycling towards a manic episode. The firmly guided approach is therefore believed to be helpful to both the therapist and the patient. Further, the guided nature of the approach has shown to give the patient a feeling of having a sense of control over the treatment protocol (Callahan & Bauer, 1999).

Medication does yield a stabilising effect on a fluctuating spectrum of behaviours (American Psychiatric Association, 1994b), but because of the non-compliance concerns and mortality rates associated with bipolar mood disorder, effective psychotherapy interventions aimed towards assisting in the prevention of relapses are warranted (Chor et al., 1988; Scott, 1996). According to Scott (1996), the main area of treatment from a psychological perspective is in the domain of interpersonal relationships. All the treatment manuals that are

considered to be useful in effective treatment and management of bipolar mood disorder have a focus on an interpersonal understanding and restructuring of relationships. Whether the belief is that bipolar mood disorder patients are over- or under-demanding of relationships, the point remains that much therapeutic work is done in the relationship arena (Miklowitz et al., 1988; Scott, 1996).

Basco and Rush (1995, 1996) developed a manual-based psychotherapy that combines principles of CBT with a psycho-educational component. The main aim of this approach is to prevent relapsing and to promote compliance with medication. CBT techniques are implemented to improve self-monitoring of symptoms, problem-solving skills, and coping strategies (Basco & Rush, 1995; Basco & Rush, 1996).

In summary form, a CBT approach (Basco & Rush, 1995; Beck et al., 1979; Palmer et al., 1995; Rachman, 2003; Scott, 1996; White, 2001) is generally guided by the following five steps:

- ✥ The therapist explores the patient's definition of the disorder in terms of the causes of the disorder, and problems associated with it. The problems are further distinguished and categorised into intra- and interpersonal difficulties and those directly associated with the disorder itself, such as financial difficulties, course severity, and relapse warning signs.
- ✥ The patient's causal theory is then incorporated within a bio-psycho-social model of understanding.
- ✥ Interactions between individual and environmental factors are discussed in depth. This includes the individual's thoughts, behaviours, mood patterns and biological aspects which are discussed with that of perceived stressors in the environment. The inter-dependency of these two domains are highlighted.
- ✥ The biological effects on the mood disorder are emphasised and self-monitoring schedules are implemented.
- ✥ Throughout the step-wise process, the concern of prophylactic compliance is addressed.

The **CBT interventions** include psycho-education, confronting adjustment problems, increasing the skill of self-monitoring, confronting factors that compromise prophylaxis

compliance, and relapse prevention (Scott, 1996). In brief, the cognitive distortions and mis-representations of the self, the world, the environment, and the future are addressed and corrected. According to Scott (1996, p. 201), "(d)ysfunctional core beliefs will need modification and problem-solving skills may need to be developed to overcome adjustment problems and reduce risk of relapse". Again, as mentioned in the FFT treatment protocol, the family and their beliefs and causation theories would also need to be explored and assimilated through CBT sessions.

The CBT technique of **homework tasks** is also implemented and used effectively. This may include self-monitoring and recording of daily activities, a thought monitoring record, and a grading of expectations and goals to achieve. Daily mood graphs may also be used to indicate daily fluctuations in severity and quality of shifting moods (Miklowitz, 2002; Scott, 1996). The manic symptoms of decreased need for sleep, changes in eating patterns and inconsistent physical exercise, are also recorded and changes from a normal stabilised pattern of behaviour are rated and if necessary, the patient should self-refer to the treating professional. The CBT techniques of **relaxation skills** (for example, breathing exercises and self-talk) are also implemented and target the conscious awareness of increased mental speed, and supply the patient with techniques to reduce the mental speed and thereby control racing thoughts, motor movements, rapid speech, and thereby generally calm the person down due to individual self-monitoring (Rachman, 2003; White, 2001).

A CBT approach adopts the same stance as discussed in the **compliance** section (**see page 51**) with regards to enhancing medication compliance. According to Scott (1995), 75% of mood relapses occur because of patient non-compliance. The stance of the CBT therapist is to emphasise collaboration and ensure that the patient has the forum to give full expression to fears and concerns with regards to taking the medication. The patient's cognitions may prevent the commitment to prophylactic treatment and should be clearly and thoroughly explored. Any cognitive distortions need to be rectified and all possible barriers to effective treatment need to covered and redefined (Goodwin & Jamison, 1990; Scott, 1996; White, 2001). Further, the patient can be given the homework task of going to research the effects of taking medications and explore both the benefits and limitations. Again, this emphasises patient control over taking medication. Practically, Goodwin and Jamison (1990) also suggest that the medication should be taken with another activity which is naturally done in a routine fashion. This would supposedly enforce the behaviour of the patient as many patients

complain that they merely forget to take their tablets (Goodwin & Jamison, 1996). Miklowitz (2002) has also suggested that the patient draws up a cost-benefit schedule to weigh the benefits and cons of compliance. The patient assumes personal responsibility by taking control of identifying potential factors that may compromise treatment. In this way, the therapeutic process is defined as an 'experiment' and is open to negotiation and changes. The emphasis is on patient-understanding and therapist assistance.

Scott (1996) believes that there is a paucity of research into prevention of relapses from a psychotherapy point of view. Scott's perspective is that the identification of potential and futuristic stressors and faulty personality traits could leave the whole treatment process ineffectual in terms of long term changes. Scott (1996) has developed the use of anticipatory strategies for prevention of relapses, such as focusing on coping skills during and after a crisis and determining what types of events may lead to cognitive distortions (Scott, 1996). The development of **coping resources** is an important technique in any CBT intervention programme. The coping resources should ideally be identified during the sessions and graded for efficacy and lastly these should be written and be put up within visual reach, for example, in the kitchen. The specifics of the coping hierarchy should be individually tailored to meet the uniqueness of each patient's life and should not be generalised. This is because of the belief that each person manifests his or her symptoms of mania and depression in an idiosyncratic manner (Scott, 1996; Rachman, 2003; White, 2001))

Interpersonal and Social Rhythm Therapy (IPSRT)

This therapy was developed by NIMH-funded researchers. The aim of the research was to help identify techniques that may improve and stabilise the course of bipolar mood disorder. This therapy uses techniques to educate people so that they can manage their sleep-wake cycles better as well as regulate daily living activities (social rhythms). There is also an added focus of improving interpersonal relationships as a means to develop better coping skills (NIMH, 2003).

This approach begins when the patient is in an acute episodic state. The sessions are set out as follows:

- ✍ Initially weekly sessions are held. During this phase, an assessment is made of the contributing life events, and also of the effects of social rhythms on previous episodes. Following the assessment, core interpersonal difficulties are evaluated to determine the possible impacts on course maintenance.
- ✍ Bi-weekly sessions are held for three months after the patient has been stabilised. This is considered to be the maintenance phase. Social rhythms are tracked, and the focus is on identifying factors that may disrupt these social rhythms.
- ✍ Monthly sessions are then held for twenty one months. This phase focuses on prevention of future episodes and in which there is continuous monitoring and on-going assessment of social rhythms and interpersonal difficulties that may arise.

The Life Goals Programme

This is a group psychotherapy programme developed by Bauer and McBride (1996). It is a structured, manual-based psychotherapy programme for groups. This programme is implemented as a part of the medical treatment. The aims are to improve compliance with the medical mode of treatment, and also to assist patients in attaining their goals, such as being able to function at work again. The time frame structure for the group is set out as follows:

- ✍ Groups meet weekly for sixty minute sessions, for an undetermined time.
- ✍ The programme consists of two phases; phase one which improves illness management skills, and phase two which aims to improve social and occupational functioning (Bauer et al., 1998).

Phase one consists of five psycho-educational sessions to improve illness management skills. This includes improving the ability to identify specific patterns of the illness effectively, such as early warning signs of relapse, specific triggers of and for future episodes, and a focus on coping strategies that are helpful, and identifying those used which are ineffectual. Each session is outcome based and generates focus points and action plans. The action plan is used to identify useful coping strategies for the minimising of future symptoms (Bauer & McBride, 1996).

Phase two is built upon a goal driven behavioural plan. There is no specified time frame within which to develop this plan and it depends on the pace of the individual members within the group. The focus always remains on goal attainment, and the patient collaborates with the therapist in working towards reaching previously unattainable goals. The goals are specified within the family, social, occupational and relaxation domains. The specified behavioural plan helps the patient realistically reach goals that were previously thwarted by the course of the disorder (Bauer & McBride, 1996).

There is ongoing development of the manual based psychotherapy approaches, in both individual and group settings. This is very promising for the concurrent treatment of bipolar mood disorder. It can be seen from the above psychotherapy discussions that the focus is on improving compliance with medication by addressing underlying personality problems, lack of education, mood disturbances, course modifiers, substance abuse concerns, and occupational and social damage and the prevention thereof. The approaches all have in common that they seek to identify idiosyncratic behavioural patterns and plan interventions accordingly. All the approaches are implemented within a psychiatric, medical framework and work as part of a biological treatment plan.

Conclusion

This chapter has covered the multi-dimensional treatment approaches that are considered to be relevant to the eradication of bipolar mood disorder symptoms. The psychiatric, medical model has been used as the foundational frame from which to understand the pharmacological and alternative treatments, as well as the spin-off psychotherapies. Within this modernistic, scientific approach to mental disorders, bipolar mood disorder is understood to be a primarily biological disease having whirlwind effects on the social surrounds. The psychiatric focus is on rectifying the biological disturbances, and the psychotherapies are aimed at re-establishing a sense of normality in the person's social, work, and familial contexts. The psychiatric and psychological services are therefore co-aligned and have the same goal in mind – the alleviation of psychological distress caused by the presence of neurobiological dysfunctions.

The role of the psychiatrist and the psychologist has been framed in this chapter as primarily an expert. The one with knowledge is believed to disperse information and corrective patterns of behaviour to those who seek it, that is, the patient. This is the essence of a modernist epistemology. The client's understanding of bipolar mood disorder is left untapped and will be explored through a postmodern lens in the chapters that follow.

CHAPTER THREE

The Philosophical Polarities: Modernism and Postmodernism

Introduction

The focus of this chapter will be to outline the opposing paradigms of modernism and postmodernism. Both perspectives will be described historically revealing the inherent assumptions from which psychotherapeutic models developed, and are currently practised. The epistemological differences between these paradigms lay the foundation for the generation of alternate theories and models of psychology. Postmodernism developed out of modernism and in many ways the antithesis of modernistic principles. As binary oppositions, the philosophies will be discussed in this chapter as interdependent, and not independent of each other. The one position allows for the existence of the other (Law, 1999). Postmodernism can be seen as an intricate tapestry of varying assumptions regarding human behaviour and social reality. It is an overarching theory of understanding and comprehending life and the meaning-making process. It is by no means a clear-cut paradigm, but rather one that has become unified over time. It did not begin as an oppositional paradigm, and yet it has taken on the momentum of being a collaborative alternative to that of modernism.

This chapter constructs postmodernism according to what the researcher has deemed to be important. As an overarching perspective it has been presented in different forms according to different writers, for example, in the arenas of literary criticism, architecture, art and psychotherapy, or as variants of constructivism, social constructionism, post-structuralism and in feminism. The explication presented here is framed according to the choice of the researcher to emphasise assumptions that will be pivotal to the ensuing chapters of this research endeavour. The school of narrative therapy, and the theory of social constructionism, will be broadly discussed as examples of postmodern thinking. Lastly, criticising the shortcomings of postmodernism that are, as yet, widely unacknowledged from within the paradigm

will be discussed. The logic for making the critique overt is to avoid reification of the constructs so that postmodernism does not merely re-invent itself as another modernist theory in the disguise of another language.

Epistemology

Von Foerster (1985, p. 520) stated that "ontology explains the nature of the world, epistemology the nature of our experiencing of the world". Epistemology is the branch of philosophy that is traditionally concerned with the nature of knowledge. The term epistemology has also been used to describe what we know and also how we come to that which we think we know (Held & Pols, 1985).

Epistemology becomes an important concept when one is trying to understand from which paradigm his or her experiential reality is constructed. The two broadest and contrasting epistemologies in the field of psychology can be framed under the modernist and postmodernist banners of distinction. Both have different conceptual ideas, methodologies, and forms of practice advocated from the position of an understanding of how knowledge is attained. This chapter will attempt to delineate both the modern and the postmodern epistemologies, and follows the understanding of Von Foerster (1985). This will be an account of how modernists and postmodernists experience the world and upon which premises these distinctions arose.

Fruggeri (1992) makes reference to the development of a new scientific paradigm, based more upon defining psychotherapy and the role and identity of the psychotherapist, rather than just developing more innovative therapeutic techniques. This would necessarily entail an epistemological perspective which would question "the premises according to which therapists define themselves, elaborate theories and practices, models and techniques, develop interpersonal, social, and institutional relationship" (Fruggeri, 1992, p. 41). Epistemology is fundamentally important for the functioning of a psychotherapist. The way that a psychotherapist expresses him- or herself in the practice of psychology, is seen to be informed by the epistemological background according to which he or she has developed a meaningful and ethical way of working (Fruggeri, 1992). Therefore a thorough understanding of various

epistemologies is a beginning point from which a work ethic can be established. The multitude of psychotherapy models that are available in the field of psychology, can all be loosely (and somewhat callously) classified under the broad epistemological frameworks of modernism and postmodernism. Another example of epistemological framing could be that of western and eastern thought paradigms. For the purposes of this chapter, western epistemological thinking will be the focus.

The Medical Model: Modernism in Practice

The medical model, also referred to as the psychiatric perspective (as discussed in **Chapter Two**), focused predominately on the premises of the ability to have direct knowledge of the world, verifying these facts through empirical and objective observation, and the importance of generalising these findings as factual scientific knowledge. This model followed that of the scientific endeavour. Bipolar mood disorder has been viewed (in **Chapter Two**) from an expert scientific lens whereby human behaviour could be clinically observed and categorised, researched, treated with pharmacological medicine, and ultimately freed of unhealthy behaviours. The intention of the scientist is to establish knowledge which is based on empirical evidence. This knowledge base is then believed to account for future predictions of human behaviour on the basis of collected signs and symptoms of abnormal behaviour. A direct effect of being able to systematically identify causes of behaviour is thought to prevent future occurrences of mental disorders (Gergen & Kaye, 1992).

The position of the treating professional is that of an expert who assumes an "advisory position" (Gergen & Kay, 1992, p. 167). The psychotherapist imposes treatment protocols based on the categorisation of behaviour into a diagnostic class, and shifts the patient's problematic behaviour to a position that is more aligned with the field of mental health. The psychotherapist works from a position of being a scientist, arming him- or herself with knowledge based on scientific research, structured observations, and the implementation of manual based therapies. According to Gergen and Kaye (1992, p. 169) and Kaye (1999), the modernist therapeutic theories, such as the psychodynamic, behavioural, cognitive-behavioural, systemic, and the humanist approaches,

contain explicit assumptions regarding (1) the underlying cause or basis of pathology, (2) the location of this cause within clients or their relationships, (3) the means by which such problems can be diagnosed, and (4) the means by which the pathology may be eliminated. In effect, the trained professional enters the therapeutic arena with a well-developed narrative for which there is abundant support within the community of scientific peers.

The therapeutic encounter, from a modernist perspective, involves therapist and patient conversations that are rational and directed towards behavioural shifts. The emphases are on accurate descriptions, progress, goals and outcomes. The suggested goals and outcomes, and therapeutic stage models used, are guided by accepted scientific research data into what will alleviate mental illness. The clarity of thought and process of rationalisation is believed to rid the person of dilemmas. The focus is on intrapsychic illness and individual well-being and this discourse is characterised by scientifically controlled observation and individualised healing. There is no focus on wider societal discourses (McNamee, 1992).

The medical model has been shown to be of use when attempting to understand the complexity of a mood disturbance, such as bipolarity. However, the medical model offers only one explanation when making sense of the life-world of an individual. There are many other discourses, such as the political and social realms which could extend our understanding beyond merely focusing on the individual. It is suggested that the medical model should be understood within the social context and cultural time from which it developed and took shape. This will hopefully account for the **entrance/birth** of postmodern psychology.

The Historical Influences

The mind-body dichotomy was strongly emphasised in the historical development of abnormal psychology. This was influenced by philosophers such as Descartes, dating back to the seventeenth century. The philosophical tenet upon which abnormal behaviour was defined was that the human mind can rationally think for

itself. The human being was differentiated from animals in the sense that man can reason and feel emotions. Therefore, any deviation from rational thinking implied the concept of madness or irrational thinking. These so-called 'mad' people required rehabilitation and cure. The statement 'I think therefore I am' coined by Descartes, provided a framework from which medical science developed and presupposed that man could be cured as long as he took responsibility and personal accountability for his illness. The medical model insisted that a person ailed with a mental illness should take responsibility for the cure of that very illness by succumbing to the said diagnosis, should take the prescribed medication, and engage in psychotherapy to rectify irrational thought patterns. The focus site of psychopathology was seen to be within the individual mind. To this day, this way of thinking has solidified in the psychiatric field and is the predominant thinking behind the manual based psychotherapeutic approaches mentioned in **Chapter Two** (Parker et al., 1995).

The Enlightenment period, which began in the mid-eighteenth century, gave rise to an intellectual group of thinkers and the scientific field of study of human behaviour was born. The modernist paradigm (also referred to as positivism) developed alongside this movement away from the religious influences of that time period. The aims of this way of thinking were to search for, and discover empirical facts, and further, to determine the true nature of reality (Held & Pols, 1985). This was accomplished through the application of the principle of reason and the ability to think rationally (McNamee, 1992; Parker et al., 1995). This strongly contrasted the era from which the Enlightenment period developed – that being the medieval epoch which was dominated by the church. During the medieval timeframe, cultural and social expectations were defined by the church. Therefore, the church assumed responsibility for truth, reason and morality.

The growth of the scientific, modernist paradigm enabled the individual to decide what was moral, true and reasonable. This information was based on the collection of observable, scientific fact. The person in society could now be held accountable for behaviours that presented as a mental illness. Before this timeframe, the church would have determined which behaviours required extinction. Modernism was therefore quite an intellectual shift away from merely accepting what might be

morally correct. In antithesis to the church's doctrine, modernism sought to base decisions rather on that which was observable and verifiable (Parker et al., 1995).

"Modernity is held together, then, by stories of progressive rational scientific discovery of the nature of the exterior world and the interior of individual people's minds" (Parker et al., 1995, p. 14). In this quote, the essence of modernist thinking is highlighted. The cultural thinking surrounding this paradigm is that of verifiable fact and the dissemination of this information across borders of differing cultures and ways of thinking. The individual, in this sense, became the universal patient. Modernism heralds a mono-vocal discourse that is generally accepted as truthful (Anderson, 1997).

The development of modernism and the psychiatric paradigm were strongly rooted in the fields of biology and physiology (the natural sciences). The direct replication of medicinal practice to the discipline of psychology (a social science) rendered credibility. Medical science has shown to be empirically sound and has throughout time gathered consumer validity. The psychiatric paradigm, grounded in western thought and practice, has also attained a status of expertise. Modern societies strive towards knowledge gain and certainty. Psychiatry and the complementary psychotherapy approaches provide the vehicle for this goal. But, this perspective has been highly criticised over the years as there are many exceptions to the clear-cut scientific rules. The exceptions came to be collectively framed under the banner of postmodernism.

The Postmodern Enterprise

Psychiatry is a moral-philosophical enterprise that pretends to be a field of medicine. Psychiatrists trained in medicine find themselves defensively pretending to practice medicine while they make moral demands on the socially marginal people with whom they work. The pressure and social costs of this travesty are incalculable. Psychologists are trained in research, philosophy, and theory. They now pretend to be miniature medical personnel, giving up the best and finest of their

beliefs for the lies and defenses of psychiatry… The personal and social

costs mount! (Simon, 1994, p. 170).

Postmodernism developed out of the modern era and began to take theoretical shape in the 1960s and 1970s. There is much confusion to pinpointing the beginnings of the postmodern era, and also in classifying which theorists belong in which school of thought. According to Potter (2000), Francois Lyotard and Jean Baudrillard are two of the most prominent names associated with postmodernism. Before Lyotard came Wittgenstein who was influential in the development of the school of linguistics. Ferdinand de Saussure, also researching the influence of language in the social sciences, developed what is known today as the school of structuralism. From this postmodern school of thought, poststructuralism emerged through the writings of Michel Foucault and Jacques Derrida. To claim that Foucault and Derrida are postmodernists would be a matter of opinion, according to Potter (2000). Neither Foucault nor Derrida named themselves postmodernists. Potter (2000, p. 163) writes,

many postmodernists are disinclined to label their own work as such. The ideas associated with postmodernism are too loose and ill-defined for it to be said to exist as a definite school of thought. It can rather be better understood as a rather nebulously floating intellectual orientation, loosely grouped together, insofar as they have a (often contradictory) connection to a number of specific arguments, propositions or key thinkers. It is something of a peculiar intellectual phenomenon. It undoubtedly exists but is difficult to pin down precisely – its rather negative attitude to pinning things down being precisely one of its characteristics.

Postmodernism can further be discussed in terms of two dimensions, being the philosophical (truth) and the aesthetic (style). The philosophical tenets of postmodernism will be discussed in this chapter as applied to the field of psychology. This considerably narrows down the postmodern focus, and there is no intention to provide a complete historical analysis of postmodernism. Rather, postmodernism will be presented in one of its forms of applications, that is, for the world of psychotherapy.

A frame of thinking that focuses on the social, historical, political and cultural influences developed out of, and away from, the modernist thinking paradigm (McNamee, 1992). Where behaviour was traditionally understood in terms of internal, intrapsychic mechanisms and emphasised the expert knowledge of the treating professional (modernism), postmodernism sought a multi-focused understanding of human behaviour and not necessarily a cure. The implications of the shift in thinking are abstract, oppositional to taken-for-granted institutional ways of thinking, and wide-spread amongst a variety of disciplines within the fields of the social sciences. To engage in a paradigm shift, one has to re-think the conceptualisation of fact, the means in and through which one conceptualises, and the practical implications and implementations of this knowledge base (Simon, 1994).

A postmodern paradigm includes and requires a contextual description of any concepts under study. The constructs of abnormality and normality took shape within a specific cultural epoch, were built through language, communication, and dialogue, and served to maintain the status quo within that society. Science, representative of that time, also served to maintain a position of power through the generalisation of knowledge. As society tends to change and transform moral values and principles, a shift in the conceptualisation of abnormal behaviour should accompany that. The principles of postmodernism allow the contradictions of the modernist paradigm to emerge. There has been much argument amongst social scientists as to which is the most correct way to conduct research. The debates that exist amongst practitioners of modernism versus those of postmodernism continue to raise polarised arguments. The constructs that will be discussed here are representative of some of the thinking in the epistemological onslaught. Each perspective vies for legitimisation and acceptance. Within the field of psychology, both perspectives have proven to have merit. But, both have critical shortcomings. Parker et al., (1995) warned that the simple act of opposing the psychiatric field could lead to yet another marginalizing paradigm. This warning will be addressed under the critical discussion of postmodernism.

Capturing Postmodernism

A postmodernist perspective has certain core assumptions that filter through the generation of theories, such as within the theoretical explications of social constructionism and hermeneutics. There is no exact definition of postmodernism as applied to psychology. Anderson (1997) considers postmodernism to be a critique of existing paradigms, and not an era, whereas Moules (2000, p. 229) considers postmodernism to be "an era, a cultural movement, a social condition, a belief system, and a way of being in and understanding the world". The theorists that purport to be postmodernists simply share certain assumptions that are the antithesis of the traditional psychology models based upon modernist principles. Therefore any discussion of postmodern tenets naturally implies a critical opposition to modernist beliefs and premises. The one paradigm naturally gave way for the other to develop and gather momentum. However, it is the assertion of this researcher that the latter paradigm (postmodernism) would have to naturally in-fold itself upon the original paradigm allowing for the development of another perspective. This process of turning back upon itself is in fact a required premise for postmodern thought, known as reflexivity (Burr, 1995). But, very few postmodern theorists have stopped to reflect critically on their grounding assumptions, and the theories have in many ways come to resemble the reified principles underlying that of a modernist paradigm (Mahrer, 2000).

Several common assumptions appear to be shared amongst writers of postmodern ideas. These will be thematically grouped and discussed below under the headings of **subjective inclusion** (implying a shift away from objective neutrality); the use of **language** in creating problems and encouraging solutions; the **power differential** that exists within the psychiatric, psychological and societal discourses; **meta-narratives and grand theories** that help to maintain positions of power, privileged knowledge and marginalized populations; and the tool of **deconstruction** and the importance of identifying and understanding **discourses** that shape the perceived reality. The ensuing discussion of postmodernism is not all-encompassing, but reconstructed here in this way for the purposes of this research.

Subjective Inclusion

A primary difference between modernism and postmodernism lies in the position of the researcher and the psychotherapist. Within a modernist perspective, the position of being an objective observer is one of the hallmarks of the scientific endeavour. This enables the social scientist to generate scientific facts (McNamee, 1992). The researcher is supposed to be able to remain neutral, free of opinion, and emotion throughout the research process. In this sense, the researcher steps away from his or her own humanity. The position of the researcher is believed to allow for the yielding of unbiased facts and sound knowledge truths that are unaffected by human input and therefore error (Hughes, 1990; Lincoln & Guba, 2000). This is reflected in the manual based psychotherapy approaches described in **Chapter Two**. The psychotherapist is given clear guidelines for how to eradicate abnormal behaviours and any deviance from these procedures may result in therapeutic failure. The implication suggests that the psychotherapist remains neutral and objective thereby creating a cure for the illness. This is in effect the actualisation of the modernist premise of cause and effect.

Postmodernism entails a move away from researcher objectivity, and if anything, invites subjectivity to be included as a part of any research or therapeutic endeavour. "This perspective would imply that psychopathology can never be diagnosed, much less understood or treated, apart from the intersubjective context in which it appears" (Downing, 2000, p. 134). The very act of giving personal input is seen to make the research more valid and legitimate exposing the foundational beliefs that shape a diagnosis or interpretation (Burr, 1995; Mahrer, 2000).

The position of the expert observer and practitioner found its momentum in the school of psychoanalysis. The basic notion of this school of thought was that there were essences within people's minds that accounted for their psychological make-up and spin-off problems. Any change in behaviour required the assistance of the expert who was believed to have blue-print knowledge about the functioning of the human mind. The application of this knowledge in the therapy setting was believed to cure the presenting symptomatology. The position of the patient was that of a dependent (Parker et al., 1995; Simon, 1994).

Within a postmodern paradigm, the psychologist is thought to be the expert on creating a context in which the patient can shift perceptions of problem behaviours and recreate a life story that is more empowering for that particular situation (Goolishian & Anderson, 1982). The postmodern therapist does not purport to have exclusive knowledge about people and their lives. The therapy setting is viewed as a collaborative event (Anderson, 1997). The subjectivity of the psychotherapist is welcomed and seen to be a vital part of the therapeutic process. There is no attempt to be objective, nor the expert. However, this position does clash with the institutions of health care which require certainty and definitive distinctions on what is considered to be normal and abnormal (Parker et al., 1995).

Within the domain of the abnormal-normal behavioural continuum, the position of the psychologist is not seen as the knowledge expert, but as part of the construction of those very constructs. It is the psychologist who, in conjunction with the client, creates the reality of normal and abnormal behaviour. According to Hoffman (1990), the postmodern therapist enters the arena of therapy without any ideas or definitions of what constitutes abnormal or dysfunctional behaviour, and without any pre-conceived models of change. She believes that the patient, the family, and the therapist co-construct meanings attached to behaviour and reality. This has implications for the treatment of traditional diagnoses of mental disorders (Hoffman, 1990).

Language: The Creation of the Sacred Illness

Firstly, as a paradigm, traditional psychology has remained within the realm of diagnosis, treatment and cure, rehabilitation centres and mental asylums. The assumptions are that the treating professional can recognise and identify dysfunctional behaviour, propose a curative treatment, and implement a plan of action to rid of behavioural abnormalities. The language and vocabulary of a modernist paradigm is assertive, blamative, and doused in certainty. For a modernist practitioner, language is used in an objective, value-free manner (Hughes, 1990; McNamee, 1992). The generation of verifiable knowledge holds weight. The means of attaining knowledge is to remain within strictly defined accepted behaviours, and to communicate knowledge through scientific languages. The language, grounded in empirical

observation, comes to reflect the world as far as it can be known (Gergen & Kaye, 1992). From this point of view, it makes sense that the psychiatrist and the traditional psychologist are able to clearly distinguish abnormality from normality, as they are equally able to distinguish good research from bad research. Any deviation from the agreed upon norm will result in unscientific research and the unprofessional rendering of services.

In psychiatry, there are set criteria defining a cohort of signs and symptoms that classify behaviour as abnormal. The language of the psychiatrist is contaminated with these classifications, such as anxiety, depression and mania. Within the psychiatric culture, these words provide a common language and it is upon this language that the reality of abnormal behaviour is created (Parker et al., 1995). A psychologist becomes versed in this psychiatric dialogue through years of study of abnormal behaviour texts as well as in the therapy training field. In South Africa for example, during the internship, the clinical psychologist is required to rotate through a six month psychiatric block in a hospital setting, in which the psychologist performs in a language setting that requires a thorough knowledge base of psychopathology. In the private practice setting, the psychologist is required to communicate with medical aid schemes in the psychiatric language (based on the DSM-IV nosology). Referrals from doctors necessitate the ability to converse in the language of the psychiatric field. For example, a person may be referred for therapy for a multitude of issues, but the behavioural expressions of these issues all exhibit the symptoms of depression, such as a lack of concentration, a loss of interest in pleasurable activities, a decrease or increase in the need for sleep and appetite, and a loss of energy. The conversation with the doctor will focus on these depressive symptoms and the doctor would expect that the psychologist is able to give concrete, evidence-based options, for alleviating the symptomatic behaviours. A person is considered to have attained a position of health when the symptoms have been alleviated. It is within the language domain that symptoms take on a position of power and come to define a person as 'being depressed'. The above mentioned examples of depressive symptoms would categorise this person as being depressed. If the person is asked how he or she is feeling, the answer would probably be simply stated as 'I am depressed'. This reality assumes a pervasive nature across all contexts of the client's life and life as such, becomes

depressing. The problem and the supposed solutions are rooted in language and the definition of constructs (Parker et al., 1995).

Postmodernism goes a few steps backwards and deconstructs the social and cultural environs that gave rise to the development of modernism. Postmodernism asserts that any attempt at understanding the constructs employed within a modernist framework must account for the developmental roots. This will allow for a contextual description of the specific language used by the modernist practioner and also the methodology of practice. Any understanding that is socially accepted is a product of that culture and historical influence (White & Epston, 1990). The constructed reality is also dependant on the economic standards prevailing during that time. It follows then that any constructions made and accepted, naturally promote certain patterned behaviours and exclude others, hence the development of the dichotomous position of normal and abnormal behaviours (Hughes, 1990; Parker et al., 1995).

Meaning is believed to be created through language as it is constructed amongst people in a conversational domain, which in turn maintains a shared reality (Fruggeri, 1992). The understanding of abnormal behaviour is rooted in cultural beliefs relevant to a particular time in history. The medium for sharing cultural beliefs is through language. What may be defined as bipolar mood disorder in one culture, may be creative talents surging to the surface in another. Traditionally language is only a "passive vehicle for our thoughts and emotions" (Burr, 1995, p. 7), whereas in the realm of a postmodern era, language is performative in that socially agreed upon constructs give way to social action. It is through shared conversation that meanings develop and determine moral behaviour (Hughes, 1990).

An important premise of the social constructionist perspective is that of the emphasis on meaning, understood to be an intersubjective phenomenon. This implies that meaning is created, experienced and shared by people in conversation and through action and interaction with one another. To live through socially constructed realities suggests that action is created and understood through dialogue and conversation. Meaning is therefore created, experiences are organised, and the self is defined, through conversational dialogues shared amongst people (Anderson, 1993).

Language can be defined in many ways in the field of psychotherapy. For the postmodernists, language constitutes and creates reality. The way that the world is ordered and experienced is contained in our language. Therefore, to understand reality, one would need to understand the language used to give definition to the world (Hughes, 1990; Moules, 2000). Further, language is used to give expression to thoughts, beliefs, ideas and opinions. In the realm of psychology, a psychologist has a base of knowledge to determine psychopathology on the basis of the medical model. But, any diagnosis offered, is done so in a self-referential manner. The principle of self-referentiality implies that no one description of a set of behaviours can be more privileged than another for accuracy, as all knowledge is subjectively offered. Therefore, any psychiatric diagnosis offered, is not done on the basis of objective knowledge, but rather on the basis of the psychologist's beliefs, ideas, analysis and interpretation (Fruggeri, 1992).

The Power Differential

Postmodernists argue that power and knowledge are interlinked and any attempt to produce knowledge implies a position of power. This is viewed from a societal perch. Any society that places emphasis on the generation of knowledge (such as the need to identify signs and symptoms of madness) has a vested interest in the outcome (mad people must be institutionalised and kept away from the mainstream population). This allows the society to maintain a status quo and a dictation of what is socially acceptable or not. In a modern capitalist society what would the role of a psychiatrist be if there was no such thing as mental illness? The psychiatrist would become redundant as would the pharmaceutical industry and the economy would suffer as a result. Therefore, it is asserted by Parker et al., (1995) that institutions that hold power and knowledge determine the way we come to understand mental illness, and mental health.

In a modernistic framework, the power is thought to be constituted through expert knowledge and complementing research projects. The research validates the assertions of mental illness and reinforces the need for further research of this objective nature. The stories that patients have to share about their said illness becomes marginalized in favour of the dominant ideology. The patient is given a

scientific formulation of the problems he or she is experiencing, which serves to reiterate the position of the patient being helpless, a failure, and in need of professional assistance. Gergen and Kaye (1992) have framed this interactional pattern as a cultural ritual in which the power position of the psychotherapist is maintained, and the patient remains ignorant and weak. In effect, the patient enters therapy with a problem story and exits therapy with the therapist's narrative. The patient is seen to aspire to the wise position of the psychotherapist. The patient never becomes aware of the psychotherapist's personal doubts or failures, and the psychotherapist is perceived to remain in an idyllic state, free of debilitating emotions. Any input that differs from this mainstream myth is believed to be 'non-sense' and illegitimate. The marginalized and subjugated paradigms have been collectively grouped as postmodernism (Gergen & Kaye, 1992).

Burr (1995) cautions postmodernists to be aware of the possibility that the attempt to provide social change through research directed towards the so-called marginalized populations, may in fact further perpetuate a political correctness that already existed. The research promulgated through the scientific modernist discourse, served to maintain the status quo of those in power and further the dependency on the medical fraternity for a position of mental health and well-being. Postmodernists can also fall into this very trap if they fail to account for the social, political, historical and cultural influences. It is asserted that at any given moment, there are power dynamics being played out through what is deemed to be socially and morally appropriate behaviour (Burr, 1995).

Meta-Narratives and Grand Theories

The psychiatric perspective is an example of a grand theory. It guides the fields of both psychiatry and psychotherapy. Any movement away from the principles of psychiatry are deemed to be 'airy-fairy', devoid of fact, and non-scientific. The grand narrative guides the people within a society. As concepts of mental illness and mental health developed, so did the field of psychiatry. The need for people to achieve a sense of mental health and to be free of debilitating emotions perpetuated the legitimacy of pharmacology, and psychology as a profession (Parker et al., 1995). Without a belief in mental illness, there would be no need for psychotherapy. The

medical aids and schemes would not endorse the payment, and the psychologist would become the equivalent of a medieval sorcerer.

Postmodernism asserts that there are many grand theories that define societal reality, and it would be wrong to assume that there is one correct and better way to live. This paradigm calls for the co-existence of multiple theories, descriptions and critiques, for example, sourcing understandings from religion, the arts, medical science and technological developments. Whereas modernism calls for the ideological position of holding to one firm set of beliefs, postmodernism entertains the possibility of multiple ways of being and poly-vocality (Anderson, 1997; Hughes, 1990).

The grand theory of psychiatry supposed a clear and verified distinction between madness and sanity. The people diagnosed with a mental illness were subjugated by the dominant philosophy, that being modernism. The psychotherapist held a position of power and privileged access to knowledge about human nature. Postmodernism would argue that people with a mental illness have their own legitimate story to tell, and within that, their own method of coping and empowerment. The danger to the evolvement of the unique story is that it would be in opposition to those in power and would counter the knowledge base that has gathered momentum in recent times. It is far easier to maintain the status quo and keep uncertainties at bay, than to question the basic premises upon which modernism was built (Anderson, 1997; Burr, 1995).

Modernism is founded upon a dualist belief, involving an objectifiable outer reality which can be discovered, and an inner mental world which can be quantified and rid of problems (McNamee, 1992). Postmodernism on the other hand, is in opposition to dualist foundations and proposes that the world is characterised by uncertainty and the need to understand and contain chaos. Any change is welcomed and static beliefs are questioned critically. The world is thought to be unpredictable, constantly created and recreated through the medium of language, and cannot simply be discovered as modernism hoped it would be (Anderson, 1997).

Deconstruction and Discourses

Burr (1995, p. 164) defined deconstruction as "attempts to take apart texts and see how they are constructed in such a way as to present images of people and their actions". There are predominately two widely accepted uses of deconstruction: **one** in which the contradictions are revealed through understanding the meanings underlying certain texts. For example, scientific reports utilise a passive style of reporting, driven by fact, leaving little or no room for questions, and they do not acknowledge researcher bias. The style of writing immediately gives the reader the impression that the document is trustworthy and valid. The **second** method of deconstruction is used to understand the history behind how the meanings were created and accepted. For example, by accounting for the cultural time of the development of modernism, one can understand how the expert premises were founded and socially accepted, especially as they developed in antithesis to the church's domination. This understanding will give background to the way meanings and truths came to be accepted and maintained, and also which power relations are carried forward through these meanings (Burr, 1995; Parker et al., 1995).

Discourses, are the collectively shared meanings of constructs. "A discourse refers to a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events" (Burr, 1995, p. 48). Discourses become evident when understood from a critical point of view. These groupings of belief systems become apparent when contradictions emerge, identifying the power relations that exist to maintain marginalized discourses. Discourses are embedded within a society and to a large extent dictate what is socially and morally acceptable or not. For example, in the realm of normal and abnormal behaviour, on a hot day, it is considered inappropriate for a woman to take her shirt off in a public place and if she does so, she may be seen to be having a mental breakdown of sorts, but if a man takes his shirt off, it is culturally understood that he is hot and would like to cool down. The gender discourses become apparent through this comparison and one can also see that the people who define normality will probably be men (Burr, 1995).

The Discourse of Diagnosis

Parker et al., (1995) outlined six categories of distinction that serve to maintain the importance of a diagnosis. These are: the individual and the social; reason and unreason; pathology and normality; form and content; purist categories versus life issues; and the professional versus the patient views. These six categories are examples of discourse where the one half of a category helps in defining the other. The eradication of one half of the category, for example abnormal behaviour, will only serve to strengthen the position of normality. Parker et al., (1995) assert that both positions need to be deconstructed otherwise the problem will simply be reconstructed in different terms. The psychiatric paradigm traditionally focuses on the individual rather than on socio-cultural influences. Society is therefore freed of any responsibility and the site of pathology is harnessed within the individual mind. The individual is thought to be irrational and not in a position to reason appropriately. The diagnosis confirms this and further emphasises the power differential between those with privileged knowledges and those without. Diagnosing certain people as pathological implies that the diagnostician operates from a position of normality, emphasising a top-down treatment approach. This is thought to be untrue by Parker et al., (1995). The need to categorise behaviours as abnormal requires that the treating professional focus on the form of distress and not the content of the presenting problem. For example, the psychiatrist may be interested in finding out about the manic symptoms the person is experiencing (for example, frequency and duration) rather than asking about the meaning that these behaviours have for that person in that context. The primary purpose is to reach a diagnosis. Patients very rarely walk away from a diagnosis with an explanation as to how this summation was constructed and what it represents (Parker et al., 1995).

A diagnosis imposes a distinctive difference between the patient and the treating professional. When a patient arrives for therapy with a diagnosis, that person has normally internalised the diagnosis as a fact and the patient's reality (or story) is constructed around the truthfulness of that concept. The patient is placed in a subjugated position of being dependant on all professionals for cure and help, in efforts towards shifting to a position of mental well-being. The discourse of diagnosis

is an imposing one and emphasises the differential power from those who dominate and those who become marginalized (Parker et al., 1995).

Traditionally, the therapist-centred approach focuses on disseminating proven scientific knowledge to those in crisis and need, that is, the patient. Typically, psychotherapy involves a history taking of the patient's story according to the therapist's frame of reference (for example in the use of the mental status exam as explained in **Chapter Two**). The next phase of therapy involves an accurate diagnosis constructed on the basis of identifying the true root cause of the dysfunctional behaviour, and implementing treatment protocols to shift the patient's narrative towards the therapist's narrative and developing new behaviours in accordance with this more adaptable and acceptable, normal way of functioning (Kaye, 1999).

Psychotherapeutic approaches that are patient-centred, that is, they have a focus on the patient's narrative, can be commonly grouped together under the philosophical banner of postmodernism. Where the modernist therapist operates from an advisory position (Gergen & Kaye, 1992), the postmodern therapist works from a "receptive helper frame" (Kaye, 1999, p. 22).

'Psychiatric Diagnosis Denial Syndrome': The Story

I now freely admit to having a mental illness that has been suspected by many since I started advancing the arguments in this book. I have Psychiatric Diagnosis Denial Disorder (Simon, 1994, p. 168).

Simon (1994) is referring in this quote to his fanatical position towards resisting the importance and ideological make-up of the field of psychiatry. The comment is made in a sarcastic tone. In the world of diagnosticians and certainty, he gave himself this diagnosis. A postmodern paradigm shares the extreme move away from scientific empirical facts. A postmodernist might very well be labelled by a modernist as being in denial of a very proven and knowledgeable reality. Often, postmodernism is accused of being too relativistic and solipsistic – a view that anything can be justified and explained without delving into the cause and effect or

without the need to offer any structured explanation of events. Narrative therapy, as an example of the postmodern philosophy, is based on the social generation of meaning, constructed in dialogue (McNamee, 1992). In this realm, there can be no cause and effect, as meaning and reality are shared amongst those who together weave a story or narrative that has an impact on the person's life-world. Downing (2000, p. 142) commented that "relativism is a concern only for those who cling to a foundational way of thinking; it is dissolved by a narrative approach which views knowledge as inherently linguistic, social, and purposeful in nature".

Stories can be understood to be representations of our need to understand the world. The ultimate aim of telling stories is to create order out of chaos or confusion. Certain stories come to have more privilege than others. These stories are constructed amongst people and are reflective of societal discourses. The metaphor of the story is used to understand how people create reality through the stories that are told, and those stories that are cast aside, or marginalized and not given primary status. Stories are therefore context and culturally specific and determined according to the people within a given society. The school of narrative therapy (White & Epston, 1990) is concerned with the stories shared amongst people, and the act of deconstructing these stories to understand the given social norms that are privileged and those that are subjugated. Deconstruction is a process that involves the breaking down of givens or normative taken-for-granted knowledges (McNamee, 1992). In theory all stories have equal status even though some are given more acknowledgement than others (Doan, 1998).

Narration involves one person sharing his/her story with another person. This is the activity of psychotherapy. Parry (1993, p. 456) states that "the very core of therapy, I propose, amounts to the deconstruction of what clients have chosen to include in relation to what they have, willy-nilly, excluded". Gergen and Kaye (1992) commented that a story is more than just a story as it incorporates a performative aspect – action and behaviour are guided by the stories shared amongst people. In this manner, stories construct social relationships and define reality. Psychotherapy, is one of the contexts within which meaning is co-created between a therapist and a patient in a horizontal manner, with no one party having more expertise than the other. The aim of psychotherapy is to co-create different narratives that may be more helpful to

the client to overcome the crisis that is faced. The psychotherapist does not have a preconceived understanding of what or how the patient thinks, acts or believes. This is co-discovered in the realm of psychotherapy (Gergen & Kaye, 1992).

To quote the narrative therapists White and Epston (1990, p. 16),

> as persons become separated from their stories, they are able to experience a sense of personal agency; as they break from their performance of their stories, they experience a capacity to intervene in their own lives and relationships. The discovery of unique outcomes, as well as the externalizing of the problem, can then be further assisted by encouraging persons to map their influence, and the influence of their relationships with others, on the 'life' of the problem.

For White and Epston (1990) problems are merely storied events that can change if the meaning attached to the event shifts. This can be achieved by re-authoring the story as it has been shared on countless occasions.

Problems and Solutions

The postmodern therapies (for example the narrative school of therapy) address what the client chooses to include and exclude in his or her story. In this way, whatever the client has previously taken-for-granted is deconstructed in order to reveal the inherent healing nature of the stories we tell, and the parts that have been subjugated in favour of what is being dominantly prescribed by overarching social discourses. The solutions to problems are believed to be in the client's control over his or her story and only need to be excavated through the guidance of the therapist (Parry, 1993).

Each problem system (the client, the problem itself, the session, the intention of therapy) is looked at as being a unique situation. The aim of therapy is problem dis-solution (Anderson, 1993). The problem is altered toward searching for a new meaning, a process which renders the problem dis-solved and not solved. In the process of shifting meanings, a new sense of personal agency is believed to emerge

and the client may experience freedom from that problem. The focus is on empowering the client to a position of no longer defining the problem in the same way.

Change is thought to be brought about by both the psychotherapist and the client having a desire for a shift in thinking and behaving. Personal autonomy and personal control are retained by the client throughout the therapeutic process. The client enters the domain of therapy with a well defined problem saturated in language that limits the possibility of change. The dependant, helpless position of the client is shifted to a position in which the client assumes personal agency over recreating life-stories that are not problem saturated. The story that the client tells is often one that is created with others in social relationships and emphasises an incapability to overcome a problem or crisis. The client therefore attends therapy in the hope of the therapist assuming responsibility and offering solutions that will fix the problem at hand. Instead, the therapist is to become aware of the ways in which the dominant discourses are subjugating the individual, and challenge them. The psychotherapist therefore needs to immerse him- or herself in the world of the client and decipher the overarching discourses which give shape to the meanings that the client has attached to the problem situation (Drewery & McKenzie, 1999).

The solutions that are sought after in a narrative therapy are embedded in the concept of deconstruction where the psychotherapist is aware of the dominant discourses that create and reinforce a position of being problem-ridden. In this regard, Drewery and McKenzie (1999) outline four specific forms that deconstructive therapy is concerned with. Firstly, the psychotherapist pays curious attention to the presuppositions that maintain the client in the problem situation rather than speaking of alternatives. The sense-making process of the client is made overt by the therapist emphasising the focus on limited narratives. Secondly, the psychotherapist is to remain acutely aware of falling into the trap of blaming an internal cause of the problem that is often very much a part of the client's languaging of the problem. Thirdly, the psychotherapist continuously highlights the belief in the client to overcome the struggle or difficulty when facing the possibility of change. This is believed to instil an element of hope and faith in the client. Lastly, the therapist listens for alternative outcomes and stories which are already being implemented but are not

given meaningful weight by the client. These marginalized behaviours may be the antithesis of the dominant understanding of the problem story. These four practice guidelines are thought to convey the essences of a narrative approach. Solutions lie in the connection between the therapist and the client and the reality that can be co-created is client-based and change oriented. The responsibility for freedom from the problem and constructive change is shared amongst all collaborators in a narrative therapeutic context (Drewery & McKenzie, 1999).

The View of the Client

In narrative therapy, the voice of the client is privileged over and above that of the so-called expert professionals (psychologists and psychiatrists). The therapeutic goal is to allow the client the opportunity to express him- or herself in a way that is not determined by the prescribed societal prescripts of 'normal' behaviour. Each society is believed to carry stories that split individuals into accepted and marginalized domains and those that fall within either sphere experience a loss of the other (Doan, 1998).

The postmodern therapies do not focus on individual inconsistencies and abnormal behavioural expressions. The focus is on exploring the individual's personal reference system in conjunction with the overarching socio-cultural framework. The problem of the client is seen simultaneously with the role of the psychotherapist and the influencing discourses that impact on the nature of the presenting problem. The description of the behavioural expression, such as a mood disorder, is broad and accountable for a multitude of influences. The simple categorical descriptors defined by the psychiatric system are only a part of the overall understanding. Within the medical model, the pathologised individual is the point of focus and there is no apparent concern for mentioning the influences of the philosophical practices of societal influence. Postmodernism undertakes this mammoth task that often leaves the psychotherapist in a position of uncertainty and doubt (Lax, 1992).

Traditionally, the client is viewed from a deficit perspective. There is a belief that something is lacking in the individual, be it the ability to be rational or a lack of coping skills. The client hands over the power to help him- or herself to the treating

professional and in this sense experiences a loss of personal agency. The postmodern enterprise does not take this victim-blaming stance (Kaye, 1999). The client is seen as experiencing a meaningful albeit painful situation. The psychotherapist takes responsibility for creating the space in therapy where the client can explore his or her life in a way that allows for self-empowerment and the ability for the client to re-write his or her story that will accommodate a resourceful approach to life's situations (Drewery & McKenzie, 1999).

Truth and Change

The notion of mental illness, especially those psychological experiences judged to be psychotic, involve not the construction of reality but the reconstruction or fabrication of reality. What constructionism makes possible is an understanding of the relationships between the construction of reality and the fabrication of reality. Once we accept that all our ideas of reality (all the truths and scientific laws of nature that we accept as true) are those that have been discovered by applying psychological rules of 'seeing' the world, then we must also accept the notion that constructionist activity is capable of being influenced by many factors that can change the nature of what is discovered to be true and lawful about the world in which we live. Constructionism thus states that there is truth and there are laws governing reality, but these laws are never known except as they are given psychological life by human beings. Under such a formulation, truth becomes far less absolute and reality far more subject to those creative processes used by human beings for reasons other than the discovery of reality. What is real may be experienced quite differently by different people in different cultures at different times in history. What is real to one person is fabrication to another (Simon, 1994, p. 80).

One of the tenets of the postmodern paradigm of thought is that the **ultimate truth** is abdicated in favour of various points of view. People cede the belief in absolute truth and minimal attempts are made to discover *the* reality. The previously

89

accepted truths as reflected in religion, ideologies and philosophies are then thought of as being merely social constructions, and others that were previously shunned now have the opportunity to be validated. The expectation that all people accept a universal truth determining right and wrong behaviour is cast aside in favour of a multi-versal truth, where there is the acceptance of multiple realities and many descriptions of the same event (Moules, 2000; O'Hara & Anderson, 1991).

Change, be it on a behavioural, or a cognitive level, is thought to arise from the process of conversational dialogue in which the client assumes a new position of self-agency and capability (Anderson, 1993). Traditionally in a modernist framework, change occurs when the therapist defines the client's story according to the therapist's frame of reference and implements new narratives devised according to the therapist's privileged knowledge. The goal is to bring about behavioural changes in the client as defined by the therapist (Kaye, 1999). In this sense, the psychotherapist acts as the moral extension of what society, the medical system, and the healthcare systems, define as normal behaviour as opposed to abnormality.

The postmodern therapist is actively involved in revising client's stories to assist them in moving from stories of chaos to control (Parry, 1993). The old stories are traded-in for new more effective plots. Modern society is seen to want to de-story the world. The focus has been on technological advancement and production control. Stories are believed to be fabrications of make-believe and the essence of time-wastage. It is against this background that postmodernism has seen modern society as one of many versions of reality. According to Parry (1993, p. 456),

> yet there is no time like the postmodern present not only to return to the story as the chosen approach for dealing with matters pertaining to the world of the living but to regard therapy as an activity to be undertaken exclusively in this mode.

From a postmodern perspective, change is brought about through the interpersonal construction of new or redefined meanings. Co-constructed definitions arise from the mutual exchange of information between the therapist and the client. According to Fruggeri (1992), this is brought about by introducing differences in the

story being shared by the client; by reframing stuck definitions, that is the therapist offers alternative meanings for the same event; offering interpretations on the patterns and connections that emerge within the client's story as told to the therapist; and lastly through the introduction of reflexivity. This process of altering meanings and making connections of patterned events, within the context of participation and self-awareness, is believed to construct an alternative story in which the patient may be emancipated from the initial problems that brought the client for therapy (Fruggeri, 1992; White & Epston, 1990).

The Position of the Therapist

Psychotherapy is inescapably a product of the ethos prevailing at a given historical period and the theoretical conventions of the times. It is a culturally constructed technology inscribed with the canonical assumptions of the culture, its paradigmatic beliefs and disciplinary practices (Kaye, 1999, p. 27).

Psychoanalysis developed in a cultural time following great scientific discoveries. It therefore follows that psychoanalysis attempted to ground itself as a scientific discipline (Gergen & Kaye, 1992). Psychotherapy was believed to be a process that would alleviate and ameliorate dysfunctional behaviours and mental illness. In a postmodern epoch, the scientific endeavour has failed to provide the certainty and answers that were once promised. The focus of psychotherapy has moved towards a more humane understanding accounting for meaning and the importance of social relationships (Simon, 1994).

Psychotherapy is defined by a therapeutic conversation – a collaborative sharing of meaning in a dialogic manner. The therapist relies on his or her expertise in creating spaces for the client to express his or her story. Once the story is being told, the therapist responds in a way that frames conversational questions, assuming a position of "not-knowing" (Anderson, 1993, p. 325). The space that the therapist creates is utilised to facilitate dialogue and a conversational process. The equilibrium between the client and the therapist is balanced in the sense that therapy becomes a collaborative act, and not a directive one (Gergen & Kaye, 1992).

The therapist is *not*:

- Expected to rely on preconceived knowledge, such as research statistics and techniques.
- Stagnantly awaiting change to emerge through an empathic and non-directed talking conversation.
- Expected to know anything, nor is the therapist expected to leave his/her prior experience and knowledge at the door when entering the room.
- Directing the client. The expertise and knowledge of the therapist is utilised to create a context of mutual collaboration **with** the client.
- Expected to make judgmental or blaming remarks, and is also not requested to make testable hypotheses in the therapy setting.
- Expected to remain unaffected by the therapeutic interaction and is expected to change in the process of problem dis-solution, just as the patient is expected to change (Anderson, 1993).

The aims of postmodern therapy for **the client** have been neatly outlined by Gergen and Kaye (1992, p. 183),

- to find exceptions to their predominating experience;
- to view themselves as prisoners of a culturally inculcated story they did not create;
- to imagine how they might relate their experience to different people in their lives;
- to consider what response they invite via their interactional proclivities;
- to relate what they imagine to be the experience of others close to them;
- to consider how they would experience their lives if they operated from different assumptions – how they might act, what resources they could call upon in different contexts, what new solutions might emerge. And,
- to recall precepts once believed, but now jettisoned.

The psychotherapist should remain respectfully curious and open to learning from another person's perspective without imposing his or her reality on the patient. Further, the psychotherapist should always remain aware of the imposing political,

social and cultural consequences of his or her own practice. This will negate the position of the therapist becoming the expert with privileged knowledge. The self-reflective ability of the psychotherapist will hopefully steer the therapist away from categorising normal and abnormal behaviour, implementing stage models of manual based therapy approaches, and prescribing limited narrative accounts and role descriptions. Together these factors add up to the role of the psychotherapist as a receptive listener and not a moral, social, and scientific advisor of right and wrong behaviour (Drewery & McKenzie, 1999; Kaye, 1992; White & Epston, 1990).

The Reification of the Narrative Metaphor: A Criticism…Or Two

Therapy as an activity of conversation can be misleading if it is understood to be 'therapy **is** conversation' versus 'therapy **as** conversation'. The former becomes a reified concept and is easily believed to be a universal truth, that is, conversation equated with the definition of therapy. The latter implies a process and is defined as a metaphor for what the therapeutic domain entails (de Shazer & Berg, 1993). If therapy is equated with a conversation then it is simplified to the belief that talking is a reasonable cure to any problem, and the role of the therapist is simply to maintain a conversation.

Gergen and Kaye (1992) differentiate the narrative metaphor on two levels that can potentially resonate with modernist thinking. The first definition rests on describing narrative constructions as a **narrative lens**, and the second is viewed as a **narrative model**. The narrative lens prescribes that the client is guided through the way that life is seen, and the narrative model is seen to guide actions. The narrative lens and model both prescribe behaviour based on what is occurring **within** the individual's mind, and not as a social act. Postmodernism heralds the shift from intrapsychic knowledge to knowledge that is formed as a social artefact. The focus on the narrative as an objectified reality, transforms a postmodern concept back into a reified modernist construct. The patient still remains dependant on the psychotherapist to recreate a more emancipating and rewarding knowledge and reality. In this respect, the act of re-storying as a therapeutic technique remains a first-order concept similar

to the scientific paradigm of displacing the patient's dysfunctional approach with the therapist's more appropriate functional approach (Gergen & Kaye, 1992).

Another concern of Gergen and Kaye's (1992) is that all too often the postmodern therapies focus on generating a single more adaptable story or narrative for the client. The authors believe that what may be constructed in the context of the therapy room may be inapplicable in the world outside of therapy as the patient may have to perform in a multitude of roles and systems. For example, empowering a patient to feel anger in the therapeutic encounter may have consequences if not accounted for on societal, work, religious, and cultural levels. Further, both the narrative lens and model naturally tend towards a focus on a singular way of being in the world. Again, the authors recommend that a person in society needs to be poly-vocal and have many narratives that fit within the different contexts that a person lives in.

Lastly, the authors Gergen and Kaye (1992) warn against accepting the replacement of one narrative over another. This resembles **cause and effect**. Empowering a client and shifting a narrative from being a victim to a victor can be just as debilitating as remaining a victim. The authors believe that narrative construction should continuously shape and re-shape stories so that clients have a multitude of ways of relating, all within the limitations of societal and historical discourses. The lack of commitment to any one narrative in particular is thought to keep away from the modernist ideal of attaining a true self and an ultimate reality (Gergen & Kaye, 1992).

Moules (2000) has taken a critical approach to postmodernism. One of the underlying assumptions of postmodernism is in fact that people should not just accept any belief with too much interest and should remain critical at all times. However, in most postmodern writings, a **self-critique** is hardly, if ever, offered. Moules (2000) has critically discussed postmodernism from a spiritual departure point, claiming that postmodernism ignores a spiritual, unexplained mystical phenomenon in the search and endeavour to focus on the construction of knowledge through language. Moules (2000) therefore argues that there are some things that cannot be languaged about, but this should not deny the existence of such factors.

Kermode and Brown (as cited in Moules, 2000), argue that epistemologically, postmodernism has become a hoax ensuring that nothing can really be known as everything remains **relative**. The authors argue this point from a feminist perspective and contend that postmodernism was invented by a white bourgeois population to divert women and other marginalized populations from participating in the scientific endeavour. This paradigmatic invention supposedly operates whilst the discourses of capitalism, patriarchy and power continue to grow and gather momentum. The authors seriously question how issues such as violence, rape, abuse and poverty can merely be the acts of social constructions. It appears that some meta-narratives have been gladly critiqued through a postmodern lens, but others have been sorely ignored or denied. This ignorance is believed to maintain the grand theory of patriarchy in a silent yet evident approach. While this criticism does have merit, the researcher questions the accountability and responsibility of these authors to conduct research in their areas of concern and share the information so that a conversational domain can occur in which these matters are discussed. On the other hand, the point of a white **bourgeois** creator of postmodernism cannot be denied. There are definite benefits to the oppositional defiance of a modernist perspective that has allowed an ethical freedom of responsibility to emerge. The deviation from modernistic constructs of normality and abnormality has in a sense allowed a freedom of responsibility to justify one's position as being relative to time, context and culture.

Moules (2000), frames this aversion of responsibility as the **loss of the individual** in the search for pluralism and universalism. In effect, postmodernist practitioners have become the extremity of modernist thinkers. Where one position focused solely on the individual to the exclusion of wider societal discourses, the other paradigm has focused on the broader systems without reference to the individual within those contexts. Being able to justify away all criticisms as being relative, the postmodern practitioner is refusing to discuss, explain, negotiate or justify the choice being made. In this sense, postmodernism renders itself untouchable to constructive criticism and feedback. This position reeks of a modernist philosophy claiming that there is a singular truth, that of constructing realities albeit in a multi-vocal and pluralistic way.

Postmodernism, taken to an extreme, moves particularity into disengagement, self-referential construction, and cynical relativism and can become a context for a loss of meaning, community, connectedness, and loss of a sense of embeddedness in and embodiment with the rest of the natural world (Moules, 2000, p. 233).

This quote is spoken in the extreme of postmodernism, where it is believed to advance the onset of **nihilism** where all meaningful structures are deconstructed and rationalised. Moules (2000) is of the opinion that it is the practitioners of postmodernism that make this perspective what it is, and further, the practice of this paradigm allows for the continuation of the social problems that amass all around us today, including the context of psychotherapy. The disengagement with the world and its inherent problems, although not caused by postmodernism, are exacerbated by the silent justification of social ills through the art and tool of deconstruction. Postmodernism becomes a passive enterprise. Modernism will all its shortcomings, was still committed to actively making an attempt to try and rectify what was discerned as abnormal. Postmodernism, in comparison, remains an intellectual and not an active movement. The disengagement from ecological practice is thought to have detrimental effects on the lack of hope and belief that is growing amongst people in modern societies. Moules (2000, p. 233) suggests that,

reawakening the core teachings of the wisdom traditions, which hold a legacy of thousand of years of human relationship with the sacred, into the living present situates meaning not only as a privilege but also as an obligation.

Constructions of reality built around cultural and social explanations leave little room for accounting for the 'third factor', the un-intelligable, and the **sacred** that has no description. There is a point to be made in that postmodernism does not offer any value or account for religious influence in constructing reality. A belief in something which cannot be articulated would be unacknowledged. Religion is referred to as part of an act, a system that has influence and meaning because it is spoken about and shared in a consensual domain. The fact that the sacred spiritual domain is hardly spoken about as an influence on a person's reality does seem to

ignore it as non-existent, or as Moules (2000, p. 234) phrased it, "we can give this soul a voice, but its life does not require our voices to speak it into being".

A further criticism laid by Downing (2000) and Moules (2000) lies in postmodernism's assertion that all realities are linguistically created and shared. This is thought to be a **narcissistic** position ignoring the past and all that history and culture has to offer present day functioning. The extreme position of the socially constructed realities implies that there is no meaning beyond that which is consensually shared among people. "The postmodern conversation is often confined to humanity and it rudely ignores the rest of the world" (Moules, 2000, p. 234). The uniqueness of human potential is a legitimate position, but according to Moules (2000), this should not imply a separateness from all that surrounds human beings. In the context of psychotherapy, meanings and workable realities are created between a therapist and a client, but there are occasions when healing occurs and behaviours shift without a logical or linguistic arrangement. Postmodernism does not acknowledge nor account for this shift. Does that mean that it does not exist?

In closing, Moules (2000) calls for the postmodern practitioner to be more self-exposing and take greater cognisance of the values, ideologies, legacies, and experiences that we bring into the conversational space of therapy. "Postmodernism offers us the legitimacy of choosing any approach in our work with families and the prerogative to claim preference for a certain one – just as long as it is recognized as preference rather than truth" (Moules, 2000, p. 236).

The criticisms yielded against postmodernism are mostly from a standpoint that is concerned that postmodernism itself has taken on an un-touchable status and instead of being one of many explanations, it has grown to have guidelines and boundaries around what is accepted or not. The critical thinking offered by the above mentioned authors will be heeded in the process of conducting a postmodern research endeavour. Overall, the researcher feels that the criticisms as laid out above are begging for postmodern practitioners to be more humane and less arrogant in the promulgation of knowledge.

Conclusion

Postmodernism asserts that there cannot be absolute truths, merely various points of view. These points of view, or meanings, are seen to organise the way people live their lives. The meanings are created amongst people in social interaction with each other and occur within specific social contexts (the theory of social constructionism). Any belief system that claims to have absolutist status is frowned upon and seriously doubted (Doan, 1998).

The postmodern paradigm resonates well with psychotherapy practice. The commonalities are emphasised in language, communication, shared consensus, definitions weighted in flexibility and context, shared understanding, and reality construction. However, when conversing with the medical fraternity (including doctors, various health disciplines, and medical aid schemes), a modernist framework may be more useful and beneficial for the purposes of legitimacy. Modernism and postmodernism need to be reframed into a paradigm that is mutually supportive as both have benefits, albeit context specific. This necessitates and justifies the development of an alternative paradigm, incorporating post – modernism.

This chapter has discussed the pivotal differences between the two most influential epistemologies in psychology. Modernism and postmodernism differ on the levels of: the nature of knowledge; the nature of reality; the constructs cause, effect, and influence; methodology; the practice of psychological theories; goals and outcomes; problems, solutions and change; and the means through which to attain knowledge. The process of knowledge gain will be addressed in the research methodology chapter that follows. Although there are fundamental discrepancies between the paradigms, it is believed that this research will provide a space in which a conversational domain can be created allowing for the emergence of an alternative reality and epistemology.

CHAPTER FOUR

Research Philosophy and Design

Introduction

The purpose of this chapter is to sketch the guidelines followed for actualising this research project. The research approach is qualitative, the epistemology is postmodern, and the research design is context driven. Qualitative research principles are assimilated with the theory of social constructionism and the domain of the interview. The research design can be thought of as consisting of three levels; firstly, the researcher's quest for epistemological understanding and congruence between theory and practice; secondly, the deconstruction and thematic analysis of conversations following the interviews; and thirdly, a synthesis of the data gathered (literature reviews and interviews), interpreted from a meta-level, and translated into matrix models. The research design has been developed and constructed in such a way that it allows for an exploration of these multiple-levels.

Qualitative Research

Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry. Such researchers emphasize the value-laden nature of inquiry (Denzin & Lincoln, 2000, p. 8).

The research approach adopted for this thesis is qualitative in nature. Qualitative research has been selected as this paradigm focuses on understanding human behaviour and definitional constructs in a manner that accounts for context. A paradigm has been defined by Denzin and Lincoln (2000, p. 19) as "the net that contains the researcher's epistemological, ontological, and methodological premises". The qualitative research paradigm is conceptually and methodologically different

from a quantitative paradigm (Hughes, 1990). The quantitative approach applies numerical values to patterned observations so that the data can be manipulated, compared, and generalised. The context is determined to be threatening to the validity of the data obtained, and is therefore controlled and/or excluded. This is supposed to maintain researcher neutrality and attain objective research results. Qualitative research, alternately, allows for explorative research projects which generate knowledge that is context and culture bound. The researcher is deemed to be accountable for the entirety of the research process, including making personal biases overt, and included as a part of the research. In qualitative research there is no effort made to adopt an objective and neutral stance, but rather strives towards constructing an inclusive and reflexive methodology (Denzin & Lincoln, 2000).

Qualitative research is often perceived to be the antithesis of quantitative research. This is not necessarily true. The two paradigms are more mutually inclusive than exclusive and complement each other. However, a blatant difference between the two schools of research can be defined according to context. In a qualitative paradigm the researcher is concerned with what, whom (the individual and the socio-cultural influences), the specific situation, and the interactional dynamics between all the people that participate (including the researcher). It obviously follows that qualitative research is more time intensive and requires attention to individual factors and influences. A quantitative paradigm is more focused on generating bulk data (Denzin & Lincoln, 2000; Omar & Alon, 1997).

Social science research focuses on the domain of human behaviours and interactions. It is a communal and shared process. Qualitative research lends itself well to the domain of meaning-making events as it is conducted in a naturally occurring environment as opposed to a laboratory setting. Further, Miles and Huberman (2001) comment that qualitative research is ideal for understanding the meanings people attach to events, social processes and the perceptions of life. Qualitative research allows a link to be made between understanding these concepts and connecting the information to the social world as it is constructed amongst people in society (Miles & Huberman, 2001).

Qualitative research techniques have been applied to social science research in the same scientific manner that quantitative, objective research has (Hughes, 1990). However, the exceptions and differences are many. The techniques of qualitative research lend themselves towards the generation of thickly described data, for example through the use of unstructured interviews. There is no attempt to reduce the complex and indivisible whole into variously split and isolated parts. The aims of qualitative research are to generate explanations and descriptions of events rather than to identify the root causes or truths that lie within human behavioural contexts (Hughes, 1990; Lincoln & Guba, 2000). For example, traditional quantitative research endeavours may try to identify a particular parental bond with a child that stimulates the development of a mood disorder. Items such as verbal and non-verbal language may be analysed for this purpose. The findings of the research would ignore or subjugate factors such as familial history make-up, socio-economic status, previous treatments, and politico-cultural environs. The fact that research might show a correlation between a parent and child under controlled circumstances, may be universally promulgated as a 'truth' and propel the investigation of a new type of psychotherapy. The role of the researcher is traditionally unaccounted for and the influences of the researcher are assumed to be legitimate and neutral.

The postmodern qualitative approaches seem to be appropriate as a choice of method to explore the lives of people diagnosed with bipolar mood disorder. This paradigm will allow the researcher to question the cultural and historical contexts of different diagnostic categories; to question how social norms and values produce families and individuals in which behaviours described by the DSM-IV manifest themselves; and to also question how the current treatments of bipolar mood disorder reproduce and maintain the dominant psychiatric discourse (Downing, 2000; Gorman, 2001; Hoshmand, 1994).

Social Constructionism: Applying Theory to Research

An approach to researching human behaviour that accounts for historical and socio-cultural contexts has been termed social constructionism (Hoshmand, 1994; Steier, 1991). In this field of psychology, knowledge is seen as a human construction and as such, cannot be an objective process. **Knowledge** is co-created amongst the

various role players in a research endeavour and the generation of knowledge is therefore believed to be local and specific to the people who participated in the project. There is no aim to achieve scientific status via research and the truths sought by positivistic methods are deemed inappropriate for human behavioural studies (Hoshmand, 1994; Lincoln & Guba, 2000; Omar & Alon, 1997; Steier, 1991). Social constructionist research is characterised by contextual markings (such as historical and cultural influences), rich or thick explanations of events, participant inclusion, researcher reflexivity, and meaning generation (Gubrium & Holstein, 2003). These characteristics differ from traditional positivistic research which focuses on objective knowledge captured via standardised procedural guidelines, which supposedly give access to the truths of the world (Hughes, 1990).

Western psychology has taken pride in the scientific manner of conducting research. The social sciences have manipulated the research principles of the natural sciences and applied them directly to the arena of human behaviour (Hughes, 1990). This yielded clear-cut assumptions about the nature of the functioning of a person by reducing the complex whole into isolated and fragmented parts. For example, bipolar mood disorder has often been studied as a disordered entity seen apart from contextual influences. The diagnosis took on a life of its own and has been treated as if it actually exists as a real phenomenon (Omar & Alon, 1997). The example of bipolar mood disorder researched from a scientific standpoint was studied via detached observation, quantification of operational constructs, and created into a reality on the basis of the research methods being objective, logical and standardised. Postmodern social constructionism enters the research arena at this point and refutes the principle of a singular truth status. Social constructionist research rejects the assumptions of universal generation of knowledge and certainty claims (Fontana, 2003; Schwandt, 2000). Traditional research is believed to control and pre-plan the research participants' experiences, whereas social constructionism views the research participant as a part of the process contributing to the development and outcome of any construct under study (Hoshmand, 1994).

Social constructionism is demarcated by focusing on "attention to context-embedded meanings, acknowledgment of the contributions of the observer and the observed, utilization of tacit knowledge, and preference for interactive modes of

knowledge construction" (Hoshmand, 1994, p. 27). These factors distinguish social constructionism from traditional positivistic science. Traditional scientific research has failed to account for how people make sense of events and how they attribute meaning to life situations. These factors are sacrificed in favour of observer objectivity and independence from the research process itself. The interpretations of the participants of the research are cast aside as subjective and are viewed as potentially threatening to the validity of knowledge generated (Gubrium & Holstein, 2003; Omar & Alon, 1997). Therefore, opinions, thoughts and observations are thought irrelevant and discarded (Hughes, 1990). Social constructionism addresses the meanings people attribute to situations by relying on human communication, shared meanings and the contexts in which meanings take shape.

From a social constructionist perspective, both the researcher and the research participants (co-researchers) are included as a part of the research outcomes. The process of conducting research is through dialogue, collaboration and the co-constructed sharing of meanings and realities (Gubrium & Holstein, 2003). All realities are given credence and value and explored equally. Any interpretations of data that are made are believed to be constructed from the researcher's way of understanding and should be verified by the co-researchers. The outcomes of any postmodern research are then also a reflection of those who participated in the research as well as the topic that was researched. Therefore, there is a **shared accountability** amongst all the stakeholders who have a vested interest in the research and not just a reliance on the techniques used to generate information and knowledge (Atkinson & Coffey, 2003). The techniques that the researcher utilises are also a comment on the researcher and are used to allow the researcher a platform from which to articulate a subject of interest. "The professional conducting such inquiry is always an embedded observer, influenced by his or her cultural and personal world-view as well as professional ideology" (Hoshmand, 1994, p. 37).

The social constructionist researcher aims toward understanding how people's meaning systems are informed and reciprocally inform the surrounding discourses. The discourses are thought to shape the way that people come to have meanings, belief systems, thoughts, feelings and experiences (Burr, 1995). Therefore, each person within society has developed systems of beliefs and values on the basis of

what is deemed appropriate or not. The judgements of what is acceptable or not is created amongst the people within a societal and cultural epoch and the research challenge is to understand the meaning making process on an individual level as it is reflected by larger discourses (Denzin & Lincoln, 2000; Steier, 1991; Terre Blanche & Durrheim, 1999).

Language is of paramount importance to the social constructionist. Meanings are thought to be created in the domain of language and therefore any attempt to understand the meaning making process would necessarily analyse the language used amongst people under study. Different social norms and values are carried through the language usage in different societies, constructing specific realities. The emphases of language and reality construction are on context bound interpretations and rich descriptions of any inferences made so that the reader can fully appreciate the social embeddedness of patterns of meaning. The language system is reflective of a collective shared understanding of signs, symbols and unspoken taken-for-granted belief systems. Understanding a person outside of this language system would not be a social constructionist research approach. Imposing a researcher's language system on the research participants, such as in positivistic research, would yield more information about the researcher than about the co-researchers (Durrheim, 1999; Keeney, 1983; Omar & Alon, 1997; Terre Blanche & Durrheim, 1999).

On Reflexivity

Through active reflexivity we should recognize that we are part of the social events and processes we observe and help to narrate. To overemphasize our potential to change things artificially swells our own importance. To deny our being 'there' misunderstands the inherent qualities of both methods – in terms of documenting and making sense of social worlds of which we are a part (Atkinson & Coffey, 2003, p. 120).

This inquiry relies heavily on contextual descriptions, focusing on processes that are conducive for understanding (Madill et al., 2000). As a reflexive researcher (Hoshmand, 1994) three dimensions are addressed at all times: firstly, the **personal**

epistemic style. This was reflected in the epistemology section in the thesis write-up (**Chapter Three**) where a postmodern approach to understanding human behaviour was offered. This has an impact on the way research interviews are carried out, and informs the meta-analysis section. Secondly, the researcher has made use of the **self as a tool of knowledge**. This implies that the researcher's knowledge base of the bipolar mood disorder spectrum was broadened, as well as the acknowledgement of how this occurred (the process models to be dealt with in a chapter to follow). Lastly, the exploration was influenced by the researcher's choice of her **personal world-view** which is believed to influence her selection of conceptual models and methods of inquiry (Lincoln & Guba, 2000). As the researcher adopted a dual-stance in this research, acknowledging both modern and postmodern perspectives (realist and dialogical modes of knowing), it is hoped that an emergent synchronised world-view will develop.

The generation of models that are representative of the literature review and the data gathered will be put forward as hypotheses and tentative explanations of a version of reality. In this way, they will remain incomplete and retain an 'as if' (Downing, 2000) quality. There is no intention to reify reality and find singular truths. Both the modernist and postmodernist positions are thought to be reifications of how reality should be perceived and acted upon. Neither epistemology has allowed for scepticism. The metaphor has been accepted as truth (Downing, 2000). From a postmodernist position, there has been a rejection of the concept truth, and as such it is also proposing a reality without acknowledging the 'as if' qualities. This researcher therefore adopts a **critical mode of knowing**, in which there is a critique of scientific knowing itself. The key characteristic of such a knowledge foundation is a doubting stance. This is a fitting (providing a recognisable description of) position for the researcher to take as she has completed research in both the domains of modernism and postmodernism, and has remained unsatisfied with the outcomes on both accounts. According to Downing (2000, p. 230), "the Critical mode of knowing takes as its object of deconstruction either societal practices or the practices of psychologists and psychotherapists, themselves". Further, he comments that "a social constructionist therapist, for example, could be characterized as alternating between these two modes of knowing" (Downing, 2000, p. 230). The two modes that he is referring to are the critical mode of knowing and the affirmative dialogical mode.

In summary, from a critical knowing position,

> the phenomenology of an academic psychologist and a psychotherapist are largely interchangeable, because this mode is not specifically associated with the 'doing' of psychotherapy. While Critical knowing can provide a theoretical framework which guides psychotherapy, a psychotherapist is more than a social critic, and it is not easy to turn social criticism into effective therapeutic interventions (Downing, 2000, p. 233).

A reflexive researcher is thought to make personal and tacit assumptions known to the reader. This opens up avenues of dialogue from which the researcher learns about his or her own beliefs and values and understands how they influence, and are influenced by the research process. This reflexivity (a process of bending backwards upon itself) shifts the research being about 'other people' (those who partake in the world of bipolar mood disorder) to include being about the researcher (the person with a vested interest and curiosity in this particular definitional diagnosis). In this sense, the research process takes on a relational and multi-directional characteristic. In modernistic, traditional research paradigms, the researcher and his or her values and beliefs are kept separate from the content of the research thereby imposing a neutral and objective outcome. But, in the socially constructed world of postmodernism, this objectivity is rendered a fallacy and instead of shying away from researcher responsibility towards the stakeholders of the research, the researcher openly questions his or her own approach to research exposing personal contradictions and paradoxes as they become known (Steier, 1991).

By maintaining a reflexive position, continuously staying in a state of questioning and flux, the researcher can expose her own grappling with the overarching epistemologies of psychology as they are actualised in practice. The paradoxes that envelop her form of practice as distinct from psychological theories can be exposed and integrated as polarities themselves.

The Interviews: A Conversational Domain

The interview has been chosen as one of the methods through which to gather data. This is deemed fitting as it is the interview setting, content, and interpretation thereof, that are the most closely aligned with a therapeutic context. It is within a conversational domain that meanings are believed to be created, shared and disseminated (Jorgenson, 1991). The purpose of the interview is to **participate** in an information gathering and sharing process with selected key role players (as defined by the researcher) about bipolar mood disorder. These research interviews will create a context in which a conversational domain about bipolar mood disorder can be established. The similarities between the contexts of research and therapy are evident, and in many ways therapy is a natural context in which research occurs. The differences for this research are that the researcher is not using therapy sessions as a source of data collection. Instead, the researcher is going to participate in a storied reconstruction of events (including commentaries on participating in therapy) that also account for socio-cultural, medical, familial and political influences. "Interviews generate accounts and narratives that are forms of social action in their own right" (Atkinson & Coffey, 2003, p. 118).

In the past, unstructured interviews have been questioned as being illegitimate sources of data as the research participant recalls information based on personal experiences and past memories. This is of course a criticism offered from a quantitative positivistic paradigm encouraging an objective researcher stance. In the realm of postmodern research, 'truth' is not questioned (Atkinson & Coffey, 2003). In fact, the opposite is suggested. The questioning of truth value is eliminated by the premise of multiple realities. In other words, what is true for that person in that cross-section of time, is what holds value. This is because the story that the person constructs is based upon the way that the world is perceived, spoken about in conversational domains, and acted upon. In this sense, "we need to treat interviews as generating accounts and performances that have their own properties and ought to be analysed in accordance with such characteristics" (Atkinson & Coffey, 2003, p. 116).

The **narrative interview** used for this research is understood to be an account or scripting offered by the research participant in accordance with the nature of the questions asked by the researcher, which reciprocally influence the researcher's questions (Gubrium & Holstein, 2003). Therefore, any deductions and inferences made from the transcribed data are also reflective of the researcher's interpersonal style and preferences (Mishler, 1986). The interview setting will be defined according to the researcher's aims and established 'rules' for interviewing spelling out the clause of indemnity and the request for participation in the domain of this research. Therefore, the 'truth' value of the interview data is co-determined by both the researcher and the co-researcher (Atkinson & Coffey, 2003).

Gubrium and Holstein (2003) comment on the differences between the *how* and the *what* of research. The way that information is gathered and the content that follows from this are believed to be equally important in interviewing. Emphasis is placed on the techniques used to gather data as well as the way that conversational dialogues take shape through this interactional process. The authors caution the researcher not to become too involved with either the how or the what of research. Instead, they advocate that the researcher finds a balance in obtaining meaningful process relevant information, a conducive context for meaning making events to occur, and the content of what is required through the interview itself (Gubrium & Holstein, 2003).

Hoshmand (1994) has differentiated between two types of interviewing when assessing human behaviour: behavioural interviewing and diagnostic interviewing. The technical differences between the two types of interviewing are based on contextual descriptors or markers. **Behavioural interviewing** is directed towards exploring the life-world of the presenting problem and is highly explorative in nature. Questions are directed towards understanding who, when, why, with whom, what and in which circumstances a problematic behaviour is developed and maintained. In the case of bipolar mood disorder the researcher would possibly explore the onset and triggers of manic versus depressive episodes to get a clear understanding of the different social patterns and individual coping styles in both phases of behaviour transition. **Diagnostic interviewing**, on the other hand, is more focused on assessing the person's mental status and refining the presenting symptomatology to fit in a

categorical box. The diagnostic interview is task focused and is conducted from an expert stance, requiring objectivity on the part of the interviewer. This is the traditional stance of the treating psychiatrist. Signs and symptoms relating to behaviour patterns are vital sources of information to confirm a hypothesised diagnosis (Hoshmand, 1994). Both styles of interviewing are thought to have merit and are distinguished for theoretical purposes. In this research process, the two positions will be combined to attain a thorough picture of the experience of bipolar mood disorder, and also to provide a context where the more traditional style of interviewing combines with an alternative approach.

Eliciting Memories

According to Atkinson and Coffey (2003), interviews are reproductions of past events. Questions are aimed at gaining a better understanding of a person's experiences and feelings based upon events of the past. Again, a traditional scientific researcher may question the validity of the interview. However, in this research setting, memories are believed to be collective descriptions of events that have been shaped by the individual and the surrounding discourses. The memories of the research participant help to shape the current belief systems and knowledge base from which a person acts. Therefore, the current viewpoint of an individual is based upon the experiences, and memories of those experiences. To disqualify the research participant on the grounds of a faulty or distorted memory is consistent with a modernist framework that makes the assumption of the existence of right and wrong accounts. In a postmodern world, the legitimacy of the individual is not questioned for right or wrong value, but rather for what meaning that memory holds for that person, and further how that memory helps shape the current lived reality.

Omar and Alon (1997) believe that memories can never be interpreted out of context. Instead, memories are recalled and understood within a current temporal domain. This implies that knowledge is contextual. "Memory is thus circular: the past is used to help understand the present and vice-versa, with both being changed in the process" (Omar & Alon, 1997, p. 217). New experiences are integrated with past experiences and this too influences the recollection of a past event. Memory distortion

is therefore impossible as the recollection of events is also dependant on present life circumstances, which in turn reshapes the past experience itself.

The research interviews will obviously depend largely on memory recall of logistical events of the past, such as, treatments offered, by whom, in which geographical location, and also for emotional events of the past (the experience of having and/or treating bipolar mood disorder). The emphasis of this research paradigm is on socially constructed realities, and the interview will be viewed as an example of a socially constructed story between the researcher and participants. There will not be a focus on the validity of a memory, but where possible, the researcher will attempt to get corroborating information from other sources such as family members. Therefore, a postmodern description of memory is included as part of the research in which the interview will provide the arena for a conversational domain inviting descriptions of past and present events as they have been experienced by the relevant person. The assumption of knowledge being a communal and shared process will be actualised through the interviews (Omar & Alon, 1997)

The Context: Mental Illness and Qualitative Research

Qualitative researchers have a responsibility to make their epistemological position clear, conduct their research in a manner consistent with that position, and present their findings in a way that allows them to be evaluated properly (Madill et al., 2000, p. 17).

Traditionally, a scientific approach to mental illness will focus on knowing or discovering the cure for an abnormal behavioural pattern. The school of positivism consistently emphasised researcher objectivity and neutrality. This was supposed to reveal the ideal truth exposing the core determinants of abnormal functioning. Strict adherence to the principles and assumptions of positivism did not actually provide curative descriptions. The symptoms may have been alleviated due to a multitude of possible reasons, but isolating which reasons has proved to be an almost impossible task (Omar & Alon, 1997). Human behaviour cannot be simplified as easily as it is do so in the natural sciences. Interactions between people provide for differences and a

magnificent array of explanations for one event in time. The most common paradigm of researching mental illness has been from a modernist, psychiatric discourse. This research will however focus on the ecology of mental illness from a qualitative, contextual approach.

To recap, modernist assumptions lead to a psychopathological realism (Omar & Alon, 1997). This means that a mental illness is believed to reside within an individual and the cause of the presenting symptoms is to be found within the individual. Therefore, a mental illness has an objective existence and can be neutrally understood by a researcher or scientist. The process of understanding is gained by determining the cure for the causes of the illness which will rid of the symptoms. From this departure, the schools of psychoanalysis, behaviour therapy, cognitive therapy and the humanist/existentialist theories took shape. The theories attempted to be mirror images of reality and took on an exacting and unquestionable stance. Truths were attainable and taught widely. The scientific endeavour was deemed the most appropriate method of extrapolating information and anything that deterred from this rigid process was thought to be mythical and anti-scientific. Psychotherapy, in an attempt to place itself legitimately within a scientific discipline, also adopted these viewpoints and assumptions.

It is apparent that the research proposed here (a postmodern qualitative approach) is alternate to the school of modernism. The foundational beliefs of both paradigms are inherently different and presume opposing views of problems, solutions, and world-views. The transition between a psychopathological realism and a "multiple relativism" (Omar & Alon, 1997, p. 190) emphasises the differences in paradigms. Mental illness can only be understood as a concept created amongst people who commonly share a definitional belief. This belief is thought to be largely shaped by those who share an interest in the definition (such as the treating medical professionals and the clients) and the larger surrounding discourses (Omar & Alon, 1997).

"Science and research are no longer the final arbiters of absolute truth, but simply very well-tried procedures for multiple debate and consensual validation" (Omar & Alon, 1997, p. 235). This quote encapsulates the departure point of this

research. The strict adherence to techniques of research will not necessarily give rise to truths and cures. Instead, this research will allow for conversational realities to be confirmed, debated and reconstituted. The scientific nature of a qualitative researcher need not be questioned as the researcher remains **accountable** to those who have a vested interest in the research, such as the research participants and the broader field of psychology. In this sense, a postmodern scientist is necessarily consensually validated rather than merely validated by technique and interpretations of data (Lincoln & Guba, 2000; Omar & Alon, 1997).

Recapping Research Philosophy: Pre-empting Research Design

The research philosophy has been described and defined from a qualitative paradigm. This has included an exposition of social constructionism and the constructs of language, meaning, shared realities, and conversational domains. The interview has been discussed not as a technique of data collection, but as a process that borders and frames a relational context within which meanings take shape. The importance of multiple realities is paramount to this research endeavour. There can be no right or wrong perception of reality, and no judgement of false memory recollections, or interpretations of events as they have occurred. The interview bisects the person's life story confronting the past in the present time frame. Therefore, it is appreciated that memories are informed by present feelings and emotions and thoughts. The story reconstruction is also guided by the researcher's questions which are created from the researcher's interests and background. Therefore, the interview is framed as a mutually communicative realm.

Mental illness is the territory of a clinical psychologist. Training of the psychologist is focused on understanding human behaviour along the full spectrum of normality to abnormality. Research is informed by the epistemology of the practitioner. Accordingly, there should be congruence between the way psychotherapy is practiced, the theoretical departure, and the research methodology. Although, just as human behaviour is understood along a spectrum, so too is the epistemological reasoning of a psychologist, moving from modernism towards postmodernism. Theories are integrated into practice moving from the intrapsychic to

the interpersonal; the individual towards the family, and further towards the socio-cultural and historical discourses; the biological and scientific towards the esoteric and alternative approaches; the communication towards the meta-communication; the content towards the process; and the pragmatics towards the aesthetics, and reflexively back upon the pragmatics. Research methodologies also find themselves placed on a continuum from quantitative approaches to the qualitative. The plotting of the researcher requires sound knowledge of all of the levels of interaction. And this plotting, will place the researcher, in context.

The Research Design

The design of this research is consistent with the grounding postmodern epistemology described above. This entails a postmodern application of research principles. The focus is on context and meaning-making systems on both individual and cultural (psychiatric) levels. This type of qualitative research has been termed contextual analysis (Madill et al., 2000); narrative analyses (Mouton, 2001); discourse analysis (Billig, 1997); theory-led thematic analysis (Hayes, 1997); and the adapted grounded theory approach as developed by Pidgeon and Henwood (1997). These differently termed approaches have the following in common:

☞ Contextualism is particularly concerned with the relationship between accounts and the situations in which they were produced (Madill et al., 2000).

☞ Research findings are context specific and only applicable to a narrow constituency.

☞ The researcher should clarify her details such as age, gender and ethnicity which helps the audience to understand the position from which the researcher writes.

☞ The aim of research is to understand social or interactional processes through reconstructing shared narratives.

☞ Inclusion of researcher reflexivity (process of critically reflecting on the self as a researcher) (Hoshmand, 1994).

The means of gathering information is from the use of open-ended interviews using convenience sampling. A semi-structured interview schedule will be utilised to gather background details of the diagnosis and subsequent treatments.

The **bipolar mood disorder** diagnosis will be deconstructed (or unpacked) in an interview between the research participant and the researcher. The initial focus may not be on therapeutic treatment, but rather on the historical co-construction of this label that reifies a person's behaviour. "A postmodern lens may pose a third alternative – that of presenting multiple views of classification while simultaneously questioning the constitutive effects of each language" (Gorman, 2001, p. 4).

Once the data has been gathered, a narrative or thematic analysis will be used to generate patterns of meaning and understanding. This will be discussed with peers and the research participants. Where possible, matrices, diagrams, drawings and process notes will be used for data generation.

This type of research has been criticised as 'soft' qualitative research as it relies heavily on the subjective inference of information (Madill et al., 2000). The aim of such research is to gain an understanding of the processes involved when attempting to discern the patterns that people with bipolar mood disorder utilise to make sense of the diagnosis, and further, how they use this information to create a lifestyle that is useful for them. The diagnosis of bipolar mood disorder has many merits of creativity that are often unheard/unspoken of and it is suggested that it is in the story of the disorder that only negative outcomes are presented. The creative genius of Van Gogh (Blumer, 2002) has shown that within the bipolar mood disorder lies an incredible ability to produce great works of art.

One of the research intentions is to build theory or models from the information gathered and presented. The research questions are aimed at "questions of meaning and explanation; questions of theoretical linkages and coherence between theoretical propositions; questions related to the explanatory and predictive potential or theories and conceptual models" (Mouton, 2001, p. 176). This aspect of the research tends more towards a modernistic framework as the intention of theory building is to make explanatory or causal claims about reality. Further, a model can be

seen as a set of statements that accurately represent a phenomenon under study (Downing, 2000). Both theories and models are seen to provide causal accounts of the world, bringing conceptual coherence to the domain of science, and simplifying an understanding of the world (Mouton, 2001). The researcher acknowledges these 'scientific' aspirations as a way of drawing a distinction (Keeney, 1983), and hopes to maintain a critical position always questioning 'as if' (Downing, 2000).

Selection of Cases

Research participants will consist of two diagnosed bipolar mood disorder patients; a treating psychologist and a treating psychiatrist. The researcher will approach practicing psychologists and psychiatrists to refer patients who are receiving medical treatment and psychotherapy. The intention of selecting this cross-section of a system is to generate a holistic understanding of the world of bipolar mood disorder including as many of the role-players as possible.

The names of all the research participants will be changed, excepting for the researcher herself. The researcher will obtain verbal and written consent to record the interviews (by means of a digital recorder which records conversations and then transfers the recorded information to a computer) and to use the information gathered for the purposes of research. **Please see appendix A for the consent form**.

Data Collection Techniques

Documentation (Hodder, 2000), refers to texts that are prepared for personal rather than official use. Examples of documents are diaries, memos and process notes. It is believed that written texts are reflective of the social context and therefore meanings are socially and culturally embedded. The text is firmly grounded in an historical context, and will be useful for the suggested study as it is congruent with the postmodern understanding of multiple realities and contexts. According to Hodder (2000, p. 704), "(t)ext and context are in a continual state of tension, each defining and redefining the other, saying and doing things differently through time". It is believed that documents collected from the co-researchers' will be additive to the interviews and observations. The documents may tell a different story, or be additive,

to the one told in an interview schedule. The researcher has found letter writing, diary inscriptions and poetry to be helpful in understanding more about a person within the surrounding ecology.

Interviews will also be used to collate data. These will be unstructured and they will be conducted with all the predetermined research participants. The interviewing format will be consistent with the postmodern assumptions of dialogue, conversation and understanding as a social process. For the purposes of this research, the following people have been identified as important to interview when trying to achieve an understanding of the world of bipolar mood disorder:

- ☙ A practicing psychiatrist.
- ☙ A practicing psychotherapist.
- ☙ Clients or patients who have been diagnosed with bipolar mood disorder, as well as their families.

In-depth interviews will be conducted with all of the above-mentioned research participants. The research participants are also interchangeably referred to as co-researchers as they too have ownership of the research project. The purpose of interviewing the people as mentioned above is to understand the meanings and understandings of all of the people (the stakeholders) who face the challenges of dealing with, or living with bipolar mood disorder. These people continuously participate in the reality of bipolar mood disorder determining its continued status and legitimacy in the psychiatric world. In this sense they contribute to the shaping of an overarching psychiatric discourse which in turn shapes the way that they live their lives.

Data Analysis

The collected data will be analysed using the techniques of vignette analysis, coding and thematic analysis, and presented in the format of text and matrices. This section of the chapter will provide detailed accounts of each method of analysis and show its application for the suggested research study.

According to Miles and Huberman (2001), data analysis should take place right from the start of the data gathering process instead of waiting until all the data has been collected. The reason for making this suggestion is so that the researcher can continuously move back and forth between the data gathered, reflect upon it, and determine if there are other more effective ways of gathering information. Further, the process of analysis is thought to be less cumbersome if it is an ongoing process and not a hurdle to be overcome at the end. The selected methods of data analysis are thought to be conducive for ongoing analysis.

<u>Vignette Analysis</u>

According to Miller et al. (1997, p. 207), vignettes (transcript summaries) have been used to address "the researcher's account of the relevant or core elements and recurrent themes" that have been recorded in the interviews, allowing for researcher latitude which includes observations and comments. The project conducted by this group of researchers entailed the mobilisation of six researchers. Each researcher had the opportunity to create his or her unique vignette based upon idiosyncratic style. This was then meta-analysed by other researchers who further generated positive and negative themes. Some of the vignettes were factual and firmly grounded in the transcribed texts, and others were hypothetical and created from the subjective position of the vignettist. Once polarities had been generated, another researcher analysed the overall collection of vignettes with the aim of picking out the essential elements, classifying them, and comparing them with each other (within the same pool of data gathered). This meta-researcher utilised his research skills to scan the vignettes for significant themes and features, including all the observations, thoughts and ideas noted by the vignettist. This researcher also searched for commonalities and differences among the totality of vignettes. Lastly, the vignettes were arranged according to categories termed, **facts; deductions; observations; and themes**, and named the style of the vignettist in accordance with the way that the categories became apparent. The identified analytical styles of the vignettists could be described as **descriptive** (a style devoid of abstraction); **deductive** (the first level of abstraction); **thematic** (moving away from the data to determine the underlying themes. This is the second level of abstraction); and **speculative** (using hypotheses

117

and interpretations and is considered to be the highest level of abstraction. This dimension is highly subjective).

According to Miller et al. (1997), vignettes used in their study provided summaries of actual research interviews, rather than the traditional function of composed vignettes written to aid a particular training or investigation. In clinical studies, Miller et al. (1997) found that there have been very few projects that utilise vignettes to summarise and reveal interesting points about a specific client population.

In this study, the research participants were approached or referred. After interviews have been conducted, vignette analysis will be initiated. This will begin with

☞ Taping the interviews (via digital recorder and/or video-tape). The interviews will be guided by the researcher's prior knowledge and readings.

☞ Process notes will be made directly following the interviews and expanded upon after reading the transcriptions.

☞ The researcher will then reduce each story into a simple vignette with the aim of distilling the main points of the interview. There may be more than one vignette per interview, especially when there are collaborative conversations with peers and the researcher's promoter.

☞ Miller et al. (1997) suggest that each vignette should be approximately two hundred words in length, including patterns of behaviour and themes from the interview material.

☞ Further, themes generated from vignettes include within-interview (features within the interview) and across-interviews (events that become themes due to their common occurrence in other interviews). A theme can be understood as a frequent occurrence of an event (Miller et al., 1997).

☞ It is suggested that a vignette be written up for each interview from both a traditional modernistic view (diagnostic) and a postmodern (behavioural) view (Hoshmand, 1994).

☞ After outlining the identified themes and patterns, the contents of each vignette will be highlighted to represent the various categories (themes, deductions, interpretations, facts). Each category will be given an operational definition for

common language consensus between the researcher and the consumers of the research.

☞ The categories will be further sub-divided into within-interview and across-interview themes. Common discourses of language usage may also be identified.

☞ The sub-categories can release information about the researcher's idiosyncratic style.

☞ All categories will then be tabulated and reflected upon in terms of the literature review and the theoretical departure of the researcher.

☞ The original research questions will then be revisited in the light of the generated patterns and themes. The vignette analysis will then be constructively discussed as a research tool.

☞ Conclusions will be made drawing on the themes, categories, and quotes from the vignettes and the original transcriptions. These will be compared to current standing research projects as a comparative analysis.

Coding

Miles and Huberman (2001) identified four important functions of coding. Firstly, coding reduces large amounts of information into smaller analytic units. Secondly, the researcher becomes part of the process of research during the data collection phase so that later fieldwork can be more focused. Thirdly, coding helps the researcher to develop a cognitive map which helps to understand and conceptualise events and interactions. Lastly, coding is useful in multi-case studies because it lays the groundwork for-cross case analysis by identifying common themes and patterns (Miles & Huberman, 2001).

According to Pidgeon and Henwood (1997), coding involves the indexing of the collected data. Crucial to this process is structured planning. This means that adequate time should be allowed between the interviews so that transcription of the material can take place. It is suggested that coding should commence as soon as possible following the commencement of data collection.

The aim is to arrive at a form of labelling which will identify important aspects of the data corpus, as a first step towards characterising these in

the degree of detail necessary for a clear understanding (Pidgeon & Henwood, 1997, p. 260).

The coding process entails the following:

☞ Beginning with the first paragraph of the transcript, the researcher asks: what categories, concepts or labels do I need to account for what is of importance to me in this paragraph? This label is then documented on an indexing card.

☞ The rest of the paragraph is then also checked for other pertinent concepts and documented. This process is applied to other paragraphs.

☞ The coding process involves the changing, re-changing and adjustment of the terms used until a fit is improved.

☞ The researcher is reminded to be constantly alert to the similarities and differences which exist between instances, cases and concepts, ensuring that diversity and complexity of the data is explored (Pidgeon & Henwood, 1997).

For a meta-level reflection, "memoing" (Miles & Huberman, 2001, p. 72) will be used. This entails the tying together of different pieces of data into a recognisable cluster. The memo writing process is done more for the researcher's clarity of thought, than for others involved in the study. This can be likened to the act of making process notes following a therapeutic session, or keeping a journal. It is suggested that memos can also be written on topics or areas of concern that are puzzling or surprising; as alternate hypotheses to co-researcher's comments; to propose a new way of generating codes; for clarification of thought; to create a general theme or metaphor that encompasses observations. The primary audience of memos is the researcher herself.

Thematic Analysis

Following Hayes (1997), the thematic analysis will proceed accordingly:

☞ Establish the themes of the analysis accounting for the theoretical background to the research.

☞ Transcribe the interviews.

☞ Identify the causal attributions made during the interview.

- ☞ Extract the attributions onto a separate list.
- ☞ Sort the attributions according to the themes of analysis.
- ☞ Examine the attributions within one thematic category and identify the general orientation.
- ☞ Compare the attributions within one category made by one set of research participants, with those in a similar category made by another set.
- ☞ Identify the general themes and conclusions which may be drawn from this comparison.

Thematic analysis is thought to be an effective means of cultivating and observing the patterns that may emerge from the interview data. Unstructured interviews allow for the generation of a wealth of information, and a thematic case analysis will help to distil the commonalities and differences that arise (Stake, 2000).

Analysis of Discourses

The thematic analysis allows the researcher the opportunity to engage in a meta-level commentary on the wider surrounding discourses that shape the ways in which people make sense of their experiences of bipolar mood disorder. Parker et al. (1995, p. 3) outlined a deconstruction of psychopathology, analysing the "practices of power that hold traditional oppositions in place". Parker et al. (1995) proposed that representations of taken-for-granted belief systems are actually bound together in shared discourses, which they defined as "systems of statements about the world that create lived realities" (Parker et al., p. 10). Following the analytical research done by Parker et al. (1995), the emergent themes will be grouped together according to textual accounts that inform the representations of meanings, that is, the discourses that shape the belief systems and experiences of those who live and work with bipolar mood disorder. Parker et al. (1995) deconstructed several pertinent discourses which shape stories of clinical categories in psychopathology. Briefly stated, they are, the individual and the social; reason and unreason; pathology and normality; form and content; pure categories versus messy real life; and professional versus popular, lay and patient views (Parker et al., 1995). This research will be guided by the analysis done by Parker et al. (1995) and a similar structure will be followed, yielding discussions of discourses for the clinical category of bipolar mood disorder.

<u>Matrices</u>

A matrix is a descriptive tool that takes shape in the form of diagrams and tabulated data. Because the information generated through the interviews will be vast, it will be beneficial to be able to visualise these descriptions. Matrices, as set out by (Miles & Huberman, 2001) will be introduced as part of the data analysis phase. The matrices help the researcher to note patterns, themes, and make contrasts and comparisons. **A time-ordered matrix** (Miles & Huberman, 2001) will be used to arrange the chronological events as they occur, and have occurred, in the life of the diagnosed bipolar patient. The process of coding will help the researcher to identify themes that are common across time and then to be tabulate this information for clarity. **A thematic conceptual matrix** (Miles & Huberman, 2001) will be used to present information that the researcher gathers from the inference of patterns and themes. **Cognitive maps** will also be utilised to track the researcher's thinking throughout the actualisation of the research as this may be beneficial for the construction of process models. These matrices are constructed by the researcher and are influenced by the researcher's socio-cultural and professional make-up. They will not be objective descriptions of a certain reality, but rather, the matrices will be an explanation as seen from the researcher's perspective, created in a dialogue with co-researchers. The models are therefore a socially constructed reality and should be understood as being embedded in the research milieu (Steier, 1991).

The life histories will be analysed in a similar way to the interviews through the use of coding information, generating themes of commonality and difference (Mouton, 2001), and critiquing the findings from a critical mode of knowledge generation (Downing, 2000).

Researcher Bias

A way of transcending the traditional problems of research validity and reliability in a qualitative postmodern paradigm will be dealt with in ways that are epistemologically congruent. The constructs validity and reliability are of vital importance within a positivistic framework. One of the aims of positivistic research is directed towards producing results and outcomes that are inherently valid and reliable

thereby being reproducible across multiple contexts. Ellis and Bochner (2000) take a postmodern approach to research and offer the following explanations for validity,

it depends on your definition of validity. I start from the position that language is not transparent and there's no single standard of truth. To me validity means that our work seeks verisimilitude; it evokes in readers a feeling that the experience described is lifelike, believable, and possible. You might also judge validity by whether it helps readers communicate with others different from themselves, or offers a way to improve the lives of participants and readers or even your own (Ellis & Bochner, 2000, p. 751).

and reliability,

since we always create our personal narrative from a situated location, trying to make our present, imagined future, and remembered past cohere, there's no such thing as orthodox reliability… However, we can do reliability checks. When other people are involved, you might take your work back to them and give them a chance to comment, add materials, change their minds, and offer their interpretations (Ellis & Bochner, 2001, p. 751).

and further, on generalisability,

our lives are particular, but they also are typical and generalizable, since we all participate in a limited number of cultures and institutions. A story's generalizability is constantly being tested by readers as they determine if it speaks to them about their experience or about the lives of others they know (Ellis & Bochner, 2001, p. 751).

These three explanations are believed to be consistent with the theoretical departure of this chapter. The research is context specific and the legitimacy of research findings lies in the consensus of the consumers of the research. In this way, accountability is shared between the researcher and the research community, including co-researchers, peers and evaluators.

The incorporation of researcher reflexivity will hopefully thwart bias on the part of the researcher. She will make her cultural, social, professional, biographical, and personal characteristics overt. This information is thought to influence the way that research data is perceived, experienced and interpreted (Lincoln & Guba, 2000; Tierney, 2000). The emphasis is on admitting that research data is attained in a social setting in which the researcher actively partakes in a meaning construction process. The need for objectivity and control is absurd within this well reasoned and advocated postmodern paradigm.

Conclusion

This chapter has two central aims: firstly to discuss the research philosophy, and secondly, to offer a research design. The philosophy of research and the research design are thought to be congruent with each other and to be well matched. A qualitative research approach has been advocated as it is a paradigm that promulgates the use of multiple methods of data collection describing problems people experience and the sense people make of these situations (Lincoln & Guba, 2000). Qualitative researchers emphasise the importance of how social experiences and meanings are created amongst people in society. It is therefore appropriate that this methodology is used for an in-depth experience and understanding of the world of bipolar mood disorder. The polarities that may exist between overarching theories of modernism and postmodernism may also emerge through such research premises and design.

The purpose of providing detailed descriptions of the research design is to allow all the consumers of the research an opportunity to understand how the chapters that follow have been constructed. The thread that links the philosophy with the actualisation of research is believed to be the notion of reflexivity (Lincoln & Guba, 2000). The research is both a personal and a professional endeavour, challenging overarching epistemologies as well as entering the domain of mental illness. Obviously then, the researcher will make the research process as overt as possible.

INTERLUDE

A Pre-Introduction to the Vignette Analyses

The vignettes that follow require some introduction. To recap briefly, bipolar disorder has been conceptualised from a modernist psychiatric framework (**Chapter Two**); followed by an epistemological exploration of opposing theoretical premises (**Chapter Three**); and the methodological make-up of the research design (**Chapter Four**). These chapters have laid the foundation for the development of the conceptual and contextual descriptions of bipolar mood disorder.

In the chapter pertaining to research methodology it was explained that a postmodern approach would be used to conduct the research. This involved unstructured and open-ended interviews with people who have been diagnosed with bipolar mood disorder, and a psychologist and psychiatrist who both work frequently with bipolar mood disorder. There are many challenges to be faced when attempting to describe a psychiatric discourse from a postmodern perspective. The two concepts (psychiatry and postmodernism) are on alternative logical levels, and have different ways of making sense of reality. Therefore, great efforts will be made to provide clarity and differentiation of epistemology for the purposes of providing legitimisation in this research domain.

To begin with, conceptualising bipolar mood disorder in the vignettes from a psychiatric perspective placed the researcher in a dilemma. Despite wanting to expose the psychiatric influences, language, and treatment protocol, the researcher fell short of being able to do so. This was due to the fact that the vignettes were gathered in a postmodern research design, and written from a postmodern framing. Therefore, the conceptual write-up of the vignettes included context and experiential preference, rather than attaining the clear-cut precision of a modernistic epistemology. The aim of providing conceptual and contextual descriptions of bipolar mood disorder from one person's point of view (the researcher's) proved to be a virtually impossible task. A way around this challenge is to provide a circular model of epistemology and description. The modernistic departure point was relatively easy to write up in the

literature review, but when it came to the actual stories of people, the modernistic principles of neutrality and observer free stances fell away and the researcher could not isolate the interviews from context and human emotion. An easier method of achieving this (in hindsight) would have been to have imposed traditional quantitative methods such as structured interviewing and even the administration of psychometric testing. These types of analyses would have yielded definitive and structured information which could have been quantified and neutrally inferred from, generalised and promulgated. The researcher's intention was not to conduct modernistic research but merely to explore the impact of modernistic constructs on the people who live with and work with bipolar mood disorder. This showed itself as a shortfall of postmodern research. It is supposedly accepting of multiple realities and truths, but in working research, it falls short of being able to be actualised in a meaningful way. A psychiatric position cannot be written about in a de-contextualised manner – not if one lives through postmodern all-inclusive premises.

The outlook of the researcher proved to have an enormous impact on the way in which the vignettes were written up, and only one paragraph in each vignette fits within a psychiatric paradigm. This paragraph explains the person's behaviour in terms of 'pure' psychiatric constructs, devoid of opinion and context. The rest of the vignette analyses are rich in description, context and emotion. Even if context and concept were viewed as a continuum the languages of description are too similar and both are embedded in context.

Instead, the researcher opted for a circular epistemology, one which views the conceptual (modernist thinking) as part of the contextual (postmodern) and vice versa, or as what Keeney (1983) referred to as complementarities. The literature review would be a partial arc description of bipolar mood disorder and the vignettes would also be a mere partial arc offering an alternative explanation. The topic of interest, bipolar mood disorder, is composed of manic and depressive behaviours, never occurring simultaneously. In the same vein, modernist and postmodernist paradigms are two ways of thinking in clinical psychology, and for both to occur simultaneously would be insanity. Just as a manic episode leads into a depressive downswing and then back into a state of mania, this thesis began with a modernist description of bipolar mood disorder according to scientific research and psychiatric nomenclature,

which then moved into these vignette analyses which will be framed in postmodern language and context (not for lack of trying to impose modernism). This should then culminate in a return to modernism in the form of practice manuals and caveats for postmodern research based on modernistic constructs. The synthesis that will follow the thematic analyses will pave the way for a discussion of future research needs and acknowledgements of strengths and weaknesses of the current research mission.

The conceptual and hypothetical construction of bipolar mood disorder from the modernist framework has value, but not complete authority. Bipolar mood disorder can be abstracted in a psychiatric problem determined frame, as well as in a social constructionist avenue. The greatest difference lies in questioning who receives the most benefit from it. From a modernist meaning generating perspective, the focus is solely upon the patient – his or her moods, behaviours, psychological make-up, attitude and family history. From a postmodern perspective, the focus is disseminated amongst all stakeholders, hence the vignette inclusion of the psychiatrist, psychologist, dead man, and the researcher. The neat and tidy position of value exclusion inherent in modernism is abdicated in postmodernism in favour of the inclusion of multiple meaning-making perspectives.

A Symptomatic Re-cap

Bipolar mood disorder is indicated when there is the presence of the following manic behavioural and psychological symptoms:

- Elated or euphoric mood representing as excessive happiness or expansiveness.
- Irritable mood represented by excessive anger and being oversensitive.
- A decreased need for sleep.
- Being grandiose or having an inflated sense of self and abilities.
- Increased talkativeness.
- Racing thoughts with poor self-monitoring.
- An increase in energy and activity levels.
- Changes in cognitive ability, attention span, perception and impulsion often leading to reckless behaviours.

In addition to the mania, bipolar mood disorder must also have the polar opposite of depressive symptoms, including:

- Feelings of anhedonia.
- Loss of interest in favourable activities.
- Weight loss and loss of appetite (or the opposite).
- A pervasive feeling of fatigue.
- Has difficulty falling asleep, or staying asleep.
- Has a poor and negative self-image.
- Struggles to make decisions and has difficulty concentrating.
- Has thoughts of committing suicide.

Once a person is diagnosed with bipolar mood disorder, he or she falls into one of these categories:

- For Bipolar I disorder: an episode of manic or mixed disorder, and at least one episode of major depressive disorder
- For Bipolar II disorder: at least one hypomanic episode and at least one major depressive episode
- For Bipolar disorder with rapid cycling: a person must meet the above criteria for type I and type II and have four or more episodes of major depression, manic behaviour, a mixed disorder, or a hypomanic episode in any twelve month period (Miklowitz, 2002).

Interestingly, from the above overview, there is no mention of who the diagnostician is, or the background and experience required to make such diagnoses. Further, there is no mention of family, societal and cultural influences, merely the person's observable behaviour. This is therefore a very accurate description provided by a modernist framing of bipolar mood disorder.

Bourgeois and Marneros (2000) offered a thorough explication of the determinants of bipolar mood disorder. These include:

- The onset of the disorder, including the kind of onset, the age at onset, and precipitation factors.

- Episodes in terms of the type, the number, the frequency, length and the symptoms.
- The cycle, emphasising the number of cycles, the infrequency of episodes and the duration.
- The intervals focusing on the length and symptoms, suicidal ideation, stability of symptom constellations and shifts in the syndrome pattern.
- Activity of the disorder insinuating that the disorder must be clinically active (much like the metaphor of a volcano).
- Inactivity of the disorder inferring that the disorder has no further re-manifestations.
- And outcome determined by the stability of psychopathological and psychological status over a three year period (including changes of personality, subjective well-being, and social and occupational functioning), suicide and mortality.

This seemingly all encompassing overview again focuses on the individual and the problem behaviour. It does provide a useful and simplified platform from which to determine the outcome of having such a diagnosis. The intricacies embedded within the bipolar mood disorder diagnosis are clarified through these points of demarcation, and again, this fits within a modernist framing.

Callahan and Bauer (1999) outlined effective psychosocial interventions for the bipolar mood disorder spectrum. This outline focused on areas of biological and genetic factors, pharmacotherapy, and psychosocial interventions, including individual, family and group based therapies. This is the domain of the psychologist and there is an apparent difference between the psychiatric perspectives previously indicated above and the psychological frame of reference. However, their exposition still focused exclusively on the person with the diagnosis. They did acknowledge that there is a paucity of research in the field of psychosocial factors that may exacerbate a person's condition (Callahan & Bauer, 1999). This research thesis is one such attempt at filling that gap, from a postmodern discourse viewpoint. Callahan and Bauer's (1999) research found that stressful life circumstances worsened both the functioning of the person as well as the predictability of medication compliance. Therefore, social support systems were deemed to be imperative in the process of recovery. The nature

of family interactions was further explained and therapies were redesigned to accommodate interactional styles of high and low emotive expressions. These were very useful and effective for 'fixing' the person. Their research then covered the domain of chronobiological factors and they found that there were definitely seasonal variances in mood as well as in the administration of certain types of treatments, for example, more people having mood phase swings in spring and autumn, and experience concurrent changes in sleep and eating patterns. Again, this provided important information for the monitoring and re-programming of the individual. Lastly, they ventured into the domain of compliance and they discovered that the factor which has most weight in determining whether or not a person will be compliant is dependant on the relationship with the treating psychiatrist. Other reasons given for non-compliance were a need to have the high mood phases to make life meaningful for the person, a feeling of being controlled by the medication, the intricate manner in which the medications have to be taken, the financial costs of taking a treatment batch, and side effects of the medications (Callahan & Bauer, 1999).

The psychosocial aspects covered by the above researchers provide necessary information for the person with the diagnosis, but one can see that their assertions have not been included in the psychiatric overviews which were published after Callahan & Bauer's study. The psychological make-up of the person is complicated and it appears simpler to stay within the safe boundaries of observable signs and symptoms. The psychiatrist has still not acknowledged the importance of the therapeutic relationship that exists between the doctor and the patient, even though research has consistently shown the value of a productive and trustworthy relationship.

Speed (1991, p. 399), who claimed to be a constructivist, said the following about the discovery of family patterns amongst the diagnosed:

> Psychotic games, high levels of expressed emotion, enmeshed patterns of behaviour are all the therapist's interventions, ideas in the therapist's head. How therapists see problems determines what those problems are (including the definition of something as a problem in

the first place) rather than the problems determining what therapists see.

This quote epitomises the discrepancy between a traditional psychiatric perspective that 'fancy-fies' the psychological symptoms evinced by a person and the more relativistic postmodern knowledge which claims that the observed interactional patterns of behaviour are mere socially shared co-constructions of reality.

A Step Higher: Contextualised Symptomatology

Having explained the signs and symptoms and mitigating factors that predict recovery (or failure to do so) from bipolar mood disorder, one should have acquired a conceptual overview of what bipolar mood disorder is, what describes it, how it is defined and how it manifests itself. Research and scientific evidence (Bourgeois & Marneros, 2000; Miklowitz, 2002) have suggested that the prognosis of someone diagnosed with bipolar mood disorder should be 'good' if a decided upon treatment protocol is adhered to. However, a person does not enter the psychiatric system alone, in isolation. On the contrary, a person engages with a psychiatrist, a psychologist, nurses, other treating professionals, family, religion, and socio-cultural systems. Therefore, a treatment protocol should include the client's treatment programme and additional prescriptions, behaviour or otherwise, for all role-players in the realm of bipolar mood disorder so that evolutionary change is brought about. This thesis aims towards growing the medical model foundation to include the wider social discourses of all factors that impinge upon the bipolar mood disorder reality, not just behaviour descriptions for the client.

In the vignettes that follow, two clients, a psychologist and a psychiatrist were interviewed focusing on their own unique and idiosyncratic constructions of bipolar mood disorder. While there will surely be common themes and trends that will emerge, it should be kept in mind that each person has a distinct background, historical influences, academic grounding, cultural make-up and making sense processes. The only common factor shared among all research participants is the researcher, and the experience of bipolar mood disorder. The open-ended interviews

involved the researcher asking each research participant to share her understanding and experience of bipolar mood disorder with the researcher. There were no limitations introduced by the researcher, rather, the researcher chose to allow the full emotional gamut. This resulted in completely different stories, based on exclusive background experiences. The common themes will therefore be inferred from the one person who interacted with these four consumers of psychiatry, namely, the researcher.

Being a psychotherapist and a researcher allowed the interview to be more of a process rather than a content – filled experience. Much detail was gathered in terms of the historical development of the disorder but the essence of bipolar mood disorder lies in an understanding of the intricate processes surrounding it. These include, the tones of voice and the nuances unique to each interview and participant. The emotional intensity of expression, the heightened intensity of passion about the subject carried through with the scribbling on paper (the psychologist), uncharacteristic hypo-giggling (the psychiatrist) and the tears and laughter of the diagnosed all seem rather flat on paper. This aspect of the research cannot be easily transcribed and translated. These are the essences that complete any treatment protocol. A nicely formulated treatment outline cannot encapsulate the mood of the person, the conversation, or the content. And this is bipolar mood disorder, as experienced by the researcher.

Through all the documented research, the researchers have failed to account for their own positions, vested interests, rationale, choices of delineation, experiences and privileged knowledges.

The contextual exposure of such a report would add value to the dry and unfinished body of knowledge that exists among the bipolar mood disorder spectrum and current body of knowledge.

The conceptual defining of bipolar mood disorder is acknowledged, accepted and built upon. This entails a brief psychiatric explanation of each participant, followed by the story within the story, as shared by the researcher, based on interview transcripts. This rendition of the interviews flows from the way the person received

the diagnosis through to who is connected to the problem. This contextual description is then further grounded in a deconstruction of the text as well as a model of contextual understanding through postmodern reflections. Each story will then be discussed in terms of the people who reflect back upon the diagnosis, for example, the person and the family; the psychologist; the psychiatrist; the discourses. This expands on the thin line of the modernistic conceptualisation of bipolar mood disorder adding an additional dimensional view.

But one may stop and ask, why? What could be the aim, intent, goal and outcome of such depth and insightful qualitative searching? Who would benefit from addressing bipolar mood disorder in this manner?

From a perspective of inclusiveness (both modernist and postmodernist) a version of reality is created within which all stakeholders accept mutual responsibility for dis-solving the diagnosis, understanding the person in the full context of all or most interactional dynamics. Isolating the person from the diagnosis has only served the academic, psychiatric and pharmaceutical industries, not necessarily the person, the family, the culture or the ideology.

The modernist-postmodernist debate is not linear as previously thought. It can be shown that they are in fact circular epistemologies and not essentially off-springs. The circular epistemology can also be punctuated through arbitrary distinctions just as manic and depressed behaviours are separated. This would create communal validation, just as people have accepted mania and depression as two oppositional mood patterns. As a mood pattern vacillates between polarised distinctions, each one enfolding upon the other, so too does epistemology, especially in the domain of psychotherapy.

Epistemological Symptomatology

Both modern/systemic and post-modern narrative discourses can be contaminated by the human need to mythologise, to say something Grand (Larner, 1994, p. 12).

133

For the purposes of clarity and communalised understanding, the 'symptoms' of both epistemologies, modernist and postmodernism, will be outlined. This will give the reader additional information, better enabling him or her to understand what the researcher is referring to when she speaks of a modernist or a postmodernist epistemology. Firstly, one would remember that an epistemology is the philosophy of knowledge or understanding how we come to know what we think we know. It follows that a modernist epistemology is concerned with underlining the principles and tenets that frame the way one knows what they know and how they know this. To begin with, a person is exhibiting signs and symptoms of a modernist paradigm if the following is observed:

✗ There is a single, unitary reality. This reality exists separate from our perceptions.

✗ There is an objective reality which can only be known through value-free research methodologies.

✗ The true findings of research can be generalised to the mass population. Context is irrelevant, and should be viewed as value-laden.

✗ Knowledge is generated from strict measurement and observation tools.

✗ The researcher is separated from the object of study.

✗ Scientific endeavour aims to discover the singular truth so that the world can be predicted and controlled.

✗ Facts can and must be separated from ideas, thoughts, abstractions and values.

✗ The search is for regularities and causal relationships between the constituent elements of the study (Krauss, 2005).

The therapeutic dangers of owning a modernist perspective are that the social and cultural contexts of clients and their problems may be ignored; the problem may be inappropriately situated within the person's mind; the therapist may impose his or her own worldviews and beliefs of correct behaviour on the client; and there is a risk of minimising the impact of wider discourses such as gender, socio-economic and power relations (Clark, 1997). This brings us to the signs and symptoms of a postmodern framework. One is said to be operating from a postmodern position if the following assertions are noticed:

- Knowledge, reality, and identity are social and discursive constructions.
- Observation, evaluation, judgement, diagnosing and intervention are all self-reflexive actions.
- Truth is a relational construction, co-created in language domains.
- World-views are merely social constructions.
- There is respect for multiple communities, local realities, and historical and cultural inferences.
- Meanings are trans-behavioural, implying that they do more than merely describe behaviour, they define, justify and interpret it.
- The researcher is part of the co-constructed reality and cannot be separated from that which is researched.
- Research generates unique meanings focusing on the construction of the meaning making process and the different factors that influence this process.
- Data analysis is an intuitive process. A researcher is part of a learning process in which knowledge is generated among all participants.
- The conceptualisation of the phenomenon under study is seen to emerge from the interaction between the researcher and the co-researchers (the participants).
- The research design should be flexible allowing for depth of understanding and therefore a valid representation of the co-researcher's viewpoints.
- There is no objective reality, but there are contextually grounded multiple realities (Flaskas, 1994; Krauss, 2005; Larner, 1994; McNamee, 1997).

An interesting question posed by Held (2000, p. 43) was:

if there is nothing systematic about therapeutic practice, if there are no generalities (about human nature) to apply to the unique particularities we find in our clients, then in what sense can therapists claim, as they do, to be experts about human pain, suffering, and growth?

This quotation brings the dilemma of accepting postmodernism to the fore. It is necessary to have some type of platform from which we develop our theories and suppositions and critically reflect on them. But at the same time there is always a danger of accepting these hypothetical claims as truths and facts.

The value of this debate for this research is in the conceptualising and contextualising of bipolar mood disorder. Attempts at contextualising bipolar mood disorder will fall too deeply into the non-expert stance of the therapist where solipsism becomes hazardous for the psychotherapeutic fraternity. But relying solely on the conceptualising of bipolar mood disorder ensnares the diagnosed person in a tangle of academic and pharmaceutical chains. Somewhere in between these two epistemological positions lies a balance.

A Way Forward

The vignette analyses that follow present contradictory challenges for the researcher. In exposing the working of a mental status exam as a descriptive psychiatric tool, the researcher initiated her preferred way of being, that is offering contextually grounded renditions of any case example given. This contextual description nullifies the principle of a mental status exam, which is supposedly meant to be a value-free, scientific instrument of data gathering. The researcher found this to be an impossibility. As soon as the person is described, the researcher was pulled towards contextual markers providing thick descriptions, and therefore moved away from conceptual markers of symptomatology. Therefore, the researcher chose to delineate the signs and symptoms of bipolar mood disorder in this pre-text chapter and allow the vignette analyses to be what they are – rich, contextual descriptions of the experiences of bipolar mood disorder from the perspectives of various role-players.

Bipolar mood disorder can be presented from both conceptual and contextual positions, but unfortunately, not in the same sentence, paragraph or chapter. The epistemologies, being reframed as circular, will allow the space for the vignettes to be postmodern resurrections of the interviews. In the vignettes that follow, the researcher assumes the position of the postmodern researcher and will therefore exhibit the signs and symptoms of such a paradigm thinker as listed above. The notion of a value – free researcher will be rendered meaningless and the reflexive position of researcher inclusion in the research process will be advocated.

CHAPTER FIVE

Conceptual and Contextual Descriptions of Marge Polyvocal: Polarised Descriptions

Introduction

This chapter will present the story of Marge Polyvocal. Firstly, a medical model description of the story will be presented following an insight-oriented interview process (Miller, de Shazer & De Jong, 2001). This aspect of the story will focus on the traditional diagnosis of bipolar mood disorder, the way in which Marge Polyvocal received the diagnosis, and the many contributing factors that brought about the diagnosis, and help to maintain its presence in her life. A thorough explication of the medical model is offered through the use of a case study and a discussion thereof. After the traditional approach to mental illness is examined, a social constructionist approach is discussed. This outline is based upon the writings of Parker et al (1995). Particular themes of demarcation are discussed in terms of the interviews with Marge Polyvocal. The postmodern tenets inform the social construction of bipolar mood disorder and this is believed to be a construction of reality based upon the relationship between Marge Polyvocal and surrounding discourses. These discourses are harvested in an effort to show an alternative way of understanding bipolar mood disorder. The chapter concludes with a discussion on the symmetry of the opposing epistemologies as they have been presented.

The opposing epistemologies of modernism and postmodernism will be practically adapted to the information obtained from the interviewing process. To recap, the modernist framework centres beliefs and methodologies on principles of regularity, generalisability, empirical and verifiable knowledge, authority and scientific knowledge superseding the lay person's experiences, the individual as the object of change, and the overarching view of truth as absolutist. A postmodern, social constructionist epistemology grounds itself in multiple realities that are believed to be shaped by those who contribute to the formation of an idea or

construct; truth being relative to context and therefore multi-dimensional; co-created and evolving meanings emerging from interactions between people; reflexive shaping of discourses and shared meanings; knowledge developed as a communal construction and meaningful to those who participate in it; and valued knowledges and experiences of a person, regardless of academic stature. One can see the stark differences between the two views of human behaviour, yet the domain of psychology requires a practitioner to be fully conversant in both languages. This chapter is an attempt to provide both languages, respectfully, and by doing so, allows the space for an alternative approach to develop.

It should be noted that in the context of describing the medical model, a person is referred to as a patient given that the relationship is between a treating expert with knowledge and a patient lacking such knowledge. In a social constructionist context, a person is referred to as a client who possesses adequate knowledge which is respected, abilities and skills to overcome her own struggle and find her own solutions. The knowledge is therefore shared equally as both participants co-construct the understanding of the problem and co-evolve a unique outcome.

Conceptual and Contextual Descriptions: The Medical Model

The interviews with Marge Polyvocal can be conceptualised from both the medical model and a social constructionist approach. The medical model follows a psychiatric interview, involving insight and symptom orientation. The social constructionist approach focuses on the story that is told, the language used, and the way in which meaning has been constructed. A way of gathering information for a psychiatric interview is through the use of the mental status exam. This is a globally accepted interview schedule that seeks to infer information about the patient's well-being at the time of the interview. Each participant will be described in terms of her appearance, her behaviour during the interview, her attitude towards the researcher, her psychomotor activity, her emotional state during the interview, a comment on any perceptual disturbances and notes on her speech, thought and orientation. These commonly used descriptors in the psychiatric setting all focus on ascertaining whether or not the patient has insight into her situation, and it also narrows the search when

looking for a diagnosis according to behaviour categorisation. It is a useful tool in that it helps the interviewer filter through a person's story to arrive at a diagnosis on the basis of fulfilled criteria for a specific disorder, as well as giving an indication of what treatment can be implemented. A symptom oriented interview has the dual purpose of identifying signs and symptoms of categorised behaviour patterns (as defined by the DSM- IV) as well as being a means to assess the current stage of the development of the disorder. Collectively, these factors will point towards appropriate treatment plans.

The psychiatric insight oriented interview (Miller et al., 2001) seeks to find intrapsychic conflicts, distorted perceptions and to identify maladjusted behaviour patterns. The aim of the intrapsychic interview is to provide a sketch of how the patient is contributing to her diagnosis, albeit unconsciously (Miller at al., 2001). Once the patterns of dysfunctional psychological defences have been identified, the psychotherapist would aim to provide the patient with insight into why the patient feels as she does. If the patient is able to gain insight into her own behaviour, thoughts and feelings, then it is assumed that change will occur, and in the case of bipolar mood disorder, the symptoms would be eradicated through insight into why mood swings occur. The intrapsychic conflicts within the individual's mind are thought to bring about destructive and self-fulfilling failures. It is only through the expert observation and opinion of the diagnostician that the correct identification of maladaptive behaviour can occur. The patient is seen to be ignorant of her own behaviour and because of this she continues to be mentally ill. The focus of assessment is the individual, and although context is included, it is very limited (Miller et al., 2001).

This individual approach to conceptualising a person's problems is tuned towards verifying observable behaviour so that an appropriate treatment regime can be implemented. It is of utmost importance to categorise a person's behaviour adequately in the most applicable category. If the diagnosis is overlooked, then the patient faces the uncertain future of taking the incorrect medication and remaining in a position of continued mental illness. It is a proven, scientific fact, that bipolar mood disorder is a psychiatric illness and requires medication for mood stabilisation (Kaplan et al., 1994). Should a person choose not to follow the medical route, it is an

inevitable fate that the moods will overwhelm the person and render her helpless, depressed, and possibly even suicidal.

To begin with, an insight and symptom oriented interview vignette will be given of Marge Polyvocal. This information is based on the researcher's interview with the patient, involving both content and non-verbal inferences. The researcher is a qualified clinical psychologist and spent six months doing a psychiatric rotation where she had to participate in giving accurate diagnoses on the basis of psychiatric interviewing. The researcher participated willingly in giving the panel of psychiatrists information that would help them with their treatment protocol. The researcher is therefore well versed in the communication style of the psychiatric system and these observations inferred from the research interviews are grounded in experience in psychiatric settings.

The Mental Status Exam

Akiskal and Akiskal (1994) suggested that a mental status exam focus on the following interview descriptors:

- ✖ The patient's appearance
- ✖ The patient's behaviour during the interview
- ✖ The patient's attitude towards the psychotherapist
- ✖ The patient's psychomotor activity during the interview
- ✖ The patient's emotional state during the interview
- ✖ The patient's perceptual disturbances (if any)
- ✖ Identifying problems in speech, thought and orientation.

The Vignette

54 year old married woman with two children. Known psychiatric patient with multiple hospital admissions. Current diagnosis, bipolar disorder 1. Does have psychotic states (in manic phases) with paranoia and delusions of thought content. Becomes obsessed that husband is having an affair and acts on disturbed thoughts by verbally attacking the other woman. Manic symptoms include overspending,

increasing telephone account, disorganised planning, forgetfulness, decrease in sleep and appetite. Remains compliant with medication throughout all phases. Depressive state includes suicidal ideation, excessive crying, anhedonia, and withdrawal. Depressive state may include anxiety episode marked by hyperchondriasis and panic attacks. Physical health deteriorating with age. Suspected sexual molestation as young adult.

The patient's appearance

Marge Polyvocal presented herself well groomed and smartly dressed for the interview. She appeared to be willing to participate in the interview. She tried to answer the researcher's questions with thought and precision, although this was not always achieved and she would lapse into divergent story lines. The patient behaved appropriately given the research context and she showed no discomfort in having the sessions recorded. On both occasions she was consistently well presented and showed that she had a good ability to take care of herself. The patient's self-image was very important to her and she made efforts to groom her hair, dress conservatively and neatly and she wore make-up.

The patient's behaviour during the interview

Marge Polyvocal's behaviour during the interviews was marginally inconsistent with the setting. She would divert her thought process into stories that were irrelevant to the context and at times inappropriate. She was respectful of the researcher's questions and explorations and waited until the researcher had finished talking before answering and talking. But, when she was talking, it was difficult to interrupt her if she was diverting and she showed that she preferred to complete what she was saying without interruption. Marge Polyvocal became overexcited at times and this was followed quickly by an outburst of tears. In this way, the patient was inconsistent. Her stories were often contradictory and she showed poor self-monitoring. Marge Polyvocal was also easily distracted and because she was not following her own story-telling process, the researcher was pressed to focus closely on what Marge Polyvocal was saying so that relevant information could be discerned from all the loose stories told. At times, the researcher felt that Marge Polyvocal could not differentiate a therapy session from a research interview and she would ask the researcher for confirmation. This further indicates that even though Marge Polyvocal

was aware of the research process, she would divert away from a question and become tangential. Her concentration was poor and she could not focus on one aspect of her story at a time.

The patient's attitude towards the researcher

In the research context, Marge Polyvocal was honest, open and giving of herself. She showed interest in the topic of discussion and felt relatively at ease with the researcher. She showed no signs of discomfort at being interviewed. The researcher played the role of a curious observer and the patient answered from a position of being a well informed consumer of psychiatry. The patient felt that she had a wealth of experience in the field of bipolar mood disorder and quite enjoyed the exposure and attention received from the researcher. Marge Polyvocal wished to provide a broad understanding of the mood disorder and treated the researcher as a novice in the realm of bipolar mood disorder. The researcher took this position willingly and remained curious. This allowed the patient to be honest about her story and she shared her feelings with unlimited intensity.

The patient's psychomotor activity during the interview

Marge Polyvocal remained relatively calm throughout the interviews, but when she relayed a story with great emotion, her tone of voice would increase and she would become excitable often knocking over her water bottle or dropping tissues. Her hands were busy during the interview and she would draw imaginary squiggles on the table cloth with her fingers, mostly in a circular fashion. When listening to the researcher's questions, she would often blink her eyelids and would answer the researcher's questions without hesitation. Her physical excitement also mirrored the opposing physical expression of stooped shoulders and hands dropped at her side when she was crying. Her psychomotor expression appeared to be congruent with her feelings.

The patient's emotional state during the interview

This aspect of the mental status exam gave the most information to the researcher. When Marge Polyvocal was retelling her story of her past experiences she would become tearful when thinking back to times that had passed. However, when she did cry, it was in the form of a helpless, uncontrolled sobbing. Marge Polyvocal

required containment and the researcher was respectful of the research context as an information mining context, and not a therapeutic session. The researcher also had to keep in mind that Marge Polyvocal was a fragile person and the researcher was ethically bound to do no harm to Marge Polyvocal. Even though the researcher tried not to push Marge Polyvocal's emotions, Marge Polyvocal often took herself beyond her own level of coping and shared experiences that were obviously painful and still fresh emotive memories, even though much time had passed by. Marge Polyvocal also showed uncontained frustration when relating stories about her own victimisation and perceived persecution. The researcher allowed Marge Polyvocal to tell her story with compassion and gently moved on to other topics of conversation when appropriate. However, Marge Polyvocal did not always remain emotionally consistent and she would vacillate between sadness, anger and desperation, and calmness. The researcher could not find a point of balance in conversation with Marge Polyvocal and was acutely aware of emotional outburst triggers. Marge Polyvocal showed that she has limited control over her emotions and her outbursts were often impulsive and context inappropriate. Again, this links back to her limited ability to monitor her own process. Her mood depended largely upon factors that pre-empted the research interviews, such as her sleep (or lack thereof) the previous night, the traffic on the way to being interviewed, interactions with her husband, and conversations that she had with other people in between interviews. She could not contain her emotions during the interview, nor could she distinguish between what would be appropriate for the interview and what would be better suited for a therapeutic session. Clearly, Marge Polyvocal's emotions overwhelmed her and she showed limited ability to contain her feelings.

The patient's perceptual disturbances (if any)

At the time of the interview, Marge Polyvocal was not exhibiting any delusions, hallucinations or psychotic features. However she has had delusional thinking in the past, especially at the time of manic episodes. It could be that the medication regime is effective in containing her inappropriate thoughts. Marge Polyvocal gave no indication that she was experiencing perceptual disturbances. However, having said that, her perception of herself was often of a victim being exposed and made vulnerable to people in her life. Her reality testing was poor as indicated by her inability to take responsibility for how she can bring about positive

changes in her life. Her focus was on making other people responsible for her situation, such as an inattentive psychiatrist, a distant husband, demanding children and having unreliable friendships.

Identifying problems in speech, thought and orientation

Marge Polyvocal showed a limited ability to express herself in any form of chronology or structure. She spoke as she felt and this resulted in a very unstructured and loosely connected interview process. She was resistant to structure and preferred to tell the story as she remembered it. Memories would enter her mind through association with another topic and she would jump straight back into another question that the researcher had asked previously. Her thought process was tangential and loosely connected. She showed difficulty in concentration and was unable to monitor her own thought process. The researcher had to assume responsibility for this, and this could reflect what other people in her life have to endure. Marge Polyvocal was orientated for time, place and space, although she did have difficulty differentiating the research process from a therapeutic session. Having acknowledged that the researcher was a clinical psychologist seemed to set the context as a therapeutic one as Marge Polyvocal is well versed in the language and format of therapy sessions. She showed limited ability to be flexible and preferred to remain in her known ways of behaving, requiring the interviewer to monitor and guide her thought processes.

This mental status exam provided the researcher with a condensed process oriented commentary of the interview with Marge Polyvocal. Marge Polyvocal showed limited insight into her own behaviour and psychological processes. She remained dependent on the researcher to provide structure and self-monitoring. She showed an inability to assume responsibility for her behaviour and one would have to deduce that she will not make a recovery from her diagnosis if she continues to be so rigid and inflexible. The contradiction lies in the fact that she presented herself as someone who would like to learn about her diagnosis and condition, yet she was not open to exploring any area that went beyond her past experiences. She could not see how she could make a difference, be it through monitoring her own mood patterns, or engaging in more physical exercise. She had excuses and justifications for most known helpful treatments of bipolar mood disorder. She preferred to be dependent on the psychiatrist's treatment and even appeared to be afraid to try anything different.

A Case Study of Marge Polyvocal

This section will introduce the contextual descriptions of how Marge Polyvocal came to receive the diagnosis of bipolar mood disorder. From the mental status exam, one can see that Marge Polyvocal has psychological, psychiatric and medical problems. Her insight was poor and she took the position of blaming others for her situation and condition. This section will now focus on the signs and symptoms which will indicate a diagnosis in the category of mood disorders. Having ascertained that Marge Polyvocal has a fragile personality and contradictory thought processes, this will be more finely filtered by focusing on behaviour expressions and Marge Polyvocal's story of how she came to receive this diagnosis.

Explaining the Title

At the time of interviews Marge was experiencing a bout of ongoing and relentless depression. Initially the researcher named this research participant, Ms Depression, but this proved to be a problem as she could not neatly be boxed into the category of depression. Although she cried through parts of the interview and told her story with a feeling of hopelessness and desperation, she also showed manic behaviour tendencies such as flight of ideas and complete lack of structure in her story telling process. The metaphor of polyvocality was thought to be more descriptive. Polyvocality implies the way that every meaning space is imbued with multiple meanings, "all chatting away in contradiction and disparity, and sometimes in conflict" (Frosh, 1995, p. 186). It was therefore thought that naming the research participant as Marge Polyvocal would be appropriate since her story is embedded within her lived experience of having the diagnosis of bipolar mood disorder, fraught with contradictions and opposing ways of behaving. Her behaviour and past experiences could not easily be framed as either manic or depressed since she rapid cycled between the two poles. On any given day, she would be experiencing an intense emotional state and the accompanying behaviour.

The re-telling of her story in a chronological order often placed her long-term memory under great stress and she felt inept for not being able to recall all of the

details of hospitalisation periods, medications taken and also names of doctors and psychologists. She had the added complication of frequent relocations within South Africa during her psychiatric treatments because of the nature of her husband's work. This further complicated her recall of the series of events that had accompanied her in her life. After the initial interview she went and made notes of what she could remember in a more structured manner to assist the researcher. Therefore, the second interview was more structured and contained.

Her deep-seated depression often led to comments about her own suicidal wishes during the interviews. The unravelling of her tale of bipolarity evoked very strong emotions and she was propelled to open up closed doors of her past. This process had an impact on her current relationships at home and she felt dejected and unworthy the more she thought about her story. Her main story line was that she had spent her life sacrificing her wishes and desires for the benefit of others, and this had simply not provided the outcomes that she had dreamed of and hoped for. The process of reflecting on a lifetime of doctors and diagnoses raised uncomfortable feelings of always being dependant on someone for support, a stagnation in terms of her own expectations in life, and the overbearing gloom of having a diagnosis of being mentally ill. These are the dark descriptors of her life.

There were sporadic lighter times as well. Marge Polyvocal felt empowered that she was in a position where she was able to impart her experiences which may ultimately impact on the lives of others in a more positive and compassionate way. Also, she gained a sense of closure as she was pulling together loose threads of her history and finally participating in a situation where she was the highlight. Another lighter shade was seen in her sense of humour which made fun of the psychiatric system and she was able to provide a caricature of herself on many occasions.

Simultaneous to the research interview process was an ongoing battle with her psychiatrist. After each session with the psychiatrist she felt worthless and had a dooming sense of being just another patient. Her primary psychiatrist had also gone overseas to attend conferences and she had begun to rapid cycle. The stand-in psychiatrist thought that this did not have a bearing on her condition and she therefore did not change her medication. For her, strong themes of neglect and abandonment

emerged at this time. The complexity of Marge Polyvocal's story was further enriched by her battles with daily living. Nothing appeared to be simple and clear-cut. The transcribing of the research interview was also indicative of this process and it took hours upon hours to transcribe and thematically analyse. The mood variation present during the interviews cannot be easily captured in transcription and therefore process comments are used where possible to provide information about the context and the meta-mood of the interview itself.

History and background

The history taking proved to be a difficult task as Marge Polyvocal had poor chronological memory of events as they occurred in the past. She has had multiple hospitalisations, all of which were effective in returning her to a more stable condition so that she could re-enter her life. She was treated in the following ways:

- Psychiatric medications (including a mood stabiliser, anti-depressants, anxiolytics, anti-convulsants, anti-psychotics, sleeping tablets, hormone replacements, over the counter pain tablets, and vitamins).
- Electro convulsive therapy.
- Psychotherapy (including cognitive behaviour therapy, psychoanalysis, and systemic family therapy).

To date, none of the aforementioned treatments have proven effective in maintaining long term behaviour change. She continues to rapid cycle and experiences severe depressive episodes and manic symptoms. This research participant has had both manic and depressive symptoms spiralling throughout her life since entering the psychiatric system in 1973. She is known to be a rapid cycler and her mood has stabilised for brief periods of time. During this 30 year period, she has been hospitalised on various occasions during which time her mood was stabilised sufficiently to be discharged and continue with outpatient treatment. She has met the criteria for a manic episode (such as racing thoughts; distractibility; a decreased need for sleep; spending sprees) and at times she has been psychotic as well (mood congruent psychotic features). She has met the criteria for a depressive episode (such as concentration difficulties; lack of sexual/life interest; thoughts of suicide; decreased

appetite; decreased need for sleep; lack of interest in pleasurable activities). This patient has been diagnosed as a Bipolar 1 type patient. This patient is compliant with medical treatment and occasionally changes her dosages according to manic or depressed episodes. She has been told by the psychiatrist which tablet she can add or subtract depending on how she feels. She presents herself as a difficult patient in that she has clear expectations of her treatment and she often feels neglected by the medical support team. The high expectations often reinforce her helpless position. If her needs are unmet then she resorts to an angered and frustrated position, dependant upon someone else to 'fix'. The family support is adequate but not ideal. The marital system is conflictual and apparently her needs are unmet. Again, her expression of perceptions of expectations of support, care and information vacillate depending on which mood phase she is in. If she is manic-sad then she tends to behave the same way as when she is depressed, that is, needy, demanding and even unreasonable. If she is manic-happy, then she becomes impulsive and reactive to her perceived unmet needs. This causes great friction and conflict between her and her support systems. The high expectations are also reinforced through the treating medical system as she is often promised that she should notify the psychiatrist as soon as she anticipates the onset of a mood shift. Unfortunately, more often than not, the psychiatrist will be unavailable to do an assessment. The pressure then falls upon her psychologist, husband and/or other friends. At the stage of redistribution of responsibility, Marge Polyvocal is highly irritated and confrontational. Her expectations, co-created by herself and others in her life-world have a reciprocal effect of conflict inducing expression.

During both mood phases, she occupies her time with domestic tasks and various hobbies. Her prognosis is dependant on the seasonal variation in mood episodes. She has a dependant personality type and tends to perceive life events in a negative light. She has relatively good insight into the causes and nature of her illness and accepts responsibility for compliance with her medical treatment. Compliance is a vital part of any treatment programme. Marge Polyvocal shows her ability to self-manage her diagnosis. Her long term memory appears to be intact although she has an unstructured recollection of events. She has complained of short-term memory problems. Her insight appears to be average to good depending on her mood (better during depressive episodes). She has many family problems and she tends to have

aggressive emotional outbursts depending on the phase of mood that she is in. She requires ongoing psychotherapy focusing on cognitive-behavioural, interpersonal, and psycho-educational dimensions.

It has been recommended that she continues with psychotherapy and she should be considered to be a chronic patient. She will require long-term treatment. She continues to see her psychiatrist on a three month basis and has bi-weekly psychotherapy sessions. Her motivation to change vacillates according to her phase of mood, and therefore remains unpredictable. Her dependant nature continues to be a problem for effective treatment.

Psychotherapy should be aimed at,
- Better control of her mood swings (identifying mood swing patterns).
- Improved effort at attaining physical health (for example, exercise).
- Learn to assume personal responsibility for the impact of her diagnosis on herself and family members.
- Deal with any past traumas.
- Encourage medical compliance at all times, especially during manic phases.
- Develop a positive attitude towards her attainment of mental health.
- Learn skills to anticipate her mood cycle change and identify potential triggers of mood swings.

The onset and progression of the disorder

Marge Polyvocal is a 54 year old wife and mother of two children. Her husband is 56 years old. Initially Marge Polyvocal went to a psychiatrist in 1973 as her husband felt that she was "like a piece of wire in the bed". The psychiatrist prescribed medication to calm her down. She recalls the stress of marital intimacy as being the perturbing factor in her so called restless behaviour. Marge Polyvocal's debilitating onset of depression with mixed manic symptoms occurred when she gave birth to her first child in 1974. She described the time as extremely difficult for her as her husband was away from home fighting in a war to defend his country's borders. When her son was six weeks old her husband was shot in Angola and she did not know if he was alive or dead. She was petrified to sleep alone at night for fear of

149

being attacked, so she developed the habit of staying awake at night with a pistol by her side to protect her son. The lack of sleep and enormous stress about her husband's well being slowly led to her first 'nervous breakdown'.

She was admitted to a psychiatric hospital for a full assessment after she threatened one of her domestic workers with a pistol and also fired off a warning shot at the neighbouring policeman as he tried to intervene in the squabble. The domestic worker had turned the washing machine knob the wrong way and had broken the mechanism. This proved too much for Marge Polyvocal and she chased the domestic worker down the road threatening to kill her. The shot fired to ward off the policeman was in a confined space of a neighbourhood and many laws of the time were contravened. She received her official diagnosis of bipolar mood disorder six years later when she revisited the hospital to greet the people she once knew. The psychiatrist called for immediate hospitalisation and she was admitted for approximately 5 weeks in which time her mood was stabilised for the first time in six years.

Marge Polyvocal described her mood swings as waves of emotions:

I would get cross and heart sore and irritated on and on and on and on. It's not like someone would go from day to day, and at that stage I would wave about 30 times a day. And most of the time when I was very anxious and they brought the anxiety down I would just jump into a depression. It actually still happens now but now you know, it is less. So that time in hospital they took… but he took bloods! About every second day, every third day.

Marge Polyvocal was stabilised with the drug lithium and her comment about "bloods" is in reference to the fact that she had blood taken to measure her lithium levels which no longer happens to the same extent. When she feels that her mood is worsening, she takes it upon herself to have blood taken and delivers the report to the psychiatrist to have it checked. This indicates the pattern of contradictory self-management versus being dependant on a professional to care for her. Neither cycle remains consistent. As soon as she has taken the initiative to look after herself, she

abstains from continuing with this. And the opposite is also true, for example, if she tires of the psychiatrist telling her the same thing over and over then she corrects the thought processing herself, and then stops and blames the psychiatrist for not being more caring and considerate. In a recent episode of rapid cycling Marge Polyvocal had blood samples taken and they were interpreted by a stand-in medical officer as being within normal range. She felt uncomfortable with this decision and went for a second opinion where it was found that her lithium levels were three times above what is considered normal range and her medication was adjusted immediately. She was told that she was toxic at the time the blood was taken.

Over the past twenty year period, Marge Polyvocal would take monthly trips to the nearest available psychiatric hospital to have her blood levels checked and a brief one hour consultation. At times she was driving up to 130 kilometres to a hospital. She remained compliant with her medication usage throughout that time period.

Marge Polyvocal had electro-convulsive shock treatment on her first admission in 1974 and several times after that. She recalled these treatments having a mood uplifting effect on her. What stands out most for her during her first hospitalisation was the relationship that she developed with her psychiatrist. It was a very meaningful relationship and she referred to him as "a shell" protecting her and teaching her how to react in certain situations. He was a role model for her and she thinks back very fondly of him and the treatment she received. This psychiatrist set a standard of treatment that unfortunately has not been able to be met by her latter psychiatrists. However, she spent a shorter time period with this psychiatrist, compared with her current psychiatrist. One has to wonder if a psychiatrist can maintain a sense of levelled empathy over a ten year period?

This first psychiatrist emigrated overseas and Marge Polyvocal felt the definite loss of his kindness and compassion. After spending so many years as part of a psychiatric setting, she felt that there were times when her therapist and psychiatrist knew more about her than her own family. Her view of her current psychiatrist, who has been treating her for the past ten years, is of a clinician who merely refills her prescription for her. She does not have a particularly good relationship with him and

she feels like a nuisance to him. On three occasions in the past year she has found errors on his written prescription and has come to the point of self-correcting the dosages. Her level of knowledge about her medication is quite outstanding considering that she is taking up to six different types of medication at any one time. A problem with that is that she is sometimes prone to adjusting her medication as she sees fit. Her psychiatrist also changes her doses telephonically without consulting her on a face-to-face level. He is faced with huge patient turnover and does not always have the time to be thorough and available. Looking back over her life, Marge Polyvocal expressed her disappointment that her closest confidantes are mental health professionals and not her family members or friends.

Ten years ago, Marge Polyvocal had a very serious breakdown when she suspected that her husband was having an extra-marital affair. The idea of him being unfaithful shook the fragile security that she had. For Marge Polyvocal this was the worst episode that she had ever experienced and she felt totally out of control. Her sexual advances towards her husband trebled and she felt rejected when he could not accommodate her needs. The assumption of him having an affair seemed a plausible explanation to her at that time. The family fights became intolerable and she was hospitalised for several weeks again. After her last stabilisation in hospital, Marge Polyvocal promised herself that she would never again be admitted to a psychiatric ward. She said that she would rather commit suicide than face a psychiatric ward and be treated "like a guinea pig".

During her periods of being hospitalised Marge Polyvocal has had many ups and downs in her encounters with the helping professions. She has been extremely offended by more than one psychologist and infuriated with several doctors' lack of knowledge of bipolar mood disorder. She has had the occasional positive relationship with a psychiatrist and a psychologist. But unfortunately, in the state health care system it is often the case that psychologists and psychiatrists are merely doing rotations through a hospital or they choose to leave the state and pursue private practices. The therapeutic relationships therefore became fragmented and short-term.

Marge Polyvocal's manic episodes require much of her time, energy and activity. She finds that she lands up doing ten things at the same time and loses

concentration and focus of the task at hand. During these times she cannot sleep either and she loses her confidence in her abilities at a dramatic pace. She has a very acute awareness when she is in a manic phase but yet she has still not found an appropriate outlet for the added energy as she cannot concentrate for extended periods of time. Her description of her manic behaviour indicates that she is unable to monitor what she is doing at the time and she notices the changes in hindsight. Her husband is aware of the mood changes, and he points them out to her, but again both seem to be helpless at preventing the mood from carrying itself out. Marge Polyvocal's manic phases are unpredictable for her and she has not yet found a way to pre-empt the mood triggers.

An example of a manic moment can be seen in the following paragraph,

I think of dusting the table cloth, or do I make the table cloth first? In the room I get the table cloth and see I have not packed the stuff in the drawer. I stop. I decide to make this note. I stop and walk up the passage into my room and peep through the window to check what the neighbour is baking. I see the other neighbour's dogs running loose on the pavement and try to go lock them up. I come back to the study. Here I go with my table cloth. I must remember to collect the duster on my way. Gee, I hear the CD playing and I realise I have not changed the Christmas CD. Oh well a few weeks behind. The table cloth is creased so I iron it and start thinking about the meeting my husband is at. I think I must phone one of my friends, but first I must unpack the dishwasher, it is two in the afternoon and it washed overnight. I saw it at least three times and meant to unpack it.

This little story write-up continues on to explain about building contractors and also an ingenious method for saving water to feed the plants. This is the average day during one of Marge Polyvocal's manic waves. In and amongst these racing thoughts, she says that she has emotional outbursts and can cry followed immediately by laughing and anger. One can only imagine how frightening this experience must be.

The person behind the diagnosis

Marge Polyvocal has many roles in her life such as being a wife to her husband, a mother to her children, and a daughter to her parents. Each role requires her to be radically different. In her marriage she is required to be subservient to her husband's needs and commands. She is the support system to the marriage and she keeps herself occupied by cooking, cleaning and caring for her husband. As a mother to her children she is often the one who has to keep secrets from her husband about their activities as both children fear their father's judgement. She often plays the peace-keeper role between the children and their father. In an interview (unrecorded) with Marge Polyvocal's daughter, the theme of loss of a motherly relationship was discussed and Marge Polyvocal's daughter felt that under the circumstances of her mother's diagnosis, she had done a sterling job raising the children. Marge Polyvocal's daughter offers her a lot of emotional support, even though she is living overseas. She sends her mother money so that she can purchase the things that she needs to make herself happy, such as material for quilting.

One of Marge Polyvocal's concerns was that she was having difficulty distinguishing between herself the person, and herself the bipolar patient. This was very difficult for her to rationalise as she believed that people stop seeing her as a person once they are aware of her diagnosis. For example, if she loses her temper or becomes sad, then both states of emotion are immediately attributed to the onset of a manic and/or depressive episode and she is carted off to the hospital. In that process, she does not get to share her feelings with the people close to her, but rather, with the psychiatrist and/or psychologist. In a sense, this further disconnects her from the people closest to her.

Marge Polyvocal wants desperately to be more than just a patient in her lifetime. She even reframed herself as a "student-in-training-for-life" and a "professional client". In both scenarios, there is merit. Marge Polyvocal does acquire certain behaviours and thought patterns through her discussions with psychologists and psychiatrists. She tries to implement what is suggested to her, but more often than not, the plans backfire under somewhat emotionally stressful occasions and then Marge Polyvocal is left with a feeling of failure.

Marge Polyvocal wanted to participate in support groups for people diagnosed with bipolar mood disorder but her husband felt that the engagement with other people with the same problem would have the effect of making her negative and more involved in misery than the preferred reality of being cured of the illness. Marge Polyvocal felt that having received the diagnosis helped her to understand the way her mind works, and also "because they medicated me properly, and it's not always the story of 'you are tensed up, get some or other calming tablets'". She felt that the naming of her problem was both beneficial and harmful. Harmful in the sense that it gave people an excuse not to listen to her, and beneficial because it gave her an understanding of her own processes. Marge Polyvocal makes an effort in her social circles to try and educate the people around her into the intricacies involved in mood swinging behaviour. She also tries to help others when she sees similar patterns of behaviour to her own. For her, the key elements in combating the mood disorder are to have an educated and knowledgeable psychiatrist, as well as a solid and trusting relationship with a psychologist.

Marge Polyvocal still encounters debilitating phases of depression in which suicidal ideation is an all too familiar solution, and ongoing manic episodes. Her psychiatrist insists that she should be able to avert the onset of manic episodes (as these are somehow feared more than a depressive episode). But, Marge Polyvocal commented that she only recognises the manic behaviour "when you've been in it for a while. In a manic phase you don't see the symptoms coming". As for markers for depression, Marge Polyvocal has an acute sense of the onset of signs and symptoms. This knowledge does not halt the phase of depression, but she believes that it does shorten the length of time that she is depressed and also offers hope that it will change. Marge Polyvocal takes personal responsibility for her mood disorder and she tries hard to learn more about the nature of the disorder and the impact that it has on her life and the lives of her loved ones. She often questions why she was punished (a religious discourse) to have gotten this problem. She was brought up being told that she had all the material things in the world that her parents never had and could never have afforded. These types of comments added to her sense of guilt and she always felt as though she did not deserve the outcomes of her parents' hard earned money when she was such an unstable person. She believes that the devil is within her and

causing her to feel the way that she does (this was an opinion of a friend that made sense to her).

The hypotheses of mental illness

There has been much speculation around the causes of Marge Polyvocal's "mental illness". Several hypotheses have been generated but not one on its own has held water for Marge Polyvocal. Initially, it was thought that Marge Polyvocal was ineffective at handling conflict and this resulted in her angered outbursts. This was further ascribed to states of tension that she could not cope with. When Marge Polyvocal became tense – meaning un-relaxed – she stopped sleeping well and became highly aggressive with people around her. Very minor social interactions have the ability to make Marge Polyvocal "tense", for example, if she feels that her husband is neglecting her because he does not phone her to say he will be half an hour late for lunch, or if the shop that she buys the material from has not ordered the exact measurements that she asked for. These moments of precipitating stressors can have the effect of shifting her into a manic episode or a depression phase.

Marge Polyvocal has been treated for epileptic symptoms, although no tests ever indicated epilepsy. She has also been medicated with anti-psychotics and anti-epileptics for "concentration problems".

There was also the hypothesis that Marge Polyvocal's mood fluctuations were due to hormonal imbalances and she was put on strong doses of hormone replacements. She felt this did stabilise her moods quite dramatically, but her psychiatrist said that it was not possible and her problems are limited to her brain functioning.

Marge Polyvocal's tensed states of being have resulted in severe grinding of her teeth and she was undergoing massive dental treatment at the time of the research interviews. She has also experienced back, neck and hand movement problems and she remains undiagnosed as to whether this could be a muscular-skeletal or nerve problem. She self-medicates the physical pain with over the counter drugs. This is in addition to her cocktail of psychiatric medicines. The physical presence of pain

exacerbates her feelings of being useless and a 'nobody' as she struggles to continue with her needle-work when she is in pain. She cannot concentrate for long periods of time (more than five minutes) when she is in a manic episode, and then once this abates, she is further debilitated due to the pain in her hands, back and neck. The feeling of uselessness can bring about a period of physical stagnation and then she becomes susceptible to a depressive episode. This is the cycle of Marge Polyvocal's life.

Conceptual and Contextual Descriptions: A Social Constructionist Approach

In the aforementioned medical model description above, the focus was on the individual Marge Polyvocal and the many systems and subsystems within which she lives and functions. To move towards a social constructionist approach requires a radical departure away from traditional psychological theories and methods of analyses (Strong, 2002). The medical model, often accused of being a-contextual, was shown to be context specific. The focus was on the individual and her categorised behaviour patterns. Even the family was mentioned in providing further understanding into the way Marge Polyvocal experiences her disorder. However, the medical model makes the assumption that it is the best and most thorough way to investigate a state of behaviour such as bipolar mood disorder. It is upon this premise that social constructionism argues for alternative, richer and thicker descriptions. It is not good enough to comment on the many systems in which Marge Polyvocal functions, such as family, society and culture. Change is still directed at the individual concerned, be it through long term psycho-analysis, family therapy, or even cognitive behaviour therapy. These schools of psychology have at their hearts individual change and modifications of patterned behaviour, be it communication or mood patterns. Social constructionism does not argue that the medical model tenets are incorrect and invalid. Rather, the disposition of a social constructionist approach is to move away from all that is constructed upon the psychiatric frame towards the way in which that particular discourse has been constructed (Anderson, 2001). This is not an easy task and it is very likely that social constructionist thought, research and application are viewed as unscientific tools. But from the perspective of social constructionist

thought, the methodology cannot be judged by scientific principles as they are constructed within scientific thought and not a linguistic paradigm (Miller et al., 2001).

A social constructionist interview process focuses on how the clients would like their lives to be different, instead of focusing on how they are caught up in a problem type of behaviour, for example, bipolar mood disorder. One of the purposes of a social constructionist interview, is to help the client identify existing strengths, knowledges, and resources that can assist in bringing about change that is aligned with the client's needs, and not necessarily the psychologist or psychiatrist's. The central idea is to co-create avenues of solutions and change, rather than focusing on all the problems. Following the medical model description above, one can see that the focus was on the problem of bipolar mood disorder and all the inherent difficulties in living with the diagnosis. This view had a lot to offer and explored the various dimensions of the diagnosis. A social constructionist interview process accepts that this will be a necessary outcome of focusing on the problem, that is, inadvertently creating more problems. Therefore, the problem talk and problem focus is thought to be a discourse, in this case a psychiatric discourse, which continues to render the client in a helpless and unchanging position. Having said that, it is important to remember that the psychiatrist is not to blame for constructing a psychiatric discourse, rather he or she contributes to the formation of that discourse with the assistance of all the other appropriate stakeholders, for example, the patient, the patient's family, the larger psychiatric academic world, the pharmaceutical industry and scientific academic psychology (Miller et al., 2001).

In the insight-oriented interviews, the medical model was followed and this process successfully allowed the researcher to reach a descriptive diagnosis of the construct bipolar mood disorder. In the social constructionist interview process, the roles of the interviewer and interviewee share responsibility for the outcome, together co-creating a meaningful research relationship (Strong, 2002). The research interviews had the aim of constructing stories of bipolar mood disorder from the person's perspective, be it a patient of the psychiatric system, a psychologist, or a psychiatrist. However, the researcher defined the context as psychiatric by selecting people with an existing diagnosis, seeking experts in the field who deal with the

diagnosis, and in this way re-enforced the existence of such a construct called bipolar mood disorder. It would be incongruent for the researcher to then comment on how the research participants only spoke of bipolar mood disorder as the researcher set this frame to begin with. Therefore, the researcher will adapt the social constructionist interview process to explore the richness that exists within the diagnosis. The focus is still on psychiatric terminology and frame of reference, but the content will be explorative, inferred and tailored towards an analysis of discourses, both underlying and emergent.

To begin with the social constructionist interview is a process oriented activity. It is within the relationship that is constructed between the researcher and the research participant that meanings merge and emerge. The language used by both research participants influences the construction of the story and the analysis thereof. In the aforementioned medical model description, the research participant was framed as lacking insight. In this social constructionist frame, one would ask if it was the nature of the researcher's questions that only allowed for a certain answer to be given, which reaffirmed the notion of lack of insight. In addition, the task of the researcher, from a medical model, was to elicit the deficits apparent within the research participant's thinking and speaking style. This task was achieved. In opposition to this way of doing research, social constructionism would focus on the strengths and opportunities that the research participant presents, giving more weight to the benefits of having been given the diagnosis, rather than focusing on the tragedy of having it. In a sense then, the researcher will also be offering a critique of her own research gathering process, from a social constructionist perspective.

A fundamental difference in epistemological approach is best observed in the actual unit of research. The insight oriented interview focused on the individual, that is, the patient, the psychologist and the psychiatrist. This reinforced the position of the diagnosis belonging to the person. The problem exists within that person, and so does the solution. This rendered the patient in a position of only being able to maintain the existence of the diagnosis itself. From a social constructionist point of view, that individual is believed to be part of many other systems, and each one requires exploration and deconstruction to gain a wider perspective on how the diagnosis is formed and maintained. To mention a few deconstruction avenues, one could look at:

- The self-perception of the research participant.
- The perceptions of family members.
- The perception of psychiatry.
- The perception of religion.
- The process of making sense of the diagnosis.
- Bipolar mood disorder as a pattern of interaction.
- Bipolar mood disorder as the solution to the problem.
- Bipolar mood disorder as the exception, as a gift.
- The inherent belief system of the person upon whom diagnoses, solutions and life stories are created.

All of these levels of description offer information about the creation and impact of the diagnosis itself. Any conceptualisation of the construct bipolar mood disorder requires these levels of abstraction. As Strong (2002, p. 81) noted, "rigorous inquiry can only bring us further descriptions of experience, nothing more".

Deconstructing Discourses of Bipolar Mood Disorder

A deconstruction, in this 'original' and 'purest' sense, identifies conceptual oppositions, recovers notions that have been excluded, and shows how the ideas that have been privileged are dependent on those they dominate (Parker at al., 1995, p. 3)

Discourses offer descriptions of phenomena in life that are scientifically unobservable. There is hardly an empirical way of testing that a discourse exists. Rather, a discourse is a set of meanings that help categorise the world in which we live (Parker et al., 1995). There are many ways to arrive at a discourse analysis, and it is dependant on the way that the researcher constructs her worldview. Therefore, this is a reflexive process, one in which the researcher constructs and is simultaneously constructed by discourses. For example, the researcher is academically grounded in the realm of psychology. This shapes the way in which she sees and understands the world. If she had been educated in accounting, then perhaps she would rather focus on the cost-benefit ratio of the implications of having a mental illness in the workplace.

In this accounting discourse, she may choose to focus on the various role players that contribute to a stable market in the pharmaceutical industry and how better to save expenditure from a market related point of view. The medical discourse discussed above has provided an explanation of bipolar mood disorder, and the beauty and richness of discourse analysis allows for the exploration of a multitude of discourses. In this research, bipolar mood disorder will be looked at as a discourse in itself, shaped and developed by other surrounding discourses, such as the psychiatric, the interactional, the psychological, the cultural and the social. All of the different discourses offer value to broadening the description of what a bipolar mood disorder is and what the implications of having it are. Clearly, from a medical discourse, once the patient has been diagnosed, the focus is on eradicating symptoms and aiming towards a curative prognosis. However, in this research domain, none of the patients recovered from the diagnosis, which implies that there is more to be understood about the simplified behavioural description of bipolar mood disorder.

The discourses under review have emerged from the textual transcriptions from the interviews. The researcher categorised and indexed the text, allowing for sets of statements to be identified. These statements, or discourses, indicate that bipolar mood disorder is constructed in particular ways, silencing others. The way in which discourses are constructed gives shape to the way in which people live their lives. Therefore, this deconstruction is imperative to understanding the way in which bipolar mood disorder is constructed by the client, the psychotherapist, and the psychiatrist.

In this discourse analysis section, a similar arrangement of categories will be used as mentioned in the vignette analysis. They are, naming the disorder; causes of the disorder; self-perception; support systems; religion; symptom expression; and perception of the psychiatrist. Initially the researcher quoted text as systematically indexed from the transcripts. Following this, she regrouped statements into sub-categories of discourses. This emerged as the table below.

Table 2: Marge Polyvocal

Category	Textual comments	A Discourse Revealed
Naming bipolar mood disorder	The doctor couldn't get me stabilised. I would wave about thirty times a day. I have this rapid cycling, this emotional and mental wave that cycles very quickly in one day. The psychiatrist even said that it can be genetic. This is my illness. They brought the anxiety down and I would just jump into a depression. I was hospitalised many times. I keep organised to get my brain straight. I would get cross and heart sore and irritated on and on and on and on and on. What did I do to get it?	1. Psychiatric / Biomedical
Causes of bipolar mood disorder	I had this terrible tension thing. I had this terrible anxiety. The diagnosis calmed down my brain. It was a terrible hormone story. I'm not sure if it happens because of the season.	1. Psychiatric 2. Medical 3. Alternative
Self-perception	The problem was with me. I fell ill. I absolutely went over. It's as if I don't trust myself. In any case I mean nothing to anybody on this earth. I don't want to be called a patient. Perhaps I could be called a student in training. Whatever I do it is not important. Nothing is great enough. I felt it was a form of punishment.	1. Psychological (negative cognitive processing).
Support systems	Your psychiatrist and your psychologist are closer to you than your husband and your children. Stuff gets so bad for me and I don't talk about it. They don't know what of me is me and what of me is bipolar. My husband wishes I can be what I was.	1. Psychiatric 2. Interpersonal
Religion	What did I do to earn this? I was this very good person. The good Lord punishes you. It might be the devil that is with me.	1. Religion

Symptom expression	I threw the water in the doctor's face.	1. Manic expression
	A wave of the sea.	
	I would do ten things at the same time.	
	Being in working mode.	
	I'm too busy.	
	In a manic phase you don't see the symptoms coming.	
	I talk more when I'm manic and talking more might get me into trouble as well.	
	I was so off my mind.	
	I am like a piece of wire in the bed.	
	I was so excited and then I was so disappointed.	2. Depressive symptoms
	You just feel like sitting in one chair and want to stay there for the rest of your life.	
	My heart aches and I feel depressed and here I sit on my own.	
	Felt as though I could sink through the floor.	
Perception of psychiatrist	He was such a fantastic psychiatrist.	1. The good doctor
	He was such a caring person.	
	He could feel compassion.	
	Like talking to a brick wall.	2. The bad doctor
	I can just give him a bloody kick.	
	He can't really understand me.	

Looking at Marge Polyvocal's tabulated text and aligned emergent discourses, one can see that her story is largely constructed according to the psychiatric and psychological dominant discourses. Marge Polyvocal has been a part of the psychiatric system for over thirty years. It is evident that belonging to this system has informed the way in which she constructs her story of bipolar mood disorder. What is most interesting is the negative light in which she perceives herself. This becomes particularly apparent when her statements are seen clustered together. The discourse of negative self-perception exists in conjunction with an overarching psychiatric discourse. Her classic rendition of her behaviour in the symptom expression category ties in so neatly with the DSM-IV descriptors of criteria for meeting a bipolar diagnosis. She was not asked to list her behaviour patterns, but rather she described herself in this way using these words throughout the interview. In many ways then Marge Polyvocal is a product of, and a co-constructor, of the psychiatric discourse.

Even though Marge Polyvocal is not particularly impressed with her current psychiatrist, as can be seen in her choice of words, she remains compliant with his advice and learned knowledge. This may indicate that she believes in the system of psychiatric treatment even though it has not brought her long term relief from the disorder. This again is a contradiction, as her 'buy' into the psychiatric system may in fact be prolonging her diagnosis of bipolar mood disorder. If she had an alternate belief system, such as a traditional South African ancestral culture, then she may define her experience as a calling from the ancestors to go through a transformational process. But, Marge Polyvocal was raised in a conservative family with strong values and beliefs in religion. One of her foundational beliefs that emerged was that her disorder could in fact be the devil within her and she is failing as a Christian to have enough faith in her religion to help her through this. Again, another self-criticism. In essence, Marge Polyvocal shares many similar personal assumptions with the psychiatric modernist framework. She believes in medicine, causation, diagnosis and cure and adhering to treatment protocols. Therefore, it can be induced that any change intervention for Marge Polyvocal would have to necessarily include the traditional expert doctor/patient advice. Marge Polyvocal does not see herself as a contributor to society or life in general, but rather a product thereof. In contradiction with that statement, the researcher will add that although Marge Polyvocal will most likely require an expert opinion, she requires the assistance of a compassionate and dedicated listener. This is not normally the characteristic of an over-worked psychiatrist with a queue of twenty patients. As Gabbard and Kay (2001) have noted, the modern day psychiatrist has fragmented pharmacotherapy and psychotherapy and very rarely participates in both modalities of treatment.

The presence of the religious and interpersonal discourses indicate that Marge Polyvocal experiences rejection in the very places where one would expect that she would gain support and assistance. This is a concerning occurrence, as any treatment protocol would ensure that the support systems are in place to assist the client with medication compliance, behaviour monitoring, and guidance towards new and more effective coping skills. In Marge Polyvocal's life, it appears that she is alone, although married with children, lonely and at times, desperate for recognition. A large portion of her struggle with bipolar mood disorder is faced alone, or with the help of her psychologist, psychiatrist and other treating professionals. In the domain of faith and

spiritual belief, Marge Polyvocal claimed to have being rejected by the church on many occasions. Added to this, her husband prevented her from participating in a church based programme for mental illness on the grounds that she may not be ready for that. Marge Polyvocal seems to be desperate to find a community where she is grounded, accepted, and senses a feeling of belonging. The only system that has provided that support, to date, is that of the para-psychiatric system. The researcher names the system 'para' as it is a fluid and changing system because of the unpredictable pattern of rotation amongst doctors and psychologists. Marge Polyvocal has the certainty that this context will be available to her albeit in an inconsistent and sometimes frustrating way. The psychiatric profession is obliged in many ways to continue assisting her deal with her changing mood patterns.

On an interpersonal level, Marge Polyvocal expressed the idea that she lives in a world of silence. She is very obedient to the wishes of her husband and has an acute awareness of what is deemed morally right and wrong. The discourse of behaving and portraying the image of being socially responsible and being an upstanding citizen often propelled Marge Polyvocal to silence her own sense of unhappiness and sacrifice her wish to be heard and accepted as a person in her own right. Marge Polyvocal also experienced many transitions in her roles as a mother and a woman in society. She worked for extended periods of time to help raise an income, and she also put in great efforts to sustain her religious beliefs as it was expected of her, often arranging teas and functions for the church, while simultaneously feeling that she was not appreciated there nor wanted. When Marge Polyvocal entered into a phase of mania, her voice seemed to return and she expressed her dissatisfaction with the ways that she was treated, "…it gives you a chance to say things that you would never say". This being contrary to what was expected of her, deemed her ill, and she was hospitalised and heavily sedated. Once she had reached a balance again, that is, returned to silence, she was discharged and allowed back into her social environments. But should she step out of line, she would be thought of as ill again. A very sad point made by Marge Polyvocal was when she said, "They don't know what of me is me and what of me is bipolar". This emphasises the way that Marge Polyvocal felt misunderstood and split herself between being a person and being a diagnosis. Silencing is a theme that seems to run throughout the diagnosis of bipolar mood disorder. The move away from depression gives way to a voice of freedom,

opinion and judgement, which is often met with resistance and subdued again through the labelling of another manic episode.

Emerging Discourses

These discourses do not just emerge from the researcher's thoughts and inferences, but rather directly from the text (the interviews). The interviews were focused on understanding the concept of bipolar mood disorder from the research participant's point of view, but they were under the direction of the researcher at the same time. Therefore, it was a process of collaboration. This particular research story was embedded in the field of psychiatry as that is the most well known script for Marge Polyvocal. For her, she has an illness and it is incurable and she will continue to live with it. However, by merely focusing on the content of the story, the experiences and difficulties she encounters are lost. Discourse analysis helps to enrich the psychiatric framing and produce alternative possibilities and meanings (Anderson, 2001). Following the outline suggested by Parker et al. (1995, pp 60-63), six types of discourses are seen to contribute to the formation of a clinical diagnosis. These are the individual and the social; reason and unreason; pathology and normality; form and content; pure categories versus messy real life; and professional versus popular, lay and patient views. These clinical categories will be adapted to this particular research interview to enrich the discourse descriptions.

<u>The Individual and the Social</u>

"You are a patient with bipolar – a little mental because it is psychiatric".

Marge Polyvocal's construction of bipolar mood disorder was researched from both perspectives of the individual and the social. In psychiatry, the individual is predominantly pathologised, "…these doctors and these psychologists that are working there at the hospital look at you as if you are stupid". It was Marge Polyvocal who received the diagnosis, but as it has been shown above, her diagnosis is embedded within her marriage, her role within her culture and her societal disposition. However, having received the diagnosis also pathologised her as having something wrong within her, within her mind, and experiencing something which rendered her in

a deficit of mental health. This discourse of individual pathology was reinforced by the psychiatrist, the various psychologists, and her family. Marge Polyvocal believed that she had something inherently wrong with her. All attempts at bringing about change were done on an individual level. When she did have family therapy, she experienced the psychologist as being unethical and too provocative. At the same time that Marge Polyvocal felt silenced by those in her life, she simultaneously protected them by maintaining a position of stability, not wanting her husband to change.

To move towards the extreme of pathologising the social domain, one could hold the psy-fraternity (both psychologists and psychiatrists) responsible for her diagnosis. The diagnosis itself rendered Marge Polyvocal in a position of being dependant on someone else for advice and guidance. However, the continuous rotation of doctors left Marge Polyvocal in a series of discontinued relationships, which mimics the mood pattern of change. The only factor that remained stable was that she would endure incredible highs followed by terrible lows, and this was something she loathed. Further, the psychiatric discourse could be blamed for making service delivery promises that were never achieved, for example, compliance equating successful recovery. Even though Marge Polyvocal followed her treatment protocol to the end, she endured great difficulties, including lithium toxicity. And yet again she would be blamed and pathologised as being blind to the onset of another manic or depressive episode, when in fact the medication was meant to be the neurochemical blocker of such an event. Again the responsibility was shifted towards blaming the individual and finding fault in what she was not doing rather than focusing on what she had done to prevent another episode of rapid cycling. According to Parker et al. (1995, p. 61), "the individual only exists against the background of society". In this light, Marge Polyvocal has sadly slipped through the psychiatric crack in the floor. Society at large has assumed no responsibility for her condition, besides in naming it and shifting responsibility to her. If Marge Polyvocal is viewed against the backdrop of society, then her society can be described as one which requires silence and subjugation of opinion, one which favours normal functioning without allowing for the idiosyncratic expression of an individual. As long as Marge Polyvocal continues to remain compliant with her medication, and fails to show progress, she is fulfilling the societal conceptualisation of madness and incurable mental illness. Marge Polyvocal did make a lot of progress, but progress that is not visible in the language

of a psychiatric frame of reference. She still experiences signs and symptoms of bipolar mood disorder but she is able to be productive, contribute to society by participating in church going activities, and educates others on the effects of having a mental illness and being shunned from society. Somehow, society has failed Marge Polyvocal and has not recognised her potential and growth as the focus has remained on the deficits of the individual rather than the merits of the contributions that she has made.

Reason and Unreason

"And stuff gets so bad for me and I don't talk about it and when I start talking about it I am off my senses already".

One of the foundational principles of understanding bipolar mood disorder from a traditional perspective requires the ability to reason. The psychotherapeutic treatment of cognitive behaviour therapy rests firmly upon this assumption. The value of having insight necessarily implies the ability to reason and arrive at a rational destination. The psychiatric premise of understanding the types of mood patterns and the nature of prediction and prevention of a relapse all suggest that the person should have an adequate ability to reason what is happening within and around him or her. In the insight oriented review above, Marge Polyvocal was shown to be limited in her ability to reason and self-monitor. This rendered her to be in a position of further localised pathology. She could not be seen to bring herself above her position and therefore remained dependant on the psy-experts for guidance and treatment. The nature of the meaning of her mood pattern was not explored by her psychiatrist. His focus was on prescribing medication (and not very accurately at that). Exploring the irrationality and unreason as Parker et al. (1995) refer to it, would mean that one would explore the impact of the mood swings on Marge Polyvocal and her surrounding systems within which she interacts. One would also explore the meanings of her mood swings, for example, being manic allowed her a platform to express her thoughts and feelings that were otherwise subjugated in favour of the dominant discourses of social standing and upholding of a conservative, obedient, righteous citizen. On the opposite pole, her depressive episodes seemed to remind her of her

unfulfilled wishes and desires and reinforced the fact that she was not living the ideal life that she had once desperately hoped for and worked towards.

Although Marge Polyvocal remained congruent with all her treatment phases and suggestions, she was still rendered helpless and dependant. One would wonder if this was not a choice of hers as the position of fighting for her opinion left her labelled as manic and not quite of sound mind, quickly hospitalised and well contained. By only focusing on the unreasoning of her mood swings could also shift her into a position of being a social pariah, being seen as eccentric and non-conformist. Marge Polyvocal's moods seem to echo this description of reason and unreason, always vacillating between the two positions. Marge Polyvocal tried her best to conform to the rational and the reasonable, yet she was still deemed to be suffering from bipolar mood disorder. Again, from a psychiatric discourse, she cannot move out of this frame. If she expresses an alternative opinion, then she is cleverly labelled as manic and if she attempts to rationalise her position then she slips into the frame of a depression. The clinical category of bipolar mood disorder neatly defies her expression of feelings and thoughts.

Marge Polyvocal showed an awareness of what it felt like to live a life of being bipolar and above all she recognised how stuck she remains, partly because of being rational and partly because she is not allowed to be irrational. "I think that it is due to lack of concentration and memory". The contradiction for Marge Polyvocal is embedded in the larger discourses that embrace her life. As a religious person, she succumbs to the path chosen for her, but as a consumer of psychiatry, reinforcing individual responsibility, she is in someway forced to assume control over her future and this dichotomous position can be very confusing to even the most rational person. Marge Polyvocal is clearly caught up in a conflict of interest between what is scientifically proven and that which is morally correct. She suffers the consequences of the polarised epistemologies within psychology.

Pathology and Normality

"If I had a different diagnosis it would be to be normal".

According to Parker et al. (1995), the position of normality naturally infers the polar opposite of pathology and vice versa. One position cannot be understood without the other. In the case of Marge Polyvocal, her behaviour was defined and categorised as abnormal, that is away from the norm. The norm was defined by all stakeholders in the psy-complex. For Marge Polyvocal to attain a sense of normality, her symptoms would have to be eradicated. The proven way of doing so is through the application of a stringent medical protocol. However, Marge Polyvocal did adhere to this protocol and somehow has not attained a normative position. If she silences her wishes, desires and needs then she could be viewed as normal. But, she fails to repress her needs and thus remains abnormal. And further, if she did repress her needs then that would also be a sign of abnormal functioning.

From a psy-system position of normality one is supposedly able to discern patterns of abnormality, but if the coin is flipped then one wonders who is pathological: The psychiatrist who continues to write incorrect prescriptions? The pharmaceutical industry that accumulates wealth at the expense of human toxicity? The psychologist who defines Marge Polyvocal as lacking insight because she fails to answer predefined questions? The society who advocates health and wellness while not having the systems in place to support such ideals? The individual who strives to attain a position of mental wellness because it is commonly defined by many as a concept which actually exists? The scientist who has proven that, in a controlled and specific society, a routined strategy of cognitive awareness decreases the rapid onset of a mood swing? Then there is Marge Polyvocal who is labelled as abnormal, and one wonders how it must be so comfortable to sit in a position of normality and accuse others of being other than that. Marge Polyvocal appears sane in the context of her wider social systems. This woman endured wars; a lack of rootedness; personal abuse; difficult pregnancies; lack of direction and meaning; marital insecurity that sent her into wild rages; non-compliant psychiatrists (since it was this system that forgot the treatment dosages and incorrectly captured them on the computer system) and religious rejection. It would therefore appear that a state of normality very much

170

Pathology and Normality

"If I had a different diagnosis it would be to be normal".

According to Parker et al. (1995), the position of normality naturally infers the polar opposite of pathology and vice versa. One position cannot be understood without the other. In the case of Marge Polyvocal, her behaviour was defined and categorised as abnormal, that is away from the norm. The norm was defined by all stakeholders in the psy-complex. For Marge Polyvocal to attain a sense of normality, her symptoms would have to be eradicated. The proven way of doing so is through the application of a stringent medical protocol. However, Marge Polyvocal did adhere to this protocol and somehow has not attained a normative position. If she silences her wishes, desires and needs then she could be viewed as normal. But, she fails to repress her needs and thus remains abnormal. And further, if she did repress her needs then that would also be a sign of abnormal functioning.

From a psy-system position of normality one is supposedly able to discern patterns of abnormality, but if the coin is flipped then one wonders who is pathological: The psychiatrist who continues to write incorrect prescriptions? The pharmaceutical industry that accumulates wealth at the expense of human toxicity? The psychologist who defines Marge Polyvocal as lacking insight because she fails to answer predefined questions? The society who advocates health and wellness while not having the systems in place to support such ideals? The individual who strives to attain a position of mental wellness because it is commonly defined by many as a concept which actually exists? The scientist who has proven that, in a controlled and specific society, a routined strategy of cognitive awareness decreases the rapid onset of a mood swing? Then there is Marge Polyvocal who is labelled as abnormal, and one wonders how it must be so comfortable to sit in a position of normality and accuse others of being other than that. Marge Polyvocal appears sane in the context of her wider social systems. This woman endured wars; a lack of rootedness; personal abuse; difficult pregnancies; lack of direction and meaning; marital insecurity that sent her into wild rages; non-compliant psychiatrists (since it was this system that forgot the treatment dosages and incorrectly captured them on the computer system) and religious rejection. It would therefore appear that a state of normality very much

induces and is induced by a state of abnormality. It would be a very brave person who declares another as insane when lithium levels can become toxic and deathly to the person taking the prescribed medications. The distinction between abnormal and normal becomes blurred when one considers all the mitigating circumstances that surround the construction of what it means to be abnormal.

Form and Content

"Because of the label I know what is going on and at least I can speak
to my doctor because you know more or less what the symptoms are".

Form in this context implies the ways in which specific behaviours are present or not, that is, the form of bipolar mood disorder in terms of signs and symptoms of manic and depressive behaviour. Marge Polyvocal was well versed in describing her behaviour in terms of the form of what she experienced. This could be indicative of the many medical contexts which she is exposed to and always has to rattle off what she is feeling in terms of the physical responses rather than the emotional. When she did express her emotionality in response to questions requiring form, she was always asked if she required a referral to a psychologist. Marge Polyvocal fits well in a medical world where the focus is on the form to the exclusion of the content. Content here means the 'what' of the form (Parker et al., 1995). This implies that content would give an indication of what the mood swings mean to Marge Polyvocal, including the various mood patterns of excessive highs, turbulent lows, and even neutral nothingness.

The most that Marge Polyvocal could answer about the meaning of her mood swings was that "I felt it was a form of punishment". This fits in with the blame discourse for an errant individual. Since Marge Polyvocal's husband wanted her to change back to what she was (and he left this description undefined for her), she felt that she had committed some colossal sin and was therefore being punished. For Marge Polyvocal, the religious discourse carried the most weight and gave her diagnosis the most substantiation, "I always think that the Lord, the good Lord punishes you. But someone said the other day, 'how do I not know that it might be the devil that is with me'". And further, "if the illness was only bringing a psychosis I

could understand but how could the illness bring all these shifts?". The answer for Marge Polyvocal is rooted in a religious discourse. Her form of punishment was mood swings and for this there appeared to be no forgiveness, it was God's will, "I am special, God decided I must be Bipolar. I know who I am, but I don't know who I must be".

The meanings that Marge Polyvocal attached to bipolar mood disorder were grounded in two non-changeable outcomes, firstly psychiatry where her life is in the doctor's hands because of the medication and secondly in the hands of religion for which she is punished. When the researcher attempted to explore the possibility of a rational reason existing for her punishment, she internalised the blame completely and said that it was perhaps because she was ungrateful as a child and now is being punished for taking her parents hard work and 'giving' natures for granted. Whatever her explanation, there is no space for changing these fixed beliefs.

Pure Categories Versus Messy Real Life

The problem is not one of refining diagnostic systems but of acknowledging that the practice of diagnosis is not appropriate to human difficulties (Parker et al., 1995, p. 62).

This clinical category has merits for both sides as was clearly shown with Marge Polyvocal, one cannot generalise and assume that labelling is a purely negative process. For Marge Polyvocal, the label gave her a direction and legitimisation in the eyes of her social contexts. Instead of being thought of as mad, she had a label and that made it a medical illness and therefore treatable. However, having said that, the label remained a chain to her leg as she never fully recovered as one would from an operation after receiving a diagnosis. Eventually, all she became was the label and she herself commented, people had difficulty distinguishing who she was and who the bipolar person was. But, this is on an individual level and excludes the larger and wider social discourses. For Marge Polyvocal as an individual, her behaviour fitted quite neatly into the boxed category of bipolar mood disorder, with highs, lows, and even psychotic breaks (for which there is a special subcategory already predefined). But, as with all human behaviour, the category cannot remain fixed for extended

periods of time. Her anxiety at times seemed to be more prominent than her mood pattern, and then there were the added physical illnesses, which one or two doctors speculated may have arisen as a direct result of overusing lithium for so many years. Further, Marge Polyvocal developed a diagnosable personality disorder of dependency as a result of her interactions with the medical fraternity over many years. She is a product of and simultaneously a contributor to the psy-fraternity.

As the insight-oriented review depicted, Marge Polyvocal's behaviour could be described as bipolar according to the specifications of diagnostic manuals. But there are many areas of her life that just pertain to everyday issues and although they could be framed as further signs of bipolar mood disorder, perhaps they are just facts of life. For example, Marge Polyvocal's religious beliefs have often been assumed to be an indication of a manic onset. This theme of religiosity is common among bipolar patients. But is it fair to label each and every corner of her life as a symptom of a clinical diagnosis? Within the psychiatric ring, it would be justified, but in the realm of everyday living she may be appropriate and when one understands the context of her religious background, very strong spiritual belief system and dedication to the church, one would see that this is a devoted Christian and has been this way all of her life.

The way that Marge Polyvocal related her story to the researcher meant that she did not achieve well on the Mental Status Exam, but from a social constructionist perspective, she told the story as it was meaningful for her and that is to be respected. From the manner in which it was relayed one could infer that she had not been asked before to give a chronological description of her experiences of having received the diagnosis, and further, what she was saying was emotional for her. Her story was being witnessed and she wanted to get it right and had a desperate need to be heard. This is substantiated by the way that she went and made notes of her bipolar time-line, unprovoked by the researcher. Marge Polyvocal's haphazard way of telling her story was a very good mirrored reflection of what it may feel like to live in a haze of mood swings and instability. Her focus and attention was sporadic as her mood patterns often are. If the researcher gained an inkling of her experience through the retelling of her story then it must be said that it is an exhausting process, and requires courage and strength to continue. Marge Polyvocal is to be admired for her perseverance and

bravery. Her diagnosis helped her to define the territory of her life, but it did not advocate steps and guidelines in terms of how to live the diagnosis. All psy-tricks and interventions never lasted long, for example, mood watches and preventative procedures. The nature of her diagnosis implies spontaneity, and unfortunately for Marge Polyvocal, her environments demand rigidity and conservativeness.

Marge Polyvocal, as an individual, has many behaviours that do not fit into the clinical category of the bipolar spectrum. This is also shown in the many medications that she takes. The pure clinical categories do not make room for her interactional patterns of communication with her family members, the social isolation that she experiences, the perceived rejection from the church, and her interpersonal style. The category merely focuses upon the way she presents herself in response to specific questions that are designed to elicit responses affirming a predestined clinical category.

Professional Versus Popular, Lay and Patient Views

> I don't want to be called a patient because I think that I am more than that, so I thought that perhaps I could be called a student-in-training because maybe one day I will be able to be such a good student that I will be level.

This quote by Marge Polyvocal epitomises Parker et al.'s (1995) concern with the disparity that exists between the psychiatrist and the consumer of that knowledge, the patient. Marge Polyvocal believes that if she had the right and appropriate knowledge then she would be freed of her "waving moods". This discourse of knowledge supposedly yields a power of action. And this discourse is purveyed through a larger societal discourse of science and perfecting human behaviour through the ability to conduct empirical research. However, the outcome appears to fail the means. In Marge Polyvocal's situation, she has educated herself in the scientific research available and even understands her dosages and self-corrects with permission from her psychiatrist. It is Marge Polyvocal who continuously corrects her psychiatrist's prescription and monitors the amount of tablets that she should and should not have. She is also well versed in traditional cognitive behavioural therapy

and is familiar with seasonal mood watches and keeping diaries of mood changes to help predict manic onsets. She can also describe many psychometric tests in detail and she has the appropriate answers. But, all this scientific knowledge has brought her little comfort and change. Her moods continue to spiral. Marge Polyvocal even asks her psychiatrist to give her notes on the treatment protocol and keeps a good record of the side-effects of medications. She has tried in many ways to engage her psychiatrist in a two-way conversation about her treatment process and her feelings associated with it. But, she found that he was in favour of writing out her prescription (albeit incorrect) and hearing that things were going better. Marge Polyvocal, being who she is, plays this psychiatric game and admits that things are well and gets her prescription and leaves the office. She has also experienced that doctors are somewhat afraid of bipolar mood disorder and when she has found a new doctor she is often met with the sentence 'I am not an expert and I can refer you to the principal psychiatrist'. Marge Polyvocal has a tremendous amount of psychiatric knowledge into the workings of her diagnosis, and she is still hopeful that one day there will be a cure and she will find it through hard work and perseverance.

If the knowledge base of bipolar mood disorder was more evenly spread to include the perspectives of clients, then perhaps the treatment protocols would be more aligned with the needs of the client. But, the psychiatric system appears to be depicting an academic statue of sorts, being above that of the client and in this way promotes a mono-logic interaction. Marge Polyvocal's knowledge has offered a great contribution to this research study and her story has provided a depth of understanding about the person behind the diagnosis. The fact remains that she has followed the psychiatric advice and still endures turbulent mood changes. Within the discourse of psychiatry there appears to be a gaping vacuum and Marge Polyvocal occupies that space.

The dominant scientific discourse provides the backdrop to the effective treatment of bipolar mood disorder, but the other discourses privileging the position of the client are silenced or rather ignored, because of concepts like 'lack of insight' and non-compliance, and therefore the ideology of curative medicine is all pervasive. Parker et al. (1995) call for a balance between the production of scientific knowledge in collaboration with the clientele and consumers of psychiatry. Any position in

favour of either one of the poles would necessarily be skewed. This research project is an attempt to balance the conception of the clinical category of bipolar mood disorder.

There is a call to allow for the power to be shared amongst all stakeholders of the process, and in this case, it would invite participation from the pharmaceutical industry, the psy-fraternities, the economic sector and the basic family institution. Together these respective collaborators could enhance the research of positive and meaningful knowledge productions. This suggestion does have a communist ring to it, but as matters currently stand, it is the consumer of psychiatry who finds herself in a lose-lose situation as she has the diagnosis to begin with (based on scientific and empirical categorisation of evidence) and even though she may adhere to a treatment strategy, the larger discourses informing her position remain untouched and altogether, imbalance is achieved. The psychological domain can begin a dialogical process bridging the gaps between psychiatry and the larger reflexively influencing discourses. Psychology – as a form of practice, can help to translate the expert knowledges with the meaningful experiences and vice versa, as psychology has the respect of psychiatry and has the ability to be versed in lay man's language. The responsibility is therefore shared amongst all stakeholders to provide change and redefine clinical categories.

Symmetry of Epistemologies

The mental status exam and history taking provided a very important platform for the secondary discourse analysis that followed. The insight-oriented review is grounded in an epistemology of rationality, whereas the social constructionist approach offered an epistemology which focused on the meaning making processes. The deconstruction of bipolar mood disorder was best explored from the detailed explanations offered through the lens of a modernist epistemology. The traditional, medical discourse confirmed that Marge Polyvocal indeed meets the criteria for bipolar mood disorder and also made reference to several context specific accountabilities, explaining the rationality for arriving at the clinical diagnosis. However, this theorising fell short of offering a broader and in depth exploration of what it means to have the diagnosis and how it feels to live out such a life. This is

where the postmodern epistemology bridged the gap between what one researches and what one practises in the field of clinical psychology.

A continued focus on the levels of systemic interaction would have only served to promulgate the area of the problem, for example, there could have been a focus on interactional patterns and rules and roles inherent within systems, feedback and self-correction. The domain of the problem would have still centred on Marge Polyvocal and the things that she is not doing or could be doing better to resolve her difficulties. From a different approach, the postmodern perspective engaged in a collaborative process whereby the researcher influenced and was influenced by the questions asked and the answers received, which reciprocally influenced the nature of the dialogue. Further, Marge Polyvocal could be understood from a discourse perspective where meanings abound and help construct the belief systems and ideologies within which she functions. The postmodern epistemology did not offer a practice guideline or a solution to Marge Polyvocal's situation, but rather a glimpse of the intricacies of how the psychiatric discourse has shaped her life and how she too has contributed to that shaping. From the postmodern perspective of multiple realities, it is accepted that the modernist framework is useful, even if incomplete.

The intention of providing a postmodern conceptualisation is not to complete the cycle but rather to provide a stepping stone towards what may lie next. It is accepted that, for now, the cycle should naturally lead back into the psychiatric frame, with added information and perhaps a greater respect for the position of the client.

Conclusion

This chapter outlined the first of a series of interviews that were completed. Marge Polyvocal was described as a lady presenting with the diagnosis of bipolar mood disorder, as defined by a psychiatric paradigm. Her story was explored from this perspective, and it was confirmed that she does in fact exhibit signs and symptoms that place her in this category. Her story was explored to show how she came to receive the diagnosis and also how it is maintained. Marge Polyvocal is a

consumer of the psy-fraternity and her story offered many understandings about the difficulties involved in living with bipolar mood disorder.

Secondly, her story was discussed from a social constructionist discourse approach. This section of the chapter moved away from the problem of the diagnosis and the focus on treatment towards unravelling the many belief systems that help contribute to the reality of having a psychiatric diagnosis. It was shown that both epistemologies of modernism and postmodernism are beneficial in the process of understanding the tapestry of a psychiatric illness. Marge Polyvocal's story was constructed with the help of many significant influences, such as the psychiatric discourse, the family background, religious belief systems, the concepts of self-awareness and self-perception, and the research context. Bipolar mood disorder, understood as both a psychiatric diagnosis and a reflection of societal norms and values, cannot be treated with medication alone. The entire spectrum of definition and understanding requires a conceptual shift so that the depth of the situation can be grasped.

The polarised epistemologies were shown to be cyclical and interdependent, just as manic behaviour infolds upon a depressive episode and vice versa. The postmodern explication is useless without the starting point of an empirical, modernist conceptualisation of bipolar mood disorder. Having said that, the modernist framing is incomplete if one merely stops at the individual, or the family, or the problem at hand. The meaning systems making up the diagnosis have to be deconstructed to understand how and why the diagnosis has such a real power and effect on a person's life. The shift of conceptualising the disorder in conjunction with the medical treatment approach, as well as grounding the person within larger discourses, brings about change. In the medical model, Marge Polyvocal will always remain a bipolar patient, and in the social constructionist frame, Marge Polyvocal is part of a society that believes in the psychiatric discourse and in many ways, surrenders to the outcome.

CHAPTER SIX

Conceptual and Contextual Descriptions of Linda Egalitarian: Life in the Balance

I still think, it's not what life is about, life is about, life is not about how things look around you. Life is about what comes from inside, life is about having hospitality towards other people, uhm, receiving them with love and enjoying each other's company, not what you have and what you prepare and what you get.

Introduction

This chapter introduces the second research participant diagnosed with bipolar mood disorder. This will be achieved by presenting the story of Linda Egalitarian in the same way as Marge Polyvocal. The initial vignette will be presented from an insight oriented interview process (Miller et al., 2001) making use of the Mental State Exam. The modernist frame of reference will be referred to throughout this aspect of the vignette analysis, focusing on the verification of the mood disorder. To broaden the understanding of bipolar mood disorder, a social constructionist perspective will then be discussed entailing a textual deconstruction and unpacking of the content as well as the nuances of the interviews held with Linda Egalitarian. This will be followed by a postmodern deconstruction and reconstruction of the life of Linda Egalitarian based on the tenets provided by Parker et al. (1995). This chapter concludes with a discussion of the symmetries of the opposing epistemologies as they are referred to throughout this chapter.

Conceptual and Contextual Descriptions: The Medical Model

The interviews with Linda Egalitarian will also be conceptualised from both the medical model and a social constructionist approach. To reiterate, the medical model follows a psychiatric interview, involving insight and symptom orientation. The social constructionist approach focuses on the story that is told, the language used, and the way in which meaning has been constructed. A way of gathering information for a psychiatric interview is through the use of the mental status exam. This is a globally accepted interview schedule that seeks to infer information about the patient's well-being at the time of the interview. Linda Egalitarian will be described in terms of her appearance, her behaviour during the interview, her attitude towards the researcher, her psychomotor activity, her emotional state during the interview, a comment on any perceptual disturbances and notes on her speech, thought and orientation. These commonly used descriptors in the psychiatric setting all focus on ascertaining whether or not the patient has insight into her situation, and it also narrows the search when looking for a diagnosis according to behaviour categorisation. It is a useful tool in that it helps the interviewer filter through a person's story to arrive at a diagnosis on the basis of fulfilled criteria for a specific disorder, as well as giving an indication of what treatment can be implemented. A symptom oriented interview has the dual purpose of identifying signs and symptoms of categorised behaviour patterns (as defined by the DSM- IV) as well as being a means of assessing the current stage of the development of the disorder. Collectively, these factors will point towards appropriate treatment plans.

To begin with, an insight and symptom oriented interview vignette will be given of Linda Egalitarian. This information is based on the researcher's interview with the patient, involving both content and non-verbal inferences.

The Mental Status Exam

As with Marge Polyvocal, Linda Egalitarian's behavioural and psychological disposition will be spelled out in the format of a Mental Status Exam, thereby

confirming her diagnosis of bipolar mood disorder, and offering information on what her particular strain of bipolarity looks like.

The Vignette

44 year old woman, married with 3 children. Known depressive with recent onset of manic episodes. Current diagnosis, bipolar disorder, type 1. Has not had delusional or psychotic features. Becomes easily agitated and frustrated. Very poor coping skills. Can become physically aggressive. Blames husband for misunderstanding and lack of security. Manic symptoms include flight of ideas, over-enthusiasm, decrease in sleep and appetite, increased activity and decreased productivity, conflict seeking behaviour, overactive sexual behaviour, and aggressiveness. Depressive state includes suicidal ideation, weight gain, loss of hope and increased helplessness, anhedonia, withdrawal from husband. Depressed state also marked by increased anxiety and thoughts of self-destruction. Patient tends to function mostly in hypomanic state and induces situations of conflict and arguing. Marriage not going well. Husband supportive but his job requires him to be away from the home often. Dependant personality traits. Patient has a tendency to be non-compliant.

The patient's appearance

Linda Egalitarian presented herself in a neat and tidy manner. The colour of her clothing at both interviews was bright, and her clothes were loose fitting, giving one the impression that she was comfortable and even confident in carrying herself. Linda Egalitarian was in a hypomanic phase for the duration of both interviews and she was full of bounce and had difficulty sitting still for extended periods of time. She told her story very enthusiastically and shifted from one story line to another. She would eventually make her point, but always in a very round-about way. She presented herself with a very forceful energy. She used her tone of voice to accentuate her points of view and she spoke animatedly with her hands. She would often shriek with excitement about a particular part in the story that she was sharing. She was the embodiment of happiness and positivity. There was a very strong contrast in mood and tone from the interviews with Marge Polyvocal in comparison to the interviews with Linda Egalitarian. The flip sides of the moods of mania and depression also

evoked stories from alternative perspectives from the two research participants. Linda Egalitarian presented herself in an almost rebellious fashion tempting people to comment on her behaviour. She was loud and outspoken and appeared to function from a position of great inner strength.

The patient's behaviour during the interview

Linda Egalitarian was very excited during the interviews. She would change topics regularly and showed a poor and inconsistent ability to monitor what she was saying. She was not actively psychotic in the interviews, but she was hypomanic. She spoke with an incredible energy, overflowed with alternative thoughts, appeared to be very confident, and could even be described as euphoric. She struggled to focus on the discussions of diagnosis and she told her story in a manner consistent with her diagnosis. However, when the interviews were interrupted by phone calls, or someone knocking at her door, she was able to shift her tone of voice and demeanour and become very professional and contained. This was often followed by short outbursts of shrieking laughter or an exaggerated movement of jumping back into her chair.

Linda Egalitarian wanted to participate in the interviews and she presented her story of bipolar mood disorder from a knowing and authoritative position. She felt that she was a source of knowledge for anyone trying to understand this diagnosis. In a sense, her behaviour could be described as overbearing and overly confident, even narcissistic. But, this did shift to a more humble position when she touched on several emotional times of her life. She would then become fragile, and vulnerable, requiring containment. But these sadder moments were generally short lived and she would move back to her more comfortable disposition of assertiveness.

The patient's attitude towards the researcher

Linda Egalitarian was respectful of the researcher's position and she showed that she has a background academic knowledge of qualitative research. This allowed her to be comfortable with the research context as she had an idea of what to expect. There was a definite air of superiority portrayed by Linda Egalitarian as she felt she was in a position of knowledge dissemination, and the researcher accepted this co-defined role. Linda Egalitarian appeared to enjoy the questioning process and revelled in the attention and opportunity to be in the spotlight. She was also very open and

trusting of the research context and she spoke with ease about very personal issues. This could have been a symptom of a hypomanic episode showing little regard for boundaries of research oriented interview contexts. However, the researcher rather chose to view Linda Egalitarian's behaviour as congruent with the platform of self-focus and excitement over being acknowledged for having a diagnosis of interest.

The patient's psychomotor activity during the interview

There were no signs of her mood being down and depressed. Linda Egalitarian was very active during the interviews and spoke in an animated fashion, making full use of her body to accentuate her point of her view. She would also utilise her facial expressions in a congruent way to further enhance her message. Linda Egalitarian did not control her manic behaviour very well and she could not sit still for extended periods of time. She would jump up and down in her chair when she was excited and continuously shifted her legs throughout both interviews. Her hands were always busy and she touched her face and her hair frequently. She would also neaten her bright skirt in a very methodical manner every so often. When she was thinking about an answer or trying to recall what point she was trying to make, she would animatedly tilt her head sideways and look upwards as if the answer she was looking for was written on the wall or ceiling. In comparison to Marge Polyvocal, Linda Egalitarian was very active during the interviews.

The patient's emotional state during the interview

Linda Egalitarian was euphoric for most of the time in both interviews. This was interspersed with moments of deep thought and a sadness that seemed to come over her unexpectedly. She told her story with great enthusiasm and this was mirrored in her physical movements. One had the sense that she was keeping up such a high energy output to subdue the sadness that was lurking. Linda Egalitarian's foundational belief is one of positivity, remaining focused on religion in the face of any adverse circumstances. This allowed her little room to acknowledge the pain and hurt that she had experienced in her lifetime. Instead she rattled through some very emotional stories, losing her way in all her sentences, and finally shrieking with laughter at how she cannot follow her own conversation. The differences between Marge Polyvocal and Linda Egalitarian were stark and apparent. For the researcher, the emotional lightness of Linda Egalitarian was comforting and not as draining as the intensity

provided by Marge Polyvocal. However, the other side of the coin is that following the conversational strings of Linda Egalitarian required incredible concentration. Linda Egalitarian did not appear to be completely contained and the researcher had the feeling that Linda Egalitarian was volatile and explosive, depending on what was being spoken about.

The patient's perceptual disturbances (if any)

Linda Egalitarian showed no psychotic behaviour at the time of the interview. She could not recall ever having a psychotic episode, although she did mention that she could get into blind rages. When in this extreme form of anger, Linda Egalitarian could not rationally understand the world around her or the people in that world and she would become consumed with intense rage. The complementary position of her euphoria gave an indication of what the rage could be like. Linda Egalitarian is a very intense person, happy or sad, angry or depressed. Linda Egalitarian believed strongly that she was a messenger of God and this could be misconstrued as religious delusion. She lives her life consistently with her religious beliefs and she makes every effort to enlighten others as to God's way. She is not always context appropriate when she preaches, but she is passionate about her belief in God and the role she is meant to fulfil in this life, helping others. Linda Egalitarian's religiosity was congruent with her mood of euphoria.

Identifying problems in speech, thought and orientation

Linda Egalitarian spoke in an unstructured way. She shared thoughts as they seemed to pop into her head. She also spoke at a very fast pace and this resulted in stumbling over her words, almost as if she could not get them out quickly enough. This is indicative of pressure of thought. She was oriented for time, space and place, but she had difficulty in recalling the chronology of past events. She would jump around from decade to decade and often changed her story according to what she suddenly recalled. She did not have a very clear or thorough recollection of the events that led to her diagnosis. She did offer a very thorough account of raising her children and being married to an unfulfilling partner. She had good recollection of the times that she was depressed, but could only offer other people's observations of her more manic phases. Her thought pattern was disjointed, interrupted and fast paced. She appeared to have an inability to consolidate her thoughts and they just seemed to

tumble out her mouth uncensored. This gave way to the odd contradiction as she would profess to be a very religious and pious observer of her faith, and this would be interspersed with swearing about her husband and dogmatic remarks about the people in the church. Academically, Linda Egalitarian showed a very sound ability to communicate her thoughts. But emotionally, there was not enough containment. This could be attributed to the fact that work was a place to channel her abounding energy into. She carried forth an extremely passionate perspective on life, filled with hope and excitement. This remained consistent over time.

The Mental Status Exam overview provided above allowed the researcher to condense a very chaotic and unstructured interview process. Linda Egalitarian did not wait for the researcher to ask questions, she offered almost all of the information requiring further probing in some instances. Linda Egalitarian is a very positive and energetic person, and this was carried forward in the interviews. However, as it was indicated above, this happy-go-lucky state could easily be disrupted and move towards an equally passionate but destructive rage. Linda Egalitarian thoroughly enjoyed the attention that she received in the interviews and she felt good about herself having had the opportunity to share information on what living with bipolar mood disorder is about.

One cannot doubt the accuracy of her diagnosis. She fulfilled the criteria for bipolar mood disorder, type 1 and 2. She received medication for this and she sought out psychotherapy. Her communication style was similar to Marge Polyvocal's in the sense that both were difficult to track, emotionally laden, and unstructured. Linda Egalitarian showed no desire to change who she is today, rather accepting herself, diagnosis included. This differed from Marge Polyvocal who is in a constant search for a cure and an eradication of her symptoms. Linda Egalitarian accepts her diagnosis and sees it as a positive comment on her ability to be energetic, passionate, committed and dedicated to all that life offers her. This could be indicative of her poor reality testing, assuming that she is behaving as others would like, and ignoring her husband's plea to change and be more subservient. Linda Egalitarian's perceived strong sense of self could indicate that she is oblivious to the social standards of what is appropriate and inappropriate behaviour. She is blatantly positive and overbearing in her energy regardless of circumstance. Linda Egalitarian may lack the ability to be

sensitive of the needs and the desires of people around her choosing to focus on what she believes is most necessary at that moment.

Linda Egalitarian believes that she has bipolar mood disorder and she also (positively) believes that she is living successfully with it. She did not indicate that she had acquired psychological skills that could help her manage her disorder. She could not acknowledge that she has a psychological problem. For her, she has a behavioural problem brought on by hormone changes, and maintained through her interpersonal relationships, both at home and at work. Linda Egalitarian abdicates responsibility for her disorder in favour of denial and a positive disposition. It is no wonder that she experiences heavy bouts of depression requiring hospitalisation for suicidal ideation.

A Case Study of Linda Egalitarian

This section will introduce the contextual descriptions of how Linda Egalitarian came to receive the diagnosis of bipolar mood disorder. The Mental Status Exam has described the psychological and behavioural aspects of Linda Egalitarian's diagnosis. This section will now focus on the signs and symptoms that validate this diagnosis. The intensely energetic life of Linda Egalitarian will be further explored to shed light on how she came to receive this diagnosis.

Explaining the Title

Linda Egalitarian was a work colleague of the researcher. She volunteered to participate in the research when she heard about the topic of interest. She was always extremely helpful and did not withdraw her interest at any time. She followed up with the researcher on a continuous basis to enquire about the development of the thesis. She was always encouraging and persistent in supporting the nature of the research. She wanted to offer the body of psychology an experiential viewpoint of what it means to be diagnosed with bipolar mood disorder. She believed in the importance of enlightening people through real-life experience and knowledge.

The researcher chose to name this participant as Linda Egalitarian as she embodied the synonyms associated with the word egalitarian, such as, free, classless, equal, unrestricted, uncensored, democratic and open. These words best describe the way in which Linda Egalitarian wanted to portray her sense of self. A very large part of her struggle has been to oppose the restrictions placed upon her by society, her marriage, her religion and her work. Her positive energy field and continuous search for hope led to the use of the metaphor of an egalitarian interactional style. She loathes being dictated to and yet all the contexts that she lives and functions in have an edge of oppression. Her goal in life would be to live more congruently with what she feels to be appropriate and necessary rather than merely living for the needs of others. Again, like Marge Polyvocal, Linda Egalitarian has made many sacrifices in her lifetime to accommodate the needs of others such as her husband, and feels angered and frustrated because of this choice inducing a sense of hopelessness and a paucity of free will.

History and background

This research participant volunteered herself as a co-researcher when she realised that the researcher's interest was in bipolar mood disorder. She is a mental health worker by profession (the exact professional body is being omitted to protect confidentiality) and she is a married mother of three children. She was diagnosed in 1992 with bipolar mood disorder type 1. Her struggle with bipolar mood disorder has included overcoming the negative effects of having being labelled with a diagnosis, and another has been to assume control over mental illness through developing an attitude of resilience. Over the years, she has been treated by several psychiatrists and psychologists. During the process of the interview she moved about in terms of the content of the conversation but she always came back to her original point of departure. She could get very 'enthusiastic' about what she was saying and then become deeply reflective and almost sad. Her diagnosis dramatically changed her life and she has felt the consequences of having a diagnosis permeate throughout all the various contexts of her life (the beginning of a problem determined system). She experienced a lack of support from her marriage, the church, as well as from friends and colleagues. She did have an extra-marital emotional affair (that is, non-sexual) pre-diagnosis and always considered her marriage to be a stressor in her life. She said

that she was often disqualified as "having my head in the clouds" both professionally and at home.

During the interview she demonstrated a great deal of self-awareness and was often able to comment on her own process. One of her discoveries was that she perceived that other people look down upon her when they find out about her diagnosis. She also felt that people misconstrue her 'passionate' and 'enthusiastic' attitude for a manic and uncontrollable mood swing. This made her feel stifled, silenced, and unacknowledged as a person. She also exists within well-defined boundaries about how she may or may not behave, that is, what is socially and culturally acceptable or not. Racism seems to be a prominent theme in her life and she finds it difficult to tolerate racist attitudes from the people around her, especially considering the nature of her work. The researcher wondered whether she is identifying with a relatively oppressed and powerless group, because she had first hand experience in what it feels like to be misunderstood and judged on the basis of external factors.

She experienced her mood swings as alternating between feelings of frustration followed by crying spells, for which she could find no particular reason or cause. She also had ongoing and unrelenting feelings of overwhelming anxiety. She never used or abused drugs or alcohol. She did have thoughts of ending her own life to free herself from the unexplained intensity of the emotional mood swings. She had compliancy problems with regards to taking her medication that had been prescribed by psychiatrists. She would stop taking the medication when her mood lifted and the anxiety decreased, and every year she would have to restart the treatment protocol. In the last few years she has settled into a more consistent routine and takes her anti-depressant medication regularly.

Her treatment included the following:
- ✥ Psychiatric medication (including a mood stabiliser, anti-depressants, anxiolytcs and sleeping tablets)
- ✥ Psychotherapy (including behaviour therapy, psychoanalysis, and couple therapy)

Her last hospitalisation was in 2001 and this was due to overwhelming stress and more intense and irregular mood swings – occurring every few days. She was initially treated with lamictin (an anti-epileptic) and cipramil (an anti-depressant). Currently she is taking efexor (an anti-depressant). At the time of the interviews she was satisfied with her relationships with both her psychologist and her psychiatrist. She could be considered to be a stabilised bipolar patient.

Ms Egalitarian believes that she has reached a point of stabilisation, and said, "I'm calm when I get home, doesn't matter what happens. I'm not getting in this frantic anxiety state, I haven't got these bounces, that's why I say to you I've got this bipolar thing in my body, because the medication makes it ok"; "Although I'm like always on a high and everyone tells me my head is in the clouds, it's to me a coping mechanism – to look at positive things"; "I don't want to ever be without this medication ever in my life".

She framed her interactional style as one that is passionate and aggressive, and she thought that that may intimidate people. She is of the opinion that others are labelling her in order to control her. She experienced weight loss due to the manic episodes and also depleted her energy by keeping busy all the time. She also gained weight when in a depressed phase and her husband did not appreciate her physical changes and wished that she would be slimmer. The suicidal ideation has diminished since she has become more compliant with her medication. She showed some psychomotor agitation during the interview, and was physically activated when becoming 'enthusiastic' about an idea. She had a tangential thought pattern and showed poor self-monitoring at times. She was very apologetic for her unstructured thought processing ability. Her mood and affect vacillated throughout the interview and she was emotionally labile at times. She showed no psychotic signs of behaviour and she did not mention any psychotic episodes in the course of her psychiatric treatment. The research participant appeared nervous throughout the duration of the interviews and she stuttered and stammered through her sentences. She also used context appropriate humour during the conversation. She showed no inappropriate mannerisms and was forthcoming with information and she offered follow-up assistance if necessary.

Psychotherapy should be aimed at:

- ✧ Maintaining mood stability.

- ✧ Continued efforts to attain physical health. She is very active and needs to continuously find better ways of expressing her energy.

- ✧ Improve her ability to assume personal responsibility for the impact of her diagnosis on herself and family members.

- ✧ Make peace with the past and stop raising conflict with her husband and colleagues over things that cannot be changed.

- ✧ Encourage medical compliance at all times, especially during manic phases.

- ✧ Maintain her positive attitude towards her attainment of mental health.

- ✧ Acquire better coping skills to deal effectively with her depressive episodes so that she does not resort to suicidal ideation.

- ✧ Resolve marital conflict.

The onset and progression of the disorder

Linda Egalitarian was 44 at the time of the interviews. She had been married for 22 twenty years to a man who is one year older than she is. She has three children and they are all in the educational system (secondary and tertiary). She is qualified as a mental health worker. Her husband is also a professional and his work requires him to be away from home for extended periods of time. The responsibility of raising the children has largely been on Linda Egalitarian's shoulders. During the years of marriage, Linda Egalitarian and her husband were required to relocate around South Africa. She had to find employment for herself in the new communities each time so that she could help sustain her growing family. Her married life has required her to be able to face changes and adapt appropriately. She has not always risen to this challenge, and has remained resistant to presenting changes that require her to adapt.

Linda Egalitarian could recall that when she was a teenager she experienced mood swings due to her irregular menstrual cycle. She found that she was very depressed during menstruation and then very happy for the rest of the month. Overall, her mood remained happy, too happy for most people around her and they often made the comment that "she has her head in the clouds". The first dip in mood that Linda Egalitarian can remember was when she returned to work after her youngest child had

turned eighteen months old. She found a job at a clinic that rehabilitated alcoholic patients. She did not receive any supervision for her case management, and eventually she crossed therapeutic boundaries and became emotionally involved with one of her patients. The cross-over of professional roles shattered Linda Egalitarian's preferred perception of herself as a helper and a healer and she fell into a depression. This was named a reactive depression at the time and was later diagnosed as bipolar mood disorder. This event took place twelve years ago.

Linda Egalitarian's last period of hospitalisation was in 2001 for a "nervous breakdown". Linda Egalitarian was experiencing ups and downs in mood that were beginning to scare her. She described this time as a phase where "everything just went wrong". She was working a very hectic time schedule and was overloaded with patients. She was also experiencing difficulties with her husband at home and she felt very unsupported, with the exception of her work colleagues. They were the ones who suggested a psychiatric interview and she was subsequently hospitalised. She described her mood swings to her colleagues as increasing in alternating ups and downs at such a pace that she was becoming afraid. The interval gap between up and down had decreased from every second week to twice in one week. She felt that she was spinning out of control and she broke down and cried uncontrollably. While hospitalised, she was placed on a different anti-depressant and in addition, a mood stabiliser.

After this last hospitalisation period, Linda Egalitarian changed psychiatrists and was placed on a combined anxiolitic and anti-depressant tablet. She takes this tablet religiously and she said that her mood felt more stabilised. For Linda Egalitarian, the anxiety has now been controlled with medication and she felt that this relieved her need to "bounce". She experienced that she is able to approach situations calmly and does not get so stressed about certain events at home. Linda Egalitarian used to self-medicate in the sense that she would take her medication consistently and then once she felt the depression lift, she would abstain from the medication. This of course led to a further depressive episode and she would have to restart her treatment protocol. Since 2001 she has taken her medication as prescribed by the psychiatrist and she feels that she is more in control of the feelings that she experiences.

The people who notice that Linda Egalitarian is on the verge of a "nervous breakdown", that is a phase of changing moods, are her husband and her work colleagues. She feels that she has been unsupported by her church and her friends. People whom she depended on for support disappointed her and did not meet her expectations of friendship. Her disillusionment with the church in her time of need (when hospitalised) was very hurtful for her, and she felt that she was ostracised by the church going community. Linda Egalitarian is a very religious person and she recognises the danger of this becoming a symptom of bipolarity. She becomes excessively involved in religious verses and praising, and this normally leads to a depressive onset.

The person behind the diagnosis

Linda Egalitarian's introduction to the world of bipolar mood disorder was through a "reactive depression" followed by extreme and uncontrollable highs. She enjoyed the highs tremendously and felt that they were moments of inspiration through which she could assist and guide other people who were in need of help (such as the alcoholics in her previous employment). The "reactive depression" was brought on because of work and marital stress. She had not acquired coping skills to deal with the stress at that time in her life. The vacillation between manic and depressive swings is always highlighted when there is marital discord. It has not been an easy relationship for Linda Egalitarian and she has felt rejected, disappointed and unloved on many occasions. She felt that her husband has diminished her self-worth over the years and failed to build her confidence. If anything, she perceived him to demoralise her and put her down. She said that he would often make comments that she is stupid and also fat. On one occasion she attributed her weight gain to the medication, so she stopped taking the prescribed medicine to control her weight better. This also served the purpose of making her husband more physically attracted towards her.

The unsatisfactory relationship has been non-communicative from the time of marrying. It was only a short while after they were married that Linda Egalitarian suggested that they attend couple therapy sessions. Her husband could not see the need for this and he refused. Throughout her psychiatric treatments her husband has declined psychotherapy. He did agree to attend one session following her last

hospitalisation period. She had carefully located a male psychotherapist thinking that her husband would connect better with a male, but after the one session he refused to go back again. The issues that were addressed in therapy focused mostly on her bipolar symptoms and bipolar interventions, and not the problems within the marriage. He has shown little interest in understanding bipolar mood disorder and he has the belief that she is capable of controlling her moods irrespective of his involvement.

Linda Egalitarian has considered divorce as an alternative to being misunderstood and devalued. But after much deliberation, she decided against divorce as her belief is grounded in religion where it would be a sin to give up and give in to the devil. She claims to have accepted the state of her marriage as unfulfilling and not always desirable but given to her as a challenge in her life. She shifted her focus away from the marital problems and focused her energy on her children and bringing them up with values and principles. Linda Egalitarian poses contradictory understandings about personal change. If she feels that she has a sense of control in the change required, then she views it as a challenge with potentially positive outcomes. But, if she feels that she is being forced to change to suit the needs of others over and above her own needs, then she resists the process. The contradiction is encapsulated in the naming of this research participant as Linda Egalitarian.

In the marriage, Linda Egalitarian perceived that she was often silenced by her husband in the sense that she was never allowed to make decisions or have her own opinion. She found that her husband had a particularly negative perspective on the future of South Africa (post 1994) and this permeated all of their social and home contexts. She, on the other hand, accepted the changes that she would experience going from an elite minority towards a community accused of horrors and having privileges taken away. She might not have liked the changes, but she decided that she would see the positive in the transition of the South African society and adjust accordingly. Her positive position infuriated her husband and he retaliated by attacking her personhood and personal appearance. Eventually, of course, she relented and took the silenced approach. But, this in no ways placated her and she bottled up the resentment towards her husband's short-sightedness. This untamed aggression always has the ability to trigger an episode of a manic outburst, which is inevitably

followed by a depressive episode filled with hopelessness and meaningless beliefs. The route out of depression seems to appear to be a re-investment of all her energy and zest for life back into a work context. This in turn can, once again, lead towards disappointment and then the cycle may begin again. Most of the changes required to lift Linda Egalitarian out of a depressive phase include a shift in perception. She carefully rationalises her way through a changing and demanding environment. Again, when she feels that she has a better understanding of her choices, then she submits or overcomes the difficulty.

The more Linda Egalitarian interacts with people the more manic she can become. She gets an emotionally charged energy from interacting with people and she gives one hundred percent of herself to those in need. If this energy is left uncontained then she eventually burns herself out. She found that in recent times she withdraws from people more and keeps to herself, always with an awareness that she can be hurt by people's lack of reciprocation and also by sheer ignorance of her needs as a woman, friend, mother and colleague. Linda Egalitarian gives one the impression that she is always walking close to the edge and she can jump up and fall down at any moment. Her abundance of energy and passion can be overwhelming and can often silence those around her. This can be easily misinterpreted by her as rejection and has the potential to pave the way to a "reactive depression".

Linda Egalitarian says that she is very often misunderstood. Her endless passion and her ability to focus on the positive in life (with gusto) is not always contextually appropriate. For example, in the workplace, if she feels that she is not being given the space to share her opinion or viewpoint, then her enthusiasm comes across as a threatening aggression. She is more aware of people's perceptions now and she tries to curtail her emotional outbursts, but she still finds this unfair and silencing. Again, this is a form of social interaction that has the potential to trigger a mood swing from a very positive and up-beat outlook towards a more sombre and hopeless position.

Linda Egalitarian's signs and symptoms of bipolar mood disorder are mainly observed in the domain of a manic episode. She can become consumed with trying to achieve a goal in helping other people to the extent that she runs herself empty. This

pattern of giving naturally leads to a place of depression where she feels "what is the point?" and she entertains thoughts of helplessness, hopelessness and even suicidal thoughts where she would like to see an end to her life. The suicidal ideation is in direct opposition to her normal positive outlook on life. The other signs of depression for Linda Egalitarian are a heightened sense of irritability and frustration which take on a very aggressive tone. She becomes impulsive and says and does things that she later regrets. The quick swing from feelings of depression to the outward expression of anger, are indicative of an underlying mood disorder. The confusing feelings remain for days on end and Linda Egalitarian tends to withdraw from people once this process begins.

The hypotheses of mental illness

Linda Egalitarian's bipolarity has been effectively controlled due to compliance with medication, positive self-reflections on her life, and the development of a positive and resilient attitude to face life's challenges. In addition to this, Linda Egalitarian has a trusting relationship with her psychiatrist and has endured many years of psychotherapy. She has a strong belief in the benefits of psychotherapy and she attends maintenance sessions (one session every few months) with her psychotherapist, whom she trusts. Her mood swings are less frequent and she feels that she has a better control over her reactions to stressful stimuli in her environment. She has acquired stress relaxation skills and she implements them effectively. She also has an undying belief in her religion and she believes that her mission on earth is to help others overcome personal afflictions and crises. She is intolerant of negative thinking, attitudes and beliefs of people around her, and her coping mechanism for this is simply to withdraw herself from these situations.

The signs and symptoms of bipolar mood disorder developed in Linda Egalitarian's life from the onset of puberty where she noticed her mood would fluctuate around the time of menstruation. In addition to this, Linda Egalitarian acknowledged the effect of the seasons on her mood. She tends to feel down and depressed when the weather is cold and cloudy. She notices an upbeat change in her mood when the season is summer and she feels an extra bounce in her step. Physiologically, Linda Egalitarian is affected by hormonal changes in her body, as

well as when her body becomes run down because of the over-investment of her energy in other people's problems. Environmentally, Linda Egalitarian is affected by seasonal changes as well as the contexts that she perceives to be potentially hostile and threatening to her sense of self. For example, if she is arguing with her work colleagues then she tends to become despondent and she can quite easily slip into a depressive phase until such time that she brings this to her awareness and changes her attitude to accept the faults of others.

Linda Egalitarian's marriage is a potential source of her vacillating moods. It is a marriage that is fraught with conflict. It does not offer her support, nurturing and growth. Linda Egalitarian found that having the disposition of "having her head in the clouds" gave the desired image or mask of being comfortable with the situation at home. Instead of trying to force changes in her marriage, she quietly accepted the state of the relationship. Although, when she finds the submissive position intolerable, she has the guise of a manic episode through which she can express her real feelings. This is not to say that the manic behaviour is used manipulatively, but rather that it provides an effective platform for Linda Egalitarian to find expression. During times of marital discord Linda Egalitarian became withdrawn, distant, and disconnected.

Linda Egalitarian seems to find comfort with the people in society who have been marginalised due to a certain unacceptable stereotyped way of thinking and/or behaving. She has a strong and compassionate belief in helping people who were previously disadvantaged – often to her husband's disapproval. She also finds comfort in sharing her life stories with people who have also met with difficulty in being accepted, such as in groups of recovering alcoholics. She has a yearning desire to be understood and to be accepted for the person that she is. This quest often disappoints her as she invests much of her time and energy into building up other people's self-confidence and perception of life, only to find that she is left behind after that person has an ideological shift in belief patterns. She tries desperately to put forward a mask of absolute positiveness and cheer and this can infuriate people, depending on the context. For example, if she is giving motivational talks to students then the students embrace her positive attitude, and if she is sharing her enthusiasm amongst colleagues who are fed up with corporate politics, then she is viewed as unrealistically positive and frustrating to those around her. Her need to remain in control of her emotions,

thoughts, beliefs and attitudes often displaces her sincerity and she can be perceived as being unreal and superficial. She is ultimately attempting to share her struggle of overcoming a somewhat abusive marriage and unfulfilling life with a more positive and affirming disposition, grounded in her religious beliefs.

No one has to remind Linda Egalitarian that she should be positive in the face of life's challenges, and if anything, one would have to remind her that it is quite alright to admit defeat and even cry. Linda Egalitarian is fighting a struggle each and every day not to give in to a negative spiral and she is completely invested in containing her bipolar mood disorder so that other people can believe in the power of positive thinking and the importance of a resilient attitude.

Linda Egalitarian's religious beliefs have a co-existing positive and negative experience for her. On the one hand, when she is in the midst of a manic episode, she praises God and recalls sermons that emphasise the power of her belief. This serves to alienate people as the context is not always appropriate. For example, being overly exuberant and enthusiastic in a time when other people are trying to process the disappointment of a particular outcome of an event. Then again, it is her very religious core and fundamental belief system that has always remained consistent in her life and offered her support when people around her have failed miserably to meet her expectations. It is always difficult to distinguish between Linda Egalitarian's religious convictions as a sign of a possible manic episode onset and to take it at face value and see it for what it is – a form of expression. Linda Egalitarian's reactions to potentially stressful situations seem to depend on her feelings of satisfaction in her marriage. When she is silenced at home, she tends to become more vocal and possibly even aggressive when in other social contexts. A definite relationship seems to exist with Linda Egalitarian and her patterns of social interaction.

Conceptual and Contextual Descriptions: A Social Constructionist Approach

Following the outline used to deconstruct Marge Polyvocal's story, Linda Egalitarian's story will be further explained. Of importance is the meaning that Linda Egalitarian attaches to having bipolar mood disorder, what it means to her and also how she lives with this diagnosis. Linda Egalitarian's life-story did not revolve around her diagnosis to the extent that Marge Polyvocal's did, but it still had a very significant impact on the direction of her life, as well as her self-view. Living with bipolar mood disorder is in essence, living with who you are. Linda Egalitarian's meaning making processes will be deconstructed to attain a deeper sense of how she makes sense of the diagnosis and how it shapes who she is as a person, a professional, a mother and a wife.

To briefly recap, this section will not focus exclusively on the signs and symptoms of bipolar mood disorder (a modernist conceptualisation), but will move towards unravelling the meaning structures that construct bipolar mood disorder from Linda Egalitarian's speech, text, and non-verbal communication as observed by the researcher. Therefore comments made about Linda Egalitarian are rooted in the eyes and ears of the researcher. There is no attempt to be objective, but rather very much a part of the textual construction to follow.

It has been shown above that Linda Egalitarian is deserving and embracing of the diagnosis. This means that she has the mood patterns of constant shift between elatedness and depression. The mood is also accompanied by inconsistent thought patterns, poor self-monitoring (yet an awareness of this), and fluctuating perceptions of others in her life. She accepted her diagnosis and chose to see it as God's will, moving away from viewing it as a punishment towards believing that being bipolar is integral to the person that she is, inspiring her to assist others in overcoming their struggles in life. A mere description of the signs and symptoms of her behavioural patterns does not yield the multitude of explanation that a social constructionist explication can offer. Therefore, both frameworks are being adopted thereby yielding thought provoking and thematic generative information that can shed some light on

what it means to live with bipolar mood disorder and how this is socially constructed, defined and refined.

From the social constructionist viewpoint, the research collaboration is believed to reflect the dual interaction between Linda Egalitarian and the researcher. Linda Egalitarian's passion for life and desire to learn and empower people, may also be reflected by the researcher's need to understand what meanings are attached to living with bipolar mood disorder. Both are intense positions, both are committed to understanding human behaviour, and both are best understood in a conversational domain. The researcher's eagerness to understand often led her to allowing Linda Egalitarian to speak at will, encouraging her through further explorative questioning, and mostly being a witness to her particular account of bipolar mood disorder. Linda Egalitarian sensed and confirmed the researcher's desire to understand the person beyond the diagnosis and she welcomed the challenge offering her most accurate and thorough memories of how she experiences bipolar mood disorder.

Bipolar mood disorder researched from a social constructionist framework necessitates an open minded and conversational arena for understanding human processes. Linda Egalitarian did not just arrive with bipolar mood disorder. The researcher acknowledged that she has it according to all modernist prescriptions, and invited her to explore her own personal meanings associated with a cut-and-dry diagnosis. Therefore, the construct bipolar mood disorder is most definitely co-defined by the researcher and Linda Egalitarian. It was a taken-for-granted reality that bipolar mood disorder exists, can be seen, and therefore has meaning.

Deconstructing Discourses of Bipolar Mood Disorder

To reiterate from Marge Polyvocal's story, the medical discourse discussed previously has provided an explanation of bipolar mood disorder, and the beauty and richness of discourse analysis allows for the exploration of a multitude of discourses. In this research, bipolar mood disorder will be looked at as a discourse in itself, shaped and developed by other surrounding discourses, such as the psychiatric, the interactional, the psychological, the cultural and the social. All of the different discourses offer value to broadening the description of what a bipolar mood disorder

is and what the implications of having it are. Clearly, from a medical discourse, once the patient has been diagnosed, the focus is on eradicating symptoms and aiming towards a curative prognosis. However, in this research domain, none of the patients recovered from the diagnosis, which implies that there is more to be understood about the simplified behavioural description of bipolar mood disorder.

The discourses under review have emerged from the textual transcriptions from the interviews. The researcher categorised and indexed the text, allowing for sets of statements to be identified. These statements, or discourses, indicate that bipolar mood disorder is constructed in particular ways, silencing others. The way in which discourses are constructed gives shape to the way in which people live their lives. Therefore, this deconstruction is imperative to understanding the way in which bipolar mood disorder is constructed by the client, the psychotherapist, and the psychiatrist.

In this discourse analysis section, a similar arrangement of categories will be used as mentioned in the vignette analysis. They are, naming the disorder; causes of the disorder; self-perception; support systems; religion; symptom expression; and perception of the psychiatrist. Initially the researcher quoted text as systematically indexed from the transcripts. Following this, she regrouped statements into sub-categories of discourses. This emerged as the table below.

Table 3: Linda Egalitarian

Category	Textual comments	A Discourse Revealed
Naming bipolar mood disorder	In a certain time of the month I would be very depressed and the rest of the time very happy. This bipolar thing. I got reactive depression. I would be crying my heart out and the next minute I would be fine. These ups and downs were scary. It's too up and down, the intervals are getting closer, not every two weeks, but half weeks. This frantic anxiety state. I've got this bipolar thing in my body. These bounces.	1. Psychiatric / Biomedical

Category	Textual comments	A Discourse Revealed
	Bipolar stuff.	
	I don't think the ups are a bad thing	
	Work pressure as well as the demanding children must have played a role.	
	Everything just went wrong.	
	It's a very traumatic experience.	
	I think I have it.	
Causes of bipolar mood disorder	I repressed everything.	1. Psychiatric / Biomedical
	I don't want to ever be without this medication ever in my life.	
	I stopped the medication because I thought it wasn't necessary anymore.	
	I got the ability to handle things, but my body wouldn't cooperate.	
	I got involved (an emotional relationship) with one of the people.	2. Interpersonal
	Work pressure as well as the demanding children must have played a role.	
	My husband didn't want a maid so I had to do all the housework as well.	
	It was aggravated by all the things that happened.	
	I believe that one has a weak point in your body, and stress will activate that weak point.	
	Relationships and mood are directly related, definitely.	
Self-perception	I couldn't cope on my own.	1. Psychological (positive and negative cognitive processing).
	I'm not prepared to be trampled on anymore.	
	Things were not going well.	
	I'll say, it's nothing, it will go over that, that thing.	
	It's to me a coping mechanism, to look at positive things.	
	Since the medication, the ups and downs are more sort of neutral.	
	There are things that I can handle now.	
	Only one thing can help and that is Christianity and resilience.	
	I know I still make mistakes, but who's going to be perfect?	
	I can control it better now because I am on my medication.	

Category	Textual comments	A Discourse Revealed
	I've got the mental ability to look at things afterwards in a different way. I don't have self-confidence, I hope that will change. Life is about what comes from the inside, life is about having hospitality towards other people. I really lost the ability in my private life to deal with people, to talk to people.	
Support systems	My husband didn't want to go for counselling. I used my colleagues and I spoke to them and they gave me a lot of support. Marriage is about commitment, it's not about feelings. Resilience is having good friends and that's what the church provides if you are really involved. I'm at the stage where I don't trust friends. My kids tell me to shut up because I can talk a lot and it doesn't upset me. I don't want to get divorced, I don't want the kids to go through that. You are the outcast. Where is the support? He didn't visit me, he didn't phone, he didn't contact me, he didn't ask me.	1. Interpersonal
Religion	I felt like I was being possessed. I'm inclined to be very religious. I'm a disciple of Jesus. I want to help people. I look at people differently to other people. Jesus tells you you have to look after yourself. When I get stressed I take a deep breath and I look up to God. If I look at what has been written in psychology books, they can relate everything back to how Jesus lived.	1. Religion
Symptom expression	I've got too much energy. I'm just with my head in the clouds. I was furious, absolutely furious. I'm always on a high and everyone tells me my head is in the clouds. The way that I get involved in what I say and my voice gets very loud. I feel passionate about what I say but I come over as	1. Manic expression

Category	Textual comments	A Discourse Revealed
	angry or dominant.	
	If I want someone to understand my point of view then I get aggressive.	
	I use all my energy up, physically.	
	I get thin.	
	My heartbeat goes up.	
	I go up. I can go very high up.	2. Depressive symptoms
	I wanted to commit suicide.	
	I was so upset.	
	I didn't want to talk.	
	I didn't even want to do anything, I just sat around and I didn't want to talk to anyone, I didn't want to hear anybody.	
	I would go to pieces.	
Perception of psychiatrist	She is the psychiatrist dealing with moods.	1. The good doctor
	She put me on the right medication and this is how I wanted to be all my life.	
	She doesn't think it's serious.	
	He gave me a lot of insights into why I should change things.	
	They just didn't listen to me.	2. The bad doctor

Linda Egalitarian's comments are more expansive than that of Marge Polyvocal. The interview with Linda Egalitarian took more time and more effort to transcribe because of her way of jumping around from one story to another. She was very difficult to follow and the process was quite exhausting. But in that, the many contradictions emerged. For the researcher, the biggest contradiction was when Linda Egalitarian made the comment that it is only with the help of supportive friends and the church that a person can overcome bipolar mood disorder, yet very shortly after she claimed that she had no friends because of trust issues and the church had been very unsupportive of her in her time of need. This was recounted to the researcher in terms of her feelings of reference in the research interviews. Yet, she felt that she had overcome the worst of her mood swings because of the support. Perhaps in theory, Linda Egalitarian would like to believe that the more correct way to be helped would be through support and she says this from a position of not having that. Linda

Egalitarian's interpersonal relationships showed to be the most destabilising factor for her.

In contrast to Marge Polyvocal, Linda Egalitarian did not frame her understanding of bipolar mood disorder from a psychiatric discourse. As can be seen from the table above, Linda Egalitarian chose to see her disorder arising from interpersonal relationships, stress, and religious beliefs. It is interesting to note how Linda Egalitarian refers to bipolar mood disorder as a "thing". She showed throughout the interview that she is more than capable of giving rich descriptions to concepts, yet she consistently referred to the diagnosis as a "thing" or "stuff". In this way, she provided a distance between herself and the diagnosis and kept it away from taking control of her life. Yet, contradictorily, Linda Egalitarian believes that the medication is an integral part of her 'stabilisation'. The researcher uses "scare quotes" here to emphasise that stabilisation is relative to the person's context. For Linda Egalitarian, stabilisation meant containing the downs and allowing the ups to continue. Clinically, one would question how stable that is. But, Linda Egalitarian did not experience depression as intensely as Marge Polyvocal. Instead, her dominant behaviour pattern fell into the realm of hyperactivity and stimulated thought processing. Marge Polyvocal sought help when she was heading for, or submerged in a manic phase, whereas Linda Egalitarian went for counselling and assistance only when she was depressed. The meaning that each person attaches to her predominant mood pattern seemed to predict the intervention. Linda Egalitarian felt that the excess of energy was vital for her everyday living and had no intention of changing this. It was useful and functional for her. Contradictorily, she wished that people would accept her for who she was comfortable being and longed for people to change their perception of her. The need and want for others to change was incongruent with how she felt about her own process of change.

Linda Egalitarian's position was one of remaining in control of her life. The way she framed bipolar mood disorder, the causes and the effect of social supports on the mood instability, all pointed towards her being in a position from where she could overcome the difficulty and rise above her mood changes. Her faith was strongly invested in a religious discourse. Her life was shaped by and continued to shape her religious beliefs. However, Linda Egalitarian acknowledged that for her religion and

positive thinking were coping skills to deal with adverse conditions in life. Linda Egalitarian constructed her diagnosis as a religious conflict. Initially being diagnosed with a reactive depression, she veered away from her marital difficulties and found comfort in the company of another man. And then it came to the point where she felt as though she was being "possessed", as shown though the increasingly unstable mood pattern. Once she broke off the affair and began taking medication, her situation improved. But a while later, her moods worsened and again this was seeded in marital discord and additionally a perceived rejection from the church. This proved to be too much for her to cope with and she was hospitalised for stabilisation. Yet again, once she had made religious sense of what was transpiring, she regained her primary position of having a positive mood and approach to life. And she continues to take her medication, religiously.

The religious discourse provided Linda Egalitarian with an inner strength, protective coping skill, calmness and inspiration. The language used by Linda Egalitarian further enhances the imagery of a colossal fight between good and bad. She made reference to a cause of bipolar mood disorder as being something within the body that is a weak spot, vulnerable, and when exposed, the body collapses regardless of what the mind says. She aims to be a good Christian at all times and by doing so, she feels that she will be protected from bipolar mood disorder. In a way, she refused to name the diagnosis, almost as if it would be acknowledging that it could potentially become a condition beyond her control and she would have to depend upon the psychiatric system to help her, something she did not want to do.

Another discourse that informed Linda Egalitarian's conceptualising of her situation was that of interpersonal relationships and in particular her marriage. She has an inherent belief that if her marriage were more peaceful then she would not have to endure the feelings of anxiety, rage, being upset, being misunderstood, and having to get very excited so that she could be heard. If Linda Egalitarian did not have her ups, then she would be largely silenced in her marital, work and family contexts. In this way, her symptoms of the "thing" are useful. She feels people have the ability to influence her mood both towards a feeling of being down and towards a feeling of being on a high. The interpersonal discourse has helped to shape the way in which Linda Egalitarian perceives her mood pattern.

Linda Egalitarian did not share the assumptions of a modernist, psychiatric discourse. But her religious beliefs are unshakable and she functions from the premise that she is always right and others are mistaken, people that is. The only 'person/entity/object' that she believes that she is answerable to is God. Her very strong belief system has created the way in which she thinks about her mood swings and her interactional patterns with people. Linda Egalitarian believes that she has overcome her diagnosis – with the exception of the extreme highs – because of her belief in religion and resilience. However, she did acknowledge that her religiosity could very well be a symptom of a manic episode if one chose to view her situation from a psychiatric foundation.

Linda Egalitarian quickly learned that to be the wife who would satisfy her husband would mean that she would have to subjugate her own voice in the marriage. Although she recognises that this is not an ideal situation, she truly believes that it would be more of a sin to divorce and also detrimental for the children. She received no support from her husband in understanding her diagnosis, and he refused to attend sessions with her and the psychologist. It appeared that one of the triggers for a downward spiral for Linda Egalitarian was the perception of rejection, both from her husband and from the church. As a person with a diagnosis, she felt that she was an "outcast" and she could not find an entry point into a social circle of friends. Linda Egalitarian leads an interpersonally lonely life, but her positive attitude and undying belief in religion carries her through. From a psychiatric perspective, one could easily say that she is in denial and she could potentially relapse should she experience rejection again.

The discourses that create Linda Egalitarian's perspective are quite different to that of Marge Polyvocal. However, both women felt that they were largely misunderstood, alone and insecure within themselves. Both share a belief in the benefit of medication and both experienced mood instability. But, Linda Egalitarian seems to be in a stronger position than Marge Polyvocal because she assumes personal accountability for her diagnosis and does not buy into the psychiatric discourse to the extent that Marge Polyvocal did. Although both women shared similar experiences with signs and symptoms of mania and depression, the reasons for

the diagnosis and the beliefs around religion, the psychiatrist and support systems differ radically.

These differences in surrounding discourses show that each person has a very unique and idiosyncratic construction of bipolar mood disorder. Therefore, a treatment model cannot simply be applied without considering the discourses that provide meaning, ideas, thoughts and feelings for the person.

Emerging Discourses

These discourses do not just emerge from the researcher's thoughts and inferences, but rather directly from the text (the interviews). The interviews were focused on understanding the concept of bipolar mood disorder from the research participant's point of view, but they were under the direction of the researcher at the same time. Therefore, it was a process of collaboration. This particular research story was embedded in the religious outlook and the human capacity for resilience as that is the most well known script for Linda Egalitarian. For her, she has a duty to fulfil in life and the energy of manic highs helps her to live this life. Following the outline suggested by Parker et al. (1995, pp 60-63), six types of discourses are seen to contribute to the formation of a clinical diagnosis. These are the individual and the social; reason and unreason; pathology and normality; form and content; pure categories versus messy real life; and professional versus popular, lay and patient views. These clinical categories will be adapted to this particular research interview to enrich the discourse descriptions.

The Individual and the Social

Because of the medication I have and the insight I have and my belief
in God, I was able to survive.

Linda Egalitarian chose to take personal responsibility for her diagnosis of bipolar mood disorder and strongly believed that with a positive attitude and God's help, she would overcome the flow of ups and downs. She seemed to be content with her life and all that it offered her. Linda Egalitarian did not blame anyone or anything

for her disorder. Where Marge Polyvocal had many questions about her diagnosed condition, Linda Egalitarian accepted her diagnosis and focused on what she could offer those in need of help. For example, she strongly believed in contributing to the field of knowledge of psychiatric illness. She thought that she had been given the diagnosis so that she could give expression to the shifting moods that she experienced, and this would in turn help others. Linda Egalitarian could not focus on her self exclusively. Each part of the story that she narrated had the larger impact on society in her mind. Linda Egalitarian's occupation also reinforced this perspective. All action was thought to be for the benefit of the community. Selfishness was sinful, and she thought of her husband in this light and despised it. Religiously, she could not give any room to verbalising what she felt about having bipolar mood disorder. She believed that it would not help anyone if she sat back and admitted that she had a problem.

The discourses of religion, sacrificial giving to others, community safety and health, and the ideal marital and family life all fed into Linda Egalitarian's conception of bipolar mood disorder. Linda Egalitarian privileged the social description of bipolar mood disorder over and above her own needs. But contradictorily, she longed for someone to understand who she is as a person, a woman, a mother and a wife. But yet she did not acknowledge that her life was co-moulded by her perception of who she was as a person, and societal expectations. This left her in a position of feeling misunderstood and lonely.

Reason and Unreason

"I was always irritated and I couldn't understand why"

Linda Egalitarian played with the idea of having to know and understand what was happening to her, and then the opposite extreme of not questioning her mood changes and accepting this as God's will and a part of the role she is meant to fulfil in her life. She quite quickly accepted the psychiatric explanation of her mood swings, initially as a reactive depression to circumstantial events, and then the more serious bipolar mood disorder. She found herself experts in the field and attended her treatment sessions with a sense of commitment. Occasionally she would falter from

her treatment protocol and she would become manic, or severely depressed, and then she would regain her control by re-complying with her medicine regime. This seemed to work well for Linda Egalitarian.

Linda Egalitarian showed an ability to be rational about her diagnosis and converted the deficit perspective of the psychiatric model into one of resilience, human experience and dedication. She refused to believe that she was the only one with the problem, and when people commented on her flighty behaviour and her unfocused thinking, she would rationalise this by thinking that she is being misunderstood and that they are trying to force her to be subservient and agreeable and that is not what she wanted to be. Linda Egalitarian showed a streak of confidence in the way that she conveyed her experience of bipolar mood disorder and somehow she found space for a unique outcome in her story, that is, believing that she was given the diagnosis and behaviour pattern as part of a larger role that she has to play in this life.

Linda Egalitarian's belief system could be seen as irrational as it almost appeared to be delusional. Her religious positions could be viewed as a symptom of mania. She felt that she was untouchable and was not able to receive constructive criticism as she perceived this as other people's attempts at changing her and they were unaware of her greater purpose. In fact, her need to help and understand others is what got her into trouble and left her feeling disappointed on many occasions. For example, having an emotional affair with a client and being let down by her friends in time of need. Both of these situations exemplify the imbalance between her needs and her perception of what she deserved, and what others were willing to give in return. She crossed boundaries of what is socially and professionally acceptable and her reasoning for doing so was simply that she was helping other people as she was meant to do. When people attempted to correct and monitor her behaviour, she felt attacked and misunderstood, trapped and lonely.

Linda Egalitarian's conversational tones wavered between positions of reason and unreason, at times providing clear and descriptive answers and then suddenly diverting off into a pocket of history where she felt there was a relevant side story to share, but never quite making the link between the two. Structured and

concrete treatment interventions would fit well with that rational side of Linda Egalitarian, but then she would also require the more unstructured and independent self exploring journey to complete her search for normality or stability. This is mirrored in her stories where she would show compliance with medication and then spiral off and attempt to control her moods on her own, enjoying the manic highs of productivity and creativity. This would be short lived and then she would seek out the more mundane and stable treatments to provide structure and treat her heavy depressive episode. Linda Egalitarian showed a high propensity to be rational, follow rational thought processes and also an ability to function well in a demanding work context. However, this would be incomplete without her need to be unrestricted in thought and action and reach out to those in help, create helping contexts and live out her inherent belief of being a disciple of God.

Pathology and Normality

"I don't want to ever be without this medication ever in my life"

By sharing this comment with the researcher, Linda Egalitarian showed her belief in the benefits achieved through a psychiatric treatment approach. Even though she did not emphasise the psychiatric paradigm as being dominant in her experience of bipolar mood disorder, every so often, she would make reference to the benefits of medicine. This indicates that she does have a belief in normality and she knew what it felt like to be moving towards a position of pathology. The discourse of pathology was not very prominent in Linda Egalitarian's story of bipolar mood disorder, but it did have a place within it. Linda Egalitarian found ways to make her life appear normal by being employed, portraying herself as a good mother and an upstanding citizen of her community. She did not fixate on being dependent on the psy-fraternity to assist her in overcoming bipolar mood disorder. She had not read widely on the topic. She did not have a very deep understanding about what makes her moods change and shift. She did not follow a structured cognitive-behavioural programme, nor any psychological treatment for that matter (with the exception of her therapeutic maintenance sessions which were focused on her marital relationship). But somewhere inside her, she felt that the medicines helped to control her behaviour.

Linda Egalitarian's perception of normality differed from Marge Polyvocal. Linda Egalitarian did not struggle with attaining a sense of normality. She could quite easily blame others for not being able to understand her, rather than accept the frame of her having to change. She believed that she behaved as she did for a good reason, and that was to help humanity. But then, contradictorily, she also believed that medicine played a part in balancing her moods and preventing an onslaught of anxiety attacks. Linda Egalitarian's behaviour is firmly grounded in context. When she is in the hospital, and describing her behaviour to doctors and psychologists, then she is undoubtedly correctly diagnosed as bipolar. But when she is at work and assisting people with their life struggles, then she is seen as energetic, creative, dynamic and passionate. However, at home, she is largely misunderstood. Her children think that she talks too much and her husband gets very irritated at her positive outlook on life. Linda Egalitarian's story of bipolar mood disorder highlights the dichotomous position of normality and abnormality, depending on which context one is choosing to see her in. She is many people to many places. She cannot be defined in a neat category. If one were to change her way of interacting then society may lose a very dedicated and compassionate person in the community, however on a family level, it would probably make life less conflictual. Linda Egalitarian's pathology is necessary and beneficial in providing grass-root caring for the community, yet unstable and disturbing to her home life. Her cycle of mood swings plays a role in the marriage, providing disruptions when she is manic and having to allow her husband to care for her when she is depressed. It is quite clear that one cannot make a very clear distinction about what is best for Linda Egalitarian. She is contextually split between being valued and validated in her community yet being looked down upon in her smaller circle of home life.

The benefits of distinguishing between pathology and normality are very important to gaining an understanding of Linda Egalitarian. She is a very intense person, and definitely diagnosable, yet simultaneously quite normal and appropriate depending on which context she is understood in. The medicines help Linda Egalitarian to cope better with the transition in environmental demands. Linda Egalitarian did not take her pathology to be a personal attack on herself or something intrinsic. She rather believed it to be a necessary part of who is she as a person.

Form and Content

The form of Linda Egalitarian's mood shifts were manic highs where she would show flight of thought, become highly aggressive, cry involuntarily and gradually burn herself out from over exertion. She would find herself in heavily conflictual relationships, both at home and at work, and she would be riddled with panic attacks. Her depressive mood swings involved overeating, feeling lethargic and perceiving herself very negatively. Her symptomatology was not grounded as much in clinical categories as Marge Polyvocal's was, but her mood swings were a definite problem, both to her and her family.

When one attempts to look at the content of her drastic mood changes, it becomes apparent that Linda Egalitarian's mood swings are deeply rooted in relationships. Her initial manic onset occurred when she became emotionally over-involved with a client. This interaction seemed to scoop her up and allow her to float until she realised that she was losing perspective of who she was and what she was trying to attain. Her depressive onsets are normally triggered by a perception of rejection, be it from the church, a colleague at work, or her husband. Both mood changes carried strong messages of relationships. She was unhappy or scared and needed to touch base again with her beliefs and aspirations in life. Linda Egalitarian turned to the church for help, to her colleagues and even to strangers.

Her mood shift created the space in her marriage for a realignment of goals and ideals. Her husband would be forced to come and visit her in the hospital, and even attend a therapy session or two. Her children would have to care for themselves instead of having their mother run around for them all day, and her work colleagues would have to take on added responsibilities and feel the pressure that she carried around. Without judging the intention or emotional gain of her mood swings, the content of her disorder appears to carry more weight than the form. In the psychiatric world, form is concentrated on, and in the postmodern psychological world, content is the focus. Linda Egalitarian escapes both categories by framing her understanding of bipolar mood disorder as a necessary mission in her life. She only delved into form or content on a superficial level and focused instead on her larger role in life.

In a way, Linda Egalitarian quite enjoyed the fact that people saw her as having her head in the clouds, being flighty and uncontained. She had no intention of behaving appropriately when she believed in getting her point across. For her, what was most important was to get the message across regardless of people's opinions. The only times that this became an issue of importance to her was when she felt isolated and ex-communicated from her friends and the church. Then she would neatly slip into a depressive phase and re-assess the situation and quietly re-enter these social domains.

Pure Categories Versus Messy Real Life

"But all the time I went to all the doctors and they just didn't listen to me"

The psy-fraternity's need to categorise and classify behaviour into researched boxes left Linda Egalitarian undiagnosed for many years. She was told that what she was experiencing was normal, yet she knew that she did not feel normal and no one was really listening to her. This was at the beginning of her search to understand herself, many years ago. That search gradually melted into a focus on her marital relationship and the unfulfilling nature of it. Linda Egalitarian tried to get help for her mood swings and changing patterns of behaviour, but her descriptions never quite fitted into a neat psychiatric category. Eventually, after being diagnosed with a mood disorder, she began to get treatment and she felt that this was effective in bringing about stability to her life.

Linda Egalitarian's life consisted of geographical changes, entry into motherhood, shifting expectations of work contexts, and involvement and disengaging from churches and communities. Linda's very strong belief in religion framed her philosophy of life and she described her story within her understanding of God's intentions. This may have been very confusing to a treating psychiatrist. The standard interview questions would have elicited information that confirmed a diagnosis of depression and possibly even anxiety, but the manic behaviour would have been left untouched as it was nicely framed as religious positivity. Linda Egalitarian did not harm anyone else and she did not have psychotic breakdowns.

Her exuberance and resilient attitude could even be viewed as her finest characteristics. But they brought conflict into her life. And she was not always comfortable with this. Communicating with Linda Egalitarian was not an easy task. Her stories were mostly disjointed and required intense listening. Her pattern of thinking was overwhelmingly scattered, but her good intentions and enthusiasm outweighed the negative. The interviews were held under stable conditions where she was controlled by her medication, and even that proved to be a difficult task, so one can only imagine how difficult it must have been to find a psychiatric category that best suited Linda Egalitarian. The psychiatrist would not be doing his/her job if a diagnosis was not given and medication prescribed. Linda Egalitarian's mood swings are the best descriptor of her diagnosis, in behavioural terms. She experiences ups and downs. The discussions above reiterate how rooted in relationships her mood swings are. But they were left undiagnosed and unchanged.

The psychiatric categories of diagnosis are very accurate on an individual level and they are helpful in bringing about individual changes, such as Linda Egalitarian's stabilisation of mood. However, on a larger level, they fall short and become almost a-contextual. Linda Egalitarian's messy life situations, such as an unstable marriage, within an unfaultable religious backdrop, within a very dislocated and violent socio-economic context, can hardly be rectified through the diagnosis of bipolar mood disorder.

Conclusion

In conclusion of this chapter exploring the vignette analysis of Linda Egalitarian, one hopes that an adequate story composition has been offered. This baseline platform will be used to generate themes of commonality and differences amongst all the research participants. In some instances, direct quotations have been used to emphasise the severity and intensity of experience. The conceptual understanding of bipolar mood disorder was provided through the help of the Mental Status Exam and the contextualisation through a deconstructive analysis emphasising text that was pertinent to overarching discourses. The next chapter offers descriptions

of the interviews and themes that have emerged from the interviews involving Faith Semantic and Professor Medi Caution.

CHAPTER SEVEN

The Psychotherapist – Faith Semantic

I think the label also alienates the person from their thinking as well. And I think the idea is 'wait a minute, I don't know if he is mad or not fully mad, but irrespective of what the symptoms mean to us, he is still a human being, deserves respect, needs to be treated like a human being, needs his dignity'. Uhm and I think often what happens, is that when people come up with a label like this, there is almost like an, like a spontaneous assumption that the person's lost their thinking powers, that he is no longer rational, that he can no longer make plans.

Introduction

This chapter introduces the third research participant, a psychologist working with bipolar mood disorder. This is done by initially explaining the reasons for choosing to name this co-researcher as Faith Semantic. This is followed by a contextual history of Faith's life and clinical experience, as well as how she understands the diagnosis of bipolar mood disorder and the supposed 'causes' of the disorder, from her perspective. This will be achieved by presenting the psychotherapist's understandings of bipolar mood disorder. The psychotherapist was interviewed to gain a broader conceptual and contextual understanding of bipolar mood disorder. In this chapter there is no assumption made that this particular psychotherapist represents the vast field of psychology. It is merely a description of the experiences of one particular experienced psychotherapist who could and would offer her understandings of bipolar mood disorder. The chapter concludes with a postmodern deconstruction and reconstruction of the psychotherapist's story based on the tenets provided by Parker et al. (1995).

Explaining the Title

The choice of naming this research participant as Faith Semantic has a dual purpose. Firstly, the word faith implies having confidence and trust. The therapeutic encounter is based upon the client trusting the expertise of the therapist to help overcome great difficulties. Therefore it seemed fitting that the psychotherapist be named a word that captures the essences of a psychotherapy process. Secondly, the surname of Semantic was chosen as the psychotherapist's theoretical stance is grounded in postmodernism and this includes the importance of understanding how words are utilised to define contexts. It is in the domain of shared language and consensus of opinion that change emerges. Hence, semantics are not to be looked upon lightly. The way in which a person describes his or her experiences of having bipolar mood disorder are grounded in the chosen words.

The interviews with Faith Semantic took place in the large and busy canteen at a very prestigious University Medical School Campus in Johannesburg. It was noisy and bustling with people coming and going, students having academic debates, doctors prancing around in their surgical outfits, and there was also someone playing on a piano in the background. It seemed a surreal context in which to conduct an interview as there was so much activity. But somehow, when the research interviews began, the noise of activity faded into the background and the intensity of the conversation took the ground position. Faith's calm and collected mannerisms, and tone of voice also created a relaxed atmosphere which was conducive to constructive debating on the state of psychology as a field of mental health and well-being. There was an element of both peace and comfort in the conversations that took place. Faith shared case histories, thoughts and ideas about therapeutic treatments, and also personal self-reflections about epistemological challenges. Many avenues of interest could be explored with Faith as the interview schedule was unstructured. This story write up will highlight the parts of the conversation that are thought to shed light on Faith's position of in the world of bipolar mood disorder.

At the time of the interviews, Faith was involved in difficult situations in her workplace. She felt that she was being pulled to fit in with the dominant school of

psychology that most psychologists practised. The majority of her colleagues subscribe to a psychodynamic framework and her ecosystemic and postmodern outlook was being met with much resistance. She felt that she was losing her ability to stand up for her therapeutic belief system. She was becoming tired of fighting the bureaucracy of what was expected of her in her place of work. She was also overloaded with patients in two therapeutic settings, one being in an office at the University and the other involved running a community clinic in the south of Johannesburg. She felt unappreciated by her supervisors and she was extremely tired.

Even though Faith was tired and felt burned out by her workload, she participated in the interviews with enthusiasm and with great interest. She felt that it was important to 'grow' the body of knowledge on bipolar mood disorder from a perspective other than a medical framework. Her belief was that postmodernists tend to be non-conflictual and seek understanding rather than explanation. Postmodernism does advocate a position of accepting multiple realities and socially constructed definitions, but what happens when modernism is raising its premises as more valid? Why are modernist assumptions disqualified in favour of a multiple-realitied position? These are some of the questions raised in this particular research interview.

History and Background

Faith Semantic has been a practising psychologist for several years. She was trained in systems theory and ecosystemics, and gradually researched and educated herself more into the paradigms of postmodernism and social constructionism. She is a strong advocate of the principles of social constructionism and she often finds that she is met with resistance from people who follow the more mainstream paradigms, such as psychoanalysis or pure cognitive behavioural therapy. The researcher and Faith have known each other professionally for a few years and the researcher approached Faith as a result of their discussions on the opposing epistemologies of modernism and postmodernism which yielded many a debate during their years of studies. Faith agreed and wanted to share her case studies of therapies she had done in the arena of bipolar mood disorder.

Faith Semantic comes from a cultural background that was considered to be previously disadvantaged during the Apartheid years, that is, pre-1994. She has always presented herself as a radical and a rebel. Within the field of psychology her ideas and viewpoints were often perceived as harsh and to the point. She did not make any effort to abide by what was deemed culturally and socially acceptable and she was often in trouble for her expression of thought. She exists in a community where the woman is mostly subjugated in favour of the man and she has very strong beliefs rooted in religion. She never tried to impose her cultural, social and religious ideologies on the researcher. She remained honest about her assumptions as a therapist and she was able to reflect upon the influences that her background has had on her style of therapy. Faith presented herself as being open to new ideas although she still carried forth very strong opinions of her own.

The research interview gave her the space to speak her stories in a language – postmodernism – that was mutually shared and respected in the research domain. She grabbed onto the opportunity for somebody to listen to her method, theory, epistemology and conceptualisation of the complexity of human behaviour. In this sense the research interview allowed her the platform to speak in a language, which in her perception, was largely cast aside as 'airy-fairy' and unsubstantiated in the world of psychiatric medicine.

Faith Semantic has spent many years working with people who have serious diagnoses of mental illness. She did her clinical internship in a government hospital in Johannesburg which caters for psychiatric patients only. The main model of treatment in this hospital was psychodynamic and that was perfectly suited to the very strong psychiatric medical model and frame of reference. Faith found that she had great difficulty adjusting to a singular vocabulary in a psychiatric context and was disappointed that other psychologists were not open to alternative ways of thinking. In hindsight, Faith recalls that perhaps she too was just as closed minded as her colleagues, as she was trying to convert them to her way of thinking. As her experience in the field of mental health has gathered momentum, she has come to realise that there should be a space for multiple realities to co-exist, and it would be unfair to expect therapists from other paradigms to become postmodernists. This realisation however, still left her feeling misunderstood as she could entertain the

world of psychiatry, but somehow people resisted the world of postmodernism and the narrative therapies as alternatives. If the narrative therapies were made use of, it was in a recipe fashion and judgement was made on the more correct way of performing such techniques. Within the postmodern frame, narrative therapy is a style of conversation that allows a person's story to be shared and explored for solutions that have been overlooked in favour of the dominant discourses. As such, there cannot be a more correct way of conducting such a therapy, unless of course, the underlying therapeutic assumptions are modernist, as was the case. This schism between therapeutic and theoretical assumptions often left Faith feeling marginalised and misunderstood.

Becoming the Bipolar Patient

Faith Semantic had some very interesting takes on what constitutes bipolar mood disorder from a postmodern narrative perspective. She came across several bipolar patients in her internship as well as in the years that followed. She included the family as a part of the therapeutic design when she could and she found this to be most useful. Her view on bipolarity is by no means straightforward and requires much explanation. To begin with, an example of the social construction of bipolar mood disorder shall be offered from one of her actual case examples:

> There was a lady that was referred to me with bipolar, that came from an African background, and she was in the hospital for two years in the wards, and the husband was told by the nursing staff that 'your wife is a bipolar disorder patient'. All along he knew that his wife was different but he never treated her as a mad person, but when he came to therapy he immediately said: 'No, but the nurses said, she is mad'. And he pulled towards the idea that he was living with a mad woman. And then he bought so well into the description, that she was a religious person before the bipolar triggered her off, so if she went to church on a Sunday which was normal for anybody else, it was an indication that she was becoming religious and he started to get hyped up and overreact and become the stressor, which made it a precipitating factor for a relapse again. And it was quite important to bring that to his attention. To look at how he was

contributing to the symptomatic behaviour. It was also very painful for her realising that her husband thought that she was mad. To the point that the children came back into therapy and said: 'My dad is accusing my mom of being lazy and mad'. You know every time she opened her mouth she was told: 'Keep quiet you're mad'. 'You don't talk sense anymore'.

In this example above, the power of the bipolar label is shown. This man did not previously think of his wife as mad in any way, just different. But once he was told, by expert authorities, that she was in fact mad, he changed his perception of her and her behaviour and she became isolated to only being able to behave in certain ways. The circular nature of causation is also beautifully illustrated in the above example: the husband reacts harshly to her need to go to church, which in turn heightens her responses to stress, and ultimately, the relationship is thrown into disarray and she requires hospitalisation for being out of control. This scenario reminds one of the nature of Linda Egalitarian's marriage (see **Chapter Six**) and also Marge Polyvocal's (see **Chapter Five**). It can be suggested that it is within the realm of social interaction and sharing of viewpoints, that the diagnosis gathers great effect, although not always in favour of the patient. The difficulty in addressing this matter for Faith is that once she psycho-educated the family, she was inviting perceptions of the patient as being incapable of self-care. However, if the diagnosis is left unattended, then the possibility exists that families can unknowingly act as precipitating stressors and this may enhance the development of manic and depressive episodes. A fine balance is of course always suggested.

On an individual level, Faith Semantic viewed a person diagnosed with bipolar mood disorder as having more than one voice of expression, a depressive voice and a manic voice. She understood bipolar patients as having two voices which were equally valid and should be treated with equal importance. The necessity of seeing a person with multiple voices has implications for the planning of a therapeutic strategy. If cognitive behaviour therapy is implemented as a generalised approach for treatment, then the therapist may actually be silencing other very important aspects of expression. Faith shared the idea that viewing a person with two voices allows the therapist to explore the information about the person that has been largely excluded in favour of presenting behavioural symptoms.

But, Faith Semantic also acknowledged the difficulties when communicating with a person who is in a fully blown manic episode. For Faith, the patient would have to be medicated first before attempting to begin conversational therapy. In her clinical experience, most of her therapies with bipolar mood disorder patients took place during the depressive phases of the mood cycle. In the therapy, Faith would focus on the residual effects of bipolar mood disorder. She agreed with the researcher that in a sense she too had bought into the concept of bipolar mood disorder as she was engaging in conversations with patients about a mood state that was not currently observable but was assumed to exist. When a patient was in a manic state, Faith reflected that she felt overwhelmed and uncontained by the patient's overbearing behaviour. Her premise was that she herself would need to be contained before attempting to contain somebody else. She openly acknowledged her bias towards not working with people who were experiencing a manic episode and she felt that it would be better to abstain until the patient has been medically controlled. Her confusion about the marriage of psychiatry and psychology was evident here as she required a psychiatric intervention which contradicted her firmly held beliefs about allowing a person to have the expression of a manic voice. Once again, theory shows that it is not always as practical as one would like it to be in a therapeutic encounter.

Working with bipolar mood disorder patients has challenged Faith Semantic to confront her theoretical premises of postmodernism as she could not implement all the wonderful ideas that she had created for therapeutic goals.

> I think immediately when I came in I was very preoccupied with deconstructing these basic assumptions and trying to change mindsets in the system, uhm, and later I really embraced the idea of equally valid and legitimate voices. I mean it is fine to say it in theory but are only postmodernist voices legitimate and valid? Or are others that disagree with that. And there was definitely a stage of uhm uhm of accepting it and denying it, embracing it and rejecting it as well, you know the transformation wasn't that smooth. To be honest and ethically correct, within one's own framework you must have the courage to reflect on your own limitations.

Faith Semantic has endured a process of assimilating her theoretical beliefs with practising psychology. The challenge of doing therapy with bipolar mood disorder diagnosed patients catapulted her into having to reflect on her foundational belief system as a therapist. She rose to the challenge of reaffirming her underlying therapeutic assumptions, and she found that many contradictions do exist within a postmodern paradigm. This was reflected back to her through her work with bipolar patients. Just as she felt uncontained when faced with a manic patient, so too did her thinking processes become overwhelming when trying to assimilate psychiatry and psychology. But, fortunately, or unfortunately, there is no known medication for an epistemological episode! Faith still reflects, mostly in solitude, about the incongruencies that present themselves in the world of the bipolar mood disorder patient.

As a professing postmodernist, Faith Semantic conceptualises bipolar mood disorder as one possible description of behaviour amongst many other possibilities. Simply stated, she initially explores what the referral agent implies with the diagnosis of bipolar mood disorder, then she moves towards her own underlying assumptions about the meaning of bipolar mood disorder, and then she also includes the interpretations of the patient. Faith's systemic background is used to generate larger and wider descriptions of the term bipolar mood disorder. She has come to accept the psychiatrist's definition of bipolar mood disorder as one possibility amongst many others. She also understands that the psychiatrist makes his or her diagnosis on the basis of his or her own knowledges and experiences and again, views this as part of a subsystem of the larger concept of bipolar mood disorder. However, when accounting for the fact that the psychiatrist's knowledge is grounded on the premise of expertise, research and medical science, she also sees this as one possible knowledge base amongst many and in that way the presence of a privileged and dominant ideology is not favoured.

There is a very fine balance required in deconstructing the psychiatric diagnosis rather than disqualifying the construct itself. This process of deconstructing labels and diagnosis can be understood as a will to change psychiatric assumptions, but this is not the case. It is accepted that the psychiatrist is entitled to his or her conceptual method of behaviour analysis, but this can also be further understood, and

needs to be, so that the patient can understand the impact of the observation on his or her life world. The meaning of being diagnosed with bipolar mood disorder is often neglected in favour of the patient receiving a list of signs and symptoms which dictate the behaviour of the patient. This is useful in that it targets a psycho-educational component of bipolar mood disorder, but it does not tap into the social construction of the concept bipolarity and the wide spread effects that this diagnosis will have on people's lives.

The 'Causes' of the Disorder

The bipolar description is one possible explanation, within the ecology of explanations. And I think to dismiss that, you cannot be postmodern in your thinking, at the same time you need to bring this description into dialogue in a therapeutic context.

Faith Semantic offered a description on the causes of bipolar mood disorder from a postmodern stance. For her, bipolar mood disorder is one possible description of behaviour and action amongst many others. She widened the diagnosis of bipolar mood disorder to include other explanations that also give meaning to the client. For example, exploring differences of self in how the client behaves in different contexts, such as at home, work, and in the family. From a postmodern viewpoint, Faith accepted the possibilities of biological, neurochemical and even intrapsychic influences on the person.

Faith Semantic did emphasise that a person with bipolar mood disorder is often silenced and restricted because of the diagnosis. The actual mood swinging spectrum of behaviour was very loosely and abstractly spoken of and Faith spoke more about the self-reflective effects of working with a bipolar mood disorder patient. Instead of focusing on what the possible causes of bipolar mood disorder could be, Faith highlighted her way of working with this type of behaviour pattern, and the implications of accepting one reality as a truth and limiting oneself in that process.

The 'causes' of bipolar mood disorder, from a postmodern perspective are believed to be part of a circular system of understanding rather than a stand-alone

concept. The psychological causes were seen to be determined by the integration of many factors and sub-systems within which the individual functions. To isolate one system and validate that more than any other would be a-theoretical. Faith took on a meta-causal level, exploring all possibilities in the here and now. If the therapy required that past influences and traumas be explored, then that is what Faith would have done. But most important for Faith was to move away from the position of identifying causal factors as that would imply something inherently wrong with the individual. And possibly something that could not be changed (such as a neurochemical imbalance) except with the absolute use of medication. Faith's modus operandi focused more on empowering the patient to recognise alternate ways of being and behaving that may be more congruent within the person. In this way, Faith aimed to empower the person over and above the presenting diagnosis so that the causes became redundant.

Faith Semantic found that her bipolar patients most often arrived with the definition of bipolar mood disorder as given to them by their treating psychiatrist. This had the impact of limiting the outlook of the patients as they believed that their situation was hopeless as there was something mentally wrong with them. Therefore, a large part of Faith's therapy was aimed at "un-boxing the diagnosis" and framing the psychiatrist's perspective as one alternative among many more. The causes were then accepted as one possibility among many realities and therapy could focus on the here-now and future domains of lived experience.

On Being Creative

Faith Semantic works from the assumption that each and every person that she meets in therapy has the potential and ability to be creative. Her experiences with bipolar clients always seemed to culminate in a search for a channel for the person's creative talents. The task for her was to somehow encourage the possibility of sharing the creativity in a way that was not damaging but healing and beneficial for the person.

With one particular client, Faith Semantic combined a narrative approach with finding the creative voice within that person. The more the client shared his poetic

talents with his therapist, the more he was observed to be improving (more by other people involved in the treatment system). Having a safe space to explore a person's talents and allowing for the creative exposure is thought to have healing effects. One of Faith's intentions was to create a domain of shared and non-threatening understanding. In this space, she hoped that alternative 'voices' to the problem saturated story can and will emerge. This inevitably allowed for the depression phase to lift and the mood to be stabilised effectively with the added benefit of medications. The hope was always to encourage a process of added alternative descriptions of a person, including ways that a person could be more expressive of thoughts, feelings and behaviours often through the use of creative talents.

The emotional world of clients was thought to be multi-layered and often silenced by family, society and possibly even religion. Once a diagnosis of bipolar mood disorder had been given, Faith felt that she had a responsibility to expand the limited description of observed behaviour. This often involved family sessions and the redefining of signs and symptoms that the client was enacting. The nature of the therapies was long-term and exploring creativity required trust, support and encouragement. This mood pattern can be taxing on any psychotherapist and requires therapeutic stamina. There is no quick-fix solution to stabilising moods. The long journey of walking with the patient inevitably unfolds the creative potential within a person.

Conceptual and Contextual Descriptions: A Social Constructionist Approach

In this discourse analysis section, a similar arrangement of categories will be used as mentioned in the vignette analysis. They are, naming the disorder; causes of the disorder; perception of the patient; support systems; symptom expression; and the perception of the psychiatric system. Initially the researcher quoted text as systematically indexed from the transcripts. Following this, she regrouped statements into sub-categories of discourses. This emerged as the table below.

Table 4: Faith Semantic

Category	Textual comments	A Discourse Revealed
Naming bipolar mood disorder	I do psychotherapy around the bipolar disorder. What is my definition and meaning around the disorder? Bipolar description is one possible explanation, within the ecology of explanations.	1. Ecosystemic
	The referral of the patient will say diagnosis of the patient: bipolar. The staring point for me in therapy is when the patient walks in the door as a bipolar patient. Catch the bipolar uhhh, illness, or germ or whatever you call it You can't deny the fact that there are symptomatic depressions, behaviours that manifest once the person has come up with the diagnosis.	2. Psychiatric / Biomedical/Neurological
	'I've got a bipolar disorder and my self esteem is very low'.	3. The patient
Causes of bipolar mood disorder	Each context is linked to another, what are the other subsystems that are structurally couple to this system? What are the basic assumptions that inform disorder?	1. Ecosystemic
	The bipolar description became a stressor, the family bought into this label, and he started to treat this patient as if he was mad. He talked about his relationships, his relationships with his mother, his father, with the nurses, with the doctors, and how his colleagues see him, and how there were amazing multiple roles and multiple relationships.	2. Family
	Analyse the different levels but you know, the starting point is the symptomatic behaviour and there may be an enquiry at maybe a neurological level, anatomy level and so forth, the search is always to explain the symptomatic behaviour.	3. Psychiatry
Perception of the patient	A bipolar patient has more than one voice. What does my patient understand about bipolar? Every time he is with the psychiatrist he keeps hearing the idea that 'you are a bipolar patient'. They're distressed at the fact that the psychiatrist does not see them more holistically.	1. Ecosystemic
Support systems	The psychiatrist can contain the symptomatic	1. Psychiatric

Category	Textual comments	A Discourse Revealed
	behaviour by medicating him.	
	What do you understand about psychotic behaviour? Or bipolar depression? And they normally enough, they mention what the psychiatrist has said. They kind of embrace that language without critically examining it. They take it so badly for granted that this description is the true one.	
	Being monitored around his disorder.	
	Especially family members, who are terrified of this psychotic label that is given.	2. Family
	It's quite important to bring the family into play with the person that I work with the patient or client or individual.	
	The sense of I need to rescue my client.	3. Psychotherapist
Symptom expression	He becomes talkative, he doesn't sleep, you know the symptomatic behaviour is there.	1. Manic expression
	The manic behaviour was contained by the medication.	
	I must say that I felt so overwhelmed by her, her symptomatic behaviour.	
	Felt very uncontained.	
	I would recognise that this person is manic and use a different kind of intervention at that point.	
	I would send feedback and say that the symptomatic behaviour seems to have decreased or he's no longer depressed.	2. Depressive symptoms
	Dealing with the residual effects of bipolar, and dealing with depression.	
	He became functional – he was quite non-functional in the sense that he couldn't go to work, he didn't feel that he was being respected and taken seriously with his father and his mother, and those dynamics changed.	
Perception of the psychiatric system	The referral agent wants you to agree with the disorder or the symptomatic presentation of the disorder.	1. Role of psychiatry
	I'm accepting the psychiatric lens because it's working for them.	
	He has explored your symptomatic behaviour. He has examined your uhm predisposing factors, your stressors, and taking into consideration the neurological changes that you may experience but that doesn't mean	

Category	Textual comments	A Discourse Revealed
	that this is the entire picture.	
	They would speak of bipolar in terms of precipitating factors, symptomatic behaviour.	
	My supervisor wanted me to do a lot more cognitive behavioural stuff.	
	You must include psychiatry because it has such a powerful impact on both the client, the family, the social context, who have ***bought*** into this description so well.	2. Psychiatric and family systems.

The deconstruction of the text in the above table reflects that Faith Semantic's understandings of bipolar mood disorder are rooted in discourses of psychiatry, the epistemology of ecosystemics, and the family and other environmental influences. It was interesting to note that when Faith Semantic made reference to a psychiatrist it was always in the form of the male gender. This may reflect her experiences of working with male psychiatrists, or be indicative of other gender discourses based upon her cultural experiences.

The textual deconstruction of Faith Semantic's interviews revealed her understandings of bipolar mood disorder, which impact on the way that she works with the bipolar diagnosis. Of particular interest was her lack of descriptions about the prominent signs and symptoms of the disorder itself. She only made loose reference to sleep patterns and speech behaviours of the patient. These behavioural markers obviously carried the most weight in terms of behavioural descriptors of this illness. She also referred to the available treatments as "medication", indicating that she did not have the knowledge of the available medications for treating this disorder. Bipolar mood disorder psychotherapies seriously advocate the benefits of psychoeducation, and it was interesting to see that Faith Semantic did not share knowledge on the available treatments or varied signs and symptoms of the disorder. Instead, her focus was on the way in which she understands and conceptualises the mood disorder. In this sense, she was focusing on a meta-level of understanding and steered away from a factual psychiatric account of what constitutes bipolar mood disorder. Even when the researcher probed further into her knowledge base of bipolar mood disorder, Faith

Semantic answered with reference to her theoretical understandings more than the content of bipolar mood disorder.

The psychiatric system seemed to be pivotal to Faith Semantic's way of working with bipolar mood disorder. This could be attributed to the fact that she worked primarily in a psychiatric setting as a part of a panel of multiple professions. Her perception of the psychiatrist as a powerful influence on the way in which the disorder was understood by her patients and their families was mentioned throughout the interviews. Faith Semantic's therapeutic goal was to deconstruct these understandings and provide an opportunity for her patients to develop broader understandings of the diagnosis. She felt that the therapeutic relationship was essential in creating the 'space' for alternative meanings to arise. Her view of bipolar mood disorder being one particular understanding shaped the way that she worked with people who had been diagnosed with bipolar mood disorder. Her cultural understandings and previous perceived experiences of being subjugated because of her race and her gender fed into her action plan of freeing people from the diagnosis and providing a therapeutic platform for change to occur. Her postmodern ecosystemic framework assisted her in legitimising the way she worked. Assumptions of multiple realties, systemic influences, and power discourses influenced her understanding of bipolar mood disorder.

Faith Semantic seemed confused about what bipolar mood disorder actually meant to her. On the one hand she made reference to it as a neurologically based illness requiring medication and control, and on the other hand she explained it as a mere description of behaviour created in conversational domains by the various role-players. The latter understanding informed her therapeutic goals and intentions and she worked towards incorporating other "voices" which were free of the influence of the diagnosis. The biomedical discourse was referred to mostly when she was describing situations where she felt helpless with a patient and resorted to a medical explanation. This occurred mostly when she was describing manic patients. Faith Semantic's story resonates with what has been described in the literature as well as the previous vignettes, where manic episodes are viewed as extremely difficult to work with and require measures of control, such as medication and physical

containment. The sense of helplessness felt by Faith Semantic is apparent in her explanation of the biomedical influences.

Emerging Discourses

These discourses do not just emerge from the researcher's thoughts and inferences, but rather directly from the text (the interviews). The interviews were focused on understanding the concept of bipolar mood disorder from the research participant's point of view, but they were under the direction of the researcher at the same time. Therefore, it was a process of collaboration. This particular research story was embedded in the field of psychiatry and ecosystemics as that is the most well known script for Faith Semantic. Following the outline suggested by Parker et al. (1995, pp 60-63), six types of discourses are seen to contribute to the formation of a clinical diagnosis. These are the individual and the social; reason and unreason; pathology and normality; form and content; pure categories versus messy real life; and professional versus popular, lay and patient views. These clinical categories will be adapted to this particular research interview to enrich the discourse descriptions.

The Individual and the Social

I think the cybernetic complementarity with the bipolar description on the one side with other dialogues on the… what's on the other side, looking at the description that hasn't been brought into play.

Faith Semantic's understandings of bipolarity incorporated various understandings of the disorder. She believed that if she co-created multiple descriptions of meanings around the diagnosis then she would be freeing the person from the chains of a limiting diagnosis. Faith Semantic did not account for environmental influences or 'causes' in her descriptions of bipolar mood disorder, but she did speak of multiple systems in which the person lives and works, for example,

each subsystem is meaningful in that… it is structurally coupled… the whole punctuation is very arbitrary. I can stop at looking at a psychiatrist, the description is one level, but his descriptions are also within a broader

description because he is his own system. So he becomes a subsystem within a system but that system is further linked to a wider system as well, and that's the clients cultural background, social contexts, family and there are other dynamics that need to be explored as well.

In her explanations of her case examples that she has dealt with, she did not make any mention of these cultural and social backgrounds. But she did make mention of the family and the importance of including their understandings and meanings in any therapeutic action plan. In this sense, Faith Semantic included a social domain of the family and tried to move the diagnosis away from an individual intrapsychic explanation. Faith Semantic tried to broaden an individual understanding of bipolar mood disorder by including the interactional systems of the psychiatrist, the nursing staff, the family and her own therapeutic interventions. By doing so, she felt that she was able to implement effective change in the patient's life.

Reason and Unreason

The connotations attached to being bipolar are 'I am mad', 'I am no longer fit to be in society', and I think that that for the client's sake needs to be deconstructed. Not for the psychiatrist but for the client's sake.

Western models of understanding human behaviour are grounded in principles of rationality and the ability to reason. The psychotherapist who works from a postmodern perspective places value in the story told by the patient and accepts it as one possible explanation for what is happening to the patient. The change process is directed in line with the patient's understanding of the disorder and not just the commonly shared psychiatric understandings. This means that the medical model's expectation of operating from reason and rationality could be replaced with contextual reason and rationality, applicable only to that particular therapeutic context. The cognitive-behavioural, psychoeducational, and manualised family therapy approaches all focus on the patient's ability to be rational and show a logical train of thought. Unfortunately, in the case of the bipolar diagnosis, this logic is mood determined and constantly in a state of fluctuation. Faith Semantic accounted for the individual in therapy and adjusted her therapeutic style accordingly. In this example where she

explains a story of 'therapeutic success' she exposes her assumptions regarding reason and unreason,

> And I think before I started with an intervention around him I kind of did a very brief assessment of my own, in terms of his intellectual functioning and daily functioning to see if I needed to speak at a lower level or not. I looked at his premorbid level of functioning as well, and also his language – whether he was a structured or an unstructured person. Every person that had worked with him before me, tried to structure this guy.

It could be said that Faith Semantic ignored the benefits of rational thinking and omitted to provide the patient with useful psychoeducational coping skills which could have assisted the patient in times of difficulty. She chose a contextual approach, focusing on the unique needs of the patient, and this may be because she did not have the knowledge of the psychiatric literature, or because she felt this style to be more ethical towards the patient and more valuable in bringing about change. Faith Semantic was open about the fact that her therapeutic style was frowned upon by her colleagues who focused solely on principles of reason and logical thought. In her attempts at moving away from westernised approaches of psychotherapeutic interventions, she marginalised herself from her professional community. Parker et al. (1995) comment that "simply to privilege unreason might be abnegating ourselves of the responsibility to help and understand others" (Parker et al., 1995, p. 61). Faith Semantic believed that moving away from a rational perspective would be more beneficial for the patient, but one would also have to acknowledge the value in combining the positions of reason and unreason. Faith Semantic's preferred therapeutic style resonated with her personal assumptions, past experiences, and cultural influences. This indicates that the psychotherapy offered to clients cannot just be determined by well researched manualised therapies as there will always be a personal inference from the treating professional.

Pathology and Normality

> I ask them, 'do you have manic symptoms? – yes; do you have depressive symptoms? – yes; and this is not all of who you are'. And there is an

233

immediate sense of relief, that 'I am more than this description' but that you know, and I think especially family members, who are terrified of this psychotic label that is given, the deconstruction is critical for their part.

According to Parker et al. (1995), the position of abnormality is inferred from that of normality. The two constructs are interlinked and cannot be seen separately. In the story of Faith Semantic this came through in her explanation of the role of the psychiatrist. The psychiatrist was the person who gave the diagnosis to the patient, which means that his position of normality was secured, and the legitimacy of the patient's story came into question. Faith Semantic turned this process around through her style of working which allowed the patient to feel credible and valued. Faith Semantic described the process of accepting the psychiatrist's diagnosis as one possible label, leaving room for moving away from this label towards a position which allowed for personal growth for the patient. She did not disqualify the psychiatrist's definition of abnormal behaviour, but at the same time, she suspended the weight that the diagnosis carried, and allowed the patient to explore alternative explanations for what was happening and what that would mean for various systems in which the patient lived and worked.

Faith Semantic accounted for the powerful nature of the label of abnormality and acknowledged the influence that this label could have on the family's perception of the patient. Much of Faith Semantic's therapeutic work was directed towards moving away from the power of the diagnosis towards seeing the person behind the label. Faith Semantic did not comment on what normality would be like in the case of bipolarity, but she did explain her understandings of how damaging the abnormal label can be, for the individual, the family, and the therapeutic relationship. Faith Semantic diverted away from answering questions about her own position of power and chose to focus on freeing the patient from the powerful diagnosis. In this way, it could possibly be said that Faith Semantic had her own conceptualisations of normal behaviour and she was working towards that understanding with her patients and their families. This would mean that she would consider the psychiatrist's diagnosis as abnormal as it was lacking context and moved towards what she considered to be normal.

Form and Content

> He came in and said 'I've got a bipolar disorder and my self esteem is very low'. And I immediately said 'you know where did you get this idea that you see yourself as having a low self esteem?' and everyone before, especially the psychologists had told him that he has a self-esteem problem so I told him to leave his self-esteem at home when he comes and to rather bring your self.

According to Parker et al. (1995), advocates of the medical model are more concerned with the form of the diagnosis that is the presenting signs and symptoms, than with the content or meaning that the diagnosis has for the person. The textual reference above indicates that Faith Semantic was more focused on the content than the form of the diagnosis. This is also reflected in the narrow description that she offered of the psychiatric diagnosis itself. However, Parker et al. (1995, p. 62) heed that "one cannot privilege content alone since it is always mediated in some form and it is not simply reification which is the problem". Parker et al. (1995) believe that the form can be helpful in bringing about change and should not be ignored in favour of form as that too would be a reification. Faith Semantic could be seen to be lacking in a focus on form as her intention was solely to deconstruct the content of the diagnosis, at the expense of exploring the form. In this way, she was promoting a fixed and defined way of attaining normality, excluding the possible benefits of understanding the signs and symptoms of the disorder through a psychoeducational component of therapy.

Faith Semantic's understandings of bipolar mood disorder were embedded in discourses of free-will, and subjugation by culture, psychology, and society. This in turn informed her way of working with patients focusing on content at the expense of form. One can see that ideally a balance between the positions is sought after. Marge Polyvocal and Linda Egalitarian's stories showed that they were grounded primarily in form and not content. Faith Semantic shows the opposite. The importance would be acknowledging the value of both form and content in any understanding of bipolar mood disorder as people within this system arrive with both conceptualisations and taking preference of one position will subjugate the other. The person with the

diagnosis has to interact with both those who highlight content and those who focus on form. To be fair, both positions would need to be included in psychotherapy so that the patient is offered the choices of which position resonates most strongly, and act on that, rather than it being decided for the patient.

<u>Pure Categories Versus Messy Real Life</u>

> They're distressed at the fact that the psychiatrist does not see them more holistically. They are distressed at this description of bipolar disorder that they get from the psychiatrist… And it defines who I am and I'm mad now and that's the discomfort for the patient.

From Faith Semantic's perspective, the label that is given to a patient has the dual function of providing a reason for the behaviour which settles the patient, and simultaneously limits the perception of who the patient is. Faith Semantic is basing her understanding on the many bipolar patients she has dealt with in her place of work. Faith Semantic chose to broaden the labels that were given to her patients, exploring alternatives which may provide the patient with a more 'holistic' understanding that the patient was seeking. Faith Semantic did not believe that the label given to the patient was all-inclusive and this informed her basic therapeutic assumption of free-will and needing to 'save her patients'.

Faith Semantic emphasised that 'madness' is relative to the context in which the person lives. She could not accept the mainstream thinking of her colleagues which neatly categorised people into psychiatric diagnoses. Parker et al. (1995) comment that the psychiatric diagnostic system may be useful for understanding human behaviour if the categories are able to remain flexible. Faith Semantic did not see the benefits of diagnosing patients because in her working context, this diagnosis became closed and fixed. The implications of this for the patient mean that no matter what the patient does to implement change, he or she will always remain diagnosed and in need of psychiatric assistance.

Faith Semantic's position was therefore more attuned to 'messy life categories' and she focused on broader ecological and contextual understandings of

the person's life-world, rather than believing in the diagnosis. Her therapeutic style was incongruent with the mainstream foundational belief system within which she worked and she found this to be a great challenge. Once again, Faith Semantic's beliefs, assumptions, and chosen way of working, were largely informed by her cultural and social background influences which impacted on her need to stay clear of 'pure categories'.

Professional Versus Popular, Lay and Patient Views

His mother clearly bought into, to the bipolar description, and she'd sit in therapy, you know, physically maintaining this distance of somebody who is contaminated. And uhm, she often became the maintainer of, of, not only of the description, but often of the symptoms as well. I think it was quite essential to, to move that.

Parker et al. (1995) propose that there is actually no real difference between professional, lay and popular views on bipolar mood disorder because they inform each other through surrounding discourses. The difference lies in who is seen to provide this knowledge and this view entrenches the psychiatrist and other professionals in positions of power over and above the patient. Faith Semantic's views were aligned with that of Parker et al. (1995), and she did not differentiate the power broker of knowledge. For her, the patient's perspective was just as, if not more, important than that of the person who gives the diagnosis.

Faith Semantic worked from ecosystemic postmodern premises which shaped her understanding of bipolar mood disorder and she was able to attain a meta-position on the understandings of her patients and their families. Her primary concern was with deconstructing the diagnosis so that broader and less limiting (from her perspective) explanations could be built up. She accounted for both professional and lay descriptions of bipolar mood disorder in her therapy sessions and made use of diagrammatic representations of ecological maps which traced the importance of the psychiatrist's explanation as well as that of the patient and the family.

Faith Semantic did not rely on the traditional psychiatric diagnosis of bipolar mood disorder to understand her patients and their behaviours. Instead she chose the alternative position of including her patient's understandings into the therapeutic strategy and structural plan for bringing about change. Faith Semantic relied on her previous experiences and cultural influences in shaping her understanding of bipolar mood disorder and this shifted her towards giving the 'lay opinions' more value than the accepted medical model's suppositions. Faith Semantic also accounted for the background experiences of her patients and tried to adapt her style to the needs of her patients. She found that the psychiatric literature did not translate well with the socio-economic levels of her patients and she therefore chose to focus on the cultural histories of the patients that were brought into therapy. In this way, she focused more on validating and legitimising the understandings of her patients and co-created mutually acceptable understandings of bipolar mood disorder for both the patient and the family.

Again, Faith Semantic fought off the psychiatric influence on her understanding of bipolar mood disorder and chose to give more credence to the lived experiences of the marginalised, that is, the patients diagnosed with bipolar mood disorder. Her own personal discourses were seen to shape the therapeutic discourse, which in turn influenced the way in which the patient viewed the disorder, and in turn shaped their lived experiences.

The category of professional versus lay knowledge was amalgamated by Faith Semantic. She did not discuss her role of being a professional with knowledge, but rather she viewed her position as being aligned with that of her patients. Her therapeutic intention was to free her patients from the powerful meaning system of diagnosis and allow for alternative stories to take shape. In this process, she too was freeing herself from the subjugation of the traditional medical approach. The discourses informing her position as a psychotherapist influenced the way in which she understood and conceptualised bipolar mood disorder. The reciprocal and mutual influencing of the psychotherapist and the patient is clearly exposed through this analysis of wider discourses. Treating bipolar mood disorder is not simply a technique or clear and objective actualisation of a manualised therapy. The way in which the

psychotherapist understands the diagnosis clearly impacts on the way in which the psychotherapist aims to bring about change in the patient's life.

Conclusion

In conclusion of this chapter exploring the vignette analysis of Faith Semantic, one hopes that an adequate story composition has been offered. This baseline platform will be used to generate themes of commonality and differences amongst all the research participants. In some instances, direct quotations have been used to emphasise the complexity inherent when working with people with a bipolar mood disorder diagnosis. The paraphrasing of Faith's comments would have lost the essences of the impact of her story-telling process. This chapter concludes the description of bipolar mood disorder from a psychotherapist's point of reference. This allows the opportunity for the entrance of the final interactional interview series, inviting the participation of the psychiatrist, Medi Caution.

CHAPTER EIGHT

Professor Medi Caution – The Medical Expert

If you are not congruent then you are disintegrated and that is my big research issue.

Introduction

In this chapter, the psychiatrist who was interviewed is introduced to the reader. This is done by initially explaining the reasons for choosing to name this co-researcher as Medi Caution. This is followed by a contextual history of Medi Caution's life and clinical experience, as well as how she understands the diagnosis of bipolar mood disorder and the supposed 'causes' of the disorder. This chapter is concluded with a description of the researcher's process comments of this particular interview. The purpose of this chapter vignette is to broaden the understanding of the view of a particular psychiatrist who works therapeutically with bipolar mood disorder by exploring her medical approach and background as well as her treatment regime, and view of the patient.

In this chapter there is no assumption made that this particular psychiatrist represents the vast field of psychiatry. It is merely a description of the experiences of one particular psychiatrist who could and would offer her perceptions of bipolar mood disorder. This psychiatrist did not treat any of the patients in the first two vignettes. The aim of the interview series is to get broad understandings of conceptualisations of bipolar mood disorder, since all role-players globally co-construct the diagnosis of bipolar mood disorder. As with the previous vignette, this chapter will conclude with a postmodern deconstruction and reconstruction of the psychiatrist's story based on the tenets provided by Parker et al. (1995).

Explaining the Title

This research interview took place in the offices of one of the leading psychiatrists at a mental hospital in the city of Pretoria, South Africa. This is a government hospital and is well known for the severity of mental illnesses that are treated in this facility. The primary forms of practice are the psychiatric medical model, together with psychodynamic and cognitive behavioural therapeutic approaches. The psychiatrist who participated in this research was learning about systems theory and she was attempting to implement a more systemic and holistic option for patient care. It was purely by coincidence that this psychiatrist's name was given to the researcher. Medi Caution offered her assistance and felt that she could learn something new and different by participating in the furthering of understanding of bipolar mood disorder.

The interview took place in Medi Caution's office which was very neat, tidy and orderly. The actual treatment facility is set amongst large trees and open well maintained grounds. Medi Caution's office looked out onto the trees and was situated in a quiet corner of the building. There was an eerie silence throughout the interview as the offices are separate from the wards and buildings in which the patients live. One would not think that this interview was conducted in the facilities of a mental hospital. Medi Caution was pressed for time as she had a very full daily schedule. This had the impact of pressurising the researcher into maintaining focus to the task at hand. The research relationship had to be established quickly and the world of bipolar mood disorder was entered into without sharing much personal background information.

In this interview, the researcher retained a very formal stance and questions were more directive than in the previous three interviews with the other research participants. Initially, the researcher felt pressured to present herself in a professional and academic manner without being too explorative. Questions and answers were given with precision, and the researcher felt Medi Caution's need to remain contained and formal. As the interview progressed, the researcher used humour to make light of certain comments of Medi Caution's and this seemed to shift the stance of the

psychiatrist. The researcher also felt that she connected with some of the information that Medi Caution was sharing and re-affirmed the psychiatrist's viewpoints. This seemed to relax Medi Caution and she began to use a quiet sense of humour when appropriate. Medi Caution appeared to be in fear of being judged for her alternative take on psychiatry and with some prompting from the researcher, Medi Caution gradually became more comfortable with sharing her knowledgeable experiences.

Initially, this interview had more of a textbook feeling and was factually based. As the interview progressed, Medi Caution became interested in the researcher's curiosity and epistemological angle. This interview then became a shared domain of conversational realities and both the researcher and the research participant began to cultivate a common understanding of the difficulties faced in the field of mental health. Medi Caution showed a keen interest to learn more about alternative paradigms of thought and shared her feelings of not being a main-stream psychiatric thinker. The importance of interviewing her in an environment that she perceived as professionally safe was highlighted. In hindsight, Medi Caution seemed to be sussing out the researcher and first becoming comfortable with the aims of the research before self-disclosing. This interview required the most energy input from the researcher as there was a definite air of mutual judgement.

From the researcher's side, the interview with Medi Caution created the most discomfort for the researcher. The researcher's encounters with psychiatrists have always been likened to that of a battle field, with a natural position of critical questioning assumed by the researcher. This position of questioning the field of psychiatry entered the research domain as a foundational belief of the researcher. It is no wonder then that the initial part of the research interview was clouded in distrust, dependence on the opinion of the expert, and quite oppositional. Medi Caution showed that there is a breakaway field within psychiatry that is moving away from traditional psychiatry towards a more holistic practice of medicine.

History and Background

So now you can imagine that it is a little bit difficult staying in the system and having the views that I have. And I respect that there is substance to what the others say so I guess I am trying to integrate it by not only applying mainstream psychiatry in a bad way.

Medi Caution's work duties consisted of service delivery (within the mental hospital as well as community settings), research, and the supervision of registrars and other medical and psychological staff members. Her passion lay in research and she felt that a state hospital afforded her the opportunity to explore the human mind in ways that could be funded, compared to attempting this in the private sector. She also kept her knowledge current by attending international and local conferences and keeping abreast with the latest developments in the field of psychiatry. She gained a lot of satisfaction from patient care but she also experienced great resistance to her methodology from her superiors. This was largely attributed to the fact that she spent too much time with individual patients and did not have a high patient turnover. In her service delivery nodal points, it was common for a psychiatrist to see approximately thirty patients a morning. She said that she would do less than fifteen as she preferred to spend at least 45 minutes with each patient exploring changes, difficulties and educating the patient into medical compliance. "…I find that if it's shorter then it just shrivels out and I don't get enough from them, and I can't give them enough". Her interest was in communicating with patients in a meaningful manner rather than just writing up repeat prescriptions. "Telling the story is healing. So I do that. That's why I take so long with patients. I let them tell their story, and I think it's a good thing".

Medi Caution was also furthering her studies by attempting to complete a Theology masters degree through a correspondence university. Her interest is in feminist theology, exploring the interface between psychiatry and women. These themes were important to her as they constantly cropped up in her 'therapy' sessions and she felt that women dis-empowered themselves by accepting taken-for-granted cultural and religious beliefs. She felt that this belief system helped to perpetuate a

pattern of helplessness and she was trying to understand that process and offer alternatives from various backgrounds, such as psychiatry, psychology and theology.

Medi Caution was open to different schools of psychology and the implementation thereof. She was professionally trained in medicine and the school of psychoanalysis. She would not have considered herself a therapist by any means but she felt it was an important part of her work to explore the world of her patients. She was very humble in her presentation of self and did not throw her experience around as a validation for her knowledge. She was curious and asked the researcher many questions about therapy and epistemology. Medi Caution felt that she had very little support from both her profession and her private life. Professionally she had tried to attend journal clubs where current trends are discussed among a multi-disciplinary team but she felt that more directive supervision would have been beneficial for her growth as a professional and an individual. She felt quite alone in the field as her methodology of a client-centred approach is still thought to be in its infancy in psychiatry in South Africa. "I have a bit of a problem with the mainstream way of doing things, uhm, because it doesn't respect the autonomy of the patient". Most of her colleagues utilise "an army approach" whereby they drug the patient to a state of incoherence and place the patient in chronic wards where little or no psychotherapy is offered. Due to understaffing and lack of resources, in the community clinics, there were no psychologists (at the time of interviews) so the onus lay on Medi Caution's shoulders to bring about stability and change. There was a psychiatric nurse who Medi Caution found to be indispensable.

Medi Caution was very positive about her career and although she found it difficult at times and personally taxing, she impressed with an absolute dedication. She showed a wonderful respect in the way that she conversed about her patients and was very thoughtful and open to ideas of progression in the field of psychiatry. Her knowledge of psychiatric medicine was impressive and her treatment approach appeared to be very focused on patient care and improvement of mental illness towards mental health. She did not blame lack of resources for any of the problems she experienced, but rather she took personal responsibility and indicated where she could change and what things she may be possibly doing wrong in the system.

Becoming the Bipolar Patient

In Medi Caution's opinion, bipolar mood disorder is "a categorised illness" according to the DSM-IV and "either you have it, or you don't". More than that, she thought that bipolar mood disorder is "an exaggeration of normal variations… in mood and reactions to life". For Medi Caution bipolar mood disorder is a psychiatric illness that can be contained through the use of medication as well as psychotherapy in some instances. 'Some instances' because if the patient is thought to be too psychotic or aggressive or unresponsive to medical treatment, then the patient is admitted to a chronic ward where little or no psychotherapy occurs. The patient remains an in-patient of the institution and awaits a cure or an improvement in interpersonal demeanour.

The behaviour of the patient is believed to be a real description of the person and change is required for the patient to retreat back to a more normalised way of behaving in society. The inner dynamics of the person are hardly understood and the outward expressed behaviour is more of a concern. The family, work, culture and societal discourses that shape a person and the presenting behaviour are largely left untouched in the psychiatric community. The patient is seen to "crumble under the load that they carry" and this is believed to be a causative factor in the development of a bipolar mood disorder. Of course, primarily a biological causative perspective is assumed. From this deduction about human behaviour, it follows nicely that a person should be medicated accordingly, and in the case of bipolar mood disorder this often involves a concoction of pharmacology such as an anti-depressant, anti-psychotic, mood stabiliser, and a sleeping tablet or tranquilliser. If the person is non-responsive to the medication, then it is assumed that there is an inherent problem within the person and perhaps even an unwillingness to change. The person is then maintained on the medications and placed in a more chronic setting. This implies that the system cannot handle the amount of time that is required for the slow changes that occur in the spectrum of polarised mood and behaviour patterns.

In a case study that Medi Caution presented at a medical meeting for continuing professional development, she took a stand against the fact that patients of the chronic wards at her institution were "forgotten". She presented the case of a

woman who was diagnosed with bipolar mood disorder with psychotic features. She wanted the woman to be afforded the opportunity of psychotherapy, even though she was unresponsive to psychodynamic treatment in the past. She was met with much resistance from the community of psychiatrists and they favoured "an army approach" of increasing her medications and isolation. Her call was for a more holistic treatment approach reasoning that the patient may be responsive to further psychotherapy if afforded the opportunity. This would mean that the woman would have to be moved back into an acute ward or at least be discussed weekly at the multi-disciplinary meetings. She was presenting from a position of hope and understanding for the patient, and she was met with traditional psychiatric resistance. The safety of psychiatry seems to lie in the certainty of medication and accurate diagnosis. However, Medi Caution had seen that the patient had a very difficult time adapting to the cultural and political transitions in South Africa. She had not accepted this and she was highly aggressive and racist towards staff members of the institution. Medi Caution felt that the patient would benefit from psychotherapy addressing these changes that she had experienced, and this might have the added benefit of returning her mood towards a more stabilised variation rather than the extremes. The patient was given the opportunity to have psychotherapy and over time her dosages of drugs were lowered. The dilemma and trade off for Medi Caution was in making the decision between allowing the patient to experience the benefits of medication and "the adverse effects of having her brain numbed".

Interestingly, Medi Caution had been 'inheriting' people diagnosed with bipolar mood disorder and had not given the diagnosis herself in many years. She administered the psychotropic drugs rather than identified the mood pattern. But she was very interested in the dynamics of mood behaviour and considered bipolar mood disorder to be as threatening to a person as the often popularised schizophrenic disorders. But, her method of issuing drug repeats and prescriptions differed from that of her colleagues. She engaged in dialogue with her patients about the dreaded side-effects of medications and always searched for the least perceived harmful protocol for the patient. Medi Caution felt strongly that the majority of psychiatrists operated from a position of expert knowledge over and above the needs of the patient. This is an issue that has been raised by both Marge Polyvocal and Linda Egalitarian. Medi Caution spent much time explaining the benefits of the medication to the patients in

ways that would hopefully make them more compliant with the use of the prescribed drugs.

Medi Caution held a very personal assumption that people should not be forced to take medication against their free will, unless of course the person has been certified and deemed to be incapable of taking personal care. Medi Caution believed strongly that medicating patients was part of a double edged sword process because the person is helped yet simultaneously emotionally numbed in many ways. For her, the free will of patients is of utmost importance. This is of course a fine balance to achieve. The battle within Medi Caution to make people dependant on psychotropic medication for mental health benefits versus allowing people to feel the emotional swings of life was evident throughout the interview. Medi Caution personalised this in the sense that she rationalised this process from a self-reflective stance, not wanting her own freedom to be dictated to by a higher power. She worked from the assumption that her patients went through a similar emotional process and she tried to converse with her patients as much as possible around this issue of benefits versus opportunity costs.

But, in summation, Medi Caution felt that medication is all too frequently prescribed as a means of coercion denying the patient the innate ability to confront life's issues, pains, and possible growing edges. "People with bipolar disorder don't like taking medication, which I appreciate". This is a very humanistic approach to the field of psychiatric medicine, and she rarely felt that her viewpoints were shared amongst members of her psychiatric community. This often left her feeling marginalised from the group of psychiatrists who commonly believe that patients should not have a choice in receiving medication as they are incapable of making such decisions. Although Medi Caution agreed with this to a point (such as in the case of psychotic behaviour which should be controlled as much and as quickly as possible), her notion was that patients still make the choice of following through with a treatment regime and as such they should be included as decision-makers in their future health and well-being. Medi Caution felt that she could explain the pros of medicine without coercing patients into taking medication on the grounds of "the doctor knows best". This is thought to have implications for the attitude of the patient toward taking the prescribed drugs

and the relative compliancy or non-compliancy thereof. If a patient understands the benefits of the drugs and has been told about the possible side-effects of the tablets, and agrees to try out the doctor's suggestions, then the patient shares the same preferred reality with the doctor and they both feel they are heading towards a position of supposed health. The resistance of the patient was well conceptualised by Medi Caution even if it is from an underlying personal assumption of free will.

The 'Causes' of the Disorder

Sometimes I think that things disintegrate so badly so that I think maybe the best thing is just to medicate, but then I'm very glad that it is not me that has to do it.

The traditional DSM-IV biological approach of observable signs and symptoms of behaviour patterns was accepted as fact by Medi Caution. The importance of an accurate diagnosis was highlighted as a major concern because prescribed medication would rest upon this deduction. The patient's outwardly expressed behaviour of manic and depressive symptoms were taken to be the hallmark of a bipolar mood disorder diagnosis. Medi Caution considered herself to be a more holistic practitioner of medicine and she tended to think about the person in terms of his or her biological, family and religious systems. She did not isolate any one particular understanding as having more weight than another. Her focus was on understanding the person and how that person's particular life-world could either enhance or possibly stunt the pursuit of mental health. She chose to engage in this process of shared realities, when in fact, she could just 'turn over patients' and keep to the expected ten minute session per patient.

Further than the cause of bipolar mood disorder, Medi Caution made the assertion that mood patterns can be maintained, exacerbated, or helped through the relationships of the patient. Medi Caution even engaged in family 'therapy' sessions at times when she felt it was important to explore the family's understanding of the patient and the effect of bipolarity on the family unit itself. Marge Polyvocal was not

exposed to this kind of relationship with her current psychiatrist and she felt the loss of personal meaning that she could have shared with her treating doctor.

For Medi Caution, the causes and subsequent diagnosis of bipolar mood disorder was relatively simple, "when you have it, you have it". The possibilities of family interaction patterns as a possible causative factor were important but not strong enough to concern Medi Caution. If relationship problems were presenting as a complicating factor in patient recovery and well being, then Medi Caution felt a need to address the matter. In hindsight, she commented, "well… it usually *is* (emphasised tone of voice followed by a light laugh) relationship problems".

A potential difficulty in treating bipolar patients was thought to be the presence of co-morbidity. Medi Caution felt that substance abuse greatly complicated matters of treatment. Medi Caution pointed out that a great concern of hers was always to question whether there was "a psychotic process going on". When speaking of her case study, there was doubt as to whether the patient was in fact psychotic as the patient had been previously diagnosed as "being completely psychotic". Medi Caution's comment on this was, "I don't actually *care* what the diagnosis is anyway. But the big thing is always, is the person schizophrenic?". If a person is diagnosed as a schizophrenic rather than a bipolar mood disorder, then the psychiatrist would have changed the medication and stopped the mood stabiliser all together. The greatest difference for Medi Caution lay in the prescribed medication. This may be somewhat contradictory, because on the one hand Medi Caution was claiming to be a professional who sought understanding and meaningful descriptions of the patient's reality, yet, when it came down to medication, Medi Caution was classically interested in dulling the psychotic expression of behaviour (common to manic patients) to the exclusion of the possibilities of multiple meanings for these behaviour patterns.

With exploration, Medi Caution did acknowledge the importance of cultural influences on the patient and the treatment approach chosen. But, her opinion was still that the community of psychiatrists are not 'buying' into the social side of psychiatry. Medi Caution believed that "we basically need to think a-new about psychiatry in South Africa. I don't find that it's useful to just apply the western model". When

asked to elaborate, Medi Caution explained that the western model referred to the DSM-IV and she felt that this diagnostic instrument was insufficient when used alone. She used the DSM-IV in collaboration with training in psychological factors; psychodynamic and psychoanalytical training; thorough cognitive behavioural training; and she adds in some systems theory background for her students.

The Approaches Informing the Positions of Disorder and Dis-order: A Bio-psycho-social Glance.

Professor Medi Caution accounted for biological, psychological and social factors in her description of bipolar mood disorder. She seemed to extend herself beyond traditional psychiatric treatment and attempted to view the patient in context of his or her background and treat accordingly. However, she felt that she was confronted with resistance from her community as it is a very high patient turnover environment. The inclusion of patient background context extended her session times and this frustrated her superiors. They felt that she should be seeing more patients and spending less time on qualitative aspects of psychiatric treatment.

One of the biggest complicating factors in the treatment of bipolar mood disorder is lack of compliance with medication. Gabbard and Kay (2001) researched the factors that influence compliance and non-compliance and found that the psychiatrist plays a very important role in maintaining compliance. Further, Gabbard and Kay (2001) called for the return of the bio-psycho-social psychiatrist. It is their belief that this mode of treatment would integrate patient care and assist patients in understanding and overcoming their disorder. But, what they suggest is a time consuming and laborious process in which the psychiatrist is both the therapist and the medicating professional. In South Africa, state run hospitals are often over burdened with patients and time spent with each patient has to be minimised. But, the thinking behind the approach could be vital for patient treatment. Psychiatrists may be constrained by factors such as time and personnel, but nothing prevents the psychiatrist from understanding the patient as being a part of wider social contexts and approach treatment from this light instead of merely seeing an individual a-contextually. As Gabbard and Kay (2001, p. 1959) state,

an exclusive focus on dosage adjustment and side effects may provide the psychiatrist with a buffer against painful empathic awareness of the patient's despair as well as offering an illusion of mastery over the complexities of psychiatric illness.

Professor Medi Caution respected the position of the patient and tried to understand the factors that may hinder the treatment process. For Marge Polyvocal, this viewpoint would have been ideal. One of her greatest complaints was that her psychiatrist never listened to her and focused merely on the side-effects and consequences of medication. Psychologically, Professor Medi Caution attempted to understand the life-world of the patient. Although she chose to frame it in a choice of free-will, coercion and religion, she still made attempts to understand the feelings and thoughts of the person behind the diagnosis. Again, this was met with resistance from her colleagues and the system in which she worked. Medi Caution, as a technique and structure oriented psychiatrist, thought that if she could re-define the DSM to include the wider systems of social and cultural discourses, people would begin to change their treatment approach. Even though her approach was still first order, cause and effect, where she was the expert and instrument of change, her visualisation of psychiatry as context inclusive is to be admired.

Conceptual and Contextual Descriptions: A Social Constructionist Approach

In this section, an analysis of discourses is explored through textual data. This information is drawn directly from the transcribed interviews and has not been altered in any way. The researcher has coded the information into thematic discourses that were inferred from a thorough reading of the transcripts. This section offers a closer look at the way in which language shapes the meanings and descriptions of bipolar mood disorder. The layout of the analysis includes the following categories of distinction: naming the disorder; causes of the disorder; perception of the patient; support systems; symptom expression; perception of the psychiatric system; and the use of medication.

Category	Textual comments	A Discourse Revealed
Naming bipolar mood disorder	It is an illness, a categorised illness uhh according to DSM. The result at that meeting everybody also felt that she was *a* bipolar. I seem to think that it is more of an exaggeration of normal variations in mood and reactions to life. Without a therapeutic relationship there would be no recovery.	1. Psychiatric / Biomedical 2. Psychological / Deficit perspective
Causes of bipolar mood disorder	I'm a little bit more psychodynamically inclined, rather than cognitive or something like that. And a bit of an interpersonal slant maybe. I'm quite happy, I don't actually *care* what the diagnosis is anyway, as long as it is not a schizophrenic process. People abusing substances along with other problems, ja, it complicates matters tremendously. If the problem happens to include relationship problems, I might explore that with the patient, well… it usually *is* relationship problems.	1. Psychological-psychiatric system 2. Co-morbidity 3. Family
Perception of the patient	I normally inherit people who are already on medication. I try to sell medication to them when I think it will really help them. Very difficult. So-called chronic patients. No escape. She is out of control, you know for herself, she can't control herself. I would also have difficulty living with her.	1. Psychiatric
Support systems	I refer patients and I just hand over and say goodbye and say "I hope you have a fruitful relationship". But I think a collaborative approach is much better. To a limited extent I have sometimes used family therapy when several family members are present. So then I try it and I also try to apply the systemic concepts as well. And I think it's a very good, very productive technique. I cannot see the patient at the same time that I speak to	1. Psychological - Psychiatric system 2. Family

Category	Textual comments	A Discourse Revealed
	the family. And it gives me an appreciation of what this patient's life is like with these people. So I find that good.	
	Culture is very important.	3. Culture
Symptom expression	She couldn't really register it and she just became flustered again, and standing up and I couldn't talk to her.	1. Manic expression & depressive symptoms
	I thought we should increase at least the anti-psychotic injection to calm her down. I thought that might be able to improve the diagnosis for being able to talk to her.	
	It's a pity that it makes people unhappy, but in a way I have distanced myself a little bit from the mood, and I'm viewing it as a process rather than suffering with it.	
	I think it's sad because it does get to a point where you can't think straight anymore.	
Perception of the psychiatric system	I think many of my colleagues see more patients.	1. Role of psychiatry
	There is a lot of pressure to see so many patients – there are a lot of people out there who apparently need appointments with psychiatrists and there are far too few psychiatrists so there is a lot of pressure to see say 30 patients in a morning.	
	I dislike that often the psychiatric profession seems to go against what the patient wants.	
	It is very medication oriented.	
	It doesn't respect the autonomy of the patient.	
	I don't enjoy the CBT approach, I find it coercive, unless the person is really informed and wants to subject themselves to it. I think it's brain-washing.	2. Psychological treatment.
Use of medication	I do appreciate that sometimes, a person can become really manic or really depressed to such an extent that it's life threatening, and under such circumstances it is extremely difficult to establish a relationship with the patient, and under such circumstances medication is somewhat uhm helpful.	1. Biomedical
	She is a certified patient. So they wanted us to drug her and control her.	2. Control and compliance
	I do experience it as a form of controlling the person	
	People with bipolar disorder don't like taking medication, which I appreciate.	

Category	Textual comments	A Discourse Revealed
	The psychiatrists wanted to take a strict army approach of just pinning her down and medicating her until she was conversable.	
	But then I always have to play off benefits of medication with the adverse effects of having her brain numbed.	

The textual deconstruction reflects that Medi Caution's understandings of bipolar mood disorder are rooted mostly in the discourse of psychiatry, which is to be expected given that she is a psychiatrist. Other informing discourses included, psychological influences as well as her perception of the family. Interestingly, Medi Caution was studying Theology at the time of the interviews, "my whole thing is that I am interested in the interface between psychiatry and religion" yet she made no reference to a discourse of religion in her understanding of bipolar mood disorder. Even when the researcher tried to explore this as a possible influence in the diagnosis and the patient's life, Medi Caution returned to a psychiatric explanation.

For Medi Caution, the naming of the disorder was simple, "a categorised illness according to DSM. And either you have it or you don't. When you have it, you have it". Medi Caution did not delve into the multiple possibilities influencing the nature of the diagnosis. Her understanding of bipolar mood disorder was grounded in the traditional medical model conceptualisation of the disorder and she used only this description throughout the interviews. Her story of working with bipolar mood disorder was framed within a psychiatric discourse. It was also within this discourse that she was able to define her role, her actions, and provide meaning for her life. She focused on the deficit-model and perceived herself to be needed by the many people who had psychiatric illnesses. She did not offer behavioural descriptors of signs and symptoms of bipolar mood disorder and just took it for granted that the DSM framework was the only legitimate reference for diagnosis.

The causes of the disorder for Medi Caution were also of no great concern. She "inherited" patients with the diagnosis and she continued with the therapeutic strategy of medicating the patient. She did not question what was influencing the person to behave in a diagnosable way, and she did not really "care" either. Her main

concern was to ensure that the patient was on the right medication for the mood symptoms. Her main aim was always to rule out any underlying psychotic processes. The Mental Status Exam was the tool used by Medi Caution to elicit information ensuring her treatment protocol was aligned with the mental state of the patient.

Medi Caution was challenged by the state psychiatric system which demanded that she consult with a certain target number of patients in one morning. In addition to this, she felt that optimal psychological help was not offered to the patient all the time. If a patient was considered to be a chronic patient, then the patient would not receive psychotherapy. Medi Caution did not agree with this policy as she felt that every person had a right to be helped, but also she acknowledged that some patients were just too "difficult" to assist.

Medi Caution's psychotherapy training was rooted in psychodynamic theory and she was comfortable using these principles and techniques. She was also interested in systemic theory and was trying to implement introduction courses for the treating professionals at the institution that she worked in. Her perspective was grounded in modernist assumptions where she believed that she was the expert and the patient was in a deficit of mental health. Her systemic approach was used more to elicit information from the patient (for example through the technique of circular questioning) rather than attempting to understand the interactional dynamics of systems. This differed to that of Faith Semantic who believed in a systemic understanding of bipolar mood disorder and worked accordingly. Medi Caution was utilising systemic concepts from a first order perspective, bringing about change as a direct outcome of an intervention, without acknowledging the influence of the psychiatrist herself.

The text in the tables above suggests that Medi Caution experienced confusion in the realm of medicating patients. On the one hand, she felt that it was her ethical and professional duty to medicate patients and alleviate abnormal behaviours. On the other hand, she was challenged with ideas of coercion and "numbing" patient's brains. A way through this for Medi Caution was to communicate with her patients and ask for feedback on any side-effects of the medication and to change the dosage if there were any adverse effects. The researcher almost had the sense that Medi Caution felt

sympathetic towards the patients and sad for them. But she chose to portray herself as being inoculated from the experiences of her patients.

Medi Caution did not conceptualise her understanding of bipolar mood disorder in terms of signs and symptoms of behavioural markers, but rather in the medications used to treat such a disorder. This was the focus of the interview. Her story was shaped around the benefits and uses of medication and she perceived the patients she treated as responsive or non-responsive to medication. Her view of the patient was limited to that of a deficit perspective, although one had the sense that she was not completely comfortable with this understanding. She made reference to cognitive-behavioural therapy as being coercive and this went against her beliefs in free-will and choice. And yet, she then commented on the necessity of certifying patients who cannot think for themselves. This was confusing for the researcher. On the one hand Medi Caution was able to comfortably determine what a normal person should look and behave like, and then on the other hand she was not comfortable with actualising this change through the well researched change oriented therapies as that would have been coercive. The discourses shaping the way Medi Caution understood bipolar mood disorder were shaped through psychiatric meanings and definitions, but her own personal assumptions and beliefs about human nature complicated this cut and dry psychiatric perspective. It would seem that instead of trying to work through these discrepancies, Medi Caution rested on the certainty provided by the psychiatric system and followed her psychiatric algorithms closely.

Emerging Discourses

These discourses do not just emerge from the researcher's thoughts and inferences, but rather directly from the text (the interviews). The interviews were focused on understanding the concept of bipolar mood disorder from the research participant's point of view, but they were under the direction of the researcher at the same time. Therefore, it was a process of collaboration. This particular research story was embedded in the field of psychiatry as that is the most well known script for Medi Caution. For her, mental illness was a clear-cut phenomenon and did not require elaboration and questioning. The analysis of discourse helps to enrich this psychiatric framing and produce alternative possibilities and meanings (Anderson, 2001).

Following the outline suggested by Parker et al. (1995, pp 60-63), six types of discourses are seen to contribute to the formation of a clinical diagnosis. These are the individual and the social; reason and unreason; pathology and normality; form and content; pure categories versus messy real life; and professional versus popular, lay and patient views. These clinical categories will be adapted to this particular research interview to enrich the discourse descriptions.

The Individual and the Social

> I did increase the medication. I thought we should increase that, at least the anti-psychotic injection to calm her down. I thought that might be able to improve the diagnosis for being able to talk to her.

Medi Caution's understandings of bipolar mood disorder shaped the ways that she understood her patients. She did not account for family or cultural influences. It was interesting that when she did include family sessions, she did so excluding the patient and solely focusing on the individual with the diagnosis. This kind of intervention would serve to maintain the intrapsychic nature of the disorder, separating the family from having any meaningful influence. It should be kept in mind that Medi Caution's foundational beliefs were grounded in the expert medical model and she did not see that it was necessary to include the patient in the family session, or account for her own role in this understanding of bipolar mood disorder. Instead of trying to understand how she too collaborates in subjugating the patient, she focused on how psychiatry was subjugating the person with the diagnosis. She sought out ways of working that would promote a view of the patient as being a human being and not merely a subject who requires medication. But, Medi Caution's language used to describe the patient differed from a position of respecting the individual's needs and wants towards believing that the patient did not know what was needed to attain a normal behavioural pattern. It may have been very useful for Medi Caution to deconstruct her own assumptions around medicating a person and how this fitted in with the pervasive community of psychiatrists who advocated heavy medication under most circumstances.

Medi Caution tried to provide the opportunity within her 'social' community of psychiatric colleagues to shift their perceptions of the diagnosed person and offer additional interventions, such as psychotherapy. But she was met with resistance from this group of people who strongly asserted that a diagnosed patient has no concept of what would be beneficial because the patients are limited in rational thought due to their conditions. There is no doubt that Medi Caution focused on the individual with the problem, excluding the influencing wider systems of society, culture, family and even her own therapeutic relationships.

For Medi Caution, diagnosis remains in the realm of the individual and any change is sought on an intrapsychic and a medical level. This tenet resonates with the other vignettes where the perception of the psychiatrist was mainly of the doctor with expert knowledge, disinterested in the wider environmental and discourse influences.

Reason and Unreason

I thought I would take a directive approach, and come across strongly, try and plant some seed of sorts She couldn't really register it and she just became flustered again, and standing up and I couldn't talk to her.

Medi Caution, being a psychiatric modernist, believed that if patients could not show a rational process of thinking, then they should be medicated to prevent them from being a threat to themselves and others. She could not add further explanation of what a rational person was, but she was certain that there were distinguishable factors between normal and abnormal thinking. For Medi Caution, the distinction between reason and unreason was very clear, patients did not have the ability to be reasonable beings and this is why they were in need of medication. For the bipolar patients, Medi Caution did not think that they were capable of rational thought and she believed that this led them to a position of being uncontrolled and therefore potentially harmful to themselves.

Medi Caution's ability to distinguish reason from unreason was based on her own assumptions of what these constructs meant. From this position, informed by tools such as the Mental Status Exam, she believed that she was able and equipped to

decide if the patient should be considered acute or chronic and receive the respective treatment for such a condition. She did not have an appreciation for cultural, social and familial influences on the ability to be rational or irrational. For her, the distinction was based upon psychiatric nomenclature, and that was sufficient.

The power of the psychiatric discourse is emphasised here. One person, in this case, Medi Caution made the decision of a person's ability to reason, which in turn was based on her own assumptions of what is reasonable or not. There was no space to question this knowledge of hers. It was accepted fact that her decision was final. The importance of the psychiatric discourse as yielded through the psychiatrist cannot be underestimated when understanding how multiple role players conceptualise bipolar mood disorder. There was no attempt made by Medi Caution to explore the meanings that her patients attributed to their diagnosis, their behavioural patterns, or compliance with medication. There was only a one-sided definitional ceremony of distinguishing reason from unreason.

Pathology and Normality

I think she is certifiable according to the normal way of doing things.

Pathology and normality are viewed by Parker et al. (1995) as interdependent concepts, and the definition of the one position is mutually defined by the other. Medi Caution was a strong believer in normal behaviour and considered herself an expert at defining abnormal behaviour. She did not question or doubt her position of knowledge. Within her context of working in a state mental institution, she was continuously exposed to behaviours which were considered abnormal. She had very clear boundaries between her work and her personal life, and when she was at work, she considered herself to be a good psychiatrist promoting mental health through the use of medication.

Medi Caution had not explored the social constructions of normal and abnormal concepts as her epistemology was firmly established in psychiatry. For her, the DSM offered all that she needed to know, along with a few psychotherapeutic techniques which could assist her in treating patients. The position of normality, for

Medi Caution, meant becoming resourceful and being in a surplus of coping skills, rather than the abnormal position of being in deficit of rational thought and coping abilities.

The understanding of bipolar mood disorder was an anomaly in mood behaviour. It is a disorder which requires medical attention, psychotropic medications, and physical containment. From this position a patient has choices, such as adhering to the medical protocol and showing improvement in behaviour; remaining in a position of acute diagnosis always fluctuating in mood; or being labelled chronic where there is literally no hope for change and the patient's medicine dosage is increased. If the patient disagrees with the psychiatrist then the patient faces the risk of being certified because of being irrational and not being able to care for oneself. The way in which the psychiatrist perceives the condition of the patient determines the patient's life-style. The psychiatrist is therefore in a powerful position of determining the outcome of the patient's life. Medi Caution hardly came across any 'normal' people as they would not have entered the psychiatric system for treatment. She inherited patients that others before her had diagnosed with bipolar mood disorder. Her benchmark criteria were based on a structured psychiatric interview which aims towards eliciting abnormal responses from the patient.

Medi Caution's understanding of abnormal behaviour was therefore informed primarily by a psychiatric discourse which draws clear distinctions between what is abnormal and normal behaviour. In addition to this, her working and learning contexts are surrounded by like-minded people, which further served to reinforce this schism between normal and abnormal behaviours. It could be said that Medi Caution was the token of normality from which she judged the patients behaviours as abnormal. There is an imbalance between the patient having any credibility in Medi Caution's contexts and her own method of assigning a psychiatric diagnosis. Her modus operandi was to search for abnormal markers of behaviour as decided and promulgated through the DSM. These markers reinforced her understandings, and defined her treatment protocol. Her meetings with colleagues and other mental health professionals also reinforced this system of seeking out pathological behaviour without considering what normal behaviour for that person might be.

Form and Content

I am more in favour of going one route, considering the symptoms as just complications that might hopefully resolve.

Form in this context implies the ways in which specific behaviours are present or not, that is, the form of bipolar mood disorder in terms of signs and symptoms of manic and depressive behaviour. Medi Caution was solely focused on the form of diagnosis and not on the content or meanings of the behaviours she was observing. Medi Caution could be seen to be acting congruently with a scientific, neutral, and objective perspective as advocated by the medical model. The implications of such an approach are probably felt more by the patient than by the psychiatrist. Medi Caution was concerned with signs and symptoms of behaviour which could best direct her treatment approach. She was not concerned with the cultural, social, and family reasons for such behaviours. According to the model of western medicine and psychiatric practice, the behaviours fell outside the realm of normal functioning and therefore needed to be corrected.

When Medi Caution was asked about the influence of co-morbid issues, such as substance abuse, she agreed that this does complicate her treatment protocol, but she did not make any reference to having a further understanding into the environmental factors influencing bipolar mood disorder. For Medi Caution bipolar mood disorder was informed by the abnormal presence of symptoms as defined by the DSM. No more than that. Her difficulties emerged when she questioned the content of the diagnosis from a personal perspective, for example, being forced to undergo cognitive-behavioural therapy just because it is the psychologist's therapeutic strategy of choice. She was not questioning the meanings that the patient had of being diagnosed, but rather her own meanings associated with coercive therapeutic measures.

It is interesting to see that Medi Caution was not happy with the traditional medical approach used within psychiatry, and she was making efforts to build up a psycho-social diagnostic tool, but she shared no way of languaging this with the researcher. It would seem that on one level Medi Caution had an awareness of the

psychiatric model being limiting for the patient, but at the same time she had no other way of understanding the patient. Her battle with bipolar mood disorder was that it gave her the opportunity to question her colleagues in their "army" approach, using top-heavy doses of medication. The actual diagnosis of bipolar mood disorder remained relatively intact.

<u>Pure Categories Versus Messy Real Life</u>

> The question with bipolar disorder is always: is it a psychotic process going on? You see with this woman she was also walking around with a schizo-affective disorder. Which apparently she presented with some years previously, completely psychotic, and now later on it was moved to a bipolar disorder. But that was also the result at that meeting everybody also felt that she was a bipolar. But the big thing is always is the person schizophrenic?.

This quote indicates that Medi Caution was mostly concerned with 'pure categories' as this directed her approach to treating the professional. She made no mention of the impact of the environment on the patient's life. She separated the family and the individual as being two distinct therapeutic systems. Her approach to bipolar mood disorder was structured and adhered to well researched treatment protocols. Her understanding of bipolar mood disorder was once again reaffirmed through a psychiatric discourse, making mention of the family, and cemented through conversations with other mental health professionals.

From a postmodern perspective, Medi Caution failed to account for the wider, surrounding social and cultural discourses, emphasising the psychiatric paradigm as the only way to understand bipolar mood disorder. Her training, colleagues, and international network of support, all served to reinforce this notion that bipolar mood disorder was indeed an intrapsychic phenomena belonging to the patient and therefore the individual remains the site of treatment. Her knowledge of family systems theory was used to solidify this approach and she used the skills and techniques of family therapy to assist her in verifying the presence of the disorder.

Interestingly, when Medi Caution was asked which disorder she would most likely have if she had to receive a diagnosis, she remarked that it would be one of the bipolar spectrum diagnoses. Her personal belief system was intertwined with that of her professional assumptions. She was able to personalise the diagnosis, yet she did not account for how her own culture and interpersonal relationships could contribute to such a diagnosis. For Medi Caution bipolar mood disorder remained an individual diagnosis, and her treatment methods reified the patient's behaviour as being deficient of normal functioning.

Further, Medi Caution believed that a patient needed one main diagnosis which defined the patient's behaviour. Even though she told stories of cases which had multiple diagnoses, somehow the bipolar mood disorder diagnosis had the most importance. For Medi Caution, human behaviour could be classified into categories of normal and abnormal behaviour and collectively, these signs and symptoms of abnormal functioning culminated in one diagnosis, bipolar mood disorder which required medication.

Professional Versus Popular, Lay and Patient Views

What my experience of patients is, is that they more crumble under the load of whatever they carry.

This quote by Medi Caution refers to her understanding of the patient's life and experiences. This quote emphasises Medi Caution's belief that the patient has a lack of coping and "crumbles" resulting in mood vacillation and instability. Parker et al. (1995) claim that there is a marked difference between how the psychiatrist views the problem and how it is viewed by the patient. This textual reference legitimises Parker et al.'s (1995) assertion. Medi Caution had clear understandings that the bipolar patient was the site of the pathology and she made therapeutic attempts to alleviate the symptoms and signs of abnormal behaviour. Medi Caution put herself in the position of being the expert on bipolar mood disorder, enabled by her profession to diagnose, guide, and treat a bipolar patient.

Medi Caution explained her understandings of bipolar mood disorder from a medical model, emphasising assumptions of expertise, scientific neutrality, and singular truths. For her, there was such a thing as bipolar mood disorder which existed within the minds of patients and the only way of ridding this disorder was through a treatment protocol of mood stabilisers and anti-psychotics.

Medi Caution's uncertainties and doubts were more on a system level of the psychiatric institution itself, but this was also a system in which she was firmly entrenched. She was uncomfortable with regime protocols of drugging a person until the patient was "numb". She was also uncomfortable with promoting medications which brought the patient physiological discomfort. And in addition to these areas which differentiated her from her colleagues, she was against the use of structured cognitive-behavioural therapy which aimed towards "trying to control behaviours by thinking about them differently". She preferred working from a position that tried to understand why the behaviours occurred in the first place. But Medi Caution did not share how she goes about this, and she even commented that she would not like to be observed in her sessions. This perpetuates the perception of psychiatry as being a closed system, not open to change and opinions of difference.

Medi Caution typified the role of a psychiatrist in the therapeutic relationship described by Marge Polyvocal and Faith Semantic. Medi Caution did not agree with standard principles of straight forward medication, but she did not give the social, cultural and familial discourses any validity either. She advocated principles of modernism in the way that she understood bipolar mood disorder, and she entertained assumptions of postmodernism in her own understanding of control and coercion. With respect to control and coercion, Medi Caution felt that people were entitled to have free-will and a choice of what medication they received. But again, this position had limitations. She defined the parameters of choice, for example, asking if the patients were comfortable with their medication, and adjusting it if necessary. She did not entertain the possibility that the patient may not like taking the medication, and if this was voiced, then the patient was perceived to be non-compliant and unreasonable. Medi Caution maintained her position as an expert on bipolar mood disorder, and the attempt to deconstruct this understanding revealed ideas and thoughts about

medication protocols and psychiatric influences, omitting the entrance of other discourses.

Conclusion

In conclusion of this chapter exploring the vignette analysis of the psychiatrist, Medi Caution, one hopes that an adequate story composition has been offered. This baseline platform will be used to generate themes of commonality and differences amongst all the research participants. In some instances, direct quotations have been used to emphasise the complexity inherent when working with people with a bipolar mood disorder diagnosis. The paraphrasing of Medi Caution's comments would have lost the essences of the impact of her own story-telling process. This chapter concludes the description of bipolar mood disorder from a psychiatrist's point of reference. This concludes the vignette analysis of the interactional interview series.

CHAPTER NINE

Deconstructing Bipolar Disorder: Thematic Disclosures

Introduction

Bipolar mood disorder is constructed in many ways by many role players. There is the psychiatrist, the psychologist, the literature, the pharmaceutical industry, the families of the diagnosed person, and the patient. There are also a multitude of cultural and social norms which also contribute to the construction of this particular mood disorder. The person that is diagnosed with the disorder is called the patient throughout this chapter. Even though a person is more than a patient, it is used in this context as a term used to describe the role of the participant in a therapeutic relationship.

From the researcher's perspective, the patient or client is silenced and subjugated in favour of the overarching psy-fraternity's decision making process. In a very thorough literature review and continued reading of bipolar research, the researcher hardly came across any writings which validated her point of view. The patient or client system was merely left out of the process. As with a modernistic medical model, the patient is the passive object that receives the diagnosis and acts in accordance with a treatment plan. This research will contribute to this gap in the current literature by elaborating on the meanings that people who have been diagnosed with bipolar mood disorder have. It would seem that these themes corroborate the importance of the psychiatric epistemology.

From a postmodern framework, the psy-fraternity has dominated the lives of patients dictated to at will as to what the ideal choice of treatment should be. And this is true and evident in the paucity of research from the patient's point of view. But, how can the medically informed disciplines be cognisant of their short comings if no one is pointing them out? Psychiatric treatments do not cure this disorder, because there is no known cure. There are assumptions and hypothetical assertions but there has been no documented cure to date. The most commonly advocated treatment

procedure is that of a combination of medication and cognitive-behavioural psychotherapy. Family sessions are also included to teach the primary care givers about the course of the mental illness.

To include all of the voices of the research vignettes that compose this construction of bipolar mood disorder, the researcher will attempt to portray both sides of the story, that is, how the person (be it a patient, psychiatrist or psychologist) constructs the definition of this disorder, as well as how each person is in turn constructed by it. There is an interactional dance between all of the people who acknowledge this disorder and attempt to achieve results by reducing the impact that it has on the people involved. This research has already shown that there are schisms in the way in which bipolar mood disorder is spoken about in the literature and how it is actualised. The strengths and resilience of diagnosed patients is often overlooked. The focus is more on the correct medicinal dose to take and adherence to a behavioural programme and is often ignorant of the needs and feelings of the person who is diagnosed.

From the vignette analyses of Marge Polyvocal, Linda Egalitarian, Faith Semantic and Professor Medi-Caution, the following themes have emerged as delineated by the researcher: power relations; the expert; the therapeutic problem; the problem of therapy; problem generated systems from the patient and psy-fraternity perspectives; connection and disconnection; meaning generating systems, and belonging. These themes highlight areas of similarities as well as differences that emerged from the research interviews and subsequent vignette analyses. The researcher has inferred these meta-descriptions from thorough and careful readings of the transcriptions, analyses and in conversation with her research promoters. The themes are not meant to be all-inclusive. Instead, they focus on the areas of value and necessary development as pointed out by the research participants. The chapter that follows is the research synthesis, which will compare and validate these themes within the larger field of bipolar literature and research.

An Overview of the Themes

The table below reflects the themes as they presented across the interviews with the patients, psychologist and psychiatrist (commonalities that occurred across all the interviews) as well as within the interviews (features that emerged within the interviews). The themes that emerged across the interviews will be discussed in detail in this chapter. These themes, in addition to the intra-interview themes will then be compared with the existing body of knowledge. The intra-interview themes, once depicted, give way to the discourses that help shape the way in which these themes were constructed.

Table 6: Overview of the themes

Theme across the Interview	Theme within the Interview	The Shaping Discourse
Power relations	Research power.	Psychological academic research.
	Power of joint systems.	Biopsychosocial.
	Pharmaceutical influences.	Biomedical.
	The languaging of power.	Social.
Expert	Psychiatric algorithms.	Bio- medical-social.
	Patient's thoughts and feelings.	Cognitive-emotive-interpersonal.
	Manual based, research based, therapy.	Biopsychosocial.
	Knowledge generating system.	Social.
Therapeutic problem	Individualised symptom recognition.	Cognitive-behavioural.
	Psychiatric algorithm.	Bio- medical-social.
	Conversational realities.	Cognitive-emotive-interpersonal.
	Diagnosis and treatment.	Bio- medical-social.
Problem of therapy	Compliance and time constraints.	Cognitive-emotive-interpersonal.
	Focus on deficit model.	Normative-deficit.
	Individualised, a-contextual.	Psychosocial.
	Family inclusion.	Psychosocial.
Problem determined systems: the patient.	Interactional diagnosis.	Cognitive-emotive-interpersonal.
	Cultural meanings.	Social.
	Family impact (reciprocal).	Psychosocial.
	Coping skills.	Cognitive-emotive-interpersonal.

Theme across the Interview	Theme within the Interview	The Shaping Discourse
Problem determined systems: psy-fraternity.	Focus on normal behaviour. Time and logistical constraints. The languaging of the patient. Self-reflexivity.	Normative-deficit. Bio- medical-social. Social. Normative-deficit.
Meaning generating systems.	Chrono-biological factors. Diagnosis as influencing other systems. Self-identification. Interdependence and shared experience.	Psychosocial. Social. Social. Social.
Disconnection and connection.	Connection – psy-fraternity. Disconnection – family and community. Shared knowledge. Connecting as normative. Disconnection as therapeutic tool.	Biopsychosocial. Psychosocial. Normative-deficit. Normative-deficit. Cognitive-emotive-interpersonal.
Belonging.	Alienation. Stigmatisation. Community support.	Psychosocial. Cognitive-emotive-interpersonal. Social.

Theme 1: Titrating Power Relations, Distilling Relationships

The theme of titrating power relations is one which emerged throughout the research process, beginning with the literature review, continuing through the research interviews, and culminating in this section of thematic analyses. Titrating power relations means that one would be looking at which person, system or institution is interacting with another to bring about a power differential. The titration of power, in the field of conversational domains, implies that one can explore the way in which people are creating differences in power through the way in which they interact with one another. In the context of bipolar mood disorder power relations emerged within the various discourses that contribute to the formation of this particular construct. At any given moment, there will be one or more discourses which are yielding more power, more authority, and more influence on another. This is thought to be an interactional dance. The titrating of power relations allows the space for the development of therapeutic constructs and interventions, problem formation and

dissolution, and dialogic conversational realms which contribute to a further understanding of any particular research subject.

To begin with, the researcher created a research question, opening up caveats of unacknowledged conceptions of bipolar mood disorder, multiple framings of reality, and generating a research domain where various role players could come together and share their knowledge on this particular topic. The researcher had the position of power in this context. She directed the conversational topics, explored further where she felt it was necessary, and stopped the process when she felt the stories were becoming saturated. But, as the researcher was in a position of power in creating the research domain, she was simultaneously powerless in knowing what knowledge would be shared, if it would be beneficial and meaningful, if co-researchers would gain value from the research endeavour, and if the researcher would be capable of translating the varied stories into one academic tapestry which made sense to the reader. The balance of power was in favour of the researcher. The researcher assumed the most responsibility for creating the research context and for engaging in an ethical and valuable study.

The power differentials that emerged through this research can be distilled into the following relationships; the doctor – patient system; the psychologist – patient system; the family – patient system; the pharmaceutical – psychiatric dynamic; the discourses – the illness; the modernism – postmodernism struggle. Each of these co-ordinated meaning systems assisted in creating the stories that were shared with the researcher, and also contributed to constructing further understandings and discourses. The shift in balance within each of the relationships also determined the way in which bipolar mood disorder was experienced, altered, and lived by each of the research participants.

The doctor – patient system, psychologist – patient system, and the family – patient system were all titrated in a triad power relation. The smallest suggestion made by any of these three systems brought about a ripple effect change process throughout the others. The relational nature of diagnosis is highlighted through this theme. The power relations are created in language, between people, through dialogic processes of communication. To deconstruct these power relations and closely

explore how these systems interact requires that the researcher infer interpretations based on the interview transcripts, process notes, and self-reflections.

The initial power differential is created when the patient seeks advice from the expert psychiatrist. Both Marge Polyvocal and Linda Egalitarian sought out medical knowledge to account for the changes that they were experiencing. They entered the therapeutic system from a point of having no knowledge and they were both dependent on the psychiatrist's expertise to diagnose their condition, treat it, and provide a cure. Over time, this power balance shifted towards the patients as their understanding and experience of bipolar mood disorder gained more value than the psychiatrist's opinion. The patients assumed a more powerful position by being in control of their medicines and by seeking alternative and more useful interventions for their problems. The psychiatrist still held the authoritative control over the patient's treatment, but the patient decided on the ultimate actualisation of the prescribed and recommended medication. The two systems shared power in this sense, and each one could effect a change in the other.

A similar pattern followed with the psychologist and the patient. The power balance was overtly seen to be in the favour of the psychologist, but again, the patient held the power of acknowledging the therapeutic interventions as useful or not. If the patient decided to go against the psychologist's advice, then the therapist was powerless over the patient's choice. The patient's relationship with power was a very hidden and subjugated one. The psychiatric discourse dictates that the power of expert authority lies in the hands of the educated professional, but this research showed that that social construction is one-sided and when viewed as a part of a relationship, the power is balanced out to fit with particular shifts in the therapeutic relationship. The difficulty of understanding this type of power differential within bipolar mood disorder, is that the power and powerlessness constructs shift in relationship depending on the nature of the mood swing. When a patient is feeling depressed, she is more dependent on the psychiatric system's input and relinquishes power in favour of guidance. Similarly, when the patient is manic, she gains perceived power over the treating system by believing that she is not in need of assistance, but that normally leads to a correction of the mania towards a more normal disposition through adjusted medication schedules. The continuous shift of power between the people involved

created the dynamic tension of shared power. What is important to recognise is that power is a perception, sometimes ordained through societal constructions, and other times created through social interaction. The psychiatrist is normally placed in a position of power by both the psychologist and the psychiatrist. The psychiatrist behaves in accordance with this as well, and often treats the patient to the exclusion of other knowledge bases, such as cultural and societal influences.

Another power relation that was evident in this research was in the relationship between the patient and the actual medication that was taken. There were many meanings surrounding the medication, such as medicine as a saviour, medicine as an agent of change, medicine as a normative cure, and the multi-layered constructions around being non-compliant with medication. Medicine itself cannot create a power differential, but the meanings that people attach to it can and did. Bipolar mood disorder is a psychiatric, medically defined construct. It therefore makes sense that a medical illness is best treated with researched medicine. The paradox enters when one realises that bipolar mood disorder is largely created and maintained through communication and interaction. This cannot be treated with medicine. The biological theory of bipolar mood disorder is on a different logical level to that of the lived experience. The research showed that medicine played a very important role in defining bipolar mood disorder. Both patients were put on medication initially to treat their problems that they were experiencing. When they were in phases of stabilisation and recovery, the medication was often decreased, which was an indication of therapeutic success. However, this would be increased with the onset of a new episode, indicating to the patient that she had failed to maintain the stabilisation. Medicine had a very powerful influence on the patient's life, as well as the family. The family were responsible for ensuring that the patient remained compliant with taking the tablets. The patient was reminded of her deficits in mood normality each day when she had to take the tablets. Neither of the patients knew about the effects that the medication was having on their brain functioning, but they were aware of the side-effects that medication could have on their lives. The side-effects, which could actually be debilitating, also have an impact on the family as they may alter the way the patient feels and therefore interacts with other people. The powerful discourse of medicine as a cure of mental illness has been instilled in the minds of psychiatric patients. There is an underlying assumption that the reason a

patient seeks psychiatric advice is to receive psychiatric medicine. This power assimilation where both patient and doctor agree on the beneficial use of medication reinforces the idea that bipolar mood disorder is in fact a real illness. The pharmaceutical industry continuously pays for research which validates the therapeutic efficacy of medicine for the treatment of bipolar mood disorder. This industry contributes to reinforcing the important role that medication plays in the treatment of bipolar patients. This power attributed to the meaning of medicine is irrefutable. There has been no research documenting the stories of patients who have recovered from bipolar mood disorder and who are no longer in need of the various medications. People who take the medication are aware that this is a lifelong commitment. Their mood is dependent on how the medication is taken, the dosage and the side-effects. Patients have to learn to adapt their way of life to this treatment regime if they want to lead a more normal life, as dictated by the psy-fraternity and pharmacological systems.

Power, in this research context, is in the words that people use to describe how they feel, who they are, and what they experience. It is also instrumental in shaping the social constructions of bipolar mood disorder. It defines the nature of relationships and determines who has the most influential position. Power has also been discussed as a concept that is capable of shifting and being flexible in the face of changing circumstances. Power differentials are indicative of the nature of the relationships within the spectrum of mood disorders. The construct of power also shows how bipolarity is a concept that is socially created and maintained. In this context, the most constant power behind meaning construction is the medicine used to treat the patient. The other relationships around power are viewed as interchangeable, shifting according to the demands of the system.

Theme Two: The Expert

A theme prevalent throughout the literature as well as the research interviews with the various co-researchers was that of the role of the expert. Traditionally, the psychiatrist is the primary expert, followed by the psychologist and then lastly there is the patient. This is a neat hierarchy and serves to benefit the person in need of mood stabilisation. From a postmodern perspective however, the client or patient is the expert, as he or she has the best understanding of what it really feels like to live with the diagnosis. But, from a modernist framing, the educated person is the expert, in this case, the psychiatrist and the psychologist. The research interviews explored the expertness of all parties, and all related their own personal expertise for certain aspects of bipolar behaviour. This complementary view enhances the theoretical premise that there is an ecology of diagnosis which does not exclude those who have the knowledge to recognise a particular behavioural and mood pattern. The person leveraging the diagnosis is just as much a part of the disorder as is the patient who receives the diagnosis. The psychiatrist has a very big responsibility when diagnosing a person with an illness as that psychiatrist will have to treat the person and assist in attaining mood normality. The patient's lack of progress is also a reflection on the treating system although it is not normative practice that the psy-fraternity is held accountable for this lack of progress or stagnation.

Each research participant gave a very informative explication of her own personal, and in some cases, theoretical understanding of the disorder. Both patients downplayed their descriptions as mere opinions, while both the psychiatrist and the psychologist rendered definitions that were grounded in academia and psychiatric literature. This may be a reflection of the schism between the patient and the treating professional where the patient is viewed as less knowledgeable. There are several ways in which the level of expertise can be discerned, such as, the expert on experiencing what it means to live with the disorder; the expert on how best to medically treat the disorder; the expert on the most effective psychotherapeutic intervention for the disorder; the expert on the prognosis and length of the disorder; and the expert on the knowledge base informing the disorder.

The expert on the experience of **living with the diagnosis** would be the patient, that is, the person who has been diagnosed with this disorder. The family and the people with whom the diagnosed person interacts, as well as the treatment team are influenced by the way in which the patient experiences the disorder and this in turn affects the patient. Once again, the complexity and ecological make-up of the diagnosis is apparent. The research interviews with Marge Polyvocal and Linda Egalitarian were focused on exploring the way in which they perceive the diagnosis as well as the implications of having such a diagnosis. The vignette write-ups further explained the many discourses that inform the way in which the stories were shared with the researcher. The difficulties of living with the disorder were mainly centred around the cyclical nature of the mood patterns, as well as the effects of taking medication for a disorder that is not curable (as yet). The disorder itself affected every aspect of the person's life and shaped how each person interacted with others, self-perception, the accomplishments in life, as well the disappointments. The researcher aimed towards externalising the diagnosis and created conversational domains which separated the diagnosis away from the person. In this way, the research participants could relate their experiences from an 'as if' perspective (for example, as if there was this thing called bipolar illness). The very realness and frightening nature of the diagnosis was conveyed to the researcher in this way. The unpredictable onset of a mood change, the impact of this on the person's relationships and self-belief, the feelings of being unacknowledged and curiously labelled as inept were all shared as elements of what it is really like to live with this diagnosis. There can be no doubt that the expert on the reality of the disorder, is the diagnosed person herself. When the patient reported to the psychiatrist that she was entering a depressive or manic phase, the treating professional either adjusted the medication, hospitalised the patient for a psychotic episode, or called in the family. Each of these scenarios involved a change in one aspect or another of the person's life. In this sense, there is an unspoken respect and recognition of the expertness that the patient holds in the experience of having the disorder.

The person responsible for being the expert on **medically treating the patient** would be the trained psychiatrist, in this case Medi Caution. The psychiatric expert has a pivotal role in correctly diagnosing the type and severity of the bipolar disorder, as well as deciding upon the most appropriate medication, be it a mood stabiliser,

anti-depressant, anxiolytic, sleeping tablets, or a combination of available treatments. This decision making process has very serious implications for the diagnosed person, as well as the people in that person's life. The choice of medication can act as a buffer for a mood change, and/or unfortunately, can also be a stimulant for a mood change, as reported with the many cases in which anti-depressants cause manic onsets. The psychiatrist would need to combine research backed expertise with that of the patient's experiences. The psychiatrist's knowledge is useless without the descriptions offered by the patient, as the patient will direct the psychiatrist as to how s/he is feeling. Psychiatrists, who ignore their patients' feelings and interpretations of the mood patterns, will no doubt have little success with bringing mood stability into that person's life. The treatment is a collaborative effort, in which the psychiatrist has knowledge which can contribute to the improvement of the patient, and the patient has the responsibility of explaining mood feelings to the psychiatrist in a logical and meaningful way. The DSM has provided a middle medium through which these people can communicate about the disorder and the treatment thereof by focusing on behavioural descriptions of mood, for example, "I feel that I don't have energy".

The research interviews all corroborated the fact that the psychiatrist is the expert with medicating the patient. There was a definite dependency on the psychiatrist's expertise for guidance, and approval of any mood phase. Even the psychologist felt that the psychiatrist has the final word in determining the treatment and prognosis of the patient. The burden of treatment, then, would rest mainly on the psychiatrist's shoulders. The influence of the medicine on the patient's life cannot be underestimated as it has huge consequences for the way in which the patient thinks, feels and behaves. The role of the psychiatrist could then almost be seen as a golden expert, the guru, the one with the power to yield ultimate change in the patient's life. This is interesting in that the role of the psychiatrist is given power by those who are diagnosed with bipolar disorder as well as by other treating professionals. There is no evidence to suggest that psychiatric treatment is more effective than a psychological intervention, yet the power is shifted towards the psychiatrist. The psychiatrist could engage in a shared responsibility ethic, including each role player's views and inputs, but more often than not (largely due to time and financial constraints) the psychiatrist welcomes the position of power and responds in an affirmative manner.

The **psychological expertise** is more often than not relegated to the psychologist. This research showed that the psychologist plays a pivotal role in maintaining, stabilising, supporting, instructing, promoting change, and monitoring the patient. For both patients who were interviewed, the psychologist was instrumental in providing a stable, affirming and supportive relationship. The psychologist was perceived by the patients as an agent of change, someone who assisted the patient to gain a better understanding of the disorder, a spokesperson for family members who could liaise and provide information, and a support system who gave of time and knowledge. The various relationships with the psychologists that patients encountered were not always beneficial, but in general, the psychologist was perceived to be more humane than the psychiatrist. The time spent with a psychologist seemed to also play a role in developing this perception, for example, in the hour spent in a therapy session versus the twenty minute session normally held with a psychiatrist. The relationship with the psychologist proved to be a stabilising factor in the patient's life-world, providing encouragement, support and understanding.

The psychologist's role in providing expertise is normally focused on the following aspects of a person's journey through the diagnosis: to alleviate symptoms of depression and mania, to reinstate a normal level of psychological and appropriate social functioning, and to prevent a relapse of further episodes. This is a tall order for any expert psychologist and requires a multitude of skills, including patience, research, collaboration, and commitment. To begin with, this research showed that the psychologist could appropriately identify the signs and symptoms of bipolar mood disorder. She also had good intentions of being able to help her patients to be able to return to normal society and remain fully functional, having trained her patients in self-recognition of the signs of a future episode. This also included family therapy sessions as well as implementing behavioural tracking systems which could monitor sleep deprivation and routine changes. These techniques were meant to alert patients to the possibility of a relapse. Unfortunately, it is common in South African psychiatric hospitals that a psychologist will only be doing a twelve month rotation through the hospital, which means that that treating psychologist would probably be unaware of future relapses. The nature of bipolar mood disorder is long term and patients are often forced to receive state treatment as opposed to the continued treatment by private hospitals, which means that patients often rotate through several

psychologists instead of having the luxury of building a relationship with one particular psychologist who can work with future relapses. This translates into a new psychologist beginning at the starting point of the treatment phases over and over again.

The psychiatric frame of reference entrenches the fact that bipolar mood disorder is a long term condition requiring life long treatment. What often happens, is that the patient's entire life is shifted towards managing this illness. The other aspects of what constitutes the patient as a person with various roles, and likes and dislikes, becomes subjugated in favour of being either a depressed person, a manic person, or both. This particular psychologist who was interviewed chose to explore other aspects of the patient's life and worked towards enhancing creative channels of expression, such as through art and poetry. This seemed to empower her patients into believing that there was more to their lives than being a diagnosed patient. Unfortunately, one does not know of the long term efficacy of such a technique.

Expertise as a theme filtered through each research participant's story. In the patients' story write-ups, they both viewed the psychiatrist as being the expert on their condition and treatment. The psychologist believed that she was an expert in creating conversational spaces in which the patient could attempt to change known behaviours. The psychologist also viewed the psychiatrist as the expert with knowledge on appropriate medication for the illness. The psychiatrist acknowledged her expertise and also felt that the patient has a right to co-determine her treatment protocol. The widely entrenched psychiatric system was seen to filter through all research interviews. These interviews also indicated that the patients are experts on their own lives and knew best which treatment was best for them, when to seek help, and when a relapse was imminent.

Theme 3: The Therapeutic Problem

For each research participant, the problem that initially brought them into the psychiatric world was mood vacillation. They were seeking an understanding as to why they feel so depressed followed by periods of excitation. They acknowledged that this pattern of behaviour was bringing disruption to their lives and making them unhappy in the long run. They were also encountering suicidal thoughts and not feeling like they wanted to face life as they had no energy to do so. This was often followed by behaviours which were mostly destructive to their lives, such as spending sprees, emotional affairs, anger outbursts, and even threatening other people's lives. They recognised (or were forced to recognise) the impact that these behaviours were having on their families, relationships, and work contexts. This is why they sought help. Once having received the diagnosis of bipolar mood disorder, they were filled with hope that there was a cure, a way out of the mood instability, a return to normality. All they would have to do was be compliant with their medication and listen to what the doctors told them to do. But this did not result in long term happiness. The mood swings continued to occur, unhappiness filtered back in, and thoughts of suicide re-occurred. This is the cycle of the therapeutic problem.

Initially, the patient presents with a depressed or a manic episode. This is the focal point of treatment: to alleviate the symptoms as they are presented for treatment. When the manic outbursts are introduced, they too become the main target of alleviation. It is well known that to achieve a balance in treating depression and mania simultaneously is no easy feat. Most bipolar patients are on five medications at once, each one attempting to balance out the effects of the other. What remains important is that the focus of treatment is on the mood variations. The therapeutic problem can also be defined separately for each person, and for research purposes, these will be separated, but in actuality, they co-exist.

The **psychiatrist** defined the therapeutic problem as one in which the person is uncontained due to mood disparities. The psychiatrist's objective is to restore normal mood patterns which do not reach extremities of suicidal ideation or wild manic outbursts. This entails the psychiatrist following a traditional psychiatric algorithm of

evaluating the patient, initiating medication, followed by continued observation and assessment, possibly including additional medications to add to a therapeutic mix of stabilisation. The psychiatrist welcomes the psychologist to work towards alleviating psychosocial stressors, and to enhance new and adaptive coping skills. This may also involve the psychiatrist diagnosing a personality disorder which would also then fall into the realm of the psychologist's expertise of treatment. The psychiatrist then follows a maintenance and follow-up treatment plan, continuously reassessing the patient and hospitalising the person if necessary, that is, if the patient is a threat to herself or anyone else.

In this outline, the psychiatrist who was interviewed followed her psychiatric protocol correctly. However, she noted several shortcomings of her approach, such as a limitation of time spent with each patient, only being able to effect change in the domain of neurotransmitter functioning when she was aware of the effects being more broad scale and also affecting the family, not having resources to refer for psychological treatment, and in a sense, promoting a pattern of more of the same instead of pattern change in the patient's life. She saw it as an inevitable process that the person would become non-compliant with the medication, probably be abusing substances, and relapse and require hospitalisation. Bipolar mood disorder was in itself a smaller component of a larger problem, that is, inadequate psychological systems of care, overworked and burnt out staff, non-compliant patients, and unsupportive family structures. Medicating the person would only be alleviating textbook symptomatology, but not effecting change on a broader social and psychological level. The psychiatrist was also basically trained in psychoanalytic methods of psychotherapy, and these have been documented to be ineffective in treating bipolar mood disorder. Her own personal take on cognitive behavioural therapy was often instituted and she tried to educate her patients rather than psychologically treat them.

Her greatest challenge was not having a team of psychologists to refer to in order to enhance her treatment protocol. Another resistance that she had was from her colleagues who believed that if a person is hospitalised due to manic behaviour then that patient is unsuitable for psychological treatment (this was also a point of view shared by the psychologist). This meant that once the person was hospitalised for

unruly and destructive behaviour, that patient was heavily sedated and placed in the very seriously ill ward of the hospital, deemed inappropriate for assistance and psychological treatment. The psychiatrist believed strongly in the value of human input and resilience and she would often clash with her colleagues' opinions in an effort to change their perceptions of a person with severe mood instability. In a context of limited resources, she was often overridden and had to relinquish her ideology in favour of mainstream psychiatry.

The **psychologist** who was interviewed believed the therapeutic problem to be psychiatric, psychological, as well as a reflection of subjugated and marginalised voices. For the psychologist, it was imperative that she adhered to the psychiatric protocol and treated the signs of symptoms of depression while simultaneously providing alternative resources for coping and recognition of a self, a personhood, beyond the diagnosis of bipolar mood disorder. She acknowledged that she was not formally trained in cognitive behavioural principles and recognised this to be a shortcoming. She attempted to institute her own understanding of cognitive behavioural therapy in treatment settings, including mood monitoring, education of how to anticipate a future episode of mood change, promoting compliance with medication, communication skills to assist in overcoming the phases of the illness, and behavioural change methodology. The psychologist firmly believed that she could not do therapy with a patient if that person was in a manic phase as she found the behaviour too unsettling and uncontained. Her premise was that if she was not coping then how could she expect a patient to cope? In a sense, the psychologist had the luxury of time and was able to explore many avenues of change with her patients as opposed to the psychiatrist who was very limited with time. The psychologist was curious about the patient's life story, how that person came to receive this diagnosis, what this meant to the patient, how the family perceived the patient (pre and post diagnosis), and what were the expectations of change. The psychologist understood the therapeutic problem to be a broad and socially defined issue rather than merely a person who has a mental disability that exists intrinsically within that person. The therapeutic problem existed on many levels, such as within the person's interpersonal capabilities, the social supports or lack thereof, the meaning that having an illness has on the person's relationships, and the psychologist's shortcomings in providing therapeutic change. The diagnosis had far reaching consequences for the psychologist

and could not merely be treated on an individual level. On an individual level, the psychologist worked towards liberating the person from perceiving him- or herself as merely a patient with a diagnosis, and sought to bring in other voices of who that person was and what he or she was about. The bipolar diagnosis often put a person in a box with limited resources and deemed that person to be dependent on the psychiatric system for an indefinite period of time. Therefore, the psychologist saw the therapeutic problem to be more than just a behavioural description of problematic behaviour to be eliminated, and she worked towards broader based change, including the family and other influences.

The psychologist felt that the therapeutic problem evolved into being a duality, firstly defining the behaviour as maladaptive and secondly, unwinding the chains of a psychiatric diagnosis to encourage the patient to move beyond the disorder and re-engage with life contexts. This meant that the psychologist was having to deal with bringing the patient back to normality, as well as de-labelling the patient so that other more opportunistic voices or ideas could be included, such as the unexpressed artistic needs, the requirement of wide vocal expressive domains, and the validation of opinion. The psychologist understood that once her patient was diagnosed with bipolar mood disorder, the family ceased to take the patient seriously and all thoughts and opinions that were out of the normal bounds of the family's rules of behaviour were deemed to be a sign of madness and mood instability. This proved to be a big challenge for the psychologist. The psychiatrist was often perceived to be the one who undermined the patient by focusing on the deficits of the patient, which the family would often internalise as 'law'. This then helped to shape the view of the patient as helpless and voiceless. The challenge for the psychologist was to reframe the patient back into a position of a sense-making person who has valid opinions, yet simultaneously acknowledge that the patient may have an episodic breakdown and become unreasonable and at that point, the family should be responsible in getting the patient the appropriate care. This has proven to be a very precarious and fine line between empowering a patient yet acknowledging that a mood relapse could occur and the person's power relinquished. The psychologist has a responsibility towards both the patient, the treating team, as well as society.

The therapeutic problem from the **patient's point of view** encompassed various aspects. There was the viewpoint that it was a curse, a form of punishment from God, a stressful response to life's challenges, a shortcoming of the patient unable to deal with problems, and the psychiatric definition of neurochemical imbalances. The patients tended to place the source of the problem within themselves, as something intrapsychic, wrong and abnormal. They understood that they needed to acquiesce to the psychiatrist's treatment protocol and comply with the medication as prescribed. They acknowledged that their mood variations were abnormal and required treatment. They also knew that they were bringing pain and disruption to those whom they loved most. The patients 'bought' into the psychiatric frame of reference and attempted to be the good patients, sticking to the advice of their treatment team. Both participants adhered to what their psychologists told them and attempted to implement behaviour change. But this did not improve their mood fluctuations. This failure to stabilise led to the self-perception of being useless, helpless, doomed for life, purposeless, hopeless, and often suicidal. It could have been beneficial for them to know that there is no research that has proven that bipolar mood disorder improves and goes away if a person is compliant. Rather, the psychiatric treatment is merely a buffer and an attempt to bring about normality, not a cure. But, not knowing that, the sense of failure was internalised which served to further reinforce the socially constructed notion that bipolar mood disorder is an intrinsic disorder and promoted the idea of a deficit within the person, and no one else.

The therapeutic problem, for the patients, was defined as an individual problem. At no point did either of the research participants blame anyone else for the diagnosis. They both conceded that they were unhappy at times in their lives and felt that they were misunderstood by family, friends, the church and work colleagues, but still they assumed full responsibility for having the diagnosis. They also understood (as they had been told by professionals and family members) that their attitude towards the diagnosis could bring about happiness. Marge Polyvocal was often berated by her husband for having a negative attitude and although she tried to improve her outlook on her life, she often remained rooted in depressive swings. Linda Egalitarian, on the other hand, tried to remain positive to the point where she infuriated her family and they believed that her happy outlook was a sign of her manic mood fluctuation.

The therapeutic problem as defined by all of the research participants was primarily grounded in psychiatric language, emphasising manic and depressive symptoms of behaviour, affecting both the patient and the people around her. The definition of bipolar mood disorder and the rendering of the diagnosis directed all treating professionals towards a treatment goal, that is, to alleviate the current signs and symptoms and prevent any future episodic breakdowns. The focus of diagnosis and intervention was the individual. The individual, treated, failed to recover and resume a normal life. This further encouraged a sense of being a failure, rejected by loved ones, and being left without a purposeful life. All of the research participants co-constructed the meaning of the diagnosis, as well as the proposed treatment. The forceful voice of the psychiatrist remained unchallenged by both the patients and the psychologist.

Social constructionism would suggest that the diagnosis of bipolar mood disorder is a meaning generating system. This implies that all the people involved co-create this diagnosis. The power differential is shifted towards the psychiatric profession, followed by the school of psychology, and lastly the patient and his or her family. At no point did the psychiatrist or the psychologist mention the importance of the influential communal definition of the disorder. Marge Polyvocal and Linda Egalitarian both lived in communities which frowned upon mental illness, suffered from a lack of knowledge about such a disorder, and operated according to religious principles of sinning, punishment and retribution. These issues were never considered to be of importance to the treating team of mental health professionals. One could argue that the therapeutic problem of bipolar mood disorder is in fact the diagnosis itself. It immediately defines the patient as inept, deficient, in need of pharmacological treatment (not always with the follow-up blood tests measuring levels of therapeutic effect). Further, the diagnosis is given as a saturated entity. There is no moving away from manic-depressive illness. This is a lifetime condition from which the patient will never completely recover. If the patient self-reports that she is feeling depressed or manic (as she was told to do by the psychiatrist and psychologist) then she is deemed to be relapsing. The language that the patient is taught to describe what she is feeling is the very foundation of the maintenance of her diagnosis moving towards a higher severity in some cases. The way in which the disorder is languaged,

seems to maintain it. The patient is given a constricted vocabulary which describes behavioural patterns, and it is through this language that the patient learns to communicate with the professionals, family members, and members of the community. Cognitive behavioural therapy does well to remind patients of their condition, and therapeutic intentions maintain the problem by focusing on the erroneous way of behaving. The therapeutic problem is best captured by those who ceremoniously define it in this case, all the role players.

Theme 4: The Problem of Therapy

This theme is intertwined with the previous theme: the two are interdependent. The problem of therapy concerns who and what is maintaining problem stories, often preventing therapeutic change from occurring. The problem of therapy is not to assign blame to any particular party, but rather serves to broaden the definitional scope of the problem at hand, in this case, the issue of the diagnostic category of bipolar mood disorder. To begin with, the researcher will deconstruct the role of the psychiatrist, followed by the psychologist, and lastly, the patients.

Bipolar mood disorder is a diagnosis that is given when a person presents with the concurring illnesses of excitation and depression, sometimes presenting together, and more often as cyclical phases of one problematic mood pattern. A person is defined as moving along a spectrum of possible mood notches, reaching extremes of uncontrollable mania and on the opposite end, debilitating depressiveness. There are predetermined markers which define the disorder as severe versus non-severe, such as experiencing depressed mood consistently over a two week period versus experiencing isolated symptoms which allow functionality but persist over time, not yielding suicidal intent. The psychiatrist is the person who is deemed responsible for giving this diagnosis to patients who present with a similar pattern as described above. A psychiatrist would be considered to be unethical should he or she not recognise the telltale signs and symptoms of manic-depressive illness. The psychiatrist is accountable to a professional board and it would be considered irresponsible for the psychiatrist not to medicate such a person. Research since the late 1800s has been advocating the administration of lithium salts for mood stabilisation, and it is the

responsibility of the psychiatrist to monitor this treatment protocol once initiated. One of the problems of therapy with regards to this treatment protocol is that the patients were very rarely, if ever, sent for blood tests to verify whether the prophylaxis was therapeutic or not. Another danger of long term lithium use is toxicity to the body if doses are too high. Marge Polyvocal experienced both situations, and both times she had asked for blood tests to be taken. The psychiatrist never recommended this to her. This unfortunate incident served to break trust between the person who has no knowledge and the person with the expertise. This type of occurrence can complicate any therapeutic treatment programme. On the other hand, both patients were slightly angry towards the psychiatric system for failing to diagnose them over many years. There is a socially constructed belief that the doctor is the expert and should know how to diagnose abnormal mood patterns. Both patients felt a sense of relief when they received their diagnosis as they believed their problem, once defined, was treatable.

Both patients also complained that the psychiatrists did not have enough time to spend with them and found the psychiatrists to be dismissive. Both had had negative experiences with doctors who were prescribing them medication. Even though they both had an understanding of the time constraints faced by the doctors, they still had an expectation that the doctor should spend more time explaining the 'ins and outs' of the disorder and listen properly to subjective experiences and life situations. It would seem that a person receiving the diagnosis of bipolar mood disorder requires attentive input from the doctor, reassurance, and up-to-date factual knowledge of what the research body is generating. These patients did not have these luxuries. The lack of time that the psychiatrist can give the patient and his or her feeling of being overworked are understandable, but at the same time, the patient's perception of being a burden, helpless, and rejected is further re-enforced through the psychiatrist's lack of attention, albeit unwittingly. Marge Polyvocal and Linda Egalitarian were both compliant (majority of the time) with their medication and it would seem that they needed psychiatric treatment which also respected them as people, as much as they respected the doctor and took the advice that was given.

Another problem of psychiatric therapy was in the way in which the 'problem talk' was saturated with words such as 'deficit', 'instability', 'poor self-monitoring'

and 'lack of insight'. The language of the psychiatrist is instrumental in keeping the patient just that. The good work carried out by the patient by remaining compliant, attempting behavioural change, and incorporating new cognitive and interpersonal styles of communication was not acknowledged. The psychiatrist converses in a language that focuses on 'problem talk', for example, asking if the patient has had any depressive or manic symptoms of late, which immediately initiates a conversation of problems to which the patient responds in problem saturated language. The cycle of conversation seems to maintain the problem of mood instability and helplessness.

The psychotherapeutic problems that emerged from this research included a lack of knowledge on the part of the therapist, the therapists' disillusionment with the psychiatric system, her marginalisation from the therapeutic community, health professionals being overworked, non-committal family members, co-morbid substance use behaviours by patients, and lack of insight from the patient. These factors were seen to hinder the psychological process of change. The lack of knowledge from the therapist centred on an absence of formal cognitive behavioural training (which has been shown by research to be one of the most effective therapies in collaboration with medication), deficient knowledge of the various types of bipolar mood disorder that are currently undergoing research, and a lack of knowledge about alternative theories of bipolar mood disorder causation, such as the influences of circadian rhythms and high expressed emotion among family members on mood.

The resistance that the psychologist felt towards the psychiatric system would also have influenced her particular way of working with patients. While her style may in fact be in favour of the patient's self-understanding and development, it was still in opposition to the mainstream. Patients are often pawns in the larger games that go on in psychiatric settings for example, if the psychiatrist and the psychologist have an antagonistic communication style, the patient is the one who may suffer as each professional undermines the abilities of the other, both in search of being the most correct. The therapist's issues of being marginalised and rejected by her own community may have played into her therapeutic intention of liberating the patient by exposing the patient to alternative voices, not discrediting the psychiatric voice, but inviting other just as powerful voices. This can have consequences for the patient as it may not be the most appropriate method for that patient who has a role to play within

his or her family. It has to be recognised that some patients just want the unfamiliar behaviour diagnosed and treated and do not want to endure life changes that could enhance their quality of life. The psychologist could then have been avenging her own subjugation through the very difficult-to-manage bipolar patients.

Other psychologists have shed responsibility for behaviour change completely in favour of the psychiatric treatment protocol and do not believe that therapy can make a difference to a person with this diagnosis. This attitude is pervasive in many clinical settings, and is more often than not a myth that is passed on from the psychiatrist to the psychologist. The framing of the patient as one without insight leaves the psychologist in a position of freedom from responsibility. The psychologist is not to blame if the patient cannot see the faulty thought and behaviour patterns (as determined by normative society). A psychologist who assumes this position is once again reinforcing societal and familial assertions that a diagnosed person has limited rights and should not be considered to be functional, and therefore not taken seriously. This would naturally keep the patient depressed as there is an awareness that all attempts at behaviour change are fruitless activities, as any opinion can be easily disqualified as being 'part and parcel' of this diagnosis.

In the same vein, many psychologists attempt to apply therapeutic techniques that are taught in university regardless of the patients' cultural, interpersonal and familial background. When a patient is referred for psychotherapy there is an implicit trust in the therapist's expertise and ability to bring about change. The psychologist has a vital role to play in the patient's life. It is the ethical responsibility of the therapist to self-educate in areas where there is a lack of knowledge. This research is showing that the problem of therapy can be the therapist's way of thinking about the therapy itself.

Both patients relied heavily on the psychologist's support, guidance, and understanding. This could also be a potential problem of therapy as there is the possibility that the patient can become too dependent on the psychologist and the therapy sessions for continued understanding in the face of familial and communal marginalisation. A diagnosed bipolar patient is a needy person, needy of affirmation when faced with continued disqualification by family and colleagues, needy of time

when most other people are writing the patient off as a demanding person, and needy of reassurance that there is still hope for change when the mood patterns continue to cycle. The patient's needs may be problematic for therapy as the patient could potentially sabotage the therapy by remaining ill in order to continue to receive the ongoing therapeutic support. Both patients were exposed to the psy-fraternity over extended periods of time and had a sound knowledge of therapeutic styles. It would not be surprising to find that they were maintaining the problems of bipolarity to enlist continued support. This is a very sad thought, but a possibility in contributing towards problems of therapy and the therapist should be aware of this type of factor. There is no quick fix for bipolar mood disorder and the therapeutic relationship is a long term one (unless the psychologist moves towards other career opportunities). As such, therapy is compromised by factors such as these, as well as the managed health care system which dictates short term therapy and successful interventions based on content. This may involve eradicating suicidal thoughts and stabilising manic behaviour, but this by no means implies that the person is back to normal functioning as defined by society.

The problems of therapy for the patients can be seen on an individual, familial, and social level. Individually, the patient brings with her, problems such as non-compliance, loss of hope, mood instability, poor coping resources, and a lack of insight. Any of these factors alone could influence the nature of any therapeutic intervention, suspending change from occurring. The treating professional would have to seriously consider the best method of treatment for each potential patient and engage in a dialogical conversation with the patient to ascertain the patient's expectations, limitations, and beneficial resources. If a manualised therapy is applied to the patient, it may be a horrible failure as it would be an authoritarian form of treatment excluding the needs of the patient. It would be easy for the professional to say that the patient is unresponsive to treatment, but research is showing that the way in which the patient makes sense of the diagnosis contributes to the outcome of any intervention. The constraint that is imposed on this situation is one of time. The psychiatrist and psychologist does not necessarily have time available to deconstruct the various meanings that the patient attributes to having the diagnosis and the implications of these meanings for the patient's life. However, having said that, if the psychiatrist and/or the psychologist can run through a behaviour checklist with the

patient, then it would be ethical to discuss the ramifications of what these markers mean for the patient. Without this shared understanding, the patient can easily fall into the basket of non-compliance and further complicate the diagnosis.

On a family level, the problem of therapy is often a non-compliant family. Family members want their loved one to be normal and treated effectively but they can also resist to going through change processes as they perceive the problem to be within the patient exclusive of their own inputs. With both Marge Polyvocal and Linda Egalitarian, the families did not want to participate in this research. The researcher also approached several other family members of people who had been diagnosed with bipolar mood disorder and they too were unwilling to participate. Their premise was that the problem was an individual one, not something that they have any control over or to which they can contribute. This reflects of a social discourse in which the family reinforces the individualistic approach to bipolar mood disorder. The family is not the system being medicated so why should they contribute to the problem or the solution? Marge Polyvocal and Linda Egalitarian felt that they were unsupported by their husbands in the treatment process. This left them feeling even more isolated and incomplete. They were frequently blamed for not being normal, not being sane, and most shortcomings were attributed to the illness (which lay inside them, remaining an invisible entity which they could not see). Another problem of therapy is the contradictory position in which family members are placed: family members are educated about being aware of the signs and symptoms of a future episode and they are given the responsibility of observing the patient and taking action when necessary. However, this also places the family in a powerful position from which they are able to decide whether the patient is having a normal or an abnormal response to a situation, conversation, or topic of debate. The family would ideally need to enter family therapy sessions where the roles were defined on an ongoing basis and restructured accordingly.

In the cases of Marge Polyvocal and Linda Egalitarian, this did not happen. Their husbands and children were instead given the watchdog status and took on the role of promoting familial status quo. The patient is then placed in an adversarial position instead of understanding the intended support, which serves to exacerbate an emotional outburst, which affirms the family's perception of this person being mad.

The family can become a problem of therapy if they are not included in any proposed intervention, having roles identified and defined, changing communication and coping styles, and enhancing the family's own resources for adapting to such a diagnosis. If these sessions do not occur, the therapy runs the risk of being overrun by the patient seeking support against the others, for which the therapist would then assume a neutral position of arbitrator. Once this occurs, it would be difficult to get the family in for family sessions as they would perceive the therapist to be taking sides with the patient. Families are vital to any treatment process as they are as much a part of the diagnosis as the patient is. There is a social discourse of blame for mental illness. This myth has been created and dramatacised through the media over the years, where parents and spouses have been portrayed as causative factors in the person's illness. Any therapeutic intervention would need to dispel this myth and enhance the ways in which the family and patient can re-establish normative family rules in a constructive manner.

The problem of therapy as influenced by society is an unspoken challenge in the psychiatric world. There are social discourses of individualism and achievement focused orientations. Anyone who does not fit into the mainstream of normal society is deemed to be a misfit, abnormal, and diagnosable. There is a surrounding discourse which prescribes appropriate behaviour that defines that which is acceptable. Both Marge Polyvocal and Linda Egalitarian fell out of the mainstream flow of society. Both were perceived as abnormal, frowned upon, and rejected by friends, communities and even the church. There was no room for troubled people who were having great difficulty coping with life. They were expected to get over their problems and return to what was considered normal functioning, without angered outbursts and outspoken opinions. Both participants felt that they were misunderstood by the majority of the people in their lives and this was largely due to people's ignorance and their contributing to the social discourse of normal behaviour. It would seem that society at large would need to be educated about the disorder and all of its intricacies so that patients are supported instead of shunned by their communities. A starting place for the reshaping of communal discourses is in the therapy rooms of psychologists and on the wards where psychiatrists medicate patients. Until such time, patients will continue to be seen as abnormal and incomplete. This in turn reinforces the powerful construct of mental illness and maintains the problem of stagnation,

reification and paralysis. The patient remains the one with the problem. In that light, there can never be a global understanding of what it means to receive this diagnosis.

Theme 5: Problem Systems: The Patient

The themes discussed above, that is, power differentials, the shared expertise, the therapeutic problem and the problem of therapy all pave the way towards the themes of problem and meaning generating systems. The research interviews brought together several voices of the people who participate in the construction of the diagnosis of bipolar mood disorder. Even though these people were not connected to one another and had no knowledge of the other person's existence, they all had one commonality, that is, they all contributed to the problem and meaning generating systems of bipolar mood disorder. All of the research participants contributed to the way in which the problem of bipolar mood disorder is constructed, actualised, and maintained. Within each story, there are various role players who also contributed to the definition of bipolar mood disorder. For the patients, there was the talk of family members, friends, and communities, as well as the psychologist and the psychiatrist. The psychiatrist related stories of her own personal experiences in treating bipolar mood disorder, of the patients and their families, as well as of her interaction with the psychologists and her perception of psychology. The psychologist told the story of her understanding of bipolar mood disorder in relation to patients, psychiatry as a medical discourse, and as an opportunity to observe and assess her therapeutic skills. All the participants shared different stories as each had its own historical and cultural make-up. But the patterns that emerge from these stories provide the common ground from which to generate a theme within this research context.

A dialogical approach to research ensures that almost every aspect of an interactional diagnosis is made overt and explicit for the reader so that further conversational dialogues can occur. This entails an ability to move beyond the traditional individualistic diagnostic procedure and see further than the signs and symptoms of a disorder. A relational diagnosis would include viewing the contribution that the patient, family, society, culture, psychiatrist and psychologist make towards the end means of a therapeutic strategy.

To begin with, there is the patient. This is the person who initiates the ritual of diagnosis. This is the person who challenges the psychiatrist and psychologist to correctly diagnose problematic behaviour as learned in academic settings. The patient has many choices around what to present and how to articulate problematic behaviour. The patient does not just arrive at the psychiatrist's door with a list of signs and symptoms of depressive and/or manic descriptions. The patient is influenced by family and wider social discourses. More often than not, a patient with bipolar mood disorder normally presents with a depressive episode. One could ask, 'how does a person know that he or she is feeling depressed?' This is the domain of socially constructed definitions. A family member, or a close friend, or a church minister may observe that a person is becoming depressed if he or she is undergoing life changes and failing to adapt adequately, thereby withdrawing and isolating herself from larger communal circles. Other signs may be continued crying for no apparent reason, a loss of will to live, an abandonment of hope, and even frustration and anger outbursts. This person, be it a spouse, friend, or confidante, may suggest that the person seek professional guidance and assistance for whatever is troubling the person's mind and heart. The person who realises that another person is in trouble (the referrer) has to have some knowledge of abnormal responses to normal events. This knowledge does not just happen to fall upon the referrer, rather, that person would have to have gained this knowledge from conversations with others, media articles or self-experience. The seed of the mental illness is co-constructed prior to the patient's entrance into a psychiatric setting.

The cultural understanding of abnormal or problematic behaviour is a socially constructed meaning generating system, and it is also a problem generating system. It is through this shared understanding that the diagnosis takes on a life of its own and becomes the person, transforming the person into a patient, a client, and someone who has a deficit that needs to be replaced with a better way of living. The problem generating system is the dance that all the people do together, informing the diagnosis, giving it momentum, and ultimately, ownership over and above a person's thoughts and behaviours. A person does not simply get given a diagnosis of bipolar mood disorder. It represents a carefully constructed tapestry of meanings and events

which predispose that person towards a definitional ceremony. In this way, the family is also diagnosed as well as the psychiatrist and the psychologist.

When the researcher asked the psychiatrist and the psychologist which diagnosis they would give to themselves if they could, they both answered bipolar mood disorder. This is an interesting point. The person who offers the diagnosis has a personal response to what is seen in another person's behaviour. It is a point of self-recognition. There cannot be an objective measure of another person's behaviour as problematic without a personal understanding of what that means to the diagnostician. In a postmodern world of diagnosis, there is no such thing as objective neutrality and intrinsic knowledge systems. These aspects of diagnosis are co-ordinated events of social collaboration, brought about by the interaction between psychiatry, psychology, the patient, family, society, universities of academia, hospital settings, pharmaceutical industries, and prevailing ideologies. It is therefore an illogical and erroneous illusion to believe that a person just presents with bipolar mood disorder. This is not an intrinsic, individual disorder. It is created, shaped and maintained through conversational meaning generating systems of interaction. This was evident in all of the stories that were shared with the researcher. The literature review gave a one-dimensional view of bipolar mood disorder, portraying the disorder as something which existed in the person, treatable through medication, and widely acknowledged as a very disabling illness. The research interviews have provided depth and understanding revealing the interactional dances that each person entertains and participates in.

Marge Polyvocal and Linda Egalitarian were very familiar with the dance of therapy, pharmacotherapy, family communication patterns (knowing when to talk and when to keep quiet), communal disdain for having an illness, and hospital rituals of admission. This, however, was a double-dance. They were simultaneously aware of the known ways of behaving, while using them to maintain the illness and maintain problem generating systems. As long as the patient remains diagnosed, the family remains captured by the illness and fixed in certain types of communication patterns, for example, 'don't excite Mom; leave Mom alone, she's not feeling well'. None of the family members wanted to participate in this research. By not acknowledging the role that they play in the life of the disorder, they are maintaining old ways of

behaving – the problem resides in the individual's head. This dance was common to both research participants. The patient received the diagnosis, was hospitalised, visited by family members, left alone to recover, returned home to resume normal functioning, relapsed, was hospitalised and so on. The focal point of treatment remained the patient. The family members played their role of a supportive structure, not changing. Only the patient was required to change. A sign of no change or relapse implicates the patient as a failure, incompetent and very diagnosable.

Marge Polyvocal and Linda Egalitarian had unsatisfying interpersonal relationships, often feeling misunderstood and emotionally neglected. One cannot say that they brought these difficult relationships upon themselves, but one can say that they maintained the problematic relational ways of being. They experienced their relationships (including friendships) as disconnecting and unrewarding. However, they perceived their therapeutic relationships to be fulfilling, supportive and vital for their continued existence. Their intimate relationships, however, suffered at the expense of their unhappiness and inability to bring themselves completely into the relationships. They maintained established roles as women of the house, cooking, cleaning and providing love and nurturing for their loves ones, but they found their intimate spousal relationships to be wanting. It is interesting how, on the one hand they were able to connect so strongly, personally and even intimately with treating professionals, yet disconnected from the people with whom they live. There was an underlying assumption that the professional has a deeper and better understanding of their situations than their own family members. This could be attributed to the fact that the professionals bought into and shared a psychiatric ideology which promoted the idea of not being well and not being of mainstream society, whereas, family members had the idea that patient should return to normal functioning 'if only…' The responsibility for change resided within the patient. The lack of communication skills and patterned way of behaviour forced Marge Polyvocal and Linda Egalitarian into fixed roles of being the patient, while the husbands remained the caring spouses incapable of contributing to the mental well-being of their wives. Over the years, Linda Egalitarian and Marge Polyvocal created stable relationships within the psy-fraternity. This indicated that they were quite capable of establishing close relationships, but nevertheless, something kept them distant from their family members. *It would definitely be beneficial in any therapeutic intervention to create a*

space of openness among family members and to invite all role players to collaborate in restructuring the nature of the family game.

The lack of connection among family members and friendship circles, as well as in religious contexts, may have encouraged Marge Polyvocal and Linda Egalitarian to maintain solid relationships with their treating professionals. The more disconnected they felt from their family, the more they turned towards professional assistance and encouragement. They both remained compliant with their medical protocol as they knew that should they change the given programme, they may face losing the only meaningful relationships that they have. However, having said that, both Marge Polyvocal and Linda Egalitarian also felt that they were not given enough recognition from the psychiatrist and at times the psychologist. Just as mood could vary from depression to mania, so too could the perception of a relationship as meaningful shift towards a perception of the relationship as detached. Never did they experience a consistent, solid relationship. Their experiences of relating were continuous, moving from distance to intense connection. The manic onsets often occurred at times when the patients felt overwhelmed, excited and energetic, and slowly disconnected from their family members. The uncontrollable emotional outbursts were often attempts at gaining closeness, connection, but in fact, the manic episodes served to reinforce labels of craziness, not of sound mind, and result in what is known as a relapse. The perceived rejection that patients experienced naturally gave way to depressive episodes in which there were mixed feelings of hopelessness, aloneness, desperation, tiredness, and disillusionment. The relationship between the patient and her family members was not described as an easy relationship, completely supportive and fulfilling. The familial relationships were more often than not infused with conflict, chaos, angered children, absent fathers, overburdened mothers, and misunderstandings. The commonality among the families (as presented by the patients interviewed) was that the pattern of interaction was unstable and unpredictable. The pattern of manic-depressive episodes could be seen as an interactional dance attempting to gain the love and support from families, friends, and caregivers. This simple assumption fits nicely within a modernistic framework suggesting that if the 'correct' 'manualised' family therapy approach is offered, patients and their families could be 'repaired' back into a state of normality. It is for this reason that the researcher rejects this hypothesis as an end in itself, and chooses to see it as one of the

many possibilities influencing the continued behavioural pattern fitting of a bipolar mood disorder diagnosis.

Theme 6: Problem Generating Systems: The Psychiatrist and the Psychologist (The Psy-fraternity)

The psychiatrist and the psychologist are discussed separately from the patients in order to facilitate the creation of more appropriate space for their influential and collaborative input into defining the spectrum of bipolarity. From the above discussion, it becomes apparent that the psy-fraternity plays an instrumental role in providing guidance, direction and support for the patients once they are diagnosed with bipolar mood disorder. The psychiatrist and the psychologist spend many years in training, learning about mental illness, the various types of mental disturbances that have been proven to exist, the treatment methodologies and the prescribed code of ethics for professional practice. The themes that emerged from the research interviews backed up these fundamental assertions throughout. The psy-fraternity were highly regarded, and accredited for their specialised knowledge. They formed an integral part of the patient's treatment process. Marge Polyvocal recalled a psychiatrist who was momentous in her early treatment. She remembered his name, surname, how many children he had, what his interests were, and in which year he immigrated to another country. This in-depth description shows just how valuable a therapeutic relationship can be to a person who is diagnosed with bipolar mood disorder.

The nature of the relationship with the treating professional lays the foundation for growth, hope and inspiration. The psychiatrist and psychologist who were interviewed did not acknowledge their influential behaviour on the patients to the degree to which the patients credited them as being influential. One psychiatrist may see up to twenty or thirty patients a day, and a psychologist can cover up to eight therapy sessions in one day. However, a patient sees one psychiatrist and one psychologist. The imbalance of relationship investment is clear. The psychiatrist and psychologist are often judged harshly for their interpersonal mannerisms by patients, who are unaware of the therapists' workload. It is not my intention to create sympathy

for the treating professionals but to rather point out the imbalance in meaning that a patient may attribute to a session versus the psychologist or psychiatrist's assigning of meaning.

The psychiatrist dealt with many diagnosed patients, and her treatment protocol remained the same: medicate, monitor and reassess, occasionally providing psycho-education (and being berated by her supervisors for spending too much time with patients). The psychologist also came into contact with several bipolar patients. Her biggest challenge was working with the preconceived ideas held by nurses and doctors about the behaviour of the diagnosed patients. Where she saw hope and potential, they saw relapse and wasted time. It is a sad reflection to see that this is how bipolar patients are viewed, especially after reading the moving stories of Marge Polyvocal and Linda Egalitarian.

Both the psychiatrist and the psychologist adapted to the role of dance instructor in their situations. The psychiatrist would decide which dance would take place, with what music and for how long. The psychologist claimed to have a more participative role and would ask the patient which dance would be best, but in the end, it was the psychologist who led the way through the steps. Any untoward behaviour was met with the end of a dance until the patient could recall the known steps and resume the old dance. The metaphor aptly describes the way in which bipolar mood disorder is lived out through the eyes of the psychologist and psychiatrist research participants.

The problem determined system is the system that is constructed to maintain the problem. It is the evolution of interactional patterns that come together to deal with the problem at hand. Bipolar mood disorder requires a diagnosis, implying that several people are immediately involved in the problem formation. There is the diagnostician, normally the psychiatrist, and then the patient. These two people immediately forge a relationship once the diagnosis is given. The patient may be hospitalised initially to stabilise the presenting mood. The problem determined system therefore widens its scope to include other treating professionals, possibly a psychologist, nursing staff, and occupational therapists. The patient also encounters other patients in hospital and recognises similar patterns of behaviour and differences

as well. On many occasions, friendships are initiated among patients and they form a supportive bond assisting each other to face their current tribulations. The family of the patient is also introduced to this system, sometimes as part of a therapeutic strategy, and at other times just to support the patient as she overcomes the mood instability causing hospitalisation. In all of these situations, the psychiatrist and even the psychologist play the chief role in uniting all of the subsystems within one larger problem determined system. The system is aimed towards fixing the problem, alleviating distressful behaviour patterns and the system should also dissolve once a sense of normality and stability is achieved. However, in the case of bipolar mood disorder, the ongoing nature of the disorder prevents a problem dissolving system.

In all of the situations described by the psychiatrist, the patient relapsed (due to various causes and influences), and both Marge Polyvocal and Linda Egalitarian walk a fine line between recovery and stability, and mood flux. The cyclical nature of bipolar mood disorder necessitates that the psychiatrist and the psychologist remain a part of the problem determined system. The individual at hand is no longer treated as the site of change. The entire system would have to undergo change for the problem to dissolve. Each person uniquely contributes to the establishment of the problem system and change cannot simply occur in one area of the system without effecting the other areas. So, for example, if a psychologist leaves her hospital rotation, this has a ripple effect throughout this particular problem determined system. The patient may have a relapse, present with a new set of depressive and/or manic symptoms and thereby reinstate the status quo. If the psychiatrist changes, the patient is normally the one who feels the greatest loss of the relationship. This too is met with resistance to change and the patient can easily fall back into known behavioural patterns.

The therapeutic dance of bipolarity is a very intricate and delicate one. The mood variations are particularly susceptible to changing and shifting environments. Both Marge Polyvocal and Linda Egalitarian showed that when they were faced with change (be it geographical relocations, career shifts, childbirth, or children reaching milestones) they experienced extreme stress and the stable mood patterns begin to change towards chaos and uncertainty. The mood itself is a measure of change and fluctuation. There is the possibility that in the face of change, the patient either does not have the verbal skills to express her fears, or worse, they are subjugated in favour

of a 'be positive' attitude dictated by other family members. This position of uncertainty, insecurity and fear can trigger off an unexpected mood response, reuniting the patient with her psy-fraternity team. The cyclical pattern would then be reinstated and once stability is returned, due to medication changes, rest, a batch of psychotherapy sessions, and a renewed licence of hope, then the patient returns to the family environment with the hope that once and for all, change has occurred.

A problem determined system, such as the one created by the diagnosis of bipolar mood disorder, has in effect stabilising properties. The relational systems that co-ordinate themselves around the diagnosis all serve to promote the status quo. There is a problem, inherent within the person, embedded in family interactional patterns, reinforced through social discourses, and maintained through the psychiatric system. *Problem dissolution would include a shift in the way in which the psy-fraternity constructs the diagnosis, the ways in which family members perceive the diagnosed patient, and the perception that the patient has of life as well as the stories that are constructed around bipolar mood disorder.*

The researcher entered these problem determined systems and reinforced the notion that there is a disorder that exists. The researcher collaborated with the research participants to evoke stories of meaning making about what bipolar mood disorder entails and the impact of this on the lives of the people who live bipolarity and deal with it on a daily basis. The problem of bipolar mood disorder was created in language and reinforced by the researcher. She consciously sought out people who had been diagnosed with this illness, found treating professionals who had experience with the disorder, and wove together stories that construct the notion of bipolarity. The disorder or problem is very real for the people who experience manic-depressive episodes. The psychiatrists and psychologists can see the signs and symptoms and aim towards treating these symptoms and alleviating discomfort in the patient's life. But this research has also shown that the diagnosis itself is a relational one, interdependent with and reliant on all the systems that come together to generate a description of behaviour which results in the diagnosis, treatment and eradication of problematic behaviours. The changes that the patients acknowledged were in the realm of mood vacillation, one episode leading into another. Often the severity of the episodes decreased over time, but all problem determined systems remained intact. *Problem*

dissolution would require a broad scale shift in ideology and co-construction of what bipolarity means to each unique person as each system comes together to solve the problem. The problem itself cannot be solved. There has been no researched permanent and long term solution for an illness that plagues thousands of people. The solution is not out there waiting to be found. It is a concept that was constructed in language and can be understood through language domains. The way in which the disorder is given so much authority over and above the patient, and the family, the society, and the psy-fraternity, effectively keeps the problem determined system intact.

Theme 7: Connection and Disconnection

The theme of connection and disconnection best describes the interactional stance of the people who were interviewed for this research. Each research participant was seeking connection, in the form of psychotherapy, with family members, with friends, among colleagues, and religiously. None of the research participants admitted that they felt connected to any particular system and all were in search of answers to their questions.

To begin with, **Marge Polyvocal** sought connection with her psychiatrist, psychologist, children, husband, parents, the larger community, and the church. She was always looking for opportunities to socialise with people and strike up a conversation. She desperately lacked meaningful communication with people. She attributed her lack of social contact to the fact that she has a mental illness and this keeps people away, as they may be afraid of her strange ways of behaving. Occasionally, she would meet up with someone else who had been diagnosed with bipolar mood disorder and she would feel an immediate connection. But these relationships were normally short lived as her husband did not want her socialising with people who have bipolar mood disorder as he was afraid that they might negatively influence her. It is also for this reason that he forbade her to attend support groups. He desperately wanted his wife to accept a normal life and tried to steer her away from anything associated with the illness. He was not interested in attending her therapy or psychiatric consultations and he was convinced that this would be better

for her if he kept his distance. This belief kept the marital relationship disconnected and prevented the patient from experiencing it as meaningful. Marge Polyvocal felt isolated and judged for having been given this illness.

Marge Polyvocal often went to extremes to find social connection, even picking up a beggar at one time and taking him for lunch just so that she could have company. Her great dreams of retirement with her husband were shattered when he decided to re-qualify himself so that he could continue to bring in an income. Marge Polyvocal was unprepared for this change to her lifestyle and she felt that her loneliness was being further embedded. Marge Polyvocal sought connection in her relationship with her psychiatrist, but she found this to be particularly frustrating. Her psychiatrist did not make himself available at her whim and she felt even further rejected. This could often lead to a manic outburst of uncontained emotion. In a follow up conversation with Marge Polyvocal, she related a story where recently her husband had decided that he would have to work longer hours, so she decided that she would get herself hospitalised as her depression was in a bad phase and she felt that she could not cope. Unfortunately for Marge Polyvocal, her psychiatrist was overseas for a conference so she was hospitalised under another doctor's care. She discharged herself early from the hospital. This scenario exemplifies the need for connection and the pain that is experienced through a feeling of disconnection.

One would have to question whether Marge Polyvocal contributed to the theme of disconnection through her overbearing mannerisms, emotional outbursts, deep seated depression and high demands placed on the people around her. But this is who Marge Polyvocal has always been, according to her. The fact that she got married, was a highly respected member of the church, and raised two successful children suggests that Marge Polyvocal was quite capable of fitting in with society. In the interviews she expressed a need for people who can meaningfully contribute to her life to make it worth living. Marge Polyvocal's behaviour often kept people disconnected from her, and sadly, it is because of her behaviour that she so desperately sought connection with others.

Linda Egalitarian sought connection with her husband, colleagues, church, children, and the parents at her children's schools, and within herself. She fought off

the negativity that surrounded people's understandings of mental illness and she believed that if she maintained a positive attitude then she would not slip back into another mood swing. As noted earlier by the researcher, one felt that her up-beat philosophy was a coping skill helping her to hide away from the pain and loneliness that she felt. Linda Egalitarian could easily swing into a crying spell within the next breath, which confirmed the shakiness of her grounding belief system.

In the past, Linda Egalitarian found herself in some very compromising situations in an effort to attain connection. These actions almost had the effect of ripping her marriage apart. Fortunately she developed insight to her actions before they had serious consequences. Linda Egalitarian, like Marge Polyvocal, remained committed to an unfulfilling marriage simply because she had made a promise before God. But this by no means meant that she experienced any marital happiness. She found her happiness in other contexts, such as in her work and in raising her children. Her very strong need to connect with people and share with them her positive outlook had the dangerous effect of burning up all her energy until she fell into a depressive phase completely emptied of her desire to carry on living. Again, her religious convictions kept her alive and fighting to stabilise her mood.

Linda Egalitarian claimed that she found connection in her relationship with her psychiatrist (after many failed attempts) and with her psychologist. These were extremely important relationships to her and she made sure that she remained compliant so that the relationships could continue to be supportive for her. Linda Egalitarian was in the fortunate position of having a private medical aid so she could choose her psychiatrist and psychologist. Marge Polyvocal was at the mercy of the state facilities and she had no choice over who was assigned to her. There is a common attitude among the psy-fraternity in the government settings that if you do not like your psychiatrist or psychologist, for whatever personal reasons, then you can 'go without care as it is obviously not that serious'. But Linda Egalitarian proved that the choice of treating professionals can have beneficial effects for the patient. It could also be that the psychiatrist and psychologist were more tolerant of Linda Egalitarian as there was a monetary influence and they were being directly paid to provide a specialised and supportive service.

Linda Egalitarian was perceived by friends, colleagues, church members, and her family as over-the-top, overbearing and conflict seeking. Her behaviour almost chased people away. Again, her need for connection is what was keeping her disconnected from people. The theme of connection is very important for someone diagnosed with bipolar mood disorder and this cannot be underestimated. The disorder is fraught with inconsistency and complicating factors, such as side effects from medication. A person with this diagnosis seeks out understanding, care and nurturance from other people, from other normal people. There is an inherent need to be noticed as a normal person filled with love to give. This often unmet need is defined as a symptom of mania. Marge Polyvocal was forever getting into trouble with her husband for baking people cakes and buying chocolates and flowers for people for whom she cared. Linda Egalitarian was disregarded for her attempts at sharing her love and caring for people whom she deemed to be in need. People often perceived this to be invasive and they put up boundaries with Linda Egalitarian by disconnecting from her, not returning her phone calls, and sometimes just being straightforward and asking her to back away. Of course this embarrassed her husband to no end and he would withdraw from her, further promoting her isolation and need for greater connection.

The psychiatrist **Professor Medi Caution** was in search of a psychiatric community that focused more on social diagnosis than merely medicating and treating the individual. Her claims for substantiating a need for further understanding into the multi-faceted illness were met with resistance from her colleagues. She claimed that her colleagues were being overworked, as she was, and due to time limitations people were not really interested in further exploring the disorder and what it means to the patients who receive the diagnosis. She went the extra mile to ask her patients questions about their experiences of having bipolar mood disorder and she was often in trouble for not seeing enough patients in one day. She also explained that there had been written complaints to her supervisors by some of her colleagues who felt that they were having to pick up her extra workload due to her need to spend more time with patients.

Professor Medi Caution believed that she was systemically grounded and found that this was not acceptable among colleagues who mostly worked from a

psychodynamic perspective. She was most grateful for the opportunity to participate in research where she could air her opinions and be listened to seriously. This seemed almost ridiculous to the researcher as she had a foundational belief that the psychiatrist is always listened to. The researcher learned that even the treating psychiatrist is silenced when attempting to step away from mainstream psychiatry. Professor Medi Caution also relayed a story of an overseas conference that she attended that was solely focused on the treatment of bipolar mood disorder. She was overwhelmed by the traditional way in which bipolar mood disorder is treated when she as well as others are fully aware that this approach seriously lacks long term benefit and change for the patient. Due to her beliefs, she experienced disconnection from her own professional community. No matter how hard she tried to attempt to treat patients traditionally she felt that something was missing and wrong and she reverted to her way of working, which included more time spent with each patient exploring how the treatment was going and what the patient's experiences were.

Professor Medi Caution claimed that she connected well with her patients and she thoroughly enjoyed her interaction with them. It would seem that Professor Medi Caution was craving meaningful interaction with the people whom she treats, instead of just monitoring their medical protocol. But this form of connection had a price tag attached, and she was judged harshly for her need. The connection with patients indirectly disconnected her from her professional community. And if she connected with her colleagues it would be at the expense of connection with her patients. She could not find a happy medium that met the needs of everyone involved. She recognised that her patients thrived off the time that she gave them and she wanted to give more, but not at the cost of her job. She was forced to play a bureaucratic game which had a substantial cost to her own self-worth as well as the progress of her patients. The therapeutic dance described in the previous theme is also influenced by such hidden discourses of what is considered to be appropriate treatment.

Professor Medi Caution was seeking alternative connection at the time of the research interviews and was furthering her studies in religious discourse. She was seeking meaning and she created other contexts of meaning generating systems considering that the psychiatric system was bringing her such resistance and disconnection. Interestingly, Professor Medi Caution refused to practise privately. She

felt that her purpose was solely to practise in the state environment where she could attempt to help those in real need of psychiatric assistance. Overall, she was very content in her work but felt that something was missing and that it was affecting her patient care. Professor Medi Caution did find connection among the psychologists who worked with her. Most of them were systemically trained and she thrived on the influence that they brought into the psychiatric hospital. Her openness to learning new ways of working and widening her theoretical scope to include wider social systems is admirable. The research interview showed that the disconnection felt by the patients who were interviewed was also evident in the psychiatrist who was meant to be the ultimate expert and remain unaffected by the diagnosis. The theme of connection and disconnection highlights the notion that the diagnosis of bipolar mood disorder is a relational one, including the powerful position of the psychiatrist, who often experiences similar patterns of feeling and thinking.

The psychologist, **Faith Semantic**, experienced disconnection which was a theme throughout her life contexts. This is probably what inspired her to tackle such an issue with her clients. It was a self-reflexive intervention, and by confronting the issue with her clients, she was confronting disconnection within herself. Faith Semantic's epistemology was postmodern and grounded in ecosystemic principles of understanding mental illness. This implied that she could not only treat the individual with the problem. She was drawn to understanding the way in which the problem creates systems and systems create problems. She was also very aware of the role that she played in this co-constructed reality. She felt disconnection from her work colleagues and she even became angry, frustrated and voiceless in the process. She connected very strongly with her clients who presented with bipolar mood disorder. She understood how the client felt disqualified by family members and silenced into a submissive role.

Faith Semantic was surrounded by colleagues who spoke a different language, having psychodynamic working ways, and she struggled to find a place where her voice could be heard. She also welcomed the research arena as an opportunity to explain her own way of working with bipolar mood disorder and to explain her understanding of this illness. She craved meaningful interactions with like-minded people, but when questioned about what she was doing to collaborate with other like-

minded therapists, she had many excuses as to why had done nothing about it. This is another reflection of how a person can co-create the reality that is a lived experience. Faith Semantic's feeling of disconnection was further entrenched by her own inability to connect with those whom she found to be exciting and challenging. Her perceived disconnection from the psychology profession was enhanced through her own actions of maintaining a pattern of disconnection at the personal cost of feeling connected and valued.

Faith Semantic's connection with her clients was in opposition to the disconnection that she experienced from the psy-fraternity. She felt that she was isolated from her therapeutic community because of her belief systems. However, she did acknowledge in the second interview that she was attempting to force her colleagues to understand her reality instead of proactively creating contexts of collaboration and shared understanding. The co-ordinated system was one which was disconnecting and yet they were all attempting to promote a sense of connection among their client population. The disparity between what she experienced and how she worked in therapy created a schism of emptiness and misunderstanding. The psychiatric discourse was too powerful for Faith Semantic and she had lost hope that colleagues and other professionals could change their ways. This may of course be a comment on her own process in which she was unprepared to change her ways.

Bipolar mood disorder remained a challenge for Faith Semantic and she worked hard at achieving an understanding that entailed multiple realities for her clients, perhaps in an endeavour to find her own acceptance somewhere within the psychiatric system. Nonetheless, Faith Semantic perceived herself to be an outsider in the psychiatric community of psychiatrists and psychologists. She accepted this position of disconnection, and unlike Professor Medi Caution who created contexts in which she could experience different realities, Faith Semantic accepted the disconnection as a sign of other people's inability to be accepting of alternative belief systems.

Theme 8: Shifting Contexts: Meaning Generating Systems

The process of engagement from the time of the patient entering the psychiatric system is imbedded within a meaning making system. Marge Polyvocal and Linda Egalitarian entered the psychiatric system as relatively young women, with young (and even unborn) children, having young marriages. The psychiatric system has been pivotal in shaping who these people are today. The behavioural pattern of manic-depressive mood swings has brought people closer to them as well as dislocated them from familiar contexts and places of belonging.

The time factor has been influential in maintaining the problem, failing to provide lasting solutions, and leaving many questions unanswered. The positioning of the psychiatrist and the psychologist has helped determine the primary mood pattern (for example, depression or mania) as well as a wide variety of emotional expressions. When Marge Polyvocal was experiencing a manic episode she was shunned by her family as well as her psychiatrist and psychologist. She was heavily sedated, blamed for not being able to foresee the onset of another episode and only allowed to return to society when she met the criteria for normality (as normal as she could portray herself to be). She endured electro-convulsive therapy, a variety of medications that even left her toxic, disconnected from the people that she loved most, labelled and judged as abnormal.

When she experienced a depressive episode, people were more understanding and helpful. Her cry for help was often laden in suicidal language. This definitely awoke her treating team of professionals and she was immediately hospitalised. She was cared for during these times and nurtured back to stability. Her mood swings were powerful predictors of other people's performances. The psychiatrist jumped at the threat of suicide, her husband paid attention when the telephone account reached astronomical amounts. The circular patterns of interaction all contributed to the continued existence of her diagnosis. Sadly, nowhere amidst the thirty years of being diagnosed has she found profound and lasting meaning. Her meaning systems are infused with trust and mistrust issues (trusting the support offered by those around her only to find it dissipating as she returned to a position of stability); connection and

disconnection (as described previously); short term dependence and long term loneliness, always having shifting beacons of support. The diagnosis of bipolar mood disorder entailed a time mastered pattern of shifting contexts. A question that the researcher asks is: 'Is the mood adapting to the context, and/or the context adapting to the mood?' Of course, the question is meaningless and unanswerable because it is a both/and position. The dance of bipolar mood disorder is characterised by shifting contexts of interaction, collaboration, people entering and exiting, relational diagnosis (for which there are no criteria as yet), and a mixed bag of feelings underlined by certainty, uncertainty and ambivalence. The bipolar scene is one of the unknown. The psychiatrist anticipates that the patient will become non-compliant with medication, the psychologist is unable to provide manualised therapeutic treatments, and the patient is deemed to be the one with the lack of insight. The psychiatric system instils a sense of distrust yet simultaneously requires that the patient trust the treatment of choice. Both Marge Polyvocal and Linda Egalitarian had no idea what their medications were treating. They did not know the difference between a mood stabiliser, and an anti-convulsant. Surely it is the shared responsibility of the psy-fraternity to educate people about the medication that they take as they give unlimited trust to the professionals who treat them?

The way in which the patients in this research domain collaborated with the psychiatrists, subjugated themselves in favour of family peace, and silenced their disgust at the lack of church support, was never rewarded. They remain bipolar patients, in need of psychiatric treatment, attending maintenance sessions to ensure the prevention of future relapses. The patient, in this context, was never accredited for believing in the psychiatric system even when it failed to achieve the goals it had hoped for.

The initial context is one of diagnostic discovery. The psychiatrist or psychologist places the complaining patient in a deficit based classification system. This action is based on years of training involving being taught how to identify behaviour patterns as maladaptive versus those which are normal. The way in which the patient expresses his or her problem begins this process. The patient is in search of a meaningful explanation for why he or she is experiencing a feeling of instability, 'ups and downs' and 'not feeling her- himself'. The psychiatrist enters this language

game by seeking out the problem as it is defined in psychiatric discourse. The patient, at this point, has a choice to believe what the psychiatrist says, or to refute it and seek meaning elsewhere. Both Marge Polyvocal and Linda Egalitarian 'bought into' the psychiatric discourse, as it offered a suitable meaning for them. They could identify with what the psychiatrist explained and they shared their experiences in the light of a psychiatric diagnosis. The disorder did not just happen to them. They co-created it by finding the diagnostic labelling process to be a meaningful one. This could be considered to be the initial shift in context, one which provided meaning.

The problem story shared by the patient and collaborated with by the psychiatrist and the psychologist assists in creating meaning generating systems, in the form of the problem determined system. These are not hierarchical systems, but rather relational systems. Each person is dependent and interdependent on differing systems at differing points. Marge Polyvocal and Linda Egalitarian had gained membership to the psychiatric system, and this was what they found to be meaningful. However, entrance into the psychiatric systems implies that there would be a shift in the roles and rules of other important systems. The family, for example, would need to also enter a phase of meaning generation and seek out understanding for what this means to them. Unfortunately, many families go through this process in isolation of professional guidance (as is the case with both Marge Polyvocal and Linda Egalitarian).

The therapeutic system that emerges initially is a problem focused one. The intention of all parties is to alleviate the depressive and/or manic symptoms. This problem system can easily become saturated with stories that focus on 'more of the same' patterned expression. The patient will share meaningful stories of how depressed or manic she is feeling, and the psychiatrist and/or psychologist will react to co-create a shared context of understanding by offering further guidance or changing the medication. The more that this problem saturated story continues, the more disillusioned the psychiatrist and/or psychologist becomes as the hope of change is minimised. The questions asked by the treating professionals inform this 'stuckness' as much as the patient's experiences do. The meaning making process exists within a context of social and psychiatric discourse. This implies that within the psychiatric discourse meaning is limited to defining behaviour as abnormal, fixing it,

and moving towards the position of normality. The psychiatric discourse lacks a sense of fluidity, of being open to change and opportunities. Attempts by the patient to indicate that there is an increase in energy (implying that the depressive episode is falling into the background) is met with a worried concern that a manic episode is en route. The psychiatric system is a therapeutic one, but it is very accurate in reifying particular behaviours as known and observable entities which exist intrinsically to the patient. The participants in this therapeutic system are limited to the patient and the psychiatrist, occasionally making space for the spouse, and this is often to educate the spouse about ways to keep the patient within normal boundaries. The context of meaningful experience in the patient's life is narrowed and constricted as the psychiatric relationship develops. This solidifies the patient's self-perception of being terminally diagnosed with this illness.

But somewhere within this therapeutic system, the patient is being imbued with meaning. The psychiatric system demands a patient-doctor relationship in which the doctor is the expert and dictates the course of events. Marge Polyvocal and Linda Egalitarian are reflections of very good and obedient patients. Has this helped their journey through bipolar mood disorder? Perhaps. Their backgrounds were rooted in authoritarian, hierarchical and patriarchal discourses. The psychiatric system was an extension of these contexts within which they were raised. Marge Polyvocal and Linda Egalitarian were both seeking contexts of stability, firstly to rectify their abnormal mood swings, and secondly to remind them of where they wanted and needed to be. They were not necessarily seeking change as much as they were looking for contexts of stability. The psychiatric system provided a very stable learning environment, with roles and rules clearly defined. Within this context, they found meaning, but not necessarily the way in which they expected.

Meaning generating systems are instrumental in bringing about a dissolution of the initial problem. Marge Polyvocal may still experience bipolar mood swings, but she is no longer as anxiety ridden and fearful as she used to be when she was initially diagnosed. She has worked through many childhood hurts, and has developed a sound position of self-confidence. She no longer berates herself for being an extra-caring person, wanting to share her love with other people. She has mood swings, and they are reflective of change in her life and her personal resistance towards that change.

Her mood swings keep her in relationship with various people in her life, such as, the psychiatrist and the psychologist. She created her own meaning by moving beyond the focus on phases of mania and depression. Linda Egalitarian shifted her meaning systems from the time of initial diagnosis. Her adolescent dreams of the perfect family life have been altered towards a realistic disappointment. She is no longer looking for external fulfilment to satisfy her broad ranging feeling of loneliness. Her mood swings did not manoeuvre her husband into any other position than that which he has already chosen. She still seeks belonging and acceptance as a person, but she is not completely focused on how wrong and inappropriate her behaviour is. She frames it as being passionate about life, no longer as scary manic outbursts. The fact that both of these research participants will need to take medication for the rest of their lives is a given. The meaning that they attribute to this is that the medication helps with providing a sense of balance in mood and thought where they cannot do it themselves. The fallacy of achieving a normal balance has been painfully lived out by both patients.

The problem of bipolar mood disorder is one which is created in language. It is the responsibility of the psychiatrist and the psychologist to expand on the various meanings that people attach to this diagnosis. Remaining within the boundaries of a classification system can only provide a sliver of meaning for the patient. And it is a meaning of deficit, always focusing on something that they do not have. This becomes a perpetuated meaning system and enforces a family, cultural and social belief that the person will always remain in deficit. Family members believe this. Society condones it.

Postmodern therapy can assist in reshaping meaningful experiences and providing broader conceptualisations of what it actually means to have this diagnosis. It is not merely a behavioural disorder, it is a psychological crisis. It is reflective of the way in which we all interact with one another and attempt to achieve authority and powerful dispositions. The manic-depressive illness brings together a battleground of opposing ideologies and conflicting feelings, bringing people closer, moving others away. It is the responsibility of all stake holders to acknowledge the way in which they contribute to this language generated problem system.

Theme 9: Belonging

Being diagnosed as bipolar provides an immediate membership to a group of people and has the added benefit of including the person as having a place of definition – you have a diagnosis, and you are normal within that group of abnormal behaviours. Surprisingly for the researcher, both research participants welcomed the diagnosis as it gave them hope that they could be helped, especially since their behaviour had been given a name and they finally knew that they were not alone in what they were feeling and acting out.

But, this sense of community and belonging wears off over time and the patients become impatient with no cure and continued mood disturbance. Families, friends and colleagues become frustrated at the lack of long-term change, as bipolar behaviour often involves a cycling of moods moving from a depressed episode to a manic phase, back into a depressive mood. Both Linda Egalitarian and Marge Polyvocal experienced their families as not having the time or patience to endure mood swings. In addition to this, families often defined any excitable behaviour as being symptomatic of the disorder. This could include becoming excited about a topic of interest, or being committed to working long hours to finish a task at hand.

The initial move towards belonging to a community ultimately leads to a position of alienation. This is also reflected in the psychiatric treatment of the person where the patient is expected to stabilise and gain control over the mood cycles. Should the mood continue to cycle, then the psychiatrist eventually becomes weary and does not invest the same time and effort into a patient who seems to be showing a lack of long term progress.

The ever present cycle within the shifting mood is also reflected when alienation moves back towards a position of community, once again. This time however the patient finds understanding among people who have been diagnosed with a mental illness and have suffered some form of perceived maltreatment by either the psychiatrist and/or the psychologist. The patient becomes more and more isolated from a familial understanding and more dependent on the psy-fraternity for support.

This position then shifts towards taking a more responsible disposition where the patient recognises that compassionate understanding is attainable through a shifting dynamic of feeling a sense of belonging and sensing a feeling of anticipated alienation. This position does not stagnate and is in continual flux.

Conclusion

This chapter revealed and discussed the themes that emerged from the research interviews. They were: titrating power relations, distilling relationships, the expert, the therapeutic problem, the problem of therapy, problem determined systems from the patient and the psy-fraternity's perspectives, connection and disconnection, meaning generating systems and belonging. One can see that the mood cycle of mania and depression was referred to from an interactional viewpoint and not on a behavioural level. This is where this research differs from that which is already available. The easy part of understanding bipolar mood disorder is in the diagnostic labelling of the person with the said diagnosis. The difficulty is attempting to understand how this construct develops, continues, is maintained, and how it can dissipate. In order to be able to understand this level of abstraction, the reader would have had to have an understanding of postmodern principles (provided in previous chapters) and the foresight to be able to integrate these assertions with those of modernist assumptions.

The conceptualisation of bipolar mood disorder has been thematically described in terms of the various aspects that create the construct as well as those aspects which contribute to the maintenance of the disorder. The disorder is a socially defined one, the diagnosis is relational, and the outcome affects more than just the individual who has received the diagnosis.

CHAPTER TEN

Reconstructing Bipolar Disorder: Thematic Synthesis

The psychiatric sciences have sought to convert human misery and pain into technical problems that can be understood in standardised ways that are amenable to technical interventions by experts. But human pain is a slippery thing, if it is a thing at all: how it is registered and measured depends on philosophical and socio-moral considerations that evolve over time and cannot simply be reduced to a technical matter (Summerfield, 2001, p. 98).

Introduction

Bipolar mood disorder is a diagnosis that is socially constructed, socially accepted, and interpersonally validated (Foucault, 1961). It was 'discovered' through a medical model lens of viewing the world. It has been maintained in conversational domains between people (Anderson, 1997; McNamee, 2002). The role players in this language game have been the diagnosed, the psychiatrist and the psychologist. Hence this research has entertained the opinions of all of these people. It is necessary to understand the conceptualisation of bipolar mood disorder to understand the nature of the treatment protocol; it is important to understand the variety of marketable psychotherapies that have been developed to combat this illness; and it is vital to understand the story of the person who has been diagnosed to gain a contextual, cultural and historical diagnosis. But these understandings are flat and unilateral if only viewed on this level.

This chapter will focus on synthesising the themes that have been generated in the previous chapter with those of the available literature. The synthesis shall provide further information on themes that resonate within the already known knowledge of bipolar mood disorder as well as highlight areas of difference. The contribution of this research to the field of psychiatric illness and psychological therapies will hopefully assist in providing future areas of development and a deeper understanding of the

constraints which limit the current body of knowledge. The themes that have been broadly delineated are the power differentials; the expert; the theme of problems; meaning generated systems; disconnection and connection; and the theme of belonging. Each theme is further deconstructed so that the intricacies of these definitional constructs can be discussed. The logic of the thematic construction and reconstruction process is to unveil carefully the multitude of meanings which co-create the illness known as bipolar mood disorder. The epistemological angle of this synthesis chapter is adoptive of a both/and approach and therefore combines modernist and postmodernist assumptions to give emphasis to the multiple constructions of bipolar mood disorder.

The Reconstruction Process

There is a therapeutic responsibility in each psychologist to remain ethical in the understanding of human behaviour by posing questions that challenge power relations (Snyman et al., 2004); infer new conceptualisations that pinpoint ethical dilemmas; and shift thinking paradigms to align with diagnostic cultures and remain inventive in the field of therapy. This could prevent the field of psychology from stagnating like a medical fraternity that ignores the uniqueness of each story that is brought forward into a hospital, a psychologist's office, or in a journal offering evidence based treatments (Lolas, 2002). Bipolar mood disorder is not treatable by a psychiatrist alone, nor by a psychologist in isolation of a medical treatment. These disciplines are bound together (Scott, 2006).

It is quite shocking to think that the exclusive treatment plan that currently exists according to researched therapies is medication in conjunction with cognitive behavioural therapy (CBT). This could be attributed to the similarities and fit of the two modalities of intervention. Some postmodernists have even reframed cognitive behaviour therapy so that it can be adapted to being more understanding of context and individual constructions of reality that are being meaningfully co-created (Lyddon & Weill, 1997). The power of the medical model in psychiatric diagnoses cannot be underestimated (Madigan, 1999). Cognitive behaviour therapy does not deny or confront any of the medical model's suppositions of reality. This approach confirms

them (Otto et al., 2005). But if it is such a prominent and necessary school of treatment the researcher wonders how she was granted her title as a clinical psychologist without a day's training in this paradigm? Does that mean that she is damaging to the bipolar mood disorder clients that she has and may still encounter?

The literature has offered many thematic generalisations in the field of bipolar mood disorder. Broadly, these are: aetiology; diagnostic criteria; thought processing in bipolar mood disorder; depressive behaviour and action, including hopelessness and suicidal ideation; the importance of pharmacological treatment; the family influences; social supports; acceptance and loss within this diagnostic spectrum; nosological distinctions; and the roles of the various treating professionals (Callahan et al., 1999; Miklowitz, 2002). But these researched tenets are unilateral, delving into an 'expert' reality at the expense of the client's narrative. The client's position is largely written up in terms of how medication has helped to find balance; the chaos of vacillating moods; the disrupting violence of thoughts and behaviours and the suicidal anguish (Bentall, 2003; Jamison, 1995). The impact of having this diagnosis is not to be underestimated. The stories of the clients neatly match the need for pharmacological treatment. There is a resonance of mutual reciprocation – a person needing treatment and an awaiting service provider (Bentall, 2003; Jamison, 1995).

Moving towards the postmodern perspective, this neatly painted picture comes apart. There is little discussion of therapeutic responsibility by any of the psy-complex role players (Parker, 1999). There is less discussion of how to modulate therapeutic skills according to mood shifts; what to do when there are repetitive lapses into deep depressions or manic highs; or a discussion of the power relations that exist within this neat diagnosis. The marginalised stories of clients being dissatisfied with the treating professionals are kept that way. The context of cultural and social make-up is left aside in favour of generalising symptoms. There has been no excursion into the world of multiple meanings and socially constructed realities. But how does one marry social constructionism and the medical model? They are grounded in opposing epistemologies and gather momentum on the grounds of differing conceptualisations of reality. But just as mania and depression co-exist, so too can social constructionism and the medical model, as separate entities meeting in the moment of rapid cycling and building upon each other. This research document will outline such a theory.

An Overview of the Themes

The table below reflects the themes as they were presented in the previous chapter. However, in this table, they are reorganised in terms of the shaping discourse, followed by the theme across the interview, and lastly, by the theme within the interview. This tabulated format indicates that the research is well substantiated in suggesting that any approach to bipolar mood disorder should be a biopsychosocial one (Ambelas & George, 1988; Griswold & Pessar, 2000; Miklowitz, 2002; Scott, 2006).

Table 7: Overview of the themes

The Shaping Discourse	Theme across the Interview	Theme within the Interview
Biopsychosocial	Power relations.	Power of joint systems.
	Expert.	Manual based, research based, therapy.
	Disconnection and connection.	Connection – psy-fraternity.
Bio-medical-social.	Expert.	Psychiatric algorithms.
	Therapeutic problem.	Psychiatric algorithm.
	Therapeutic problem.	Diagnosis and treatment.
	Problem determined systems: psy-fraternity.	Time and logistical constraints.
Cognitive-emotive-interpersonal.	Expert.	Patient's thoughts and feelings.
	Therapeutic problem.	Conversational realities.
	Problem of therapy.	Compliance and time constraints.
	Problem determined systems: the patient.	Interactional diagnosis.
	Problem determined systems: the patient.	Coping skills.
	Disconnection and connection.	Disconnection as therapeutic tool.
	Belonging.	Stigmatisation.
Social	Power relations.	The languaging of power.
	Expert.	Knowledge generating system.
	Problem determined systems: the patient.	Cultural meanings.
	Problem determined systems: psy-fraternity.	The languaging of the patient.
	Meaning generating systems.	Diagnosis as influencing other systems.
	Meaning generating systems.	Self-identification.
	Meaning generating systems.	Interdependence and shared experience.
	Belonging.	Community support.

The Shaping Discourse	Theme across the Interview	Theme within the Interview
Normative-deficit	Problem of therapy.	Focus on deficit model.
	Problem determined systems: psy-fraternity.	Focus on normal behaviour.
	Problem determined systems: psy-fraternity.	Self-reflexivity.
	Disconnection and connection.	Shared knowledge.
	Disconnection and connection.	Connecting as normative.
Psychosocial	Problem of therapy.	Individualised, a-contextual.
	Problem of therapy.	Family inclusion.
	Problem determined systems: the patient.	Family impact (reciprocal).
	Meaning generating systems.	Chrono-biological factors.
	Disconnection and connection.	Disconnection – family and community.
	Belonging.	Alienation.
Biomedical	Power relations.	Pharmaceutical influences.
Research	Power relations	Research power.
Cognitive-behavioural.	Therapeutic problem	Individualised symptom recognition.

The table above depicts the various ways in which bipolar mood disorder is co-constructed in reality. These realities are multiple and multi-versal, bringing together several voices of difference. The grand theories (Parker al al., 1995) that overarch the communal definitions are the following: the psychiatric discourse affirming that this is a disorder that exists within the person's mind (Fulford et al., 2005); the biopsychosocial approach which advocates that abnormal behaviour is located within a person's mind in interaction with surrounding environmental influences (Scott, 2006); the cognitive-emotive-interpersonal dynamic, which focuses on the patient and recommends what could be done to improve mental health and alleviate mood swinging symptoms; the medico-social theories that postulates that the psychiatrist needs to integrate the biomedical knowledge with the patient's environment therefore providing a more holistic treatment (Morriss, 2004); and the normative-deficit perspective which emphasises the way in which the person is framed as being abnormal and constantly in search of acquiring the skills that would enhance behaviour, thoughts, mood stability and feelings (Madigan, 1999). These are all grand theories, accepted by the relevant communities as given truths about bipolar

mood disorder. It is true that they lack a socio-cultural, political and historical analysis, and this will be provided as the current research body lacks the knowledge of the impact of these discourses on the bipolar mood disorder descriptions, but this will also become yet another grand narrative, a truth to be accepted.

To keep grand theories from becoming that, that is reified constructions, one would need to stay in continuous conversation about the topic at hand and contribute to the current ways of thinking about the way in which bipolar mood disorder comes to be a reality (Armstrong, 1998; McNamee, 2002; Parker, 1999). A way of achieving this is to momentarily suspend what we think we know and allow other assertions and viewpoints to enter the conversational domain. The themes that follow will highlight both grand theories and the voices of difference that have emerged from this particular research. It has been noted by the researcher that the body of research calls for the exploration of meanings that the patient has about the diagnosis as well as treatment (for example, Griswold & Pessar, 2000; and Scott, 2006). But to date, no research has explained how to go about this exploration of meaning and what the possibilities could be. These were pre-designed aims of this particular thesis.

As this research was grounded on principles of social constructionism, this thematic synthesis will attempt to describe the ingredients that together become the bipolar mood disorder diagnosis. There is no attempt made to provide further research into what causes or sustains the illness, as this has been well described in the research to the point of saturation. There have been no recent developments in this field and the traditional treatments still apply. In this moment of stagnation, this research will reflect on what and how this disorder as a construct is formed and maintained, rather than the illness itself.

This research, in collaboration with the psychiatrist, the psychologist, and diagnosed patients, created meaningful contexts from which the researcher could generate pertinent themes for the construction of bipolar mood disorder. Each co-researcher offered her story as a reflection of the way in which she makes sense of the illness. Social constructionism strives towards understanding the meaning making processes of people as they are created in conversation with one another (Anderson, 1997). Conversational dialogues occur through the way in which language is used to

convey and express opinion and meaning. The language used by co-researchers assisted in revealing the emergent themes of power and expertness; therapeutic issues; the relationships that form around the diagnosis; and the feelings of connection, disconnection and belonging. To begin with, the literature will be reviewed in the light of these themes.

Theme 1: The Power Differentials

> A de-construction is a process of critical reading and unravelling of terms, loaded terms and tensions between terms that construct how we read our place in culture and in our families and in our relationships, and how we think about who we are and what it might be possible for us to be (Parker, 1999, p. 7).

Titrating power relations, that is, looking at which action of one individual, system, or ecology reacts with other individuals, systems and ecologies that brings about difference, change and meaning is very applicable to this research context. The relationships that were formed in this research context reciprocally influenced one another on both macro and micro levels. The way in which power was perceived among the various research participants revealed a hierarchical process within the psychiatric system. The starting point was the aspect of diagnosis itself. This requires expert knowledge on the part of the psychiatrist who is educated in the causal symptoms of behavioural expression. The psychiatrist was viewed as the most powerful role player in creating and maintaining the ideology of deficit and abnormality. It must be said that the psychiatrist was acting according to her reality which was standardised with its own cultural values and norms. The aim of psychiatry is to define, diagnose, implement treatment, treat, and monitor people who step out of the mainstream definitions of normality (Foucault, 1961). The outcome of such a profession is that there are people who are being diagnosed. This immediately entails the development of a relationship, however one sided it may be. The overt power was seen to lie with the psychiatrist and the covert power with the patient as it was the patient who decided whether to act compliantly or not.

The power of the psychiatrist is embedded within a psychiatric and biomedical discourse enforcing the belief in a sick person requiring healing. These doctors are trained in ways which should alleviate distress, discomfort, and psychological pain. It is within the domain of the brain that ultimately they seek change. The introduction of pharmacological treatment implies a direct impact on the neurochemical processes within the brain and therefore the body and therefore the way in which the patient thinks and sees the world. The advances in the field of psychiatry have been tremendous and there is a continuous generation of research which substantiates the need for further research into the most therapeutic treatment of bipolar mood disorder. The question that arises is for whom is this research useful? (Simon, 2003). When each research study is carefully analysed, it is easy to find the loopholes, such as who was included and who was excluded (normally the non-compliant patients)? Was the research applicable to only manic episodes, depression, or both? Would the research be applicable to patients who are rapid cycling? Does the climatic environment make a difference to the long term outcome of the treatment researched? Is it the medication that is making the difference, or is it the wider environment which actually stabilises the person? Was the control group that was used in the study experiencing the same symptoms as the people who were treated, and if so, how was that measured (Armstrong, 1998)? These are all modernistic questions, all framed towards finding the truth. From a postmodern perspective, one would be less concerned with isolating research outcomes and more concerned with understanding the way in which this reality has been constructed.

Postmodernism is not anti-psychiatry and yet it is not openly inviting either. It is more of a body of collected theories which remains sceptical of the assertive belief within any particular ideology, psychiatry and psychology included (McNamee, 2002). It is from this critical perspective that this literature was assimilated with the following research themes.

Individual Power

Individual power is rendered in the psychiatric discourse through constructs such as, diagnosis and treatment. This necessarily implies that there is a power differential between the person who treats and the person who is treated. A

psychiatrist diagnoses a person so that a predictable prognosis can be achieved, in this case, the alleviation of mood symptoms (Macartney, 1987). Macartney (1987) argues that there is absolutely no point in diagnosing a person if that person is not going to recover and will therefore remain ill. The truth of the diagnosis should be secondary to the treatment aimed at assisting the person recover. Psychiatric disorders were shaped by the evolving socio-cultural and political movements during the 1970s (Horwitz, 2002). There was a shift towards making psychiatry align with the greater scientifically grounded medical fraternities, and this resulted in psychiatric illnesses being standardised according to generalised behaviours. This resulted in the art of diagnosis being reformed into an objective, neutral and professional opinion. Psychiatry did not develop a greater science. Rather it was placed into a scientific discourse, moving away from the previous descriptive agency (Horwitz, 2002).

The traditional psychiatric algorithm for diagnosis consists of "a series of questions linked by lines labelled with the answers, which lead either to the next question, or, less often to the diagnosis" (Macartney, 1987, p. 1326). Algorithms were thought to bring about certainty and predictability. While this may be true in general medical practice, it is not often the case in psychiatry. Bipolar mood disorder warrants multiple treatments, which are made to fit neatly into the algorithm. This knowledge base is owned by the psychiatrist. But the psychiatrist implements the algorithm as a treatment guideline in collaboration with the patient. This implies that the psychiatrist interprets the messages that the patient gives him/her. This simple process rendition indicates how the treatment process is actually informed through language and how meanings are co-created. The treatment of bipolar mood disorder is thus a social construction, subjective and value-laden (Fulford et al., 2005).

From a modernist position, the psychiatrist is the responsible person for accurately diagnosing the illness and providing the best treatment. The psychiatrist is well trained in the pharmacological treatment of illnesses. The psychiatrist is supposed to treat the person in a non-subjective, neutral, scientific manner, inferring the diagnosis on the basis of the patient's problem description. The psychiatrist is deemed to be the person with the absolute knowledge, underlined by rational reasoning, objectivity and empiricism (Foucault, 1961). The abundance of research articles that are available following this way of thinking inform the way psychiatry is

practised. It is assumed that the problem of bipolar mood disorder resides within the individual, is sustained through psychosocial influences, and is best alleviated through medication and cognitive behavioural treatment (Berk et al., 2006).

A postmodern perspective would advocate that the problem itself is a socially constructed phenomenon, co-created by both the patient and the doctor and informed by historical and cultural discourses which shape the way in which the problem is discussed (Hoffman, 1998). For example, there has to be an existing belief that a doctor can assist a patient with a problem, that is, a foundational belief (Mahrer, 2000) in the accuracy and benefits of medicines and pharmacological treatment. The language used to inform the problem formation also determines the interpretation of the diagnosis. Power, from a social constructionist viewpoint should be a shared endeavour (Anderson, 1997).

A critical psychology perspective accounts for the ways in which power is used to distil relationships of inequality, subversiveness, and subjugation (Madigan, 1999). Keeney (1979) suggested that psychiatric nomenclature reified and labelled human behaviour as a singular description, for example, 'I am bipolar'. This psychiatric epistemology reinforces and is mutually reinforcing of the belief in truth discovery, and the existence of abnormal behaviour. According to Snyman and Fasser (2004), psychotherapy practised as an extension of modernism serves to fulfil certain functions, which includes freeing the creative potential within the patient, focusing on the intrapsychic elements that constitute abnormal behaviour, being clinically and scientifically inclined to remain a neutral agent of change, deriving a causal attribution of problem descriptions, and delivering expert guidance from the basis of knowing the truth about the problem at hand (Snyman & Fasser, 2004). These therapeutic assumptions are seen to guide the therapy towards freeing the patient from the disorder that is problematic.

Relationship Power

Psychiatry, psychology, and other helping professions – such as social work and family therapy – have welded themselves onto the scientific

project and appropriated their slice of proprietorship (Madigan, 1999, p. 150).

This quote from Madigan's (1999) writings on the relationship of power and discourse exemplifies how power is a socially constructed entity, rather than something that exists and can be observed. In the realms of mental health, it is imperative to note that psychiatry and psychology have attempted to gain power status by latching on to the tails of scientific approval. Bipolar mood disorder is a wonderful example of how this construct has been owned by science to the exclusion of alternative discourses, such as the socio-cultural, political and economic contexts. The stories that were gathered in this research context have shown how power exists within the relationships that people have with one another. These power relations shape and are shaped by all of the role-players. Power, or the perceptions of power, are ways of describing an interactional process.

Fulford et al. (2005) have critically analysed the standard model of psychiatric treatment and attempted to fill the gap between objective knowledge (rendering one person in a more powerful position than the other) and value inclusion. This proposed theory aims to include the psychiatrist as part of the collaborative relationship. The difficulties faced by the psychiatrist are pointed out in the following quote (Fulford et al., 2005, p. 78):

With mental disorders we shift across the boundary from moral-humanistic to medical-scientific concepts, from the freedom of action and choice of everday human discourse to the determinism and causal laws of science.

The power knighted to the psychiatric fraternity has placed the practice of psychiatry in a dilemma. It is a field that is mandated to diagnose and treat a population of abnormal behaviour. But these abnormal behaviours are culturally bound, socially inscribed (Madigan, 1999), and dialogically shaped and attributed meaning (Anderson, 1997). Further, these diagnostic categories are formed in conversational language. The tools and techniques provided to psychiatrists and psychologists affirm the position of having one truth and one discovered reality. This

is then reaffirmed through research which is focused on particular groups of people who fit into that prescribed version of truth (Cooper, 2004).

Szasz (1960), who was instrumental in beginning the anti-psychiatry movement, suggested that mental disorders are actually moral rather than medical problems. However, in this context of shared domains, this theory does not hold water. The grand theory of bipolar mood disorder being merely a moral problem is equal to the current psychiatric theory which holds that bipolar mood disorder is a medical illness (Jamison, 1995). Neither theory is practical. Research has shown that there is room for both theories to work side-by-side (Morriss, 2004). The search for defining human behaviour as categorisable and therefore treatable as it is in the medico-scientific discourse (Horwitz, 2002) has failed psychiatric science, but from the "philosophical value theory, it is a success" (Fulford et al., 2005, p. 81).

The discourse of power is sustained within networks of psychological power. The therapeutic relationship is inflicted by these socio-cultural histories and they shape the realities we face. When a bipolar mood disorder patient is seen in therapy, it is important to recognise where and how this diagnosis was constructed. The psychiatric discourse, power laden with scientific constructs and backed up by scientifically based efficacy studies has reason to advocate such a position. In an attempt to align with modern science and receive recognition, funding, and approval as a science it has aimed towards objective, value free, absolutist and generalisable reasoning (Fulford, 2005; Madigan, 1999). This will inform a therapy in which a psychologist engages. Madigan (1999, p. 156) suggests that "power is normalized, rendered into discipline, practised routinely by subjects upon themselves as they re-enact the premises of their culture". The DSM-IV and its predecessors are examples of social constructions which have been accepted by a community of stakeholders and practised widely. The aim of society in general is to promote well-being and mental health. Psychiatric science is an arm of normalisation in this regard (Lolas, 2002).

Institutional Power

The relatively value-laden nature of mental disorder arises not from scientific deficiency (lack of knowledge of causes) but from greater

value complexity. In the future we will indeed know much more about the causes (biological, psychological and social) of human experience and behaviour. But this will do nothing to resolve questions about exactly which kinds of experiences and behaviours are negatively evaluated, and, hence, pathological (Fulford, 2005, p. 82).

Bipolar mood disorder was originally a descriptive collection of signs and symptoms which were best described as a manic-depressive condition (Wolpert, 1977). The most appropriate form of psychiatric treatment was lithium, but lithium cannot be patented as it is a naturally occurring salt. The research arena has been targeting the benefits of alternative medicines in achieving mood stabilisation with drugs that can be patented, marketed and distributed. This also brought about the definition of bipolar mood disorder including the spectrum disorders which fall along a mood continuum. Horwitz (2002) has argued that the diagnosis itself is a response to social, economic and political powers pushing the psychiatric setting into a more scientific medicine. In this sense, bipolar mood disorder is a social construction, created by researchers, scientists, and psychiatrists and bought into by psychologists, patients and their families (Horwitz, 2002).

The power rendered by institutions (implying large organising bodies that disseminate knowledge, rules, and norms) is again a relational one. Pharmaceutical companies are being exposed as assisting in and contributing to the advances of the concept of abnormal behaviour requiring treatment. Healy (2006), did an analysis of the ways in which pharmaceutical companies are promulgating their drugs through the media, and found that even though the most effective treatment of bipolar mood disorder is with mood stabilisers, the academic psychiatrist has not reached consensus on what the construct mood stabiliser actually means (Ghaemi, 2006; Healy, 2006; Sachs, 1996). The implications of this are huge, especially for the lives of people who were interviewed in this research. There is a dilemma facing psychiatry over issues of non-compliance (Scott, 2006) and what is interesting is that there is no scientific proof of exactly what the medicine does, good or bad.

Healy (2006) goes on to comment on how bipolar mood disorder has been socially constructed as an illness deserving drug treatment. In an effort to remain

scientific, journal series have been initiated, such as the *Journal of Bipolar Disorders* and *Bipolar Disorders*, and further there are annual conferences focusing specifically on bipolar disorders, sponsored by pharmaceutical companies. {The psychiatrist who was interviewed had attended such a conference and commented that it was amazing how the focus was purely on medicating the patient}. The media releases from some pharmaceutical industries enforce the idea that bipolar mood disorder is a lifelong condition, unmanageable without drug treatment protocols. These media releases are widely and freely available on the Internet, along with mini-questionnaires that allow you to test if you have bipolar mood disorder and advocate that if you do show symptoms then you should speak with your doctor and take the appropriate drug. The research body also enforces this ideology that a life without drugs will be more painful and destructive as demonstrated in, the work of scientists, such as Baldessarino (2005); Ferrier & Thompson (2003); Goodwin (2002); Kusumakar (2002); Morriss (2004); and Robinson and Ferrier (2006). Yet, Healy (2006) goes on to say that there is no research which shows that unmedicated patients with bipolar mood disorder have a higher risk of suicide. Healy's comments (2006) are centred on challenging the overarching ideologies that enforce psychiatry as the primary and most effective form of treatment. It is doubtful that his assertions will be taken seriously. Pharmaceutical companies are contributing vast amounts of funding to the research domain, as well as creating jobs which sustain developing economies. The diagnosis of bipolar mood disorder is shown to be more than an individual diagnosis, having repercussions for the patient as well as the psy-fraternity.

Foucault (1979) suggested that power is not the possession of people, but rather a dynamic that represents the way in which people interact together. The power differentials that exist within the world of psychiatry and psychology are located within particular ideologies which are sustainable and useful to all stakeholders. This does not mean that all people will benefit from the power differentials that are created within societies, but it does mean that some people (in this case psychiatric patients, psychologists, and even psychiatrists) will be marginalised and subjugated in favour of the dominant discourse and prevailing ideology. *It is within this context that people with bipolar mood disorder should be treated, as people who are placed on the periphery, being deemed powerless due to their intrapsychic and biomedical disturbances. The psychiatric patient and the powerful treating professionals should*

be viewed as collaborators in the shaping of discourse. The way in which these people are dominated through power and institutionalised beliefs is important to consider when attempts are made to understand how bipolar mood disorder is conceptualised (Foucault, 1979).

Theme 2: The Expert

The theme of the expert is essential to the understanding of how bipolar mood disorder is constructed by all the people who participate in the diagnosis and treatment of such a disorder. This is relevant to the discourses of psychiatry, psychology, and the patient. This research showed that even though there are multiple experts in the arena of bipolar mood disorder, there are also gaps of knowledge. Each research participant felt that there was more to be known about the illness, and sought knowledge on a continuous basis in an effort to fill the gap. The concept of 'the expert', the one with all the knowledge, could be a socially created fallacy. There are specialists in the field of bipolar mood disorder and each authority figure claims truth status. The pharmaceutical industry has been shown to be a powerful source of information and meaning generation enhancing the buy-in to the drug of choice. The psychiatrist, supported by psychiatric research, holds authority over the best medicine practice and the most influential techniques for raising a state of mood stability. The psychological research verifies the importance of having specialised treatment for the diagnosis of bipolar mood disorder. The patient, from a social constructionist viewpoint, is seen as a key collaborator in the definition of bipolar mood disorder. The expert is not just one entity, one truth, and one authority, but rather an amalgamation of various meaning making systems which contribute to bipolar mood disorder being a widely treated problem. These will now be explored in the literature.

The Psychiatric Discourse

The process of being inscribed into the DSM-IV text always requires
that a trained – that is to say, highly specialized – professional whose
expertise affords him or her the opportunity and privilege to unlock the
secrets of the disordered body (Madigan, 1999, p. 152).

The psychiatric discourse overbearingly assumes that the patient has limited or no knowledge of the illness and therefore requires expert assistance in managing this condition. While it may be true that the patient will not understand the intricacies of medicinal treatment, the way in which the patient experiences bipolar mood disorder is also determined by the psychiatric treatment process. Cooper (2004, p. 24) openly admits that the psychiatric community has desperately attempted to align psychiatry with mainstream medicine and science by focusing on the ideology that there is one truth that exists and can be generalisable to many people, when in fact "knowledge of the nature of psychiatric illnesses is rather superficial". Further he states that "clinical psychiatrists make few diagnoses in the sense of identifying known abnormalities which underlie the presenting symptoms". Rather, psychiatrists identify symptom clusters and take this as a representational fact requiring a diagnosis. The clinical judgement of the psychiatrist as expert is reinforced even though the psychiatrist has very little, if any, understanding of what underlies the symptoms that they are medically treating (Cooper, 2004).

Healy (2006) pointed out that the bipolar spectrum disorders (ranging from hypomanic episodes to cyclothymia) have only recently gained importance. The original main diagnosis of bipolar mood disorder has been expanded to include the bipolar mood disorder variations which still require medication. This emphasises how bipolar mood disorder and its variants are socially constructed in relationship. The psychiatrist, as an expert, has a moral and social responsibility to medicate a patient for what he or she believes is causing that person discomfort and destruction (Fulford et al., 2005). The need to belong to the scientific community has placed psychiatry in a double-bind in that it professes to have the knowledge to treat bipolar mood disorder and yet it is sorely lacking in the neutrality, objectivity and scientific empiricism that is meant to inform this discipline (Summerfield, 2001).

Summerfield (2001, p. 98) claims that,

society might reflect that the medicalisation of life, which has gathered pace in this century, tends to mean that distress is relocated from the social arena to the clinical arena.

But a theme that emerged from the research was that psychiatrists may not be ready to deal with such an onslaught of relationships. Many psychiatrists are poorly trained in psychotherapy and there have been calls for training in cognitive behavioural therapy (CBT) skills (Wright et al., 2002). Wright et al. (2002) noticed that psychiatrists are being excluded from the treatment process due to a lack of knowledge in the area of psychosocial interventions, and as such, they proposed that the psychiatrist moves beyond diagnosis, risk management and medication prescription towards engaging in therapeutic practices with the patients they treat. This further attempt at empowering psychiatric knowledge is simultaneously an acknowledgement that the psychiatric community falls short of being the experts on the lives of patients. The call for psychiatrists to undergo CBT training should in any case further solidify the position of authority and specialised knowledge.

The psychiatric fraternity has been empowered through models such as the DSM-IV. But such a classification system has been shown to be value laden in the process of assigning a diagnosis. The psychiatrist is placed in a position where he or she has to impart clinical judgement in a way that is value-free. But the act of judging someone else's experience as troubling and impairing of functional behaviour requires a value based judgement (Summerfield, 2001). The difficulties with assessing a patient as bipolar are profound. The person often presents for treatment in a depressive phase and not during a manic episode, and in addition to this, patients who have participated in research have shown a notoriously poor recollection of behaviour and actions during manic episodes (Bentall, 2003). These aspects confound any possibility of a scientifically appropriate diagnosis to be rendered (Greenhalgh, 1999).

The psychiatric discourse, as a child of modernist belief systems and attributions, has not contributed to the field of mental health as it had initially promised to (Fulford et al., 2005). The fact that bipolar mood disorder patients remain unstable and suffer mood vacillations indicates that there is more to a person's illness than the biomedical approach. The objective truth, as purported by the psychiatric fraternity, was one of mood instability, influenced by a multitude of factors, such as biochemical disturbances, psychosocial influences and heredity. This powerful discourse is sustained through scientific premises, yet there has been no evidence

which suggests that psychiatry has achieved its purpose of identifying the causal factors in the treatment of bipolar mood disorder. The psychiatric discourse plays a very important role in constructing how patients feel about themselves and their situation. The psychiatric expert wields a powerful position in shaping the meanings that the patient has of the illness.

The Psychotherapeutic Discourse

Psychologists are encouraged to think that they are able to change things, but they are part of a dense network, the 'psy-complex'. This network comprises the theories and practices which locate thinking and feeling inside individuals. Psychologists systematically delude themselves about their power in this apparatus, and this makes it all the more difficult for them to develop a critical reflection on the role power plays in people's experience of distress and their fraught relationships with professionals who are trying to help them (Parker, 1999, p. 9).

The psychologist as an expert has been researched from a technique perspective within the scientific paradigm. The most complementary therapy for bipolar mood disorder has been recognised to be CBT (Scott, 2006). These studies that have been conducted emphasise symptom alleviation, relapse prevention, symptom control, and lifestyle changes. The patient is treated as an individual, separate from social, cultural and historical discourses. The patient, individualised in this way, is the site of treatment. From this perspective, psychotherapy has aimed towards rectifying the abnormal behaviour in favour of a normalised epistemology.

The discourse in the bipolar literature is firmly rooted in an individualistic, scientific and objective truth paradigm. This version of what constitutes bipolar mood disorder cannot be merely dismissed, but is also recognised as one particular version of a truth. Therefore, this section will briefly outline the manualised treatments for bipolar mood disorder as advocated by surrounding literature, psychologists and psychiatrists. To begin with one must understand the language of the research field, which is aptly captured in Frank et al's., (1999, p. 587) research on the benefits of adjunctive psychotherapy for bipolar mood disorder:

These preliminary findings suggest that psychotherapy may augment the effects of pharmacotherapy in this population and further implicate instability as a primary mediator of outcome in bipolar disorder.

The way in which the language is used to describe the people involved in bipolar mood disorder is reflective of the perceptions held by the researchers. The people researched are called a 'population', implying that they are different from other populations given their diagnostic status. Further, there are broad assumptions made that drug treatment is the primary treatment, and psychotherapy secondary. This places the psychiatric discourse in the position of power over and above the 'augmenting' psychotherapies. This is an example of the inequality and marginalisation that occurs in the field of psychiatric research. It should also be noted that this research received funding grants, as do most in this realm of clinical psychiatric research.

Nevertheless, there is still the accepted research belief that has been generated by a wide variety of mental health professionals. Most research follows this scientific, disconnected and expert objective stance. The methodology of the research is quantitative and based on the premises of scientific truth. The aim of the research efforts is to distinguish which combination of factors show an improvement on the individuals' behaviour and which factors compromise the outcome of a return to normality. All of these manualised therapies could be criticised as being 'blaming' – towards the individual, the family and social support systems. The aim is to find and discover the way in which people interact that predisposes them to faulty behaviour. In an effort to pathologise the individual, and then the family, the manualised therapies have achieved success, as will be shown below.

The five manualised therapies of importance (as deemed by surveying the abounding literature), are: **prodrome detection** (Perry et al., 1999); **psycho-education** (Bauer & McBride, 1996; Callahan & Bauer, 1999; Miklowitz, 2002; Peet & Harvey, 1991); **cognitive behavioural therapy** (Scott, 1995, 1996, 2001, 2006); **interpersonal and social rhythm therapy** (Frank et al., 1999); and **family-focused therapy** (Miklowitz et al., 1988, Miklowitz et al., 2003). All of these approaches

serve to reinforce the discourse of a disorder as belonging to the individual, or in some cases, as being sustained by the family. These therapies also follow a scientific endeavour in that they prescribe a truth assumption, that is, if you follow these rules then you will have a better outcome. This premise is built on generalisable and predictable truths (Greenhalgh, 1999) as espoused by a discourse of science.

These therapies were discussed in detail in the initial literature review (**see Chapter Two**). However, it is important to point out that irrespective of the epistemological assumptions informing these therapies, there are common features which bound the therapies together in a fight against mood relapses. These are: psycho-education about the illness; promotion of medication adherence; promotion of a regular daily routine and regulated sleep patterns; monitoring of mood; detection of early warning signs of mood instability and implementation of strategies to prevent the onset of full blown episodes; and to implementation of general coping strategies such as enhanced coping and problem solving skills. All of these therapeutic aims are directed at the site of pathology, that is the individual and in some situations, the family members. The discourse is one of overcoming the onslaught of mood vacillations, and the method is to rectify the way in which the individual copes with the illness. Following a medical discourse of treating the illness, it is not unreasonable that these assertions have been discovered by researchers. There is no mention of the importance of the dialogical and interactional relationships which are the basis of these interventions, and there is also no attempt made to understand the ways in which the therapist contributes to the formulation and treatment of such a problem. There is only a problem with a certain solution.

As an example of the scientific language used to espouse these researched formulations one can see the 'power' and 'expert' discourses emerge in the language used to describe the problem at hand: 'teaching patients'; 'seek prompt treatment from health services'; single blind randomised controlled trial'; 'control group'; standardised interviews'; 'clinical improvements'; 'prodromal symptoms'; and 'common serious mental illness'. These are just a few examples to point out the view of the person with the illness, the position of the researcher, and the scientifically saturated language. It is thought that the adherence to such strong protocols will necessarily yield more scientific and applicable research as there is no value in

personal subjectivity (Snyman & Fasser, 2004; Tarnas, 1991). This in itself is a problem for bipolar mood disorder. The disorder is a socially constructed one, the reality of its existence is a co-created one, and the maintenance of this illness is embedded in scientific discourse.

Another example of shifting the blame to the individual is evident in the conclusions reached by Sajatovic et al. (2004, p. 264):

> Adherence to treatment for bipolar disorder may be enhanced by interventions that address issues of appropriately taking medications to manage illness. For proper outcomes, promotion of adherence must be integrated into the medication management of bipolar illness.

Again, this quote emphasises the contrast between a person without knowledge and an expert with knowledge. Words such as 'proper' and 'adherence' suggest that there is a right way to deal with bipolar mood disorder, even though research is not backing this hypothesis. There is no mention of the qualities and nature of the treating relationship, but rather there is an assumption that the patient should be held responsible for the treatment process and the expert with knowledge remains untouched by the illness itself.

<u>The Patient's Expertise: Not Knowing</u>

The body of literature lacks a discussion of the patient's expertise on the matters of bipolar mood disorder outcome. In both the psychiatric and the psychological research there has been a complete focus on the illness itself (to the exclusion of the person), on the person completely (to the exclusion of the family) and on the family itself (to the exclusion of wider informing discourses).

From a postmodern, social constructionist research approach, the person is located within communal networks, within which meanings are generated between the various role players (Madigan, 1999). Bipolar mood disorder is an eruption of meaning, imbued in discourses of science, history, culture and society. From a scientific perspective, the defined patient is the site of pathology, but in understanding

the way in which this socially constructed diagnoses gains legitimacy, the reality as experienced by the patients would need to be explored. This research has shown that the patients themselves hold many of the 'secret' discoveries that science is desperately in search of. This included power relations and how they shape the event of bipolar mood disorder; knowledge and expert systems and how they serve to maintain the status quo and subjugate the patient to a form of treatment; the definition of the problem at hand and how it is conveyed in a story to the treating professionals; the responsibility of maintaining a compliant attitude on the basis of the treatment approach being a meaningful experience; and the they ways in which the diagnosed illness fits within the patient's life-world and world-view.

The patient, as the site of treatment from a scientific standardised medical model of treatment, is deemed to be the one in need of behaviour rectification. **This research refutes the broader based psychiatric literature as it was shown that the way in which the patient experiences bipolar mood disorder is pivotal information for any desired treatment outcomes.**

The patient without knowledge (Madigan, 1999) was shown to be an apparent and underestimated feature of the conceptualising of bipolar mood disorder. The research participants did not show a sound knowledge of their drug treatments, they were unaware of the impacts of mood vacillation and signs of early detection, and they were also unaware of family influences and social rhythms. Their outcome of continued mood swings could be a result of their lack of knowledge or it could be that they are still in a process of making sense of the illness, in collaboration with the people in their lives. Each research participant had a fortune of knowledge to offer to the realm of bipolar research, but their language was non-scientific, and jargon free. Their experiences with the illness were filled with issues of relinquishing power and responsibility to the experts, being the outcast in family and social surroundings, and having an illness which was intrinsic and crushing. These are all therapeutic themes which remain unresearched in the broader literature.

Some Gaps in the Literature: A Postmodern Reflection

Postmodernism focuses on generative knowledge, multiple realities, conversations of possibilities, relational engagements, meanings that are embedded in relationships, and reflexivity (Burr, 1995). The research body of knowledge is embedded within scientific, psychiatric and medical model approaches to understanding the complexity of bipolar mood disorder. There is a paucity of research into the experiential realities of the people who actually live with the diagnosis as well as the people who participate in constructing this illness. The emotional aspects of bipolar mood disorder have been left out of the researched body of evidence.

The majority of the evidence based research that was reviewed operated from a scientific paradigm eschewing the importance of relationships, language and meaning making processes. In the body of research, most studies imported the use of a control group which did not receive therapy and assistance, and a group which did. The aspect that was never confronted in the broad research was that of relationship and multiple realities. A postmodern reflection of any research shows that meaning is created in relationship with other people, through language and conversational processes (Anderson, 1997). It is therefore a possibility that the people who received assistance, psycho-education, and guidance into their mood patterns, showed clinical improvement (a value laden judgement as there can be no neutral and objective observation) **because they were involved in a dialogical relationship with the researchers**. This varied from interviews, to long-term follow-ups, to creating social support systems for diagnosed patients, versus those who received no intervention and continued on their own individualised treatment. The relationships that were formed for the patient, through the defined research aims, may have been more curative than the actual content of what was expected to be learned. However, since the actual patient's stories were never made explicit in these research endeavours, this will remain a hypothesis of this researcher.

The diagnosis and confirmation of the presence of the bipolar mood disorder is confounded by a lack of knowledge. All research participants felt that they were in a search for answers and explanations. On a broader level the broad research literature mimics this very assertion by continuously seeking an answer for a cause. It is a

relatively easy position to be in to comment on what the effects of treatment on various aspects of the diagnosis were, but this still eludes the scientific principles of discovery. The correlations that were deemed important by the scientific researchers could easily be criticised as being a-contextual, population-specific, value-laden, and biased towards confirming the need for pharmacological treatment since most studies are being sponsored by pharmaceutical industries. The social construction of bipolar mood disorder has been shown to be evident in the non-neutral diagnostic procedure, which incurs value judgements from the psychiatrist; the discovery of bipolar mood spectrum disorders; the journal series which have been implemented in honour of this fascinating diagnosis; the development of newer patented drugs that show treatment efficacy; and in the discourses of power and history which have shaped psychiatry to be an extension of medical science and modernistic principles.

The treatment modalities that have been researched all have in common the following principles:

- Therapist as expert.
- Therapist as instrument of change through knowledge dissemination.
- One truth of bipolar mood disorder being a biomedical illness maintained by psychosocial stressors.
- Generalisablity of treatment techniques regardless of context, culture and individual experiences.
- Emphasis on deficits, and what is missing from a normal person.
- Failure to acknowledge personal, interpersonal, social and cultural resources.
- Focus on one meaning system, that is the patient with the illness, excluding the treating professional's input (Anderson, 1997; Madigan, 1999; Snyman & Fasser, 2004).

Harré (1995) suggested that the 20th century has seen the movement of three paradigms in psychological research: the first two being described as behaviourism and cognitivism, and the turn towards discourse as representing the third movement. Constructs such as bipolar mood disorder would have to be looked at as a construction and communicated through discourse. Mental illness, as such, is thought to be located within a discursive sphere. He also purported to believe that the cognitive realm of

physiology co-exits with a symbolic one in which discourses are shaped and maintained (Harré, 1995). He says,

> neurophysiological processes are governed by the causality of physics and chemistry, discursive activities are governed by the rules and conventions of symbol use. It gives us always a double job to do as psychologists (Harré, 1995, p. 158).

Harré's (1995) thesis is that the discourse turn should not throw out scientific research as non-sensical and abusive, but rather incorporate it into the psychologists' realm of practise as one possibility among many. Clearly, this is the position that any ethical postmodern psychologist is going to have to assume to incorporate the multiple meanings that co-exist in defining bipolar mood disorder.

The patient's knowledge has been shown to be problematic as it is inferred from memory (Bentall, 2003) and these memories are often thought to be confounded by psychosis, racing thoughts and unclear thinking styles. However from a postmodern view, truth resides in a shaping discourse and the position of the patient and his or her knowledge is paramount for bringing about change. The memories of the patients who are interviewed are social accounts embedded in context. The way the person perceives his or her past is crucial for understanding the processes involved in bipolar mood disorder regardless of truth and validity (which are scientific constructs). Memory is thought to be a cultural phenomenon (Atkinson & Coffey, 2003). The memory is shaped by the norms and values of what is deemed socially acceptable or not. The past experiences of the patient shape the narrative enactment in the present and are reflective of wider social discourses (Atkinson & Coffey, 2003).

A process of debilitating the expert through self-reflexive questioning has been suggested by Madigan (1999). This position involves asking oneself the questions: what ways do we perform and perpetuate the diagnosis of bipolar mood disorder and deem the patient as a person without knowledge? To what extent does our knowledge and expert reference ensure the patient remains without knowledge? For how long would one ponder on the biomedical influences and how does this shape the therapeutic discourse and the multiple relationships within it (for example, with

the patient, the psychiatrist, and the hospital staff)? How can a therapist deconstruct the psychiatric viewpoint without totalising all the relationships involved up to date in the patient's life? What discursive restraints of the psychologist's training, age, gender, and socio-economic class could limit the therapeutic conversations? How can one not respect the biomedical inscription while remaining respectful to the patient and his or her story? To date, there has been no research that has indicated the role of the expert and the impact of the expert on the system being treated. This current research sought to fill these gaps and focused on the patient's rendition of the story of bipolar mood disorder, as well as the psychologist and psychiatrist. This process revealed a multitude of factors which are not present in the broad based literature which defines bipolar mood disorder.

Theme 3: The Theme of Problems

The research highlighted the following problems of therapy and therapeutic problems: individualised symptom recognition; psychiatric algorithms; problem saturated conversations; focus on diagnosis and treatment; compliance and time constraining factors; the importance and ir/relevance of the deficit model; a-contextual techniques of intervention; and the importance of including the family. The literature review will therefore include an overview of bipolar literature, as well as therapeutic schools of reference and value.

The initial point of diagnosis occurs in a conversational domain (Parker, 1999). The process of diagnosing a person with a problem is one which is value laden and not objective and scientific as previously thought (Fulford et al., 2005). The empirical studies that have been conducted in the arena of bipolar mood disorder, with focus on cohort and randomised trials are not necessarily applicable to the individual with the problem as this would be imposing an a-contextual ideology (Greenhalgh, 1999). Greenhalgh (1999) also made reference to the dissonance one experiences when attempting to impose generalised research into therapeutic contexts. The CBT approach is one example of this dissonance actualised. The therapist may have very good intentions of focusing on problem identification of negative thought patterns and the resolution thereof, but the patient may be in a position of suicidal intent. The

problem solving techniques of the therapist would be ill applied if the patient's suicidal threats were not dealt with first and foremost. In the same vein, not all patients respond to the medical treatment of lithium even though the research advocates this as the most favourable mood stabiliser.

The Problem as a Social Discourse

The socio-cultural discourses shape the way in which the person assigns meaning to a supposed diagnosis. These meanings are imbued with power and knowledge systems, self-perspective, and socio-cultural belief systems (Anderson, 1997). The problems of therapy and the therapeutic problems are all examples of the ways in which these ideologies are carried out in practice.

Parker (1999, p. 6), commented on the position of the family as follows:

Families absorb and reproduce images of pathology that are present in the culture, and these images are held in place by patterns of meaning that are interlaced with patterns of power.

This quote emphasises the point that families are culturally bound and behave through acceptable norms and values and predisposing belief systems. The family patterns of communication are easily pathologised and previous schools of family therapy have attempted to correct them (Selvini et al., 1978). But, from a postmodern therapeutic position, the family is culturally ordained. The way in which the family communicates about the diagnosed patient is informed by broader discourses of religion and social stature. These beliefs would need to be deconstructed to align with the multiple realities experienced by all family members (Madigan, 1999).

There has been no research in the bipolar scholarly domain which looks at the belief systems that are upheld through the social organisation of the family. Rather, there is a focus on determining which interactional patterns within the family yield the most instability in the diagnosed patient (Miklowitz et al., 2003) reducing stress in the family through enhancing the coping skills of family members (Callahan & Bauer,

1999), and educating the family in becoming astute observers in the diagnosed person's behavioural patterns assisting in isolating potential mood swings (Miklowitz et al., 2000).

The approach to families within the realm of bipolar mood disorder research is repetitive of the individualised research. Yet again, the assumption is that there is a deficit that exists in the family – for example, they do not know how to communicate properly about emotionally laden issues; they do not have the knowledge or skills to properly assist the patient to return to a position of normality; and they do not know how to cope with a diagnosed person in the family. There is no focus on understanding how the family is shaped and shapes the diagnosis, and there is no attempt to understand the coping skills and resilience factors that inform the family as they are informed through social and cultural discourses. The research to date, is purely reformative, corrective, and blaming.

The families in this particular research refused to participate in the research interviews. This was a respected discourse of not talking about the ill person as it perpetuates the illness if given any credence. The stories of the research participants were meaningfully informed by discourses of silence, madness, and religious outcasting. As this is a research domain, there was no attempt made to influence the perceptions of the family and induce change. But it is interesting to note that the families have an expectation of the illness worsening if it is spoken about. The denial of the illness is also what contributed significantly to the silencing discourse which shaped the stories that were shared.

The Problem Defined: Multiple Perspectives

The therapeutic schools of psychotherapy can be broadly divided into three groups for the purposes of this research discussion. To begin with there are the traditional, first order therapies, followed by the second order cyberneticians, and lastly the social constructionist therapies. The problems inherent in a therapeutic system can be slotted into the belief systems of each of these overarching groups. Firstly, there will be a brief overview of each group for the purposes of shared understanding.

The traditional, first order modernistic framework produced schools of therapy that were aimed towards problem-focus and problem resolution. This grouping of therapies includes psychoanlaysis, behavioural therapies, cognitive behavioural therapies, and early systemic therapies. The basic assumptions of this group can be summarised as follows:

- There is a knowable and objective reality.
- The model to be adhered to is one of normalcy.
- The therapist is the expert.
- The therapist's role is to diagnose and assess the problem at hand.
- The therapist takes an active role in guiding the person/problem to normalcy.
- The symptom is caused by problems in lived experience.
- Change occurs as an either/or dichotomy.
- The client is dependent on the therapist to cure or fix the problem (Frosh, 1995; Larner, 1995; Lyddon & Weill, 1997; McNamee, 1997).

Atwood (1997) described these therapies as being built on the premise that there is a thing called normalcy and the task of the therapist is to return the person with the problem to this preferred way of being. The invention of family therapy took these traditional schools of therapy to another level, and focused on the symptoms as communications of underlying problems as they are enacted in the family. Madanes and Haley's (1977) strategic family therapy focused on symptoms as they were presented in the here and now, without focus on the meanings these symptoms might have for family members. The aim of therapy was to break up cycles of faulty interactions through the implementation of paradoxical or direct interventions. The symptoms were viewed as power struggles, attempting to control or influence other family members into behaving in manipulative ways. Hayley asserted that symptoms were maintained through an abnormal hierarchy within the family and that this should be corrected. Minuchin's (1974) structural family therapy aimed towards providing a problem-solving technique to the dysfunctional family context. For Minuchin, the family operated according to societal norms and values and structured itself in dysfunctional patterns of communication and therefore required interventions for restructuring. This entailed active guidelines on putting boundaries in place. The

structure and organisation of the family was the seat of pathology. Boundaries were thought to be the rules and regulations that separate the system from its environment, either allowing in too much interaction, or not enough. The therapist aims to join the family, negotiate with the system, and then rectify faulty boundaries (Minuchin, 1974).

Schools of family therapy shared the following common principles:

- There are multiple ways of interpreting one objective reality.
- The model to be adhered to is one of normalcy.
- The therapist is the expert and knows the truth.
- The therapist is the therapeutic tool of change.
- The site of pathology is located in the family system.
- The symptoms are functional and serve to maintain the status quo of the family.
- Change occurs as an either/or dichotomy.
- The client is dependent on the therapist to cure or fix the problem.
- The focus is on the deficits within family structures (Atwood, 1997; Boston, 2000).

DeShazer (1985) was instrumental in developing the solution-focused therapies which steered away from problem definitions. His premises were based on patient resilience and self-solving skills. The patient would enter the problem field by describing the problems as they were experienced and the therapist would explore areas in which the problem was not residing assisting the patient to envision a future without the problem. The therapeutic parameters of solution-focused therapies were along the lines of the family therapies described above, with one or two differences, for example, there may be a reality, but it remains unknowable; normality models are not adhered to; and the symptom is brought about through problems of lived experience.

Second-order cybernetics and social constructionism were born out of a paradigm which asserted that the therapist cannot remain neutral and objective to the process of symptom alleviation as he or she is actually changed by what was been thought of and enacted (Gergen, 1985; Hoffman, 1987, 1990). The social

constructionist, second order therapies theories are varied and broadly informed by various disciplines; however, they share common assumptions, such as,

✖ Reality is a social creation founded in social interactions.

✖ The patient determines and defines what is normal.

✖ The therapist is an active collaborator with the client system in an effort to co-create new stories that hold potential and possibility for change.

✖ The patient is the diagnostician and does the assessment of the problem.

✖ The therapist is transparent and is informed by reflexive questioning.

✖ The problem is one with lived experience and the patient does not know how to solve the problem.

✖ There are no absolute truths or realities.

✖ Reality is co-constructed through language and is in a process of mutual reciprocation with the socio-cultural environment.

✖ This socio-cultural environment contains socially constructed meanings for behaviours and deems which behaviours are appropriate and which are inappropriate.

✖ The dominant meaning systems of society are lived experiences that are shared within the family.

✖ The site of problems is located in the experience of the person. Problems are not viewed as functional in maintaining the system or as a manifestation of underlying pathology. The way in which problems are languaged gives an indication of the way in which solutions can be narrated.

✖ The focus is on possibilities, unique outcomes, and meaningful experiences (Anderson, 2001; Boston, 2000; Held, 2000; Speed, 1991; Strong, 2002).

The problems of therapy and therapeutic problems as generated through this research can now be neatly slotted into one of the above schools of thought. The individualised symptom focus and the treatment through psychiatric algorithms would be seen as fitting well within the initial and traditional schools of therapy where the site of the problem was believed to be within the person, and that person was uniquely pathologised. Problems of compliance and time constraints could be well understood through the conceptual lenses as offered by the strategic and structural premises. The irrational compliance and non-compliant cycle of behaviour could be seen to be

manipulative of the patient over the family bringing about disruption in an effort to shift the status quo. The time constraints of psychiatrist's could result from the patient's dependency needs and may even fit well in the traditional school of therapy in which the patient cannot adapt to limited resources and blames this as a reason for being ill, showing a lack of insight. The deficit model perspective fits well with both traditional and first order family therapists who aim towards a model of normalcy. The patient is the one who requires change and therapeutic efforts are directed towards achieving this aim. The a-contextual techniques and the importance of including the family would be apparent in all of the approaches described above.

The social constructionist therapies are against implementing techniques that are incongruent with the contextual history of the patient (Anderson, 1997). The family system's inclusion is imperative for any form of change, be it traditional or postmodern. The difference is in the view of the family. From a postmodern perspective, the family is not the site of pathology, but rather a contributor to the shared reality of functional and dysfunctional behaviours as it is co-defined in language parameters (Anderson, 1997; Atwood, 1997).

The problems of therapy and therapeutic problems are all answerable and solvable through one of the methods described above. The important point is that the method used to attain change depends on the epistemology of the therapist. The way in which problems have been defined in the bipolar literature is constricting and does not allow for the possibilities of alternative realities to enter. The therapists who ascribe to family therapy models of intervention have mostly moved away from scientific rhetoric and are moving towards a discourse informed reality. This could explain why there is a paucity of research from these models of therapy within the field of psychiatric literature.

The Emergent Problem

Greenhalgh (1999) proposed that the interaction between the psychiatrist (or doctor) and the patient entails a very postmodern concept of interactional performance in a meaning generating process. For Greenhalgh (1999), the initial starting point of the therapeutic relationship is in the socialised expectations of both doctor and patient.

This type of conversation is focused on the illness, with the added expectation that a solution will follow. This focus on the person as ill invites four other more submerged texts to appear (Leder, 1990). Briefly these are,

* An experiential text which is the meaning that the patient will assign to the symptoms and what they represent to that person, thoughts, and previous interactions with other people about the illness.
* The narrative text invites psychiatry as we know it. In this form of text, the psychiatrist interprets the patients presenting problems from the way in which the story is shared with the psychiatrist.
* The physical or perceptual text includes a physical examination of the patient to rule out any differential diagnosis.
* And the instrumental text which is the extension of diagnosis and involves blood tests and any other medical testing which would supposedly confirm or reject the psychiatrist's hypothesis about the presented illness.

Based on Greenhalgh's (1999) account of the narrative influence on diagnosis, it should be acknowledged that the diagnostic process is a collaborative one. The expectations of the patient lay the foundation for the psychiatrist to be the expert. The psychiatrist, in turn, may have suggested guidelines for diagnosing the patient, but he or she should realise that this is a value and theory laden informed decision and not an objective and neutral interpretation (Armstrong, 1988). The psychiatrist should therefore respect the patient enough to collaborate in a meaning making and decision making process (Greenhalgh, 1999).

The problem itself has been shown to be constructed in many ways, depending on the way in which problems and solutions are defined. The most widely advocated and scientifically legitimised perspective is that of the medical, psychiatric discourse.

The Problem as a Moral Judgement

Psychiatry is a moral-philosophical enterprise that pretends to be a field of medicine. Psychiatrists trained in medicine find themselves defensively pretending to practice medicine while they make moral demands on the

socially marginal people with whom they work. The pressure and social costs of this travesty are incalculable. Psychologists are trained in research, philosophy, and theory. They now pretend to be miniature medical personnel, giving up the best and finest of their beliefs for the lies and defenses of psychiatry (Simon, 1994, p. 170).

Modern literature focuses on the moral judgement of behaviour as acceptable or not. This is particularly relevant in the domain of bipolar mood disorder. In this context, a moral judgement implies that a person is judged to be without reason and in deficit of logical thinking if certain criteria are met. These criteria, however, are based upon moral and not scientific judgements. The ways in which the questions are asked in order to ascertain whether or not a person is depressed will definitely have an effect on the answer. The person asking the questions is the one with the position of power and it is according to his/her moral standing that the answer is diagnosed (Foucault, 1961).

Armstrong (1998) thought of the construction of a disorder as following a process of five stages. In brief, these are: introduction, confirmation and corroboration, dissent, expansion, and diffusion. Bipolar mood disorder was introduced many years ago, and coined by Kraepelin in 1899. This disorder was confirmed through science, and psychiatry thought manic-depression to exist as an integrated phenomenon (Foucault, 1961). This was followed by dissent among practitioners of psychiatry who advocated that it was actually two separate disorders, requiring alternative treatments. From this, a wide body of literature was formed to address these issues, mostly from a psychiatric and pharmaceutical interest. The end result has been diffusion involving practice guidelines and manualised therapies which promulgate the scientifically researched principles. Postmodernism has turned this natural evolution of disorder construction on its head and has reverted to the introduction phase.

A postmodern description of the medically defined condition of bipolar mood disorder refutes the diagnosis as being a scientific one, and focuses on the way in which the definition has yielded power over time, satisfied key role-players and cemented them into positions of authority and knowledge. A postmodern rendition of

bipolar mood disorder would begin with understanding that the diagnosis is a relational one, one which is morally judged and implies a deficit of knowledge, behaviour, and/or thought. The judgement, the ultimate rendering of a diagnosis is an act of social control, and not necessarily from a knowledgeable perspective as this research has shown. The negative aspects of a manic episode, such as hypersexual behaviour and spending sprees are netted through the diagnosis of illness. The diagnosed patient is forced to assume personal responsibility in ridding herself of these behaviours. Failure to do so is a sign of non-compliance. The difficulty is in deciding when this judgement becomes a moral one superseding that of science. Hypersexual behaviour, irresponsible spending, and aggressive outbursts (as experienced by the research participants) were deemed to be signs and symptoms of a manic onset. But there is no research to indicate that these behaviours are in fact indicative of brain dysfunction or bipolar mood disorder markers. This is a moral judgement, based on societal and cultural norms and values, enforced through the voices of psychiatry and psychology.

The spiral of diagnosis culminates in blame. The patient is blamed for a lack of control, an illness that cannot be seen, and for not being good enough (McNamee, 2002). The patient in turn blames psychiatry for being non-present and hardly available. The research backs the person who prescribes the medication. The family cede control to the treating professionals. And religion can even turn its back on the patient. The social condition of hierarchical power and knowledge is reinforced. There is no known cure for bipolar mood disorder, but there is a moral judgement which dictates that if a patient abides by a treatment protocol, relief is expected. Failure to achieve this is solely the responsibility of the patient. The morality of the treatment team remains intact, and the patient is subjugated and marginalised in favour of the dominant scientific discourse (Parker et al., 1995).

The descriptive criteria for an episode of bipolar mood disorder have been criticised as being too vague and not all-inclusive (Berk et al., 2006). Parker et al. (1995) would argue that this is because people cannot be fitted neatly into little boxes, because they are socially constructed beings influenced by moral-political discourses. The fact that scientific research strives towards being all inclusive and knowledgeable indicates that this is a moral attainment. There is a need for science to solidify itself as

the system which provides all answers to human problems. Berk et al. (2006, p. 462) explain why effective and early diagnosis is so important,

> people with undiagnosed BD frequently suffer continued chaotic existence. With the most common age of occurrence of illness being in adolescence or young adulthood, undiagnosed BD can disrupt the normal development of social skills and relationships and have a negative impact on education and earning potential.

It must be kept in mind that Berk's research was funded by the pharmaceutical industry, and this informs their research advocating the benefits of early and accurate diagnosis. Having said that, any person would be shocked into seeking professional advice for any mood alterations based on the information provided in the quote above. The advice offered by Berk et al. (2006) is frightening and propels people towards seeking a cure for the problems they experience or else they will be doomed and destined for an impoverished life, alone, and destitute. Is this scientific fact or moral judgement? The morality lies in deconstructing the alternative position and wondering what rules dictate 'normal' development of social skills and the ability to relate. These are not scientific constructs, instead they are socially constructed ideologies defining the perfect citizen. There is no mention of whether people who have taken the prescribed medication have better social skills and relationships and earn more. There is only the daunting thought of how awful life would be if the diagnosis and treatment are not provided. This is an example of the morally defined bipolar mood disorder construct, with all of its meanings and social justifications, cloaked in scientific discovery.

The shift in naming bipolar mood disorder as a replacement for manic-depressive illness was also a moral act. The scientific literature did not show that a person stops experiencing episodes of mania or depression when given the diagnosis of bipolar mood disorder, but rather, the names are hidden and masked within a more appropriate polarity continuum. This supposedly contains more variations of the mood disorder no longer being constricted by the dual opposites of mania and depression. The name bipolar mood disorder is more fitting in the sense that it allows

for the areas which science cannot explain. Instead of becoming more definitive, it has loosened its hold on expert knowledge.

Theme 4: Meaning Generating Systems: Bipolar Epistemologies

This theme generated through the research interviews assisted in understanding the way in which each research participant told a life story. Meanings are embedded in relationship and relationships are constructed through language, all within meaningful contexts which discursively shape discourse (Gergen, 1994). Language and meaning generating systems were metaphors developed by Harlene Anderson and Harry Goolishian (Anderson, 1997; Anderson & Goolishian, 1992), and reflected the move towards a postmodern era, in which problems were viewed as relational and not individualistic, no longer as intrinsic to a person, but rather the outcome of a collaborative event in which meaning is co-created and constructed. The move away from modernist thinking was also evident in the way that therapy was shifting towards a language of potential and resources and away from the saturated premise of deficit based understanding, assessment and labelling (Anderson, 1997; McNamee, 2002). The important notion that evolves from a postmodern way of thinking is that meanings are embedded within language and discourse rather than being scientific facts out there waiting to be discovered. In the context of research on bipolar mood disorder, this translates into there being a necessary space for scientific, psychiatric rhetoric, along with other perspectives which widen the definition of bipolar mood disorder as it is currently understood to include broader based social and cultural discourses.

Psychiatric Science and the Postmodern Interpretation

Reification attributes a real existence to some conceptual abstraction – interpreting some symbolic model as if it were a real thing. For example, a client may label a recurrent pattern of thoughts, feelings, and actions in some situations as incompetence – but, concepts like incompetence are ideas, not things. Reification leads a person to think of such patterns as always there and functioning (Ford & Urban, 1998, p. 33).

The following are examples of the scientific language of bipolar mood disorder, reflecting the way in which the disorder is conceptualised and treated (please see the List of References for the full reference).

Table 8: Journal Series

The Title	The Journal	The Author & Publication Year
The early warning symptom intervention for patients with bipolar affective disorder	Advances in Psychiatric treatment	Morriss, 2004.
Major stressful life events and other risk factors for first admission with mania	Bipolar Disorders	Kessing, Agerbo, & Mortensen, 2004.
Enhancement of treatment adherence among patients with bipolar disorder	Psychiatric Services	Sajatovic, Davies, & Hrouda, 2004.
A randomised study of family-focused psychoeducation and pharmacology in the outpatient management of bipolar disorder	Archives of General Psychiatry	Miklowitz, George, Richards, Simoneau, & Suddath, 2003.
Randomised controlled trial of efficacy of teaching patients with bipolar disorder to identify early symptoms of relapse and obtain treatment	British Medical Journal	Perry, Tarrier, Morriss, McCarthy, & Limb, 1999.
Individualized stress vulnerabilities in manic depressive patients with repeated episodes	Journal of the Royal Society of Medicine	Ambelas & George, 1988.
Management of bipolar disorder	American Family Physician	Griswold & Pessar, 2000.
Adjunctive psychotherapy for bipolar disorder: effects of changing	Journal of Abnormal Psychology	Frank, Swartz, Mallinger, Thase,

The Title	The Journal	The Author & Publication Year
treatment modality		Weaver, & Kupfer, 1999.
Psychotherapy for bipolar disorders – efficacy and effectiveness	Journal of Psychopharmacology	Scott, 2006.

The purpose of the tabulated information above is to emphasise the exact language used when describing research into this disorder. The language is representational. It reflects scientific fact, without space for question. The person who is targeted is the individual, the one who has received the diagnosis. The facts within the article are generalisable. For example, Management of Bipolar Disorder (Grisswold et al., 2000) is meant to be applicable to all people who have received this diagnosis and for all people who treat this illness, regardless of background, training, culture, history and societal similarities and differences. These are just a few of the examples of bipolar mood disorder research which is available. They all emphasise the disorder as something which actually exists: it can be therapised, changed, modified, observed, manipulated, and determined, according to these authors, published in these respectable journal series. These are the assumptions of a modernist framework. The disorder is a known reality which can and should be scientifically and medically treated (Greenhalgh, 1999).

The meaning systems generated and sustained within a scientific and modernist framing are very useful when trying to understand the intricacies of bipolar mood disorder and what the disorder actually means. Within a modernist perspective, structure and fact are knowable, discoverable, and definable. The above titles represent this belief system. Bipolar mood disorder is a disorder which can be treated, should be understood, and must be contained. In this research, the research participants all shared their common belief in bipolar mood disorder being a reified, acceptable and medical fact. This was not questioned. This also helped to create a language domain through which people could talk about what they were feeling, categorised within signs and symptoms of behavioural patterns. But this modernist frame also kept the people stuck, in search of better medicinal practice, more balanced

ways of living, and desperate for the answer which would explain the reason for the illness, and then obviously, the spin-off cure.

From a postmodern perspective, knowledge is socially constructed; the expert and the non-expert are interdependent; and all knowledge is embedded in context, culture, discourse, language, personal experience, and idiosyncratic understanding (Anderson, 1997; Atwood, 1997; Burr, 1995; McNamee, 2002). These assumptions imply that the scientific discourse is embedded within a culture, a context, informed by language and shaped through conversational domains. The scientific psychiatric paradigm cannot be understood in isolation of these facts (Foucault, 1961). Psychiatry is given credence by the people who seek out psychiatric help for the problems that they face. Psychiatry does not hold the absolute truth as it has long promised, but it does offer one particular version of the truth, which cannot be viewed a-contextually, just as narrative therapy cannot be understood without context. The difficulty lies in the fact that psychiatry purports to hold the truth, when in fact, no cure has been produced and people are invested in the search of the right way of doing therapy with bipolar mood disorder as if that would bring about a cure. Strict adherence to a treatment protocol only serves to maintain the status quo. Moving away from this paradigm requires an acknowledgment of the multiple factors that shape the way in which bipolar mood disorder is conceptualised and treatment actualised.

The table above reflects that there is a "singular, stable and knowable reality" (Lyddon et al., 1997, p. 76). Bipolar mood disorder is seen as an objective entity and people who receive the diagnosis believe that they have the attributes of the diagnosis and should adhere to treatment for symptom alleviation. Postmodernism allows the space for questioning these taken-for-granted realities and offers the view of grand narratives which shape the way we understand social phenomena. This means that the psychiatric perspective would be a grand narrative, a universal truth, laden in reified truth and a unique reality only accessible by those who have expert knowledge (Lyddon et al., 1997).

Bipolar mood disorder is constructed in language. For this to happen, there have to be people who speak a similar language. The signs and symptoms of behavioural patterns that have been neatly discerned through the psychiatric and

modernist psychological paradigm have become reified. Science did not discover bipolar mood disorder: an observer did. From a postmodern perspective, the knower is intertwined with the knowledge and the person representing the behaviour (Anderson, 1997). Therefore, any diagnosis that is levelled at another human being, is a reflection of the professional with knowledge. This was made evident through the research vignettes as both treating professionals would have chosen bipolar mood disorder as a diagnosis of choice reflecting the self. As time progresses, scientific research is aimed towards cost alleviation and pharmacological persuasion. The initial intention of understanding the bipolar mood disorder spectrum of behaviours has ended up in treatment manuals, prescribed therapies, and pharmacological interventions. The person with the disorder has been shelved as the object, the generalisable, the reified, and the universal. The framework of psychiatric meaning is not a meaningless entity, but a partial arc of a more enveloping description, one which gives credence to the perspective of all people who participate in this dialogical social construction (Anderson, 1997; Parker et al., 1995).

> Social construction suggests that we examine relatedness – that is, what people are doing together in the interactive moment – and understand any sense of individuality, internal constructs or beliefs as emerging from these forms of relatedness (McNamee, 1997, p. 102).

This research showed the way in which both patients and professionals come together to co-construct the disorder of bipolar mood disorder. Together they gave the bipolar mood disorder a life of its own, a name, a treatment, a life story shaped by this disorder, which in turn shapes the nature of the disorder. The diagnosis was shown to be a relational one, formed in relationship, and maintained in relationships with wider discourses, central to this conceptualisation, being psychiatry. The emphasis on psychiatric treatment and cognitive behavioural therapy would be understood as linguistic constructs, again, taking on a life of their own. There is no such thing as a cognition, but there are people who talk about a cognition as a meaningful entity promoting the point of deficit or need for attainment. One may ask, practically, what does this mean? From a social constructionist view, this would mean that no reality, including postmodernism itself, should be taken to be fact and completely accepted. The beauty of transformation and potential for change and growth lie in the

deconstruction of the institutions and grand narratives that shape the realities we believe without doubt or creative thinking. However, translating this into monetary terms implies that the way in which these constructs are thought about may not be the way in which they are languaged, for example in the context of managed health care which demands assessment and accuracy of diagnosis and treatment, and not a critical questioning stance (McNamee, 2002). Bipolar mood disorder becomes a reality when a therapist accepts a patient for treatment of the condition of bipolarity. The way in which the therapist works with the person and the various discourses is descriptive of the conceptualising of the disorder, even if the psychiatric nomenclature is believed to be only a partial arc of a description. Greenhalgh (1999, p. 324) referred to the concept of "misplaced concreteness" to describe the process of not being able to apply researched evidence to clinical practice. In this case, postmodern constructs are in themselves examples of misplaced concreteness, just as psychiatric research is not generalisable and universal. Postmodernism is very similar to modernism in this sense, as postmodernism advocates meaning making processes regardless of the situation in which that may occur. Failing to make meaning would imply a modernist philosophy when in fact it may be grounded in postmodernism but not applicable within a specific context.

Meaning in Diagnosis

Meaning making as a process of understanding what bipolar mood disorder means and to whom, is largely debatable. Reframing the problem and searching for a narrative which is free of psychiatric language, is in itself a modernist assertion. It steers towards a finite truth and knowable reality (Larner, 1995). Held (2000) has succinctly outlined all meaning making processes which underlie a therapy of choice. These are divided into three parts: the description of the problem; the cause of the problem; and the solution to the problem. Each of these levels informs the other. From a psychiatric perspective, bipolar mood disorder is described according to observable signs and symptoms of behavioural complications and faults. The causes are asserted to be biopsychosocial, and the solution is dual based, including pharmacotherapy and individual and/or family therapy. This is how sense is made of the bipolar mood disorder. From a postmodern frame of reference, the psychiatric paradigm is seen to be a form of social control, moralistic and scientific, and deficit based. The cause is

deferred in favour of explanation and co-constructed realities which shape the way in which the disorder evolves. The cure is void of meaning, as there can be no cure for a discourse and a languaged event. Alternatively, there is meaning attributed to the way in which the disorder is understood among the multiple stakeholders (Frosh, 1995).

Speed (1991, p. 399), commented that "how therapists see problems determines what those problems are… rather than the problems determining what therapists see". This is the golden thread that ties together this research. Whether modernist or postmodernist, the way in which the observer sees and makes sense of the problem is pivotal for what happens afterwards. In the literature review within this research, the perspective of the patient was silenced, and the position of the expert knowledge maker was favoured. The therapist and the therapeutic assumptions were not questioned, or refuted, but rather accepted within the postmodern premise of multiple realities, allowing each their own place within a diagnostic context.

Speed's (1991) assertion is crucial when applied to this research. The way in which bipolar mood disorder is conceptualised is determined by the person making sense of the diagnosis. The diagnosis itself is not a reified entity with an existence of its own. It is given life and momentum within a definitional space. In this case, psychiatry has the most powerful voice among the polyvocal chorus that exists. To follow a psychiatric discipline, one would have to believe in the deficit-model and language around these deficits and abnormalities. Treatment would involve a rectification of undesirable behaviours, and a cure would be a return to normality, as defined by the professional, and not the patient. One has to be very clear about which epistemology informs a therapeutic disposition. There is no better or more correct epistemology (Larner, 1995), but the way in which knowledge is created, generated, and shared is largely based upon theoretical and practical premises.

In the case of bipolar mood disorder, Larner's (1995) proposed theory of paramodernism may be most appropriate. A paradmodern perspective is the "knowing in the not-knowing, power in the non-power, the first-order stance in the second-order stance" (Larner, 1995, p. 208). The paramodern, applied to this context of diagnosis and psychiatric treatment would propose that while simultaneously following the known criteria and descriptions of bipolar mood disorder, the therapist assumes a

doubtful stance in relation to that knowledge in the therapeutic moment. This theory acknowledges the powerful psychiatric discourse and expert knowledge systems and stands in erasure (Parker et al., 1995) of it, suspending complete belief in any overarching all encompassing reality, and simultaneously participating in creating new meanings within these communal discourses. Simply stated, "to resist powerful forces of oppression and injustice in society, therapists must be powerful and knowing, while being non-powerful and non-knowing in therapeutic conversation" (Larner, 1995, p. 210).

Theme 5: Disconnection and Connection

His tormenting loneliness and sense of being an outcast were reflections of an omnipresent, though sometimes hidden, depression; they erected a barrier that isolated him from human companionship. Being in a crowd and becoming aware of the closeness of happier people in it intensified the loneliness and drove him further back into himself. He longed for intimacy with others, yet sought out solitude: it was the lesser of two evils. When he felt rejected or unsuccessful in a task, the self-doubt and self-depreciation of depression were intensified. Feeling guilty and doubting his own worth, he often thought that others regarded him as bad and worthless; human intimacy therefore threatened him with punishment and shame (Lubin, 1972, p. 2).

The reality of bipolar mood disorder is socially negotiated. Social constructionism is centred on a belief in the importance of relationships (Raskin, 2002), and the co-ordination of events that occur between people in interaction that brings about meaning making systems (McNamee, 2002; Shotter, 1993). A feeling of connection and disconnection implies movement within a relationship. Given the nature of the bipolar mood disorder, there is continuous movement between phases of mood, interactional patterns, and perceived distance and closeness. The focus of the literature has been on the individual and on identifying the site of pathology. The interactional patterns that emerge around this social construction of a disorder have been neglected.

Jamison (1995, p. 215), a leading psychological authority on bipolar mood disorder (having been given the diagnosis herself), said the following about the illness:

> For someone of my cast of mind and mood, medication is an integral element of this wall: without it, I would be constantly beholden to the crushing movements of a mental sea; I would, unquestionably, be dead or insane. But love is, to me, the ultimately more extraordinary part of the breakwater wall: it helps shut out the terror and awfulness, while at the same time, allowing in life and beauty and vitality.

This quote by Jamison is very interesting in that her book focuses on biological genetics, psychological rationality, and scientific logic as explanations for this disorder, and then she culminates with an overarching description of the necessity of love and care. Within the psychiatric frame of reference, relationships are only viewed as a blamative aspect of bipolar mood disorder, for example in the highly expressed emotions of family interactional patterns (Miklowitz, 2002). The connection that is offered through relationships is sorely underestimated.

A mood disorder constitutes the highest risk factor for suicidal acts (Rihmer & Pestality, 1999). The reasons for this high risk have been cited by Rihmer et al. (1999) as under-diagnosis or misdiagnosis; co-morbidity; the choice of method for the suicide attempt; social prominence; and creativity. A loss of stature and energy due to the cyclical nature of the mood swing may leave a person feeling depressed and therefore more prone towards suicidal action. Rihmer et al. (1999) suggest that the role of the treating professional is to see past the veneer of the impulsive behaviour and recognise the severity of the mood instability. This would supposedly allow for appropriate care. The authors go on to say that:

> Only then can the physician provide the requisite compassionate care that provides the context of a therapeutic alliance in which the physician can learn about the patients' assets – such as their social and creative bent – and, while treating them medically, minimize the destructive potential of the unstable mood states (Rihmer et al., 1999, p. 672).

Again, it is the nature of the therapeutic relationship that is pivotal in providing an understanding and caring relationship from which bipolar mood disorder can be explored. One can only imagine how lonely and desperate a patient can become without a relationship of connection. Bipolar mood disorder serves well to provide opportunities for disconnection (Jamison, 1995) through erratic and unreasonable behaviours. The contradiction of the disorder lies in the fact that the person who receives the diagnosis is in fact seeking relationships of connection, but achieves disconnection, which becomes a platform for the logical conclusion of suicidal intent.

Schlebusch (2005), a well known South African researcher into the phenomenon of suicide, advocated that the "doctor-patient relationship is the nucleus of the psychotherapy process" (Schlebusch, 2005, p. 63). He believes that it is through this beneficial relationship that a person's suicidal intent can be lessened, depression ameliorated, and the person's psychological suffering can be reduced. For Schlebusch (2005, p. 63), death is not what is desired, but rather, "escape from unbearable psychological anguish is what the patient wants". Jamison (1995) would agree with this assertion. One would ask, how this is possible, given the time constraints and inherent difficulties associated with psychiatric practice within South Africa. The body of bipolar mood disorder research, the authoritative voice of reason, does not even focus on the therapeutic relationship as important, but rather on what the professional needs to do to the patient to bring about change (for example, Whitfield et al., 2003; Wright et al., 2002).

Johnson et al., (1999) determined that social supports are instrumental in shaping the course of bipolar mood disorder. They concluded their research by saying that "it appears that both positive and negative aspects of relationships are important determinants of bipolar symptoms" (Johnson et al., 1999, p. 563). The outcome of their research was to advocate that social supports are untargeted interventions which may be useful in alleviating specific phases of the disorder. Their research points towards the inclusion of family and interpersonal psychotherapy for any treatment of bipolar mood disorder (Johnson, et al., 1999). The disconnection experienced by bipolar patients would seem to be a silenced aspect of the illness, with the focus leaning towards amelioration of signs and symptoms of overt behaviours. The pattern

of shifting manic and depressive episodes would necessitate an understanding of alternating patterns of connection and disconnection.

Griswold and Pessar (2000) support the notion that psychosocial stressors precede the onset of manic symptoms and cause mania to escalate rapidly. The fact that the patient is in direct interaction with people means that a bipolar patient is potentially always exposed to the possibility of a manic episode. Obviously, this vulnerability is also exacerbated by a range of factors, such as sleep variations, the therapeutic effect of the medication, and thoughts about the self and others.

The family inclusion in any diagnosis and treatment is especially highlighted in bipolar mood disorder because of the serious effects that the behaviour can have on the family, which include risk taking behaviours involving sexual deviance, gambling, spending sprees, and high speed driving. The family should also be made fully aware of the procedures to follow in the case of getting their loved one committed to an institution as well as the legalities involved in overspending while under treatment and in a manic phase. Common feelings experienced by family members are "guilt, anger, grief and ambivalence" (Griswold & Pessar, 2000, p. 1354). In the research that was conducted for this study, family members played a minimal role in the patient's treatment. Husbands did visit their wives during periods of hospitalisation, but only briefly. They both refused to consult with the psychiatrist and the psychologist for educational purposes. The research participants expressed the belief that their children experienced the feelings documented by Griswold and Pessar (2000) more so than their husbands. They also felt that they were helpless in changing these feelings and this contributed to their feeling of depression. No family therapy sessions were attended by either of the research participants.

Further, Griswold and Pessar (2000) suggest that the following issues be dealt in family based sessions: education about the effects of medication; warning signs of relapse; stress management techniques; sleep hygiene; the benefits of regular eating and exercise habits; the cons of alcohol and caffeine intake; and managing work and leisure activities (Griswold & Pessar, 2000).

Goin (2002), explained the process of disconnection and subsequent connection as necessary steps in coming to terms with the bipolar illness. She describes the patient's reactions as predictable and includes emotions and feelings such as denial, anger, ambivalence, and anxiety. These feelings can contribute to the patient disconnecting from social support systems, and should therefore be addressed in any clinical setting. Themes that were highlighted by Goin (2002) included loss and compliance. Loss refers to loss of relationships, employment, marriage, familial relationships, and extended family connections. Goin (2002) goes on to say that these relationships can be so adversely effected by the disorder, that they may even be seemingly irreversibly damaged. Compliance, according to Goin (2002), is seated in knowing the patient. This perception is contrary to popular literature that advocates that the patient is responsible for compliance. From Goin's (2002) perspective, compliance centres on understanding the patient within context, and therefore being more informed as to the hindrances that may obscure a treatment plan. According to Goin (2002), the bipolar patient will be better off if these feelings mentioned above are worked through in therapy and if issues of loss and compliance are properly dealt with. Again, Goin's (2002) comments refer to the value and necessity of a therapeutic relationship. Goin's (2002) paradigm of thought is psychodynamic and refers to concepts of transference and counter-transference; but regardless of the school of thought, her intention is to assist the patient to deal with the diagnosis and disorder as it creates havoc in the relationships of that person's life. Goin (2002) concludes that the role of the clinician is to be a containing force, providing a stable environment for the patient's thoughts and behaviours. The aspect of therapeutic connection cannot be emphasised enough.

On the other hand, there are the psychiatric researchers who claim the following:

> The weight of evidence suggests that the presence of cognitive dysfunction in bipolar affective disorder is a core and enduring deficit of the illness. The deficit is best characterised as an impairment in the attentional or executive control of action, and represents an important marker for future neurobiological and pharmacological research (Ferrier & Thompson, 2002, p. 295).

The influence of such researchers' assertions on the course of psychotherapy is paramount. They conclude their research by saying that therapy should account for the patient's inability to store, process, and retrieve new information, which could hinder the patient's ability to learn new behavioural responses. This type of research promotes an ecology of disconnection, separating the patient from the 'expert' doctor. The focus on the deficit model clearly contributes to a hierarchical relationship in which the patient is in deficit of cognition and the doctor is the expert in knowing this. The irony is that the most effective psychological treatments to date are the cognitive behavioural therapies, which rely heavily on cognitive processing, problem solving abilities, and the capability to acquire new information (Scott, 2006). This research by Ferrier et al. (2002) contradicts what is widely accepted as fact.

Holmes (2000) advocated that it is the psychiatrist's responsibility to equip him- or herself with the necessarily therapeutic skills to be able to engage in meaningful conversational realities with patients. The call for psychiatrists is to move from efficacy towards effectiveness (Holmes, 2000). This type of movement towards the biopsychosocial practice of psychiatry would surely assist with providing sources of connection and not merely pharmacological input.

Whatever the nature of the therapeutic intervention, one should be aware that the patient vacillates between positions of feeling connected and then disconnected. This can be attributed to the mood swing of the day, and can be elevated by interactions with family members and friends, as well as psy-complex practitioners. The ecology of the treatment system, the discourse of psychiatry and deficit-based models of understanding, and the discursive practice of psychotherapy, all inform the way in which connection is felt and perceived as well as disconnection. The world of the bipolar patient is neatly constructed in terms of psychiatric influence, and yet it is exactly this influential system which places a shaft of disconnection between the professional with knowledge and the patient without reason. The importance of connection and disconnection cannot be neglected when dealing with this particular social construction.

Theme 6: Belonging

The theme of belonging is a loosely defined one. It cannot be found in psychiatric literature as it is a vague concept, which cannot be reified or observed, or measured. It is embedded within context and is infused with multiple meanings. For some people, belonging is a membership to a particular group, and for others it is an association with a culture, or a place. The way in which belonging is constructed in the world of bipolar mood disorder is indeed reflective of wider social discourses. The therapeutic intention of understanding bipolar mood disorder necessitates an investigation into the ways in which people collaborate to form meaningful places of belonging.

In overview, the diagnosis of bipolar mood disorder immediately implies several places of belonging: within a psychiatric system; within a grouping of society which is considered abnormal and in need of medical treatment; and as a person with a deficit seeking a surplus, in this case knowledge acquisition and control of thoughts, behaviours and feelings. The diagnosed patient also exists within family, social, cultural and religious institutions of belonging. The schism felt between these taken for granted places of belonging and the associated feelings of disconnection implies a contradiction and a need for deconstruction.

To belong to the diagnosis of bipolar mood disorder, one would have to exhibit sufficient deficits which are observable and languaged between the doctor and the patient. From a postmodern perspective, the construct bipolar mood disorder is in itself a mere construction of reality (Walker, 2006). It does not really exist and can be redefined by all the stakeholders. The construction of bipolar mood disorder creates the reality of bipolar mood disorder. This is evident in the nature of the questions asked by the doctor as well as in the widely accepted nosologies of description. The reality that is entered and entertained by both the doctor and the patient is one in which they create the way in which bipolar mood disorder shapes the patient's life and is concurrently shaped by it. You cannot get bipolar mood disorder, but you can create a language system which defines this disorder and in turn defines the people within the diagnostic cluster. This offers a space for belonging.

The reason that this theme is important and has relevance is because of the way in which it was prevalent among all of the research participants. The ways in which their lives were shaped around the diagnosis of bipolar mood disorder created a need and a search for belonging. This search included a yearning for a sense of belonging to communities which were no longer rewarding (such as the church, friendships, and professional circles) as well as a need to belong to communities which were understanding and non-judgemental of the illness, and of the way in which psychiatry and psychology was practised. The diagnosis immediately labels a person as not being within a normal range of behaviours and actions. The category of placement is on the fringe of society, ill, and dependent on others to make life decisions. Who would want to belong to a community that has no overt voice, and cannot assume personal responsibility for choices and decisions without them being thought of as irrational and unreasonable?

Belonging is also a socially constructed phenomenon implying that a person is respected and legitimised. The way in which the literature creates belonging for the patient is within a relationship of imbalance. The patient is deemed to be in need of expertise and the doctor is thought to be in control of the knowledge. Any efforts to shift this given relationship will cause disruption and the patient will be labelled non-compliant and rebellious, unreasonable and also possessing a lack of insight. The other extreme is just as rejecting. A postmodern relationship that claims to be non-hierarchical is just as damaging. The research has shown that psychiatry has a definitive place in understanding bipolar mood disorder and medication may be necessary in providing thought coherence and mood stabilisation. The art of engaging in relationship, a postmodern construct, cannot alone provide the stability required for normal behaviour, from a modern perspective (Strong & Lock, 2005).

Psychiatry itself does not belong within traditional scientific frameworks either (Tarnas, 1991; Walker, 2006). Postmodernism does not explain the need and the necessity of psychiatric treatments. Psychologists who do not practise either modernist or postmodernist premises are left not belonging (Larner, 1995). Patients who do not adhere to a treatment protocol are deemed untreatable. Scott (2006) relates the reasons for bipolar mood disorder not being a primary research concern among the helping professions as follows: medical treatment backed up by biological research

has been the only prescribed treatment of choice; there is a misconception that people fully recover from episodes and therefore they are able to return to premorbid functioning; and lastly, patients were thought to be unsuitable for psychotherapy given the nature of the mood swinging pattern of behaviour. The discourses of medical and biological inferences, views of normal and abnormal behaviour, and deficit-based approaches, have all shaped bipolar mood disorder to be what it is today. There is no scientific evidence which states that bipolar mood disorder is more malleable to treatment, or that patients can be more suited to psychotherapy. The social discourse redefining bipolar mood disorder by various stakeholders is behind the reformulation of bipolar mood disorder as having a necessary place within the field of psychiatry and therefore as being worthy of attention.

The disorder itself has lacked belonging and has shifted in its name from manic-depressive illness to bipolar disorder to make it more widely available for diagnosis and discussion. The treatment of the disorder under the name bipolar mood disorder has allowed for a wider array of treatment in terms of drugs of choice, as well as therapeutic interventions. The disorder itself did not change, but the perceptions of what it represented, did shift.

Within a modernist deficit paradigm, belonging is a non-scientific construct and belongs to the softer psychological sciences (Parker, 1999). The postmodern turn within psychiatry and psychology is calling for a reinvention of commonly accepted terms, such as bipolar mood disorder and curative treatments (Healy, 2006; McNamee, 2002; Walker, 2006). The shifts away from reified concepts such as mood instability, signs and symptoms, observable behaviours independent of the observer, all call for a more socially grounded and contextual understanding. The difference that this will make for a theme such as belonging, is that it will have meaning, for all of those who participate in the definitional context of bipolar mood disorder. The move towards potential, away from diagnosis, is one example of changing world-views (McNamee, 2002). People are beginning to embrace the idea that a construct such as belonging, or the opposite position of alienation, should have an accepted place within the literature. Jamison (1995) exemplifies this when she refers to the importance of the relationships in her life as being instrumental in providing stability.

The postmodern influence brings with it uncertainty, and a need for fluidity and constant change. This resonates with the bipolar diagnosis. The modernist epistemology is flat, scientific, one-dimensional, objective, and free from emotions. This is the perfect example of what the treatment methodologies are trying to attain, that is, a stable sense of normality, as opposed to change, observer inclusion, self-referential and reflexive thinking, and multiple created collaborative constructs. Bipolar mood disorder, in this sense, heralds the movement of postmodernism. The belonging that a person feels should be indicated in the way in which that person is able to change, experience opinions of difference, share oppositional and thought provoking ideologies, and not feel rejected at the end of the day. The need for belonging is not just a concept relevant to the patient being treated, undergoing changes in known ways of behaving, but also in the world and work of the psy-fraternity, the community, the society, the religious beliefs, and the cultural norms and values. If the postmodern move towards flexibility and fluidity was accepted on a broader scale, people would not feel alienated and rejected, but understood and accepted for all the differences they bring to colour the world of psychology.

Bipolar mood disorder is a meta-reflection of the way in which psychiatry itself is not fulfilling the promises of cure and mental health through the benefits of pharmacological intervention that it promised. The mood variations continue. To bring about change one would need to shift to another epistemological level and understand change for whom, and to what end, and at what cost for all the people involved. The relationship of treatment is what is crucial. The mood swings are embedded within relationships and the overt behaviour is commentary on the fluidity of process and meanings. The shift towards understanding a person's behavioural inconsistencies within context, within discourses which discursively shape interventions, is what is needed, rather than a globalised and generalised scientific rhetoric which seeks to blame and blocks knowledge of difference. The bipolar mood disorder spectrum of understandings and definitions allowed for each person who participated in this research to belong to a research domain, provide knowledge, and achieve a sense of self-worth and belonging. The moods may continue to spiral, the treatment may fail or succeed, but the stories have been shared and offer intricate understandings of how each person, be it patient or treating professional, is

contradictorily exposed, fallible, and a failure in the eyes of science. It is no wonder given the great skill of adaptation and flexibility.

Griswold and Pessar (2000) recognised the effects of stigmatisation on the patient and recommended that this issue be addressed through collaborative relationships, such as the doctor – patient system. They argue that the stigma associated with diagnosis should be displaced with the benefits of education and support, and should be continuously negotiated with the assistance of the family doctor, and/or psychiatrist, and/or psychologist.

When a person is diagnosed with bipolar illness, there is an immediate membership given to the psychiatric fraternity. The patient belongs within a medical system of treatment. This treatment has certain rules and regulations, such as remaining compliant with medicine and therapy sessions. Any deviance from the prescribed rules of interaction can have serious consequences for the future treatment of the patient. There are mutual expectations which are formed in the relationship between the psychiatrist and the patient. The patient expects that the treating professional will be supportive, providing guidance and knowledge, and aim towards cure. The doctor expects that the patient will adhere to a prescribed treatment. Any deviation from the mutually defined expectations can leave the patient in a position of being rejected from belonging to this particular community.

The theme of belonging, a softer psychological and philosophical construct, was important in allowing for an understanding of the social construction of bipolar mood disorder. The advocated treatment approaches, such as CBT, will fall short if they do not account for this integral theme which runs through the course of the diagnosis, knitting together all the role players into a tapestry of a socially defined mental illness. Bay et al. (2002) found that a psychological sense of belonging (or lack thereof) is a greater predictor of major depression than other commonly understood factors, such as social supports, conflict and loneliness. The traditional therapies aim towards developing social support systems through family interventions and family restructuring processes. Conflict has long been associated with the bipolar spectrum disorders and patients are often taught alternative methods of dealing with conflict and shifting interpersonal communication styles. Bay et al.'s (2002) research

is interesting because it impacts on the way in which bipolar mood disorder is understood. Depression, being one pole of the spectrum of mood disorders, is grounded in relationships and forms of connection. Belonging is what each research participant was seeking in this research context. Medication cannot treat belonging. This is the work of the psy-fraternity together reformulating the way in which bipolar mood disorder has been defined, treated, and understood.

Conclusion

The themes in this chapter have been discussed in terms of the surrounding field of existing research and literature. There have been areas of similarity, but probably more of a difference. Bipolar mood disorder is not a simple diagnosis and the research discussed above has highlighted some of the contradictory and subjugating elements of the way in which bipolar mood disorder is currently understood. Any conceptualisation of bipolar mood disorder entails a thorough and detailed explication of underlying assumptions, epistemological framings, and discourse dynamics. The diagnosis itself has been shown to be a non-scientific construct, one which is grounded on moral and social standards. The preferred treatment models do not balance with the way in which the disorder has been defined. The schisms that were extrapolated from the research interviews suggest that bipolar mood disorder is multiply defined, loosely understood, and drenched in meaning making processes.

Themes such as connection and belonging, systems of power differentials, problem determining and meaning generating systems, all indicate that bipolar mood disorder is more than a linear spectrum or continuum of mood disorders. It is a cyclical process, reflexive and discursive. Bipolar mood disorder is created by people, and in turn creates the way in which people view the world, and themselves, and interact accordingly. Bipolar mood disorder could very well be reconstructed in any treatment setting according to idiosyncratic definitional ceremonies of shared communal interchanges. The disorder does not need to remain scientific and narrowly constructed to be cured. Broader based understanding offers a position of nothing to lose and all to gain. This thematic reconstruction has attempted to offer one such

deconstruction of the intricacies within a psychiatric term which shapes the way people live.

CHAPTER ELEVEN

Process Models: Demarcating Nodal Points

Introduction

This overview of the research provides four models which map out the processes of this thesis. Firstly, the research process is viewed, highlighting the permeability of the construct of bipolar mood disorder, shaped by meaning patterns and problem discourses. This diagram is aligned with the research chapters that dealt with bipolar mood disorder conceptualisation and contextualisation. Secondly, a grand overview is presented which focuses on the epistemological creation of bipolar mood disorder and details the multiple factors which reciprocally shape such a diagnosis. This model also journeys the researcher's position throughout this research. The third simplistic model neatly indicates the rolling and circular nature of linguistically defined problems and formulates the interlinking steps involved in problem definition. The last model presents an overview of the themes generated by this research, entailing a brief description of the relational value embedded within each theme, and exposing the interactional dance between them.

Bipolar Mood Disorder Construction: A Cross-Sectional View

If one could slice the thesis one would be able to view the way in which the stories of bipolar mood disorder culminate to form a circular description. The model below (figure 1) is an attempt at depicting an interactional dance between the construct 'bipolar mood disorder', the various knowledges that give shape to it, the patterned constructions that confirm the diagnosis as a possible reality, and the problem discourse which entrenches the diagnosis. The notepads in this diagram cover three broad areas that were explored in this research, including the existing literature, the emergent discourses and emergent themes. The outer circle connects all of these elements together, and the internal connectors indicate the reciprocal influences of these dimensions.
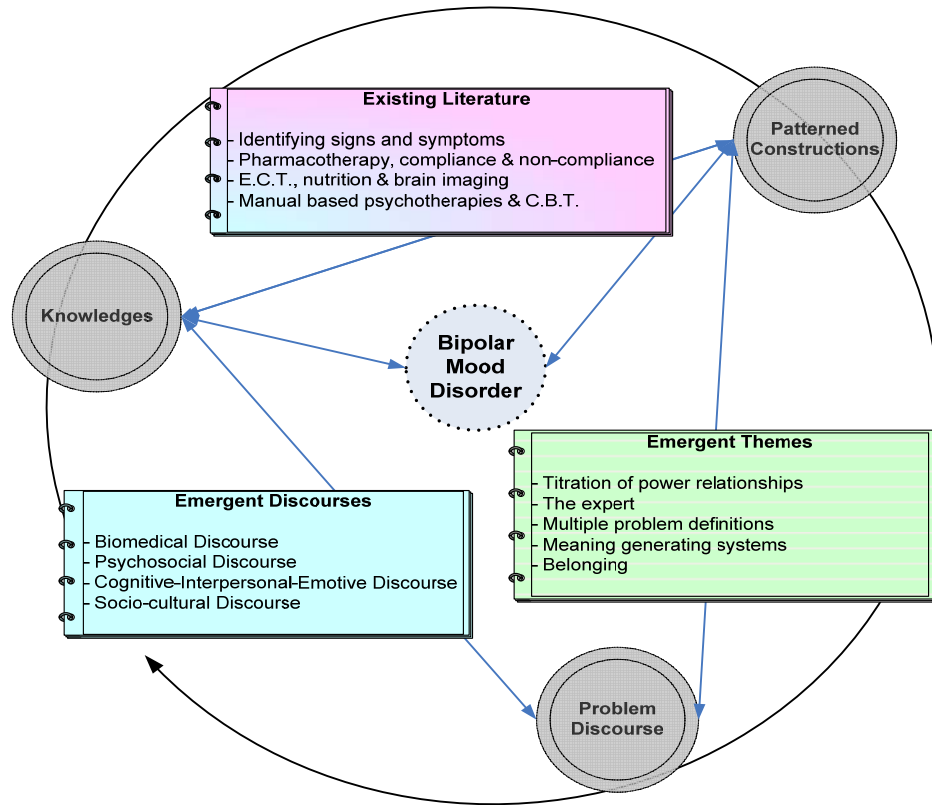
Figure 1: Problem-Determining Systems

Bipolar mood disorder: An Epistemological Story

The process model that has been created to diagrammatically represent this thesis is constructed on the basis of circular and reciprocal interactions. This is not meant to be a static diagram, but rather one which is dynamic and interactional. The observer's position also contributes to the understanding of the model. A model can be seen as a set of statements that accurately represent a phenomenon under study (Downing, 2000). Both theories and models are seen to provide causal accounts of the world, bringing conceptual coherence to the domain of science, and simplifying an understanding of the world (Mouton, 2001). Although these are 'scientific' aspirations, they are also a way of drawing a distinction (Keeney, 1983), and this researcher hopes to maintain a critical position always questioning 'as if' (Downing, 2000).

The model below (figure 2) has juxtaposed the journey of the researcher. The researcher began with a research question which queried the value of epistemology in

working with bipolar mood disorder. This could be seen as the outline or framing of the model. Looking into the world of bipolar mood disorder from a postmodern perspective was one possible view taken by the researcher. Following the literature write-up, the researcher was swayed towards a modernist position, doubting her postmodern beliefs and entertaining uncertainty. Entering the world of bipolar mood disorder allowed for further thick description and multiple descriptive levels of meaning emerged. The simple diagnosis of bipolar mood disorder began to unfold and showed that 'it' could not be simplistically viewed from an either/or position of modernism or postmodernism.

The polarised positions of mania and depression were embedded within multiple discourses, relationships, language, and models of medicine. Exploring bipolar mood disorder widened the researcher's lens to include the necessary positions of a both/and approach. This meant that previously held assertions underlying postmodern assumptions were re-invented and assimilated within a medical framework, and the traditional medical model was seen to be a possible system within a broader postmodern theory. Both positions necessitated legitimisation.

The diagram that follows (figure 2) has its starting point in the centre of the circle. This is then meant to broaden outwards towards the bordering four systems which look into the circular model. The arrows, within and on the outside of the model indicate the flow and movement of the ecological map. If one cut out the circle and rotated the blue shaded areas, then one would see that the psychologist shifts from the mutual influence of the psychological discourse, the family, and power relations, towards conceptualising diagnosis, or even being exposed to the psychiatric discourses, which shape the field and practice of psychology.

The same could be done with the outer green shaded area which would then shift meaning to align with a modernistic, postmodernistic, relationship and/or bipolar lens which give meaning to the way in which the discourses are reciprocally shaped. Therapeutic techniques, actualised from a modernist position are very different from the grounding assumptions of postmodern 'techniques'. This diagram is meant to be

captured in momentum, not static. In this process, causal relations may be depicted, but they should be quickly deconstructed through the momentum of movement.
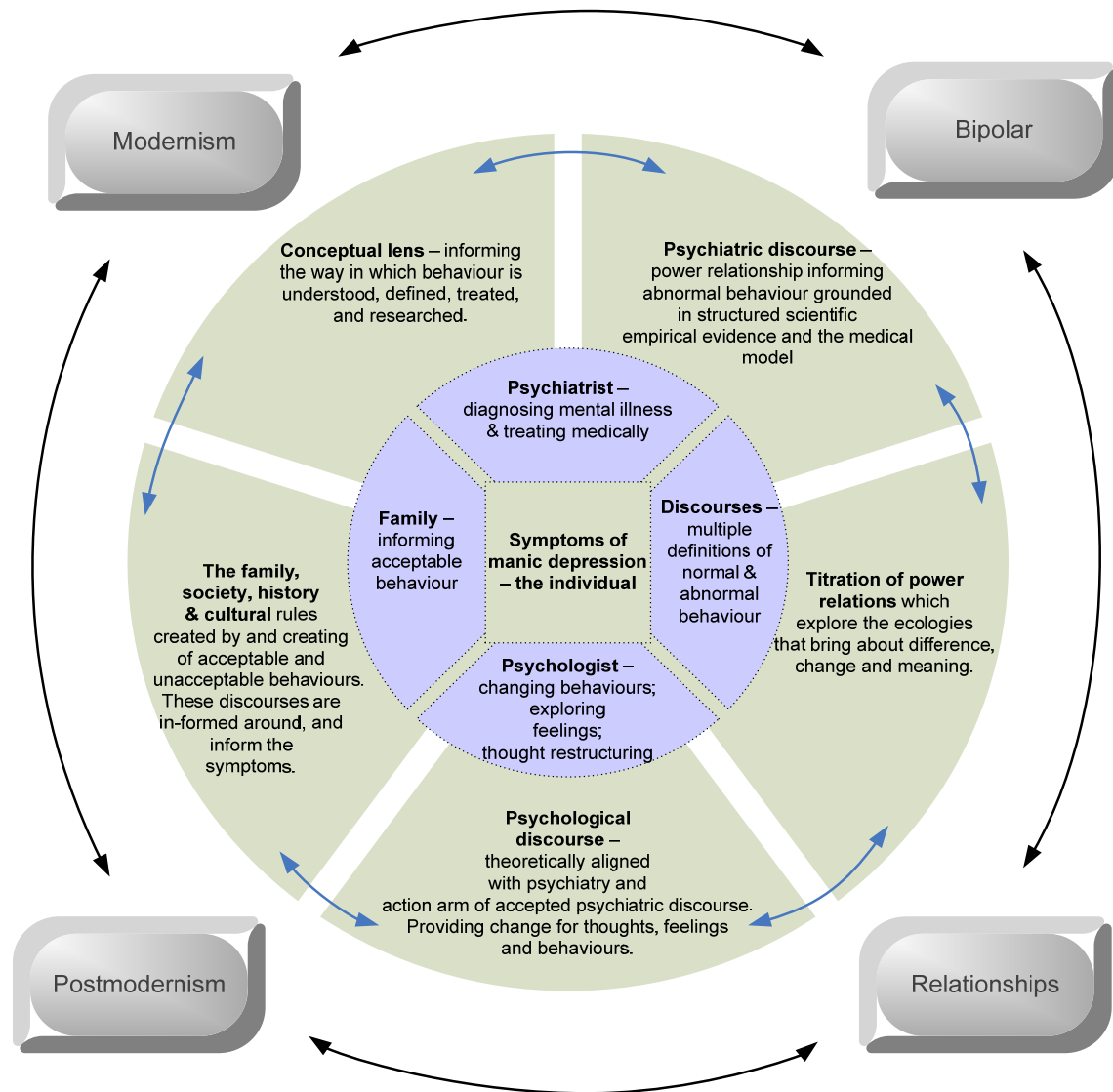

Figure 2: Polarised Epistemologies – Conceptualising Bipolar Mood Disorder

The construction of bipolar mood disorder was informed by many discourses, levels of relationships, and belief systems. These systems all merged together to linguistically co-create a problem-determined system (Guterman, 1996). Once the system was formed, patterns of abnormal versus normal behaviours were entrenched, psychiatric and psychological treatments were embarked on, and families shifted ways of behaving, both protecting and limiting the person with the diagnosis.

At the outset, bipolar mood disorder appeared to be a clear-cut, and well-researched phenomenon (a meta-narrative). A person would be given the diagnosis if he or she expressed symptoms which mimicked that of a mood disorder involving mood swings from mania to depression, vice versa, and even simultaneously co-occurring. This would lead to medical interventions, cognitive-behavioural therapy, psycho-education, and hopefully mood stabilisation. This is what the body of literature purported to be a 'truth'. But, this research showed that there are many intricacies involved in diagnosing, treating and living with the disorder. These aspects have not been spoken of in previous research.

On a   process level, the elements of research that have been omitted from previous research projects have been the arrows presented in the diagram above (figure 2). The content, from a formal expert position (Guterman, 1996) has been well documented in previous research endeavours. The informal content, that is, the position of the client, has been left unexposed in favour of the treating professional (Guterman, 1996). The research into bipolar mood disorder has therefore been static, unrepresentative, and monologically created and disseminated. This thesis has explored the many levels of interaction, embracing linguistic problem formulations, exposing contradictions, and culminating in circular inferences.

The postmodern assumptions of reciprocal interactions, self-reflexivity, and acceptance of multiple ontological descriptions, have been actioned through this thesis. But, this was only made possible once the modernist concept of bipolar mood disorder existing as a knowable entity was accepted, albeit as a meta-narrative. Demarcating bipolar mood disorder as a 'truth', existing as a disorder, and treatable through psy-complex knowledge and interventions, allowed for the circle to turn and alternative positions to be viewed. There is value in the modernist descriptions as they have been offered through research and literature, but they only focus on formal content, and not process and informal content. The circular model indicates that there are many levels of description and lived experience, and modernism is one of them, just not the only one, as research would have one believe.

Creating the Problem: The Circular Formation of a Linguistic Event

The model below (figure 3) further describes the way in which the problem is created by the client and the psy-fraternity, along with the discourses and accepted views on abnormality. This is a simplistic description of the process involved in the evolving process of diagnosis and lived experience.
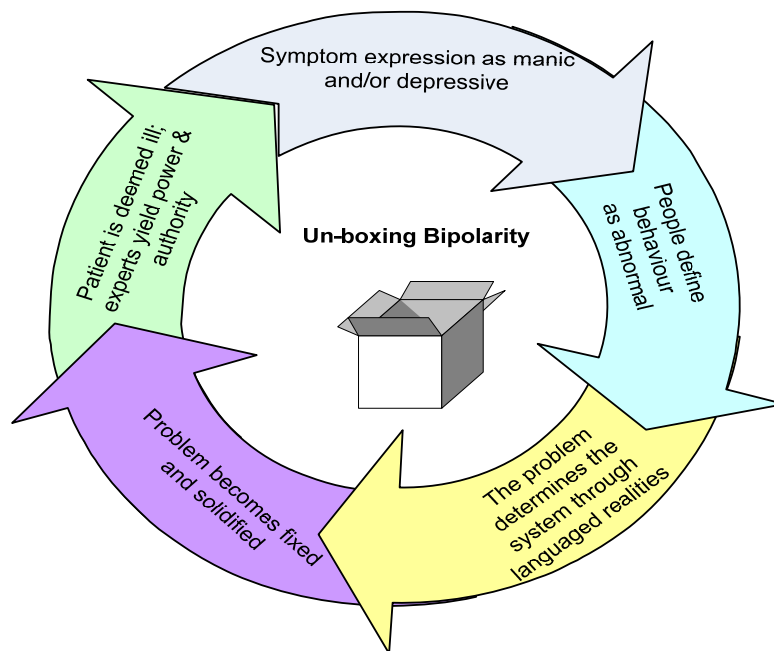
Symptom expression as manic and/or depressive

Patient is deemed ill; experts yield power & authority

People define behaviour as abnormal

Un-boxing Bipolarity

Problem becomes fixed and solidifed

The problem determines the system through languaged realities

Figure 3: Linguistically Problem Determined System

The diagram above depicts one of the ways in which bipolar mood disorder is linguistically co-created. Bipolar mood disorder is shown that it is not an entity which exists in isolation of people, instead it is informed by the people who experience and deal with it. Each level of bipolar description entails a circular description of development. To move between a psychological discourse and a psychiatric discourse, the problem at hand is re-defined and re-shaped. This process involves a further layering of meaning and reality construction, and so the process un-folds.

Traditional medical model researchers would have one believe that the problem is intrinsic to the individual and can therefore be treated through medication

and thought restructuring techniques. When the site of pathology is shifted to include the family, they too undergo family therapy and psycho-education to improve the signs and symptoms of mood instability as represented by the individual. These problem formulations are powerful in that they promote the position of an expert knower and an uninformed participant. This research has aimed towards including the positions of all the role-players and naming them expert owners of their own idiosyncratic knowledge processes. The power differentials firmly keep the diagnosis in the hands of the professionals, subjugating the person with the illness to a vicious circle of failure, constant mood instability, and a label that is inescapable. This research has looked at the multiple discourses which have collectively shaped the diagnosis, including that of the traditional medical approach and the more oppositional postmodern framework. Bipolar mood disorder is not necessarily a continuum of mood variability, but very possibly, a circular description of many layered discourses which gain expression through symptoms of mood.

Thematic Synthesis: Exploring the Stories

The model below (figure 4) depicts a diagrammatic representation of the themes that emerged from this research thesis. The themes were embedded in the context of bipolar mood disorder, from inception towards multiple descriptions. Each theme was interdependent and could be superimposed upon multiple layered realities, be it the psychiatric discourse, the psychological, or even the broader society. The diagram that follows indicates how each level of description emanates from the social construction of bipolar mood disorder and in turn redefines the diagnosis. The story of bipolar mood disorder is separated into chapters and follows a logical order for the benefit of clarity and complexity. But, in essence, all of the chapters in this thesis are intertwined and contribute to the postmodern conceptualisation of bipolar mood disorder. The need for simplification and process modelling is aligned with a more scientific paradigm of research, defining the outcomes for readers. But, given that this is a research project which has allowed the space for multiple realities co-existing (that is, both modernism and postmodernism), it is necessary to provide these models as a point of departure for self-conceptualisation and determining one's own beliefs.

The models are created for discussion purposes, hopefully creating the space for arguments, personal ontological development, and epistemological uncertainty.
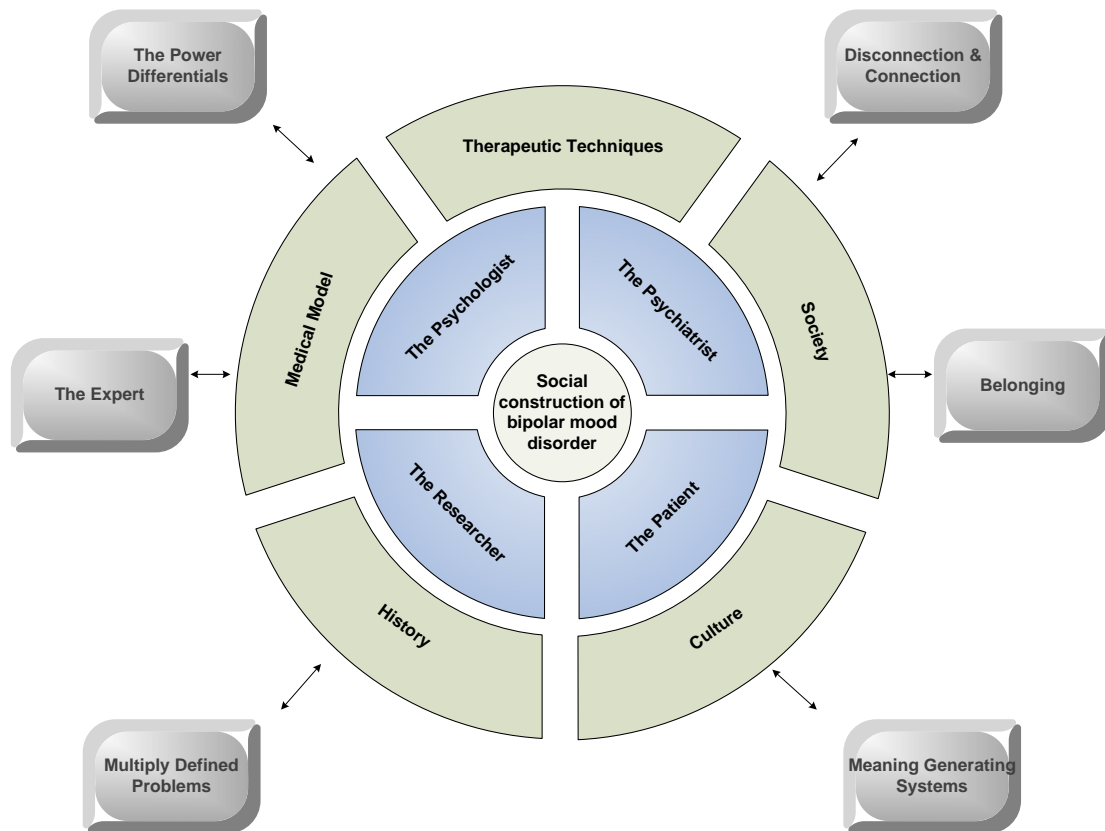

Figure 4: Thematic Synthesis

The inner circle begins with the defining of a person's behaviour as abnormal and fitting within the medical model's classification system. This nucleus of the research was seen to be a collaborative event, shaped by the views of the patient, the psychiatrist, the psychologist, and the researcher. The co-researchers arrived at each interview with their own histories, belief systems, and knowledge structures. Therefore, the outer level of history, society, culture, medical model and therapeutic techniques contributed to defining the behaviour as bipolar. The themes that emerged from this ecological development included multiply defined problems, meaning generating systems, the expert, belonging, the power differentials, and connection and disconnection. The seed of bipolar mood disorder is grown through the interactions of these multiple layers of human and knowledge interfacing. All of these factors, systems, and conversational domains shape, and are shaped by, the diagnosis of bipolar mood disorder.

The treatment of bipolar mood disorder is therefore not merely the individual with the diagnosis. Medication can alleviate suffering, mood and thought distortion, but a cure remains impossible unless the problem formulation is shifted towards being inclusive rather than exclusive. Bipolar mood disorder serves a function in keeping systems together, and the label also allows the person to feel that there is something actually wrong, treatable with medication. The society demands emotional and mental well-being, and any aberrations should be eliminated. The diagnosis of bipolar mood disorder creates a nodal crisis point, bringing together various psy-complex role players, family members, and interpersonal shifts, which are all deemed necessary for attaining a position of mood normality. The diagnosis itself is therefore informed by wider discourses, which in turn, shapes the discourses that inform meaning. Simplistically diagnosing and treating the person deemed ill will fall short of symptom alleviation, which will in turn feed a negative cycle of failure and helplessness. The themes that have been generated in this research are in themselves meta-narratives, waiting to be deconstructed and built upon, preventing stagnation in the field of psychotherapy and within the theoretical domain of psychology. The intention of the research is to provide congruence between epistemological starting points and the process of actualising these tenets. One way of doing so, is through the deconstruction of taken-for-granted beliefs, such as the 'water-tight' diagnosis of bipolar mood disorder.

CHAPTER TWELVE

Conclusions and Recommendations

Psycho'therapy' is an educational process between two or more people, one of whom is called therapist and the other patient. These individuals work together toward changing the personal operating paradigm of the individual referred to as the patient. Psycho'therapy' is an enterprise directed by the science of psychology and justified by the tenants of humanistic morality. It is a process that has a historical and social context with political, economic, spiritual, and creative ramifications. As a process, psycho'therapy' is embedded in the everchanging social, political, educational, and religious institutions that comprise a society. It is both affected by and affects the totality of the social enterprise of which it is a part.

L. Simon (1994, p. 174)

Introduction

This chapter will provide an evaluation of the research project. Strengths and limitations of the thesis will be explicated, and attention will be given to recommendations for future research.

Evaluation of the Study

The research aims of this thesis were demarcated according to five areas of interest. Each aim was intricately connected to the next one and they have been discussed separately to provide clarity.

The **first** aim was to write up a literature review covering the **traditional** and historical understandings of bipolar mood disorders. This gave an overview of the historical development of manic-depressive illness to the currently defined bipolar

mood disorder. Various research findings were presented in terms of diagnosis, prognosis and outcome. Treatment strategies and interventions were also addressed. The review focused primarily on the psychiatric paradigm and steered away from the philosophical debates of postmodernism. This was a modernistic overview and description of bipolar mood disorder.

A **second** aim was to offer a **postmodern** description of the bipolar mood spectrum. This entailed research interviews with two diagnosed bipolar disorder patients (bipolar type I), a psychotherapist and a psychiatrist who work with the defined disorder. These interviews were conducted from a qualitative, social constructionist stance. The intention was to generate meaningful descriptions of patterns of behaviour associated with the diagnosis.

A **third** objective was to explore the possibility of a **synergy** between the two above mentioned aims (the two polarised epistemological positions) through the use of a meta-analysis. This hopefully contributed to the philosophy of psychology and generated theoretical principles useful for epistemological research.

The **fourth** aim was to translate the meta-analysis into a **practical** component for use in psychotherapy. Suggestions were made for providing congruence between a philosophy (objective three) and a practice in current psychological thinking and psychotherapy. This was largely explored through the thematic synthesis chapter.

The **fifth** objective was to outline or suggest a preliminary **conceptual framework** as an integration of the above. This was illustrated diagrammatically in terms of process models for the understanding of bipolar mood disorder. This included a description of the researcher's role and allowed for the emergence of contradictions within the field. This also provided an arena for further research, peer review, and dialogical criticisms.

The psychotherapeutic domain can benefit from broader understandings of psychiatric diagnoses in terms of congruence between philosophy and practice. This implies that both positions (modernist and postmodernist) need to be explored and comparatively criticised so that new knowledge can be generated for future criticism

and ongoing dialogue. The field of psychotherapy can be prevented from stagnation with such research aims. Currently there are three broad approaches to treating bipolar mood disorders. They are the family focused treatment (Miklowitz & Goldstein, 1990), the Life Goals Program which is a group approach (Bauer, McBride, Chase, Sachs & Shea, 1998), and the cognitive behavioural approaches (Fava, Bartolucci, Rafanelli & Mangelli, 2001). These three schools of therapy, resting on modernistic assumptions, have all shown significant reductions in symptomatology when treating this disorder.

The Research Process

To explore the lives of people diagnosed with bipolar mood disorder, the postmodern qualitative approaches seemed to be appropriate as a choice of method. This paradigm allowed the researcher to question the cultural and historical contexts of different diagnostic categories; to question how social norms and values produce families and individuals in which behaviours described by the DSM-IV manifest themselves; and to also question how the current treatments of bipolar mood disorder reproduce and maintain the dominant psychiatric discourse (Downing, 2000; Gorman, 2001; Hoshmand, 1994).

The inquiry relied heavily on contextual descriptions, focusing on processes that were conducive for understanding (Madill et al., 2000). As a reflexive researcher (Hoshmand, 1994) three dimensions were addressed at all times: firstly, the **personal epistemic style**. This was reflected in the epistemology section in the thesis write-up. The explication of a postmodern approach to understanding human behaviour was given, which impacted on the research interviews, and informed the meta-analysis section. Secondly, the researcher made use of the **self as a tool of knowledge**. This implied that the researcher's knowledge base of the bipolar mood disorder spectrum was broadened, as well as the acknowledgement of how this occurs (the process models). Lastly, the exploration was influenced by the researcher's choice of her **personal world-view** which influenced her selection of conceptual models and methods of inquiry. As the researcher adopted a dual-stance in this research, acknowledging both modern and postmodern perspectives (realist and dialogical modes of knowing), an emergent synchronised world-view developed.

The research aims were actualised through the following pre-determined research method. The method that was advocated at the beginning of the research had to be pliable and remain flexible for the emergent needs of the research domain. The structure that was provided at the outset of this research did indeed shift to accommodate the research needs. The discourse analysis section was added to the research methodology to provide further in-depth analysis of the transcripts.

Interviews were used to collate data. These were unstructured and they were conducted with the research participants. The interviewing format was consistent with the postmodern assumptions of dialogue, conversation and understanding as a social process. The collected data was analysed using the techniques of **vignette analysis, coding and thematic analysis,** and was also presented in the format of text and matrices.

According to Miles and Huberman (2001), data analysis should take place right from the start of the data gathering process instead of waiting until all the data has been collected. The reason for making this suggestion is so that the researcher can continuously move back and forth between the data gathered, reflect upon it, and determine if there are other more effective way of gathering information. Further, the process of analysis is thought to be less cumbersome if it is an ongoing process and not a hurdle to be overcome at the end. The selected methods of data analysis were thought to be conducive for ongoing analysis.

The interviews and vignette analysis included the following:
- Taping the interviews (via digital recorder). The interviews were guided by the researcher's prior knowledge and readings.
- Process notes were made directly following the interviews and expanded upon after reading the transcriptions.
- The researcher then reduced each story into a simple vignette with the aim of distilling the main points of the interview.
- Themes were generated from vignettes included within-interview (features within the interview) and across-interviews (events that become themes due to their

common occurrence in other interviews). A theme was understood to be a frequent occurrence of an event (Miller et al., 1997).

✗ A vignette was written up for each interview from a traditional modernistic view and explored through a postmodern lens.

✗ Common discourses of language usage were also identified, and tabulated.

✗ All categories were then tabulated and reflected upon in terms of the literature review and the theoretical departure of the researcher.

✗ Conclusions were then made drawing on the themes, categories, and quotes from the vignettes and the original transcriptions. These were then compared to current standing research projects as a comparative analysis.

Coding reduced large amounts of information into smaller analytic units, allowing the researcher to become part of the process of research during the data collection phase so that later fieldwork could be more focused, and coding helped the researcher to develop a cognitive map which helped to understand and conceptualise events and interactions. Lastly, coding was useful as it laid the groundwork for-cross case analysis by identifying common themes and patterns (Miles & Huberman, 2001).

The coding process entailed the following:

✗ Beginning with the first paragraph of the transcript, the researcher asked: what categories, concepts or labels do I need to account for what is of importance to me in this paragraph? This label was then documented on in the margin of the transcript.

✗ The coding process involved the changing, re-changing and adjustment of the terms used until a fit was improved, with the assistance of the promoter.

✗ The researcher was constantly alerted to the similarities and differences which exist between instances, cases and concepts, ensuring that diversity and complexity of the data was explored (Pidgeon & Henwood, 1997).

The **memo** writing process was done more for the researcher's clarity of thought, than for others involved in the study. Memos were also written on topics or areas of concern that were puzzling or surprising; as alternate hypotheses to co-researchers' comments; for clarification of thought; and to create a general theme or

metaphor that encompassed observations. The primary audience of memos was the researcher herself.

Following Hayes (1997, p. 114), the **thematic analysis** proceeded accordingly:

� Identifying the causal attributions made during the interview.

✘ Extracting the attributions onto a separate list.

✘ Sorting the attributions according to the themes of analysis.

✘ Examining the attributions within one thematic category and identifying the general orientation.

✘ Comparing the attributions within one category made by one set of research participants, with those in a similar category made by another set.

✘ Identifying the general themes and conclusions that could be drawn from this comparison.

Matrices, as set out by Miles and Huberman (2001) were introduced as part of the data analysis phase. The matrices helped the researcher to note patterns, themes, and make contrasts and comparisons. A time-ordered matrix (Miles & Huberman, 2001) was used to arrange the chronological events as they occurred, in the life of the diagnosed bipolar patient. The process of coding helped the researcher to identify themes that were common across time and then to be tabulate this information for clarity. A thematic conceptual matrix (Miles & Huberman, 2001) was used to present information that the researcher gathered from the inference of patterns and themes. Cognitive maps were also utilised to track the researcher's thinking throughout the actualisation of the research as this was beneficial for the construction of process models.

The **discourses** under review emerged from the textual transcriptions from the interviews. The researcher categorised and indexed the text, allowing for sets of statements to be identified. These statements, or discourses, indicated that bipolar mood disorder is constructed in particular ways, silencing others. The way in which discourses are constructed gives shape to the way in which people live their lives (Parker et al., 1995). Therefore, the deconstruction is imperative to understanding the

way in which bipolar mood disorder is constructed by the client, the psychotherapist, and the psychiatrist.

In the analysis of discourse section, a similar arrangement of categories was used as in the vignette analysis. They were, naming the disorder; causes of the disorder; self-perception; support systems; religion; symptom expression; and perception of the psychiatrist. Initially the researcher quoted text as systematically indexed from the transcripts. Following this, she regrouped statements into sub-categories of discourses, and tabulated the information. The tabulated data of text from the transcripts was then further deconstructed into categories following the outline suggested by Parker et al. (1995, pp 60-63). Six types of discourses are seen to contribute to the formation of a clinical diagnosis. These are: the individual and the social; reason and unreason; pathology and normality; form and content; pure categories versus messy real life; and professional versus popular, lay and patient views. These clinical categories were adapted to these particular research interviews to enrich the discourse descriptions.

Vignette analysis, coding, thematic analysis, memoing, matrix tables, and discourse analysis were all used to generate the themes of this research. There was overlap between the proponents of each model, and the researcher extrapolated that which was pertinent to her field of study. The models described in the research design chapter and mentioned above, did not really focus on the back-and-forth nature of the research analysis process. The researcher found that she was constantly moving forwards, for example writing up the vignette analysis, and then having to move backwards to the transcripts to check and re-look at what was said. This cyclical process continued through to the thematic write-up section where the researcher was continuously checking that the coding and thematic analysis had indeed yielded a common theme when it is was viewed from a meta-level.

The research design yielded in-depth discussions of the meaning making processes which are integral to an understanding of bipolar mood disorder from a patient, psychologist, and psychiatrist reference point. The family position could only be inferred from the stories as they were told by the patients as families declined to actively participate in this research process.

The **emergent themes** of this research were:

- The power differentials (individual, relationship and institutional power).
- The expert (the psychiatric, psychotherapeutic, and patient's expertise).
- The theme of problems (social discourse, multiple realities, emergent problems, and problems as moral judgements).
- Meaning generating systems (psychiatric science and the postmodern interpretation; meaning in diagnosis; connection and disconnection).
- Belonging.

These themes were carefully explored and thoroughly discussed, revealing multiple levels of meanings and discourses, which collectively shaped the stories that were shared with the researcher. The themes were then compared to the existing body of research on bipolar mood disorder. This entailed a critical discussion of bipolar mood disorder, both from a modernist and a postmodernist positioning. The scientific facts, truths, and reality of bipolarity were critically questioned and analysed from the basis of the themes that had emerged in this research. Bipolar mood disorder was shown to be not a simple psychiatric diagnosis intrinsic to an individual, but rather one which is created in language domains through the sharing of knowledge and meanings. The literature review and comparative analysis indicated that bipolar mood disorder has been researched and treated on a surface level, when compared with the deep exploration of a postmodern position. The understandings of bipolar mood disorder are woven together in collaboration with multiple systemic interactions and cannot be simplified through a scientific lens. This research also gave credence to the position of the person who is diagnosed and this is rarely touched on in the existing body of knowledge on bipolarity. Hopefully, the psychotherapeutic literature will be enriched from the addition of such a perspective, moving beyond the technique oriented cognitive-behavioural and psycho-educational approaches.

This research will now be assessed by offering a discussion on the limitations and strengths of such a study. This discussion will highlight areas of future consideration, as well as potential pit-falls when exploring bipolar mood disorder from polarised epistemologies.

Limitations of the Study

This study focused on the experiences of those who live with and deal with bipolar mood disorder. It could therefore be considered to be a **subjective** inference on the world of bipolarity, and not fitting within the psychiatric body of literature – one which is backed by scientific principles of empiricism and objectivity. The aim of the research was to remain in the realm of lived experience and personal narratives, but if viewed from a modernist position, the study falls short of being neutral and value-free. The researcher had a vested interest in understanding the complexities involved in bipolar mood disorder, and although she disclosed this to the co-researchers and through her memoing process, her views were shaped by her own personal histories, culture and prior knowledge.

The stories that were shared by the co-researchers in the collaborative interview could be seen to be **fiction** rather than fact. There is no clear-cut way of determining if the experience of bipolar mood disorder was real, in any scientific sense. This is a risk that was discussed by Rosenblatt (2000). Rosenblatt (2000) commented that he did not believe that the aim of conducting research was to reveal truth and fact, but instead to point out the emerging patterns and themes from the stories that were shared with him. He also discusses the discourse of truth in research and acknowledges that there is a shared understanding that research is about divulging truth value. In this research, the co-researchers also shared this truth belief and they all made contact with the researcher following the interviews to offer additional information that they thought was more accurate (in terms of dates and times, medication protocols, or additional ideas that they thought of post-interview). The discourse of truth is embedded in a modernist framework, and this research was not focused on seeking truth, but rather on understanding the way stories about bipolarity come to be told in the way that they are, with diversity and difference.

This study could be criticised for being **context-dependent**. The nature of postmodern qualitative research advocates rich contextual descriptions, but these can be over-inclusive if viewed from a modernist position. The fact that the research interviews were laden in context and specific situational markers prevents a wide

generalisability of research findings (Held, 2000; Raskin, 2002). These stories are specific to the people who shared them. Having said that, the way in which bipolar mood disorder is constructed through language and in relationship, is a universal construct. That is to say, that the focus should be on the process of bipolar construction, rather than the content of the diagnosis. The existing literature focuses purely on the content of bipolarity, and while this is helpful for expert knowledge acquisition, it falls short of assisting the person who has been diagnosed. The process of understanding problem-determined systems as collaborative events could be generalised to the wider population, in that we all exist within social networks, regardless of the content of diagnosis, the problem, or the situation. The discourses that shape the way we come to understand problematic behaviours cannot be ignored in favour of surface level descriptions.

The **time intensive** nature of qualitative research, along with its multiple checks and balances, open interpretations, and conversational non-endings with peers, promoters and co-researchers, may seem to be a great effort, when compared with quantitative analysis which could generate numeric data, easily transferable into generalisable categories for broad based dissemination. The context rich descriptions could also become a challenge for the reader of the research as it takes time to build upon layers and layers of information, yielding theoretical constructs. This is why the researcher makes her intentions explicit at the introduction and conclusion of each chapter, informing the reader about the nature of the chapter and how it will link with the section that follows.

The **multiple voices** of the research participants could be seen to be confusing for researchers who aim towards establishing truth and validity. The multiple professions included in this research almost dis-empowered the overarching medical fraternity by aligning a psychiatric interview with that of a diagnosed patient. The respected hierarchy was drawn into critical analysis, and no one story was favoured over another. This could raise a concern over who has the most knowledge input for an understanding of bipolar mood disorder? Should it be the medical professional who is well trained and versed in psychiatric lingo, or the psychotherapist who spends years building therapeutic acumen and sharpened skills, or should it be the mentally ill and diagnosed patient who is undoubtedly taking a batch of medications to promote

a sense of normalcy? Depending on the position of the reader, a choice will be made. The researcher, however, chose to view each story with equal value, learning in each collaborative encounter. The multiple voices entertained in this research were necessary to gain a cross-sectional perspective on bipolar mood disorder, as viewed by the people who live and work with the diagnosis.

The **postmodern** descriptions that were discussed in terms of the emergent discourses could be viewed as promoting truth (albeit many of them), insight, and a hierarchical structure because a process needs to be followed in order to attain a discourse perspective (Held, 2000). In the process of negating modernist assumptions and premises, postmodernism may also be at fault for being prescriptive and dogmatic. There has not yet been a postmodern study of bipolar mood disorder and this research was a starting point for redefining a psychiatric classification in a postmodern light, but the process should continue, preventing this postmodernist take on bipolar mood disorder from becoming another grand-narrative. The time intensive nature of such a study prevents this next step from evolving in this context.

The modernist question of **'so what?'** cannot be clearly and simply answered at the culmination of all of the research findings. It could be answered from a modernist position, claiming that medicine, family therapy, cognitive behavioural thought restructuring, and mood-monitoring all contribute towards a more balanced state of well-being, affirming current literature. But that would be 'more of the same' and validating of what is already well documented. The research aims were not aligned with a 'so what?' questioning style, and can therefore not be evaluated on such a line of inquiry. The value of this research is evident in the multiple layered meaning systems that emerged from the research interviews. The problem definitions and power relations converged in this study providing commentary on the creation of the diagnosis of bipolar mood disorder – a diagnosis that has never been scientifically proven to exist. The question of 'so what?' could easily be turned around and posed to the field of psychiatry questioning the value of diagnostic labels and asking for results proving that the discovery of the diagnostic category has in fact made individuals, families, and cultures better off for knowing their diagnostic status.

Strengths of the Study

The strengths of this study are in themselves socially negotiated events. From a postmodern perspective, this research was able to elicit information which evolved into multiple descriptions of bipolar mood disorder, incorporating the medical model as one possible explanation. The research took a critical view of scientific progress in the field of bipolarity by exposing the many flaws within the psychiatric system as told by the co-researchers. This could be seen in the lack of training, knowledge of drug interactions, psycho-educational knowledge, and time-burdens limiting treatment. The current body of literature is not aligned with the specific difficulties encountered within the South African context of over-burdened psychiatric institutions and a lack of man-power to assist those with diagnoses. Another postmodern premise that was actualised through this research was that of the socially constructed self. It was shown how a person diagnosed with bipolar mood disorder constructs a self-view around a model of deficit, as informed by wider social discourses (Boston, 2000).

The postmodern and modern assumptions informing these polarised epistemologies were thoroughly explored in this research. The modernist search for truth, absolute knowledge, rationality, reason, objectivity, and empirical evidence were explored in contextual descriptions of living with bipolar mood disorder. These modernist assumptions formed the cornerstones of the bipolar diagnosis, but they fell short of offering a meaningful experience for those who live and work with the diagnosis. The postmodern premise of entertaining multiple realities instead of one singular truth, allowed for an understanding of the many ways bipolar mood disorder is understood by those who live with it, for example, as a punishment of God, an intrinsic deficit, lack of normalcy, a gift, and a neuro-chemical imbalance.

The social deconstruction of bipolar mood disorder revealed the diverse ways in which the diagnosis is constructed, maintained, and experienced. The research design, data and discourse analysis allowed for the emergence of meaning making systems. The stories of the co-researchers were deeply embedded in, and reflective of, a wide variety of overarching discourses, such as, the discourse of religion – defining

a good person from a sinful person; the bio-medical discourse which gave credence to the search for cure and the deficit hypothesis; the cognitive-emotive-interpersonal discourse which shaped the way in which people viewed normal and abnormal behaviour and sought to rectify destructive thought patterns; the social discourses which created the way in which cultural values dictate appropriate and inappropriate behaviours; and the psychosocial discourse which opened up discussions of alienation, belonging, connection and disconnection.

The thematic analysis brought about areas of bipolarity that have remained up until now, un-researched. The discourse perspective afforded through a postmodern lens has added value to the narrowly described, researched, and formulated diagnosis of bipolar mood disorder. Bipolar mood disorder is not just about mood swings and medication. Change in patterns of behaviour cannot be brought about through the administering of clinical techniques and tablets alone. This research has shown that the problems have determined the systems through linguistic co-constructions of deficit, normalcy, compliance, mood stability, and mental illness. Change on one level of bipolar mood disorder, for example, the physical and neuro-chemical restructuring, will not necessarily bring about change on a societal view of abnormality. The logical levels are different. The medical model, and all its principles, would have to be acknowledged and acquired within a postmodern conceptualisation of bipolar mood disorder. The two epistemologies are not mutually exclusive, just as mania and depression are not.

The positivistic constructs of validity, reliability, and generalisability are of utmost concern, ensuring that the data collected is value-free, objective, and empirically grounded. There is still uncertainty in postmodern research circles about translating these three pillars of research into postmodern principles. Therefore the outlines proposed by Hoshmand (1994), Pidgeon and Henwood (1997) and Stiles (1993) will be followed for this section.

Stiles (1993, p. 601) stated simply that reliability "refers to the trustworthiness of observations or data; validity refers to the trustworthiness of interpretations or conclusions". Obviously, in a postmodern qualitative approach to research, these demarcated lines of trustworthiness are not as clear-cut as in positivist research,

because the research is based on premises of subjectivity, value-inclusion and transparency. Pidgeon and Henwood (1997, pp. 268-270) and Hoshmand (1994) have suggested areas of illumination which could contribute to good practice without losing the essences of meaning generating research designs. They are:

- **Keeping close to the data: The importance of fit**. The researcher clearly defined all constructs, concepts, and psychiatric terminology throughout this research document. This allowed for reader clarification and ensured that the researcher, the promoters of the research, and the reader all shared similar definitions of the constructs used in this research.

- **Theory integrated at diverse levels of abstraction**. This research was built up on theory, existing literature, and meaning generating interviews, which then enfolded back upon theory and literature. One of the aims of this research was to explore the theoretical backgrounds of bipolar mood disorder and question the practicality of theory in psychological practice. Theory was therefore integrated throughout this research. Areas of confusion, surprise, and contradiction were raised in the memoing of the researcher and tracked with the development and shaping of the research stories.

- **Reflexivity**. The interdependence of all role-players in this research was acknowledged through reflexive processing. Again, this is reflected in the memoing process of the researcher, as well as in journaling, which tracked the change in thoughts, conceptualisation of bipolar mood disorder, and multiple conversations held throughout the research process. Each 'section' of this thesis enfolded upon the next emphasising the pivotal principle of reflexivity. The literature review impacted on the epistemological write-up, which influenced the research design itself, which had consequences for the interview transcriptions and coding process. These pre-empting occurrences were constantly shared with colleagues and written about. The thematic and comparative analyses were approached on another level of conceptualisation with the assistance and guidance of the research promoters. This process then embraced the way in which the transcripts were analysed in collaboration with the researcher's own views, knowledge and background. The process models are also reflective of the reflexive nature of this research as they are depicting dynamic relationships, ready for additional commentary and input.

- **Documentation**. The paper-trail for this research is evident in the continuous explanations offered to the reader, as well as in the memoing, journaling and scribbles of the researcher. The research promoter also ensured that a constant back and forth process was adhered to by guiding the researcher back to initial statements, to receiving clarification, and adjusting previous assertions if needed. The process notes of the researcher also track the development of this thesis.

- **Theoretical sampling and negative case analysis**. In the case of this research, bipolar mood disorder has not previously been explored from a postmodern approach. The cases which do not fit this emerging conceptual system are many as they were approached from a traditional medical model in the surrounding literature. In a sense then, this research has been oppositional to what is already accepted in the domain of bipolar mood disorder. Within each story shared with the researcher, there were aspects of similarity and of difference. For example, there was clarity in knowledge of the symptoms of mania and depression, but in terms of treatments and perceptions of treatment there were opposing and dissimilar views. The process of deconstruction has yielded information about problem-determined systems and the integration of discourses and individual meaning making processes. Being a unique and subjective experience, these tenets of the research could be further researched as points of demarcation and development among other people with this diagnosis. Hopefully, this type of 'positivist' aim would yield more difference than similarity.

- **Sensitivity to participant realities**. According to Pidgeon and Henwood (1997, p. 271), "…be cautious of taking respondent's accounts wholly at face value". This is an important point to note for two reasons. Firstly, it is a realist supposition, and secondly, a researcher should remain irreverent or face the risk of affirming grand-narratives. The process of deconstruction and discourse analysis assisted the researcher in viewing the co-researcher's stories as a need for seeking truth, a need to contribute to understandings of human behaviour, and a need to share a life-story, with an empathic listener. The discourse analysis, being a postmodern tool, created the opportunity to steer away from 'believing in stories' towards understanding how these stories are constructed and the impact of these discourses on the creation of problems, deficits and lived experiences. The 'hidden agendas' of the research participants were discussed in the thematic analysis section when various hypotheses and assertions were offered by the

researcher. Since this research is not geared towards truth and discovery, the co-researcher's reality was seen to be co-created with the researcher in the language domain of the research interview.

- ✖ **Transferability**. This concept means that the findings of this research could be applied to a study in a context similar to this one. This aspect of transferability (replacing the positivist term of generalisability) was made possible in this research through the detailed write-up of the vignette analyses, from both a modern and a postmodern position. The contexts of the research interviews were explained in detail, as this detail provided important information for the collaborative event of shared experiences. The difficulty foreseen by the researcher to actualise transferability would be in finding people who were experiencing the same phases of mood swing as the people interviewed at that time, taking similar medications and having similar life histories. The content of the stories could not be easily transferred, but the thematic outputs could be transferred to other areas of diagnostic research. The important aspect to note is that the thematic generation is a cyclical and dynamic process, infused with reflexivity, and involving epistemological debate.

- ✖ **Persuasiveness**. The ultimate stamp of validity and reliability emerges in this aspect of research. The reader has to decide if the conceptual theory building process and the practical actualisation of these premises is sound, interesting and worthy of promulgation.

- ✖ **Viability to the parties concerned**. For Hoshmand (1994) validity is of core concern to the people who may find the research useful and of worthy knowledge, and should not be concerned with the provision of truthful and accurate knowledge. The way that usefulness and worthiness is decided on is through reflexive self-evaluation (as performed by this researcher) and subjecting the research to the professional community who can also judge the fit of theory and generated research.

- ✖ **Process validation**. This concept is aimed towards uncovering the motivational and interpretative contexts in which the responses were gathered. This would supposedly ensure that the research will be reflexive, providing a contextual account of the inquiry. Again, the researcher provided in-depth and solid details of the research interviews, focusing on ensuring that the research participants stories were adequately shared with the reader, that chronological events were

explained (even though they were shared with the researcher in a haphazard manner), and that their stories were fully explored according to the information provided. Context was one of the heartbeats of this research. To be a-contextual would be a modernist supposition, which would be antithetical to the postmodern approach. Part of the over-inclusive and time-intensive limitations of such a study could be accounted for by the need for providing process validation.

Hoshmand (1994) has also called for multi-method research designs, which could provide many alternative ways of understanding and conceptualising the raw data post-collection. This research utilised several overlapping methods to ensure that qualitative research principles were adhered to, and constantly checked, thereby enhancing an ethical research disposition. The additional discourse analysis was implemented to take the research beyond thematic and patterned descriptions towards theory building and postmodern conceptualisations of bipolar mood disorder.

Recommendations for Future Research

Any attempt to arbitrarily polarize thought, behavior, and emotions into clear-cut 'sanity' or 'insanity' is destined to fail; it defies common sense and it is contrary to what we know about the infinite varieties and gradations of disease in general and psychiatric illness in particular. 'Madness', in fact, occurs only in the extreme forms of mania and depression; most people who have manic-depressive illness never become psychotic. Those who do lose their reason – are deluded, hallucinate, or act in particularly strange and bizarre ways – are irrational for limited periods of time only, and are otherwise well able to think clearly and act rationally (Jamison, 1993, p. 96).

This section will explore the ways in which this research could be taken forward for further investigation. These suggestions are made in hindsight, looking back over the shoulder of research, highlighting areas which were untouched, interesting and in need of further inquiry.

Bipolar mood disorder is increasingly becoming a common diagnosis, culturally legitimised, and promoted through psychiatric awareness and pharmacological interest. In South Africa, the varieties of available treatments have not kept pace with the increase in diagnosis of this mood disorder. Psychologists tend to be familiar with the tenets of cognitive-behavioural therapy, but not necessarily within the realm of bipolar mood disorder. Perhaps on-going training and education could highlight the intricacies involved in the bipolar mood disorder construction. It may also be asserted that psychiatrists should be informed of socio-cultural influences which could shape the way meaning is attributed to compliance and non-compliance issues. This of course, would be an ideal of promoting well-being, and is not always possible in the context of limited resources, overbooked diaries, and time limitations. The reasons for these hindrances could be further explored, with an aim at accentuating potential areas of opportunity, rather than focusing on the lack thereof. Compliance itself is an issue worthy of further exploration. This could greatly contribute to improved adherence to treatment protocols, if the meanings attached to taking medication are more fully explored. The psychiatric discourse is perceived (by the co-researchers and the psychologist) to be authoritative and powerful. Compliance, or rather non-compliance, is viewed as a hallmark of remaining unstable in mood. The multiple meanings associated with compliance issues could be pertinent in promoting the health of those diagnosed with bipolar mood disorder.

The families of the research participants declined to participate in this research, even if it just meant completing an open-ended questionnaire. The families of bipolar mood disorder patients may provide additional information which could be useful in further understanding how problems are maintained in the family system, as well as how families shift and shuffle around periods of mood instability, hospitalisations, conceptualise normal versus abnormal behaviour, and their view of a loved one taking psychotropic medication for a diagnosed mental illness. This could also yield inferences on societal, cultural, medical, and social discourses which shape and are shaped by the family system.

The researcher also engaged an epistemologist to participate in this research, but he withdrew due to personal reasons. This person was very well versed in both positions of modernism and postmodernism, with particular views on epistemology

and mental illness. Therefore, the researcher depended on available research, literature, and journal articles to inform her about epistemological points of debate. This often led to situations of doubt and uncertainty as she could be conceptually swayed depending on the nature of what she was researching (this process of research required journaling and many conversations which assisted with clarity of thought). Epistemology, the study of how we know what we know, has direct implications on the knowledge and practice of psychology. In this research context, epistemological discussions were important for allowing the medical model to have a place, as well as providing the opportunity to explore bipolar mood disorder through the wider angled lens of postmodernism. The way in which bipolar mood disorder is understood and conceptualised is intricately and recursively linked to the epistemological positioning of the observer.

The postmodern perspective has guided the researcher in re-formulating bipolar mood disorder from a multi-layered perspective. In this research, the social, cultural, historical, political, individual, and familial discourses were spoken about as influential on the maintenance of the diagnosis. The power relationships that exist within bipolar mood disorder as revealed in this research could be further explored, particularly within the South African context. Although the biomedical model carries the most authority and legitimisation for the diagnosis of bipolar mood disorder, the cure remains elusive, possibly because the illness itself is constructed on another logical level, including moral judgement, socially acceptable behaviours, and deficit perspectives. These aspects that have arisen in this research could be given more attention in future, which could positively contribute to the way in which psychotherapists work with such diagnoses.

This research focused on a cross-sectional analysis of the construction of bipolar mood disorder itself, through conversational domains of interviews, peer forums, promoter feedback sessions, and continued reading. The direct people involved in this study were two patients, one psychologist, and one psychiatrist. The indirect people were many. Whenever the researcher was asked about her studies, people shared a story about someone they loved, cared for, or treated who was diagnosed as bipolar. It may be of value to further investigate the bipolar mood disorder spectrum of behaviours with all its intricacies with larger groups of people,

including gender differences, age groupings, racial groupings, religious backgrounds, private versus government care, as well a broader range of psy-fraternity role players. The larger the research population, the less intensive is the focus on meaning-making processes. However, having said that, other research projects need not be over-inclusive, but more specific with the intention of complementing the larger system of diagnosis.

Lastly, this research should be prevented from becoming another grand-narrative. Ways around this are through communicating and sharing ideas, notions and conceptualisations of bipolar mood disorder. The wheel should continue to turn, thereby preventing the field of psychology becoming a static and an expert knowledge system, advocating the one true way to live.

Conclusions

This thesis has explored the experiences of bipolar mood disorder from the position of the patient, the psychologist, and the psychiatrist. Bipolar mood disorder is thought to be a socially constructed diagnosis, which in turn creates the experience of having the diagnosis. The ways in which the diagnosis is lived is a collaborative event, involving many systems of interaction, such as the social, cultural, and family contexts. These systems are believed to be formed around the problem and are reciprocally reinforcing thereby co-creating the diagnosis and the disorder. This research has opened up the possibility of having multiple perspectives on bipolar mood disorder, from inception towards curative measures. Within the postmodern paradigm, the theory of social constructionism has been utilised to language the development of the diagnosis and provide research methods for further exploring the ways that the disorder has become a shared reality.

The thematic and discourse analyses were interpreted according to the linguistic practices used by all the research participants in interviews that were held with the researcher. Bipolar mood disorder is a social construction, a moral and social judgement, approved and justified by the medical discourse, and accepted by patients, families, and treating professionals. The many factors implicit in this social

construction were openly explored in this research, and yielded pertinent themes which were compared with the existing body of knowledge. Bipolar mood disorder reciprocally forms and informs overarching and prevailing discourses. This research explored many of the ways that bipolar mood disorder is linguistically constructed, such as through the biopsychosocial discourse; the social discourse; the normative-deficit discourse; the biomedical discourse; and the cognitive-emotive-interpersonal discourse. These surrounding discourses shaped the ways that the co-researchers shared their stories with the researcher. In addition, these discourses informed the co-researchers views of bipolar mood disorder, their perspectives on the causes and cures of the diagnosis, and most importantly, these discourses helped construct and maintain a sense of self within family, medical, and social settings.

The themes generated by this study were: the multi-dimensional levels of power titrations on an individual, relationship, and institutional level; the psychiatric and psychotherapeutic expert position, as well as the relevance of patient non-expertness; a deconstruction of the many understandings of problems, from social discourses to moral judgements; meaning generating systems which transpose definitions of problems into enacted realities, covering psychiatric science, postmodern interpretations, meanings within diagnoses, and feelings of connection and disconnection; and lastly, the theme of belonging which encapsulates many of the unspoken feelings experienced by people who live and work with this illness.

The psychiatric exposition of bipolar mood disorder has centred on an individual deficit perspective, with clearly defined boundaries between the expert with knowledge and the patient in need of help. This research has shown that the person with the diagnosis co-creates the disorder in collaboration with the psy-fraternity, promoted by wider discourses, and maintained through reflexive loops of interaction. The co-researchers contributed to the field of psychology by sharing their explanations, stories, thoughts, and fears with the researcher. The dominant discourses were evident in their storied realities, but the subjugated and marginalised discourses, such as institutional power, and meanings within the diagnosis, were also given value and importance. There may not be a cure for this diagnosis, but there is room to linguistically reshape the way in which the diagnosis is informed, maintained and perpetuated.

REFERENCES

Akiskal, H.S., & Akiskal, K. (1994). Mental Status Examination: The Art and Science of the Clinical Interview. In M. Hersen & S. M. Turner (Eds.), *Diagnostic Interviewing*, (pp. 25 - 54). Plenum: New York.

Akiskal, H.S., & McKinney, W.T. (1973). Depressive Disorders: Toward a Unified Hypothesis. In E.A. Wolpert (1977) (Ed.). *Manic-Depressive Illness: History of a Syndrome* (pp. 509-537). International Universities Press, INC.: New York.

Akiskal, H.S., & Pinto, O. (1999). The Evolving Bipolar Spectrum. Prototyopes I, II, III, and IV. *Psychiatric Clinics of North America, 22*, 517-534.

Akiskal, H.S., & Pinto, O. (1999). The Evolving Bipolar Spectrum. Prototypes I, II, III, and IV. *Psychiatric Clinics of North America, 22*, 517-534.

Ambelas, A., & George, M. (1988). Individualized stress vulnerabilities in manic depressive patients with repeated episodes. *Journal of the Royal Society of Medicine, 81*, 448-9.

American Psychiatric Association. (1994a). *Diagnostic and statistical manual of mental disorders (4th ed.)*. Washington, DC: Author.

American Psychiatric Association. (1994b). Practice Guidelines for the Treatment of Patients with Bipolar Disorder. *American Journal of Psychiatry, 151* (suppl.), 1-36.

American Psychiatric Association. (2000). *American Psychiatric Association: Practice Guidelines for the Treatment of Psychiatric Disorders*. American Psychiatric Association: Washington.

Anderson, H. (1993). On a roller coaster: A collaborative language systems approach to therapy. In S. Friedman (Ed.). *The new language of change: Constructive collaboration in psychotherapy* (pp. 323-344). New York: The Guilford Press.

Anderson, H. (1995). Collaborative language systems: Toward a postmodern therapy. In R.H. Mikesell, D-D. Lusterman, & S.H. McDaniel (Eds.). *Integrating family therapy: Handbook of family psychology and systems theory* (pp.27-44). Washington: American Psychological Association.

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

Anderson, H. (2001). Ethics and Uncertainty: Brief Unfinished Thoughts. *Journal of Systemic Therapies, 20*(4)**,** 3-6.

Anderson, H., & Goolishian, H. (1992). The Client is the Expert: A Not-Knowing Approach to Therapy. In S. McNamee and K.J. Gergen (Eds.). *The Social Construction of The Therapeutic Process* (pp. 25-39). Sage: Newbury Park.

Armstrong, E.M. (1998). Diagnosing Moral Disorder: The Discovery and Evolution of Fetal Alcohol Syndrome. *Social Sciences Medicine, 47*(2), 2025 – 2042.

Atkinson, P., & Coffey, A. (2003). Revisiting the relationship between participant observation and interviewing. In J. F. Gubrium & J. A. Holstein (Eds.). *Postmodern interviewing* (pp. 109-122). London: Sage Publications.

Atwood, J.D. (1997). *Challenging Family Therapy Situations: Perspectives in Social Construction*. Springer Publishing Company: New York.

Balderssano, C.F. (2005). Assessment Tools for Screening and Monitoring Bipolar Disorder. *Bipolar Disorders, 7*, 8-15.

Basco, M., & Rush A. (1995). *Cognitive-Behavioural Treatment of Manic-Depressive Disorder*. Guilford Press: New York.

Basco, M., & Rush, A. (1996). *Cognitive Behavioural Therapy for Bipolar Disorder*. Guilford Press: New York.

Bauer, M.S., & McBride, L. (1996). *Structured Group Psychotherapy for Bipolar Disorder: The Life Goals Program*. New York: Springer.

Bauer, M.S., & McBride, L., Chase, C., Sachs, G., & Shea, N. (1998). Manual-Based Group Psychotherapy for Bipolar Disorder: A Feasibility Study. *Journal of Clinical Psychiatry, 59*, 449-455.

Bay, E., Hagerty, B.M., Williams, R.A., Kirsch, N., & Gillespie, B. (2002). Chronic stress, sense of belonging, and depression among survivors of traumatic brain injury. *Journal of Nursing Scholarship, 34*(3), 221-226.

Beck, A.T., Rush, A.J., Shaw, B., & Emery, G. (1979). *Cognitive Therapy of Depression*. John Wiley and Sons: New York.

Bentall, R.P. (2003). *Madness Explained: Psychosis and Human Nature*. Penguin Books: London.

Berk, M., Berk, L., Moss, K., Dodd, S., & Malhi, G. (2006). Diagnosing Bipolar Disorder – How Can We Do It Better? *The Medical Journal of Australia, 184*(9), 459-462.

Billig, M. (1997). Rhetorical and discursive analysis: How families talk about the royal family. In N. Hayes (Ed.), *Doing qualitative analysis in psychology* (pp. 39-54). UK: Psychology Press.

Blumer, D. (2002). The illness of Vincent van Gogh. *American Journal of Psychiatry, 159*(4), 519-526.

Boston, P. (2000). Systemic Family Therapy and the Influence of Post-modernism. *Advances in Psychiatric Treatment, 6*, 450-457.

Bourgeois, M.L., & Marneros, A. (2000). The Prognosis of Bipolar Disorders: Course and Outcome. In A. Marneros & J. Angst (Eds.), *Bipolar Disorders: 100 Years After Manic Depressive Insanity* (pp. 405-436). Dordrecht: Kluwer Academic Publishers.

Bowden, C.L. (1996). Role of Newer Medications for Bipolar Disorder. *Journal of Clinical Psychopharmacology, 16*, 48-55.

Bowden, C.L., Brugger, A.M., Swann, A.C., Calabrese, J.R., Janicak, P.G., Petty, F., Dilsaver, S.C., Davis, J.M., Rush, A.J., & Small, J.G. (1994). Efficacy of Divalproex vs. Lithium and Placebo in the Treatment of Mania: The Depakote Mania Study Group. *Journal of the American Medical Association*, *271,* 918-924.

Bowden, C.L., Calabrese, J.R., McElroy, S.L., Gyulai, L., Wassef, A., Petty, F., Pope, H.G.J., Chou, J.C., Keck, P.E., Jr., Rhodes, L.J., Swann, A.C., Hirshchfeld, R.M., & Wozniak, P.J. (2000). A Randomized, Placebo-Controlled 12-Month Trial of Divalproex and Lithium in Treatment of Outpatients with Bipolar I Disorder: Divalproex Maintenance Study Group. *Archives of General Psychiatry, 57*, 481-489.

Burr, V. (1995). *An introduction to social constructionism*. London: Routledge.

Cade, J.F.J. (1949). Lithium Salts in the Treatment of Psychotic Excitement. In E.A. Wolpert (1977). (Ed.). *Manic-Depressive Illness: History of a Syndrome* (pp. 347-355). International Universities Press, INC: New York.

Calabrese, J.R., Rapport, D.J., Shelton, M.D., & Kimmel, S.E. (2001). Evolving Methodologies in Bipolar Disorder Maintenance Research. *British Journal of Psychiatry, 178*(suppl. 4), 157-163.

Callahan, A. M., & Bauer, M.S. (1999). Psychosocial Interventions for Bipolar Disorder. *The Psychiatric Clinics of North America, 22*(3), 675-688.

Chor, P., Mercier, M., & Halper, I. (1988). Use of Cognitive Therapy for Treatment of a Patient Suffering From a Bipolar Affective Disorder. *Journal of Cognitive Psychotherapy, 2*, 51-58.

Clark, D.A. (1997). Is Cognitive Therapy Ill Founded? A Commentary on Lyddon and Weill. *Journal of Cognitive Psychotherapy: An International Quarterly, 11*(2), 91-98.

Clark, L., Iversen, S.D., & Goodwin, G.M. (2002). Sustained attention deficit in bipolar disorder. *British Journal of Psychiatry, 180*, 313-319.

Clement, S., Singh, S.P., & Burns, T. (2003). Status of bipolar disorder research. *British Journal of Psychiatry, 182*, 148-152.

Colom, C., Vieta, E., Martinez-Aran, A., Reinares, M., Goikolea, J.M., Benabarre, A., Torrent, C., Comes, M., Corbella, B., Parramon, G., & Corominas, J. (2003). A randomized trial on the efficacy of group psychoeducation in the prophylaxis of recurrences in bipolar patients whose disease is in remission. *Archives of General Psychiatry, 60*(4), 402-7.

Cooper, J. (2004). Disorders are Different from Diseases. *World Psychiatry, 3*(1), 24.

Coryell, W., Scheftner, W., Keller, M., Endicott, J., Maser, J., & Klerman, G.L. (1993). The Enduring Psychosocial Consequences of Mania and Depression. *American Journal of Psychiatry, 150*(5) 720-727.

Craighead, W.E., & Miklowitz, D.J. (2000). Psychosocial Interventions for Bipolar Disorder. *Journal of Clinical Psychiatry, 61*(Suppl. 13), 58-64.

Denzin, N.K., & Lincoln, Y.S. (2000). Introduction: The discipline and practice of qualitative research. In N. K. Denzin and Y.S. Lincoln (Eds.). *Handbook of qualitative research (2nd Ed.)* (pp. 1-28). Thousand Oaks: Sage Publications.

de Shazer, S. (1985). *Keys to Solutions in Brief Therapy*. Guilford: New York.

de Shazer, S. & Berg.I.K. (1993). Constructing solutions. *Family Therapy Networker, 12*, 42-43.

Dickerson, V.C., & Zimmerman, J.L. (1995). A Constructionist Exercise in Anti-Pathologizing. *Journal of Systemic Therapies, 14*(1), 33-45.

Doan, R.E. (1998). The king is dead; long live the king: Narrative therapy and practicing what we preach. *Family process, 37*(3), 379-385.

Downing, J. N. (2000). *Between conviction and uncertainty: Philosophical guidelines for the practicing psychotherapist*. Albany: State University of New York Press.

Drewery, W., & McKenzie, W. (1999). Therapy and faith. In I. Parker (Ed.). *Deconstructing psychotherapy* (pp. 132-149). London: Sage.

Duke, P., & Hochman, G. (1992). *A Brilliant Madness*. Bantam Books: New York.

Durrheim, K. (1999). Research design. In M Terre Blanche & K Durrheim (Eds.). *Research in practice: Applied methods for the social sciences* (pp. 29-53). Cape Town: University of Cape Town Press.

Ehlers, C., Frank, E., & Kupfer, D. (1988). Social Zeitgebers and Biological Rhythms: A Unified Approach to understanding the Etiology of Depression. *Archives of General Psychiatry, 45*, 948-952.

Ellicott, A., Hammen, C., Gitlin, M., Brown, G., & Jamison, K. (1990). Life Events and the Course of Bipolar Disorder. *American Journal of Psychiatry, 147*(9), 1194-1998.

Ellis, C., & Bochner, A. (2000). Autoethnography, personal, narrative, reflexivity - researcher as subject. In N. K. Denzin and Y.S. Lincoln (Eds.), (pp. 733-768). *Handbook of qualitative research (2nd Ed.).* Thousand Oaks: Sage Publications.

Fava, G.A., Bartolucci, G., Rafanelli, C., & Mangelli, L. (2001). Cognitive-Behavioral Management of Patients With Bipolar Disorder Who Relapsed While on Lithium Prophylaxis. *Journal of Clinical Psychiatry, 62*, 556-559.

Ferrier, I.N., Stanton, B.R., Kelly, T.P., & Scott, J. (1999). Neuropsychological function in euthymic patients with bipolar disorder. *British Journal of Psychiatry, 175*, 246-251.

Ferrier, I.N., & Thompson, J.M. (2003). Cognitive Impairment in Bipolar Affective Disorder: Implications for the Bipolar Diathesis. *British Journal of Psychiatry, 180*, 293-295.

Flaskas, C. (1994). Postmodernism, constructionism and the idea of reality: A contribution to the 'ism' discussions. *Australian and New Zealand Family Therapy, 16*(3), 143-146.

Fontana, A. (2003). Postmodern trends in interviewing. In J. F. Gubrium & J. A. Holstein (Eds.). *Postmodern interviewing* (pp. 51-65). London: Sage Publications.

Ford, D.H., & Urban, H.B. (1998). *Contemporary Models of Psychotherapy: A Comparative Analysis (2nd Ed.).* John Wiley & Sons Inc.: New York.

Foucault, M. (1961). *Madness and Civilization*. Routledge: London.

Foucault, M. (1979). *Discipline and Punish*. Vintage: New York.

Frank, E., Swart, A.H., Mallinger, A.G., Thase, M.E., Weaver, E.V., & Kupfer, D.J. (1999). Adjunctive psychotherapy for bipolar disorder: effects of changing treatment modality. *Journal of Abnormal Psychology, 108*(4), 579-87.

Frosh, S. (1995). Postmodernism Versus Psychotherapy. *Journal of Family Therapy, 17*, 175 – 190.

Fruggeri, L. (1992). Therapeutic process as the social construction of change. In S. McNamee & K.J. Gergen (Eds.). *Therapy as social construction* (pp. 41-53). London: Sage.

Fulford, K.W.M., Broome, M., Stanghellini, G., & Thornton, T. (2005). Looking with Both Eyes Open: Fact *and* Value in Psychiatric Diagnosis? *World Psychiatry, 4*(2), 78-86.

Gabbard, G.O., & Kay, J. (2001). The Fate of Integrated Treatment: Whatever Happened to the Biopsychosocial Psychiatrist? *American Journal of Psychiatry, 158*(12), 1956 – 1963.

Gergen , K.J. (1985). The Social Constructionist Movement in Modern Psychology. *American Psychologist, 40*, 266-275.

Gergen, K.J. (1994). Realties and Relationships: Soundings in Social Construction. Harvard University Press: Cambridge, MA.

Gergen, K.J., & Kaye, J. (1992). Beyond narrative in the negotiation of therapeutic meaning. In S. McNamee & K.J. Gergen (Eds.). *Therapy as social construction* (pp. 166-185). London: Sage.

Ghaemi, S.N. (2001). On Defining "Mood Stabilizer". *Bipolar Disorders, 3*, 154-8.

Ginsberg, G.L. (1979). Psychoanalytic Aspects of Mania. In B. Shopsin (Ed.). *Manic Illness* (pp. 1-10). Raven Press: New York.

Goin, M.K. (2002). Providing Psychotherapy for Patients with Bipolar Illness: A Clinical Imperative. *Psychiatric Services, 53*(8), 931 – 932.

Goldberg, D. (1996). A Dimensional Model for Common Mental Disorders. *British Journal of Psychiatry, 168*(suppl. 30), 44-49.

Goldberg, J.F. (2000). Treatment of Bipolar Disorders. *Psychiatric Clinics of North America: Annual of Drug Therapy, 7*, 115-149.

Goodwin, F.K. (2002). Rationale for Long-Term Treatment of Bipolar Disorder and Evidence for Long-Term Lithium Treatment. *Journal of Clinical Psychiatry, 63*, 5-12.

Goodwin, F.K., & Jamison, K.R. (1990). *Manic-Depressive Illness*. Oxford University Press: New York.

Goolishian, H.A., & Anderson, H. (1982). Strategy and intervention versus nonintervention: A matter of theory. *Journal of marital and family therapy, 18*(1), 5-15.

Gordon, A., & Rasmussen, S.A. (1986). Mood Related Obsessive-Compulsive Symptoms in a Patient with Bipolar Affective Disorder. *Journal of Clinical Psychiatry, 48*, 27-28.

Gorman, P. (2001). Teaching diagnosis from a postmodern perspective. *Journal of systemic therapies, 20*(1), 3-11.

Greenhalgh, T. (1999). Narrative Based Medicine in an Evidence Based World. *British Medical Journal, 38*, 323-5.

Griswold, K.S., & Pessar, L.F. (2000). Management of Bipolar Disorder. *American Family Physician, 62*(6), 1343 – 58.

Gubrium, J. F., & Holstein, J.A. (2003). Postmodern sensibilities. In J. F. Gubrium & J. A. Holstein (Eds.). *Postmodern interviewing* (pp. 3-18). London: Sage Publications.

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

Guterman, J.T. (1996). *Doing* mental health counseling: A social constructionist re-vision. *Journal of Mental Health Counseling, 18*, 228-252.

Harré, R. (1995). Discursive Psychology. In J.A. Smith., R. Harré., & L. Van Langenhove (Eds.). *Rethinking Psychology* (pp. 143-159). London: Sage.

Harvey, N.S., & Peet, M. (1991). Lithium Maintenance: 2. Effects of Personality and Attitude on Health Information Acquisition and Compliance. *British Journal of Psychiatry, 158*, 200-204.

Hayes, N. (1997). Theory-led thematic analysis: Social identification in small companies. In N. Hayes (Ed.), *Doing Qualitative Analysis in Psychology* (pp. 93-114). UK: Psychology Press.

Healy, D. (2006). The Latest Mania: Selling Bipolar Disorder. *PLoS Medicine, 3*(4), e185.

Held, B.S. (2000). To Be or Not To Be Theoretical: That is the Question. *Journal of Systemic Therapies, 19*(1), 35-49.

Held, B.S., & Pols, E. (1985). The confusion about epistemology and "epistemology" – and what to do about it. *Family process, 24*, 509-517.

Hodder, I. (2000). The interpretation of documents and material culture. In N. K. Denzin and Y.S. Lincoln (Eds.), (pp. 703-715). *Handbook of qualitative research (2nd Ed.).* Thousand Oaks: Sage Publications.

Hoffman, L. (1987). Toward a Second Order Family Systems Therapy. *Family Systems Medicine, 3*, 381-386.

Hoffman, L. (1998). Setting Aside the Model in Family Therapy. *Journal of Marital and Family Therapy, 24*(2)**,** 145-156.

Hoffman, L. (1990). Constructing Realities: An Art of Lenses. *Family Process, 29*, 1-12.

Holmes, J. (2000). Fitting the Biopsychosocial Jigsaw Together. *British Journal of Psychiatry, 177*, 93 – 94.

Horwitz, A. (2002). *Creating Mental Illness*. University of Chicago Press: Chicago.

Hoshmand, L.T. (1994). *Orientation to inquiry in a reflexive professional psychology.* Albany: State University of New York Press.

Hughes, J.A. (1990). *The philosophy of social research (2nd Edition).* London: Longman Group UK Limited.

Ivey, A.E., Ivey, M.B., & Simek-Downing, L. (1987). *Counselling and Psychotherapy: Integrating Skills, Theory and Practice (2nd edition).* Prentice-Hall International, Inc.: London.

Jamison, K.R. (1993). *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament*. Maxwell Mcmillan International: New York.

Jamison, K.R. (1995). *An Unquiet Mind*. Knopf: New York.

Jamison, K.R., & Akiskal, H. (1983). Medication Compliance in Patients with Bipolar Disorders. *Psychiatric Clinics of North America, 6*, 175-192.

Jamison, K.R., Gerner, R.H., & Goodwin, F.K. (1979). Patient and Physician Attitudes Toward Lithium: Relationship to Compliance. *Archives of General Psychiatry, 36*, 866-869.

Johnson, S.L., & Roberts, J.E. (1995). Life Events and Bipolar Disorder: Implications from Biological Theories. *Psychological Bulletin, 117*, 434-449.

Johnson, S.L., Winett, C.A., Meyer, B., Greenhouse, W.J., & Miller, I. (1999). Social Support and the Course of Bipolar Disorder. *Journal of Abnormal Psychology, 108*(4), 558-566.

Jorgenson, J. (1991). Co-constructing the interviewer/co-constructing 'family'. In F. Steier (Ed.). *Research and reflexivity* (pp. 210-225). London: Sage Publications.

Kaplan, H.I., Sadock, B.J., & Grebb, J.A. (1994). *Synopsis of Psychiatry (7th Ed.).* Williams & Wilkins: Baltimore.

Kaye, J. (1999). Toward a non-regulative praxis. In I. Parker (Ed.). *Deconstructing psychotherapy* (pp. 19-38). London: Sage.

Keck, P.E., McElroy, S.L., Arnold, L.M., Dewan, N.A., & Bennett, J.A. (2000). The Costs of Treatment of Bipolar Disorder. In A. Marneros & J. Angst (Eds), *Bipolar Disorders: 100 Years After Manic Depressive Insanity* (pp. 437-448). Dordrecht: Kluwer Academic Publishers.

Keeney, B.P. (1983). *Aesthetics of change.* New York: Guilford.

Kessing, L.V., Agerbo, E., & Mortensen, B. (2004). Major Stressful Life Events and other Risk Factors for First Admission with Mania. *Bipolar Disorders, 6*(2), 122 – 129.

Kilzieh, N., & Akiskal, H.S. (1999). Rapid-Cycling Bipolar Disorder: An Overview of Research and Clinical Experience. *The Psychiatric Clinics of North America, 22*(3), 585-607.

Kraepelin, E. (1904). Introductory Lectures on Clinical Psychiatry. In E.A. Wolpert (1977) (Ed.). *Manic-Depressive Illness: History of a Syndrome* (pp. 9-32). International Universities Press, INC.: New York.

Kraepelin, E. (1921). Manic-Depressive Insanity. In E.A. Wolpert (1977) (Ed.). *Manic-Depressive Illness: History of a Syndrome* (pp. 33-111). International Universities Press, INC.: New York.

Krauss, S.E. (2005). Research paradigms and meaning making: A primer. *The Qualitative Report, 10*(4), 758-770. Retrieved April 20, 2006, from http://www.nova.edu/sss/QR/QR10-4/krauss.pdf.

Kusumakar, V. (2002). Antidepressants and Anti-Psychotics in the Long-Term Treatment of Bipolar Disorder. *Psychopharmacology Bulletin, 26*, 409-427.

Lam, D.H., Watkins, E.R., Hayward, P., Bright, J., Wright, K., Kerr, N., Parr-Davis, G., & 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 – 52.

Larner, G. (1994). Para-Modern Family Therapy: Deconstructing Post-Modernism. *Australian and New Zealand Family Therapy, 15*(1), 11-16.

Larner, G. (1995). The Real as Illusion: Deconstructing Power in Family Therapy. *Journal of Family Therapy, 17*, 191 – 217.

Law, I. (1999). A discursive approach to therapy with men. In I. Parker (Ed.). *Deconstructing psychotherapy* (pp. 115-131). London: Sage.

Lax, W.D. (1992). Postmodern thinking in a clinical practice. In S. McNamee & K.J. Gergen (Eds.). *Therapy as social construction* (pp. 69-85). London: Sage.

Leder, D. (1990). Clinical Interpretations: The Hermeneutics of Medicine. *Theoretical Medicine, 11*, 9-24.

Lincoln, Y.S., & Guba, E.G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin and Y.S. Lincoln (Eds.), (pp. 163-188). *Handbook of qualitative research (2ⁿᵈ Ed.).* Thousand Oaks: Sage Publications.

Lolas, F. (2002). Bioethics and psychiatry: a challenging future. *World Psychiatry, 1*(2), 123-4.

Lubin, A.J. (1972). *Stranger On The Earth: A Psychological Biography of Vincent Van Gogh*. Holt, Rinehart and Winston: New York.

Lyddon, W.J., & Weill, R. (1997). Cognitive Psychotherapy and Postmodernism: Emerging Themes and Challenges. *Journal of Cognitive Psychotherapy: An International Quarterly, 11*(2), 75-89.

Macartney, F.J. (1987). Diagnostic Logic. *British Medical Journal, 295*, 1325-1331.

Madanes, C., & Haley, J. (1977). Dimensions of Family Therapy. *Journal of Nervous and Mental Disorders, 165*, 88-98.

Madigan, S. (1999). Inscription, Description, and Deciphering Chronic Identities. In I. Parker (Ed.). *Deconstructing psychotherapy* (pp 150-164). London: Sage.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies. *British journal of psychology, 91*, 1-20.

Mahrer, A.R. (2000). Philosophy of science and the foundations of psychotherapy. *American psychologist, 55*(10), 1117-1125.

Maj, M., Pirozzi, R., Magliano, L., & Bartoli, L. (1998). Long-term Outcome of Lithium Prophylaxis in Bipolar Disorder: A 5-Year Prospective Study of 402 Patients at a Lithium Clinic. *American Journal of Psychiatry, 155*(1), 30-35.

Malkoff-Schwartz, S., Frank, E., Anderson, B., Sherrill, J.T., Siegel, L., Patterson, D., & Kupfer, D.J. (1998). Stressful Life Events and Social Rhythm Disruption in the Onset of Manic and Depressive Bipolar Episodes: A Preliminary Investigation. *Archives of General Psychiatry, 55*, 702-707.

Manning, J.S., Haykal, R.F., & Akiskal, A.S. (1999). The Role of Bipolarity in Depression in the Family Practice Setting. *The Psychiatric Clinics of North America, 22*(3), 689-703.

Marneros, A. (2000). On entities and continuities of bipolar disorders. In A. Marneros & J. Angst (Eds.), *Bipolar Disorders: 100 Years After ManicDepressive Insanity* (pp. 461-464). Dordrecht: Kluwer Academic Publishers.

Marneros, A., & Angst, J. (2000). Bipolar Disorders: Roots and Evolution. In A. Marneros & J. Angst (Eds.), *Bipolar Disorders: 100 Years After Manic Depressive Insanity* (pp. 1-36). Dordrecht: Kluwer Academic Publishers.

McNamee, S. (1992). Reconstructing identity: The communal construction of crisis. In S. McNamee & K.J. Gergen (Eds.). *Therapy as social construction* (pp. 186-199). London: Sage.

McNamee, S. (1997). Marrying postmodernism with cognitive psychotherapy: A response to Lyddon and Weill. *Journal of Cognitive Psychotherapy: An International Quarterly, 11*(2), 99-103.

McNamee, S. (2002). The Social Construction of Disorder: From Pathology to Potential. In J.D. Raskin & S.K. Bridges (Eds.). *Studies in Meaning: Exploring Constructivist Psychology*. Pace University Press: New York.

McPherson, H., Herbison, P., & Romans, S. (1993). Life Events and Relapse in Established Bipolar Affective Disorder. *British Journal of Psychiatry, 163*, 381-385.

Miklowitz, D.J. (2002). *The Bipolar Disorder Survival Guide: What You and Your Family Need to Know*. The Guilford Press: New York.

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. (1990). Behavioral Family Treatment for Patients with Bipolar Affective Disorder. *Behaviour Modification, 14*(4), 457-489.

Miklowitz, D.J., Goldstein, M.J., & Neuchterlein, K.H. (1995). Verbal Interactions in the Families of Schizophrenic and Bipolar Affective Patients. *Journal of Abnormal Psychology, 104*, 268-276.

Miklowitz, D.J., Goldstein, M.J., Neuchterlein, K.H., Snyder, K.S., & Mintz, J. (1988). Family Factors and the Course of Bipolar Affective Disorder. *Archives of General Psychiatry, 45*, 225-231.

Miklowitz, D.J., Richards, J.A., George E.L., Frank, E., Suddath, R.L., Powell, K.B., & Sacher, J.A. (2003). Integrated family and individual therapy for bipolar disorder: results of a treatment development study. *Journal of Clinical Psychiatry, 64*(2), 182-91.

Miklowitz, D.J., Simoneau, T.L., George, E.A., Richards, J.A., Kalbag, A., Sachs-Ericsson, N., & Suddath, R. (2000). Family-Focused Treatment of Bipolar Disorder: One-Year Effects of a Psychoeducational Program in Conjunction with Pharmacotherapy. *Biological Psychiatry, 48*, 582-592.

Miles, M.B., & Huberman, A.M. (2001). *Qualitative data analysis (2nd Ed.)*. London: Sage Publications.

Miller, G., De Shazer, S., & De Jong, P. (2001). Therapy Interviewing. In J.F. Gubrium & J.A. Holstein (Ed's). *Handbook Of Interview Research: Context And Method* (pp. 385-410). Sage Publications: Thousand Oaks, California.

Miller, T., Velleman, R., Rigby, K., Orford., Tod, A., Copello., & Bennett, G. (1997). The use of vignettes in the analysis of interview data: Relatives of people with drug problems. In N. Hayes (Ed.), *Doing Qualitative Analysis in Psychology* (pp. 201-225). UK: Psychology Press.

Minuchin, S. (1974). *Families and Family Therapy*. Harvard University Press: Cambridge.

Mishler, E.G. (1986). *Research interviewing: Context and narrative*. London: Harvard University Press.

Morriss, R. (2004). The Early Warning Symptom Intervention for Patients with Bipolar Affective Disorder. *Advances in Psychiatric Treatment, 10*, 18-26.

Moules, N.J. (2000). Postmodernism and the sacred: Reclaiming connection in our greater-than-human worlds. *Journal of marital and family therapy, 26*(2), 229-240.

Mouton, J. (2001). *How to succeed in your master's and doctoral studies: A South African guide and resource book*. Pretoria: Van Schaik Publishers.

Mukherjee, S., Sackeim, H.A., & Schnurr, D.B. (1994). Electroconvulsive Therapy of Acute Manic Episodes: A Review. *American Journal of Psychiatry, 151*, 169-176.

Murphy, F.C., & Sahakian, B.J. (2001). Neuropsychology of bipolar disorder. *British Journal of Psychiatry, 178*(suppl. 41), 120-127.

NIMH, (2003). http://www. nimh.nih.gov. *National Institute of Mental Health.* Office of Communications. Bethesda, Maryland.

O'Hara, M., & Anderson, W.T. (1991). Welcome to the postmodern world. *The Family Therapy Networker, 15*(4), 18-25.

Omar, H., & Alon, N. (1997). *Constructing therapeutic narratives*. New Jersey: Jason Aronson.

Otto, M.W., Smits, J.A.J., & Reese, H.E. (2005). Combined Psychotherapy and Pharmacotherapy for Mood and Anxiety Disorders in Adults: Review and Analysis. *Clinical Psychiatry, 12*, 72-86.

Palmer, A., Williams, H., & Adams, M. (1995). Cognitive Behaviour Therapy in a Group Format for Bipolar Affective Disorder. *Behavioural and Cognitive Psychotherapy, 23*, 153-168.

Parker, I. (1999). Deconstruction and Psychotherapy. In I. Parker (Ed.). *Deconstructing Psychotherapy* (pp. 1-18). Sage Publications: London.

Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing psychopathology*. London: Sage.

Parry, T.A. (1993). Without a net: preparations for postmodern living. In S. Friedman (Ed.). *The new language of change: Constructive collaboration in psychotherapy* (pp. 428-459). New York: The Guilford Press.

Peet, M., & Harvey, N.S. (1991). Lithium Maintenance: 1. A Standard Education Programme for Patients. *British Journal of Psychiatry, 158*, 197-200.

Perry, A., Tarrier, N., Morriss, R., McCarthy, E., & Limb, K. (1999). Randomised Controlled Trial of Efficacy of Teaching Patients with Bipolar Disorder to Identify Early Symptoms of Relapse and Obtain Treatment. *British Medical Journal, 318*, 149-153.

Perugi, G., Toni, C., & Akiskal, H.S. (1999). Anxious-Bipolar Comorbidity: Diagnostic and Treatment Challenges. *The Psychiatric Clinics of North America, 22*(3), 565-583.

Pidgeon, N., & Henwood, K. (1997). Using grounded theory in psychological research. In N. Hayes (Ed.). *Doing qualitative analysis in psychology* (pp. 245-273). UK: Psychology Press.

Post, R.M., Uhde, T.W., Roy-Byrne, P.P., & Joffe, R.T. (1986). Antidepressant Effects of Carbamazepine. *American Journal of Psychiatry, 143*, 29-34.

Potter, G. (2000). *The philosophy of social science*. London: Prentice Hall.

Rachman, S. (2003). *The Treatment of Obsessions*. Oxford University Press: New York.

Raskin, J.D. (2002). Constructivism in Psychology: Personal Construct Psychology, Radical Constructivism, and Social Constructionism. In J.D. Raskin & S.K. Bridges (Eds.). *Studies in Meaning: Exploring Constructivist Psychology* (pp. 1- 25). Pace University Press: New York.

Rihmer, Z., & Pestality, P. Bipolar II Disorders and Suicidal Behaviour. *The Psychiatric Clinics of North America, 22*(3), 667-673.

Rivas-Vazquez, R. A., Johnson, S.L., Rey, G.J., Blais, M.A., & Rivas-Vazquez, A. (2002). Current Treatments for Bipolar Disorder: A Review and Update for Psychologists. *Professional Psychology: Research and Practice, 33*(2), 212-223.

Robinson, L.J., & Ferrier, I.N. (2006). Evolution of Cognitive Impairment in Bipolar Disorder: A Systemic Review of Cross-Sectional Evidence. *Bipolar Disorders, 8*, 103-116.

Rosenblatt, P.C. (2000). Interviewing at the border of fact and fiction. In N. K. Denzin and Y.S. Lincoln (Eds.). *Handbook of qualitative research (2nd Ed.)* (pp. 893-909). Thousand Oaks: Sage Publications.

Sachs, G. (1996). Bipolar Mood Disorder: Practical Strategies for Acute and Maintenance Phase Treatment. *Journal of Clinical Pharmacology, 16*, 32-47.

Sajatovic, M., Davies, M., & Hrouda, D. (2004). Enhancement of Treatment Adherence Among Patients with Bipolar Disorder. *Psychiatric Services, 55*, 264-269.

Schlebusch, L. (2005). Depression and Suicidal Behaviour. *SA Family Practice, 47*(5), 61-63.

Schou, M. (1983). *Lithium Treatment of Manic-Depressive Illness: A Practical Guide (2nd Ed.)*. Pratteln: Basel.

Schwandt, T.A. (2000). Three epistemological stances for qualitative inquiry. In N. K. Denzin and Y.S. Lincoln (Eds.). *Handbook of qualitative research (2nd Ed.)* (pp. 189-213). Thousand Oaks: Sage Publications.

Scott, J. (1995). Psychotherapy for Bipolar Disorder. *British Journal of Psychiatry, 167*, 581-588.

Scott, J. (1996). The Role of Cognitive Behavioural Therapy in Bipolar Disorder. *Behavioural and Cognitive Psychotherapy, 24*, 195-208.

Scott, J. (2001). Cognitive Therapy as an Adjunct to Medication in Bipolar Disorder. *British Journal of Psychiatry, 178*(suppl. 41), 164-168.

Scott, J. (2006). Psychotherapy for bipolar disorders – efficacy and effectiveness. *Journal of Psychopharmacology, 20*(2), 46-50.

Selvini, M., Boscolo, L., Cecchin, G., & Prata, G. (1978). *Paradox and Counterparadox*. New York: Aronson.

Shopsin, B., Georgotas, A., & Kane, S. (1979). Psychopharmocology of Mania. In B. Shopsin (Ed.). *Manic Illness* (pp. 177-218). Raven Press: New York.

Shotter, J. (1993). *Cultural Politics of Everyday Life: Social Constructionism, Rhetoric and Knowing of the Third Kind*. University of Toronto Press: Toronto.

Simon, E. (2003). Family focused psychoeducational therapy decreases relapse and rehospitalisation in people with a manic episode and bipolar disorder. *Evidence Based Mental Health, 6*(4)**,** 114-114.

Simon, L. (1994). *Psycho"therapy": Theory, Practice, Modern and Postmodern Influences*. Praeger: London.

Simoneau, T.L., Miklowitz, D.J. Richards, J.A., Saleem, R., & George, E.L. (1999). Bipolar disorder and family communication: Effects of a psychoeducational treatment programme. *Journal of Abnormal Psychology, 108*(4), 588-597.

Snyman, S., & Fasser, R. (2004). Thoughts on Ethics, Psychotherapy and Postmodernism. *South African Journal of Psychology, 34*(1), 72-83.

Soares, J.C., & Mann, J.J. (1997a). The Anatomy of Mood Disorders – Review of Structural Neuroimaging Studies. *Biological Psychiatry, 41*, 86-106.

Soares, J.C., & Mann, J.J. (1997b). The Functional Neuroanatomy of Mood Disorders. *Journal of Psychiatric Research, 31*(4), 393-432.

Speed, B. (1991). Reality Exists O.K.? An Argument Against Constructivism and Social Constructionism. *Family Therapy, 13*, 395 – 409.

Stake, R.E. (2000). Case studies. In N. K. Denzin and Y.S. Lincoln (Eds.). *Handbook of qualitative research (2nd Ed.)* (pp. 435-454). Thousand Oaks: Sage Publications.

Steier, F. (1991). Introduction: Research as self-reflexivity, self-reflexivity as social process. In F. Steier (Ed.). *Research and reflexivity* (pp. 1-11). London: Sage Publications.

Stiles, W.B. (1993). Quality control in qualitative research. *Clinical Psychology Review, 13*(6), 593-618.

Stoll, A.L., Severus, W.E., Freeman, M.P., Reuter, S., Zboyan, H.A., Diamond, E., Cress, K.K., & Marangell, L.B. (1999). Omega-3 Fatty Acids in Bipolar Disorder: A Preliminary Double-Blind, Placebo-Controlled Trial. *Archives of General Psychiatry, 56*, 407-412.

Stoudemire, A. (1994). *Clinical Psychiatry for Medical Students (2nd Edition).* J.B. Lippincott Company: Philadelphia.

Strong, T. (2002). Constructive Curiosities. *Journal of Systemic Therapies, 21*(1), 77-90.

Strong, T., & Lock, A. (2005). Discursive Therapy? *Janus Head, 8*(2), 585-593.

Summerfield, D. (2001). The Invention of Post-Traumatic Stress Disorder and the Social Usefulness of a Psychiatric Category. *British Medical Journal, 322*, 95-8.

Suppes, T. Webb, A., Paul, B., Carmody, T., Kraemer, H., & Rush, J. (1999). Clinical Outcome in a Randomized 1-Year Trial of Clozapine Versus Treatment as Usual for Patients with Treatment-Resistant Illness and a History of Mania. *American Journal of Psychiatry, 156*(8), 1164-1169.

Szasz, T.S. (1960). The Myth of Mental Illness. *American Psychologist, 15*, 113-8.

Tarnas, R. (1991). *The Passion of the Western Mind: Understanding the Ideas that Have Shaped our World View*. Pimlico: London.

Terre Blanche, M., & Durrheim, K. (1999). Social constructionist methods. In M Terre Blanche & K. Durrheim (Eds.). *Research in practice: Applied methods for the social sciences* (pp. 147-172). Cape Town: University of Cape Town Press.

Tierney, W.G. (2000). Undaunted courage: Life history and the postmodern challenge. In N. K. Denzin and Y.S. Lincoln (Eds.). *Handbook of qualitative research (2nd Ed.)* (pp. 537-545). Thousand Oaks: Sage Publications.

Tohen, M. (2000). Antipsychotics in Acute Mania. In A. Marneros & J. Angst (Eds.), *Bipolar Disorders: 100 Years After Manic Depressive Insanity* (pp. 373-386). Dordrecht: Kluwer Academic Publishers.

Tohen, M., Sanger, T.M., McElroy, S.L., Tollefson, G.D., Chengappa, K.N., Daniel, D.G., Petty, F., Centorrino., F., Wang, R., Grundy, S.L., Greaney, M.G., Jacobs, T.G., David, S.R., & Toma, V. (1999). Olanzapine Versus Placebo in the Treatment of Acute Mania. Olanzapine HGEH Study Group. *American Journal of Psychiatry, 156*(5), 702-709.

Van Putten, T., & Marder, S.R. (1987). Behavioral Toxicity of Antipsychotic Drugs. *Journal of Clinical Psychiatry, 48*, 13-19.

Van Scheyen, J.D., & Van Kammen, D.P. (1979). Clomipramine-Induced Mania in Unipolar Depression. *Archives of General Psychiatry, 36*, 560-565.

Von Foerster, H. (1985). Apropos epistemologies. *Family process, 24*, 517-521.

Walker, M. (2006). The Social Construction of Mental Illness and its Implications for the Recovery Model. *International Journal of Psychosocial Rehabilitation, 10*(1), 71-87.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

White, C.A. (2001). *Cognitive Behaviour Therapy for Chronic Medical Problems: A Guide to Assessment and Treatment in Practice*. John Wiley & Sons, LTD.: New York.

Whitfield, G., & Williams, C. (2003). The Evidence Base for Cognitive-Behavioural Therapy in Depression: Delivery in Busy Clinical Settings. *Advances in Psychiatric Treatment, 9*, 21 – 30.

Wolpert, E.A. (1977). (Ed). *Manic-Depressive Illness: History of a Syndrome*. International Universities Press, INC.: New York.

Wright, B., Williams, C., & Garland, A. (2002). Using the Five Areas Cognitive-Behavioural Therapy Model with Psychiatric Patients. *Advances in Psychiatric Treatment, 8***,** 307-315.

APPENDIX A

Letter of consent

Dear

Thank you for choosing to participate in this Doctoral research study. The focus of the study is on bipolar mood disorder and the implications of having this mental illness for the person; family; treating psychotherapist; and psychiatrist. In order to attain information that is relevant, I would like to explore the experiences and knowledges that you have regarding the diagnosis, the life of the disorder, relevant exposures to the psychiatric system, and any possible benefits of having this disorder. I am interested in your perspective of the psychiatric world as you have experienced it. Through your participation as a co-researcher, I hope to understand the life-world of bipolar mood disorder.

Your participation in this research endeavour entails two interviews, lasting approximately two hours each. Each interview will be digitally recorded, and transcribed. You will be given the opportunity to read the transcripts and offer your input and feedback.

Please note that:
1. You are under no financial obligation or commitment.
2. All information will be treated with strict confidence. Your name will not be reflected in the thesis, nor will I discuss your name with any person not directly involved in the study.
3. You can withdraw from the study at any time that you choose. Although, it is hoped that you will find the conversations beneficial to your understanding of bipolar mood disorder and the state of psychology/psychiatry. Your story will also be of benefit to other people who have been given such a diagnosis.
4. I cannot guarantee that you will derive any benefits from participating in this project.

Thank you again for agreeing to participate.

Name:_____ Date:_____

Physical address:_____

E-Mail address:_____

Signature:_____

APPENDIX B

Excerpts from Memoing

Post-Scripture Reflections: The Postmodern Therapist Returns

When writing up the research that others have meticulously documented, a stance of the expert knower was assumed. It was very comforting to be able to make assumptions on the basis of other people's assertions. The feeling of certainty was attained and used effectively. The complexity of the disorder could be grasped by following a logical process of deduction formulated on the basis of gathered facts.

Biologically, research consistently continued to show that the identified patient has a neurochemical and neuropsychiatric vulnerability that predisposed him or her to developing the full spectrum disorder. Logically following this claim is the treatment philosophy of pharmacology. The signs and symptoms of the disorder **can** be identified, rectified, improved, eradicated and maintained with the compliant usage of medication. But the question arises, *what if the patient does not want to comply with a life-long commitment to taking tablets?*

Following this question, the next logical level appears. That is, address the factors that prevent a person from complying with the treatment regime enforced by the treating physician. This allows for the clinical psychologist to enter the picture frame. Now the psychosocial factors are addressed, researched, documented, and promulgated through journal writings, conferences, and peer reviews. But the question arises, *what makes a person maintain a 'dysfunctional' behaviour even in the light of individual, family and organisational interventions?*

This superimposed level of abstraction requires a shift of thinking on the part of the observer. And further, it leads to many more unanswerable questions. Such as, *what if the 'dysfunctional' behaviour as diagnosed by the professional is actually a creative well of potential and actualising ability? What if the erratic behaviour*

patterns are unbearable for significant others to accept and hence the enforcement of a treatment regime?

These abstract and intangible questions meet the requirements of this research endeavour because one of the underlying assumptions of this study is to challenge the modernist perspective of bipolar mood disorder from a postmodern initiative, and vice versa. In this way, the polarised epistemologies within the field of psychology are turned on their heads and differences may be allowed to emerge, hopefully providing congruence between practice and preaching. Both modernism and postmodernism have become reified realities, explaining each other by means of oppositional thought. Neither are internally congruent.

In reflection, the following opposing views have emerged from this literature review:

Construct	A modernistic view	A Postmodernist View
Reality	Absolute. Single verifiable truths	Relative. Multiple realities
Role of clinician	Expert	Non-expert; reflective and inclusive
Technique	Reliance on valid techniques	Reliance on the use of self
Research	Yields quantifiable generalisations	Yields qualitative descriptions relating to felt experiences
Modelled understanding	Principles of causation	Principles of reciprocal influence. Cause and effect are cyclical
Problem formation	Identify and treat	Identify and understand
System of concern	Medical treatment	Medical treatment as part of an ecosystemic outlook
View of client/patient	Client/patient dependency	Client/patient emancipation and resumption of responsibility
Outcome	Generation of facts. Generalised treatment protocol	Generation of storied realities. Outcomes are emergent
Human participation	Humans present with the illness	The illness is socially constructed by humans
Symptom focus	Identify and alleviate	Understanding meanings associated with symptoms; focus on potential and creative channelling of symptoms.
Change agent	Agent of normality	Agent of critical commentary; merge normal and abnormal definitions.

It was a taken for granted belief that modernism was associated with an **a-contextual** principle and postmodernism the opposite. From the literature exposition, this assumption has proven to be untrue. The modernist does assume a position of being a realist, expert, fact-finding scientist, but throughout all research read, contextual factors were mostly accounted for. From the times of Kraepelin, the

context has been included as part of the description of the disorder. All compliance issues are addressed in a contextual manner. The manual-based psychotherapies are contextual, but, they are all **first order systemic approaches.** The observer/clinician/psychiatrist is not affected by the changes or fluctuations that the client presents. This has been a point of interest. The psychiatric paradigm, albeit modernist, does account for the environmental surrounds. The clear difference is that the psychiatrist holds a societal position of power, respect of expertise, and control. Change is sought after in a unilateral manner – the patient changes and the medical fraternity remains the same. The role of the various professions within the psychiatric paradigm (treating professional, psychologist, nurses, researchers) assume that they are the advocators of change and dictate the most effective way to improve the prognosis of the patient on the basis of acclaimed research.

As a pre-introduction to the research interviews – which will be written up from a postmodern stance – the researcher will outline the postmodern assertions of reality, people, medical systems, meaning, behaviour, and interactions. From this postmodern overview, the methodology of the research process will be legitimised and explicated.

Post-Scripture Reflections: The Epistemological Confusion

Entering the arena of philosophical debate of what constitutes human behaviour proved to be a daunting task. One can become overwhelmed by the amount of literature available on the topic. Initially the researcher dared to explore both eastern and western philosophies. This journey provided more questions than answers and for the purposes of this research mission, it was simply too broad and had to be narrowed down. This took the format of focusing (for the time being) on western paradigms of epistemology – or more directly – the paradigms of modernism and postmodernism.

Within the western spectrum of philosophical and academic thought, there lies much confusion and duplication. The traditional modernist assumptions have grown to assume new names and elaboration, as have the postmodernists. In a way, the

original paradigms have been bastardised to suit the various continental ways of thinking and academic movements.

The concepts that have been discussed in this chapter have reflected the contradictions, over-simplifications and repetitions. But yet, although so much has been said, and no doubt more will be documented, there is still a gap between a mediation of the oppositional paradigms. Context requires the ability to be versed in both paradigms, yet the paradigms themselves reject the basic assumptions of each other. ***Where does this leave the psychotherapist who has to function in both worlds?***

A concern that has emerged from this philosophical discussion is aimed at the lack of an integrative framework from both epistemological positions. Both paradigms have shown to be consistent in their equal belief in their own world-views to the exclusion of the other. This could be likened to that of a couple's therapy session in which both parties have differing outlooks and beliefs. ***How could the institution of a relationship be worked at if there was no mid-point of compromise?***

This raises the point that perhaps the integration of epistemologies is doomed for failure as both speak a foreign language and neither appears prepared to learn the other without heavy criticism. The postmodernists claim to believe in multiple realities, yet not at the cost of accepting a modernist world-view.

The postmodernists have cleverly found a way to re-write theories about meaning and the origins of belief systems. But, practically, the focus is on 'going-with-the-flow' in a world that demands structure. That allows for a multitude of contradictions to emerge.

The attempt was made to write the chapter from an objective point of view. This was an impossible task. Often, there was a solo conversation (between the researcher and the multitude of books and articles) arguing one point from one perspective, and severely criticising that same point from another paradigm. No definitive clarity emerged, and the internal discussions still continue. While the researcher recognises the short-comings of the modernist perspective, she also cannot

practically convert postmodern assertions into a workable reality. Postmodernism offers the researcher a very creative, free, and explorative tool from which to understand human behaviour. But, how this translates into a practical therapeutic practice is still unknown.

The next challenge is to explore the methodology and research design. Postmodernism will be a cornerstone from which the research interviews will be carried out. At this point in time, it would appear that the principles of postmodernism may allow the researcher the freedom to explore the socially constructed world of bipolar mood disorder. This will be on a meta-level and will be process oriented, unlike the previously documented content research (chapter two). The questions that remain at this time are: ***will the process research be able to explain the content issues that face individuals, families, and cultures, on a daily basis? Will the intellectual academic world of postmodernism be translatable into a workable reality for the average client seen in the therapeutic context?***

Departing from the philosophical discussion, the researcher can now activate her own epistemological assumptions. Every theme and discussion discussed up to now has been a comment on the researcher as much as it has been about the content. The confusion and uncertainty are accepted (not without an internal argument giving way to many dilemmas) as part of the research journey.

Post-Design: Doubt In-Certainty

The methodology chapter has provided a concrete platform from which to abstract interpretations of human behaviour. Provided with textbook certainty about research paradigms and techniques of research, I have dabbled in continuous doubt (is this good enough), tediousness, and self-reprimanding punishments. A pivotal question reverberating through my mind has been: So what? What is new? How boring!

A pervasive feeling throughout this chapter has been one of doubt. Will I achieve what I want to? At what cost and to whom? ***How will I be perpetuating the***

dominant academic discourses that lack the compassion to understand human behaviour? All the questioning has now been channelled into a 'box' (the research design) which will allow for certain stories to emerge. The 'box' will also dictate how these stories should be understood. And of all madness, I am the creator of the 'box'. In some ways then, I am in-folding the process upon myself. And that is what I wanted to do…

Before constructing this chapter I spent long hours debating my own conceptualisations and ideas. It took many, many, many long days of thought to come to a place where I could even think of attempting to correct the errors of my previous chapter. That is not a good way to enter the chapter write up of methodology. Along the way through this chapter I vacillated between positions of complete certainty and all-consuming belief in my ideology, and the ever present voice of doubt judging my ideas irrelevant.

This chapter is then a culmination of a balance between certainty and uncertainty. No doubt there will be suggestions for a better way of doing research, but this chapter is a reflection of my journey through the annals of research methodology. The outcomes are evident in my way of thinking, and in my way of practice. There is a magnificent torrent of new and fresh confusion flowing through my mind, and conversations with colleagues have taken on an almost 'schizophrenic' nature which could very well be labelled hallucinatory. On the other hand, it does not take an effort to go to places of certainty, and with an **ethical construction** in progress, this certainty is also brimming to the surface of my thought and talk.

The ethics of research have not been demarcated and allowed their own space in the chapter write-up as it is my belief that ethics are a meta-level process that emerge rather than dictate. A beginning point of ethical construction has been finding sanity between theory and practice in the realm of research. The two forms of psychological practice (theory and practice) are now talking in a similar language and hopefully, alternative realities can be created under the elusive banner of 'research'.

In my previous chapter you added a very valuable comment on the theory of grand narratives, and I have imposed it upon my own thinking. The comment said:

"not all stories are equally valid as some do not respect difference, gender, ethnicity etc. One of the aims, therefore would be to deconstruct stories that dominate others and co-construct alternative realities/meanings". My own personal 'grand narratives' are slowly being exposed and for the moment, the process is highlighting the ever present tension between theory and practice. The research design authoritatively states 'how' to research my chosen area of interest. I laugh. 'As if' there is a right way. And then I am coldly reminded that this is an academic adventure, and there will definitely be a more correct way of exploring human nature…