

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

Abstract

Bipolar mood disorder has been traditionally researched, explored, and explained from a modernistic, psychiatric perspective. The purpose of this paper 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 article 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 methodologies such as vignette and thematic analyses for textual deconstruction and reconstruction. The following themes emerged as being pertinent to the construction of bipolar mood disorder: *The power differentials (individual, institutional and relationship power); The expert (the psychiatric, the psychotherapeutic and the patient's expertise); The theme of problems (as discourses, moral judgements, emergent dilemmas, and multiple realities); Meaning generating systems (modernism and postmodernism, meaning in diagnosis, and connection and disconnection); Belonging*. The themes add value to the way in which bipolar mood disorder is understood and worked with in therapeutic domains, widening the taken-for-granted 'truths' about the intrinsic nature of such a diagnosis.

This paper explores how bipolar mood disorder can be constructed from both epistemological positions of modernism and postmodernism. The specific focus of this paper is in explicating a postmodern take on a traditionally accepted psychiatric diagnosis. The aims and intentions are to explore the alternative ways of understanding the diagnosis itself, the way it is experienced by those who have been diagnosed as well as the professionals who work with the illness, and then to provide commentary on the discourses which shape the way we understand human behaviour. To begin with, a traditional view of bipolar mood disorder is offered through the medical model lens. This overview focuses on current research within bipolar mood

disorder and demarcates areas of importance in the psychiatric paradigm. This is followed by a postmodern rendition of the underlying assumptions of this theory, as well as its application in the context of bipolar mood disorder. A social constructionist approach to research is then described with reference to the research design, data collection and analysis and commentary on reliable and valid research claims. The emergent themes of this research are then portrayed using the stories that were shared with the researcher. The researcher has steered away from the comparative literature in this section (given the space limitations) and is instead giving the emergent themes their own legitimisation. This is followed by a brief discussion of the emergent themes in collaboration with the overarching epistemological paradigms, and then a conclusion is offered.

Defining bipolar mood disorder: The medical model

Bipolar mood disorder is traditionally understood as a debilitating disorder of mood fluctuation including episodes of mania and depression. 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 type 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, (1994), 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 (1994; 2000).

The aims of therapeutic interventions are “to alleviate acute symptoms, restore psychosocial functioning, and prevent relapse and recurrence” (Scott, 2006, p. 46). The largest influencing knowledge base for understanding bipolar mood disorder is the medical model, focusing on deficits and abnormal behavioural patterns. The conceptual understandings of bipolar mood disorder have focused on patient management (American Psychiatric Association, 1994); identifying signs and symptoms of manic and depressive behaviours (American Psychiatric Association, 2000; Kaplan, Sadock & Grebb, 1994); co-morbid impeding factors, such as the personality disorders (Perugi et al., 1999); pharmacotherapy (Callahan & Bauer, 1999), including mood stabilisers, anti-depressants, and anti-psychotics; electro-convulsive therapy (Schou, 1983); nutrition (Stoll et al., 1999); brain imaging (Miklowitz, 2002); psychosocial stressors, chrono-biological factors, and medication compliance (Callahan & Bauer, 1999); psychoeducation (Bauer & McBride, 1996); family focused therapy (Simoneau et al., 1999); cognitive behavioural therapy (Scott, 1996); and interpersonal and social rhythm therapy and the life goals programme (Bauer & McBride, 1996). The focus of treatment is the patient.

This existing literature has largely been accepted by both psychiatrists and psychologists and treatment approaches are aligned with the assumption that the patient is the one with the deficit and is therefore the site of treatment. Bipolar mood disorder is viewed through an expert scientific lens whereby human behaviour can be clinically observed and categorised, researched, treated with pharmacological medicine, and ultimately freed of unhealthy behaviours.

The medical model is helpful in understanding the bipolar mood disorder spectrum 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).

The postmodern invention

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 largely omitted from the body of research.

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. Postmodernism focuses on generative knowledge, multiple realities, conversations of possibilities, relational engagements, meanings that are embedded in relationships, and reflexivity (Burr, 1995). 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 patients' stories were never made explicit in these research endeavours, this will remain a hypothesis.

The correlations that have been deemed important by 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 is 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.

A social constructionist research approach

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 participate 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).

To research the stories of people who live and work with the diagnosis of bipolar mood disorder, a postmodern qualitative research approach was adopted. 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).

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 (Burr, 1995).

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). This research required an approach which accounted for the multiple perspectives of those who live and work with the diagnosis of bipolar mood disorder. Instead of focusing on traditional signs and symptoms of behaviour and available treatment protocols, this research focused on the shaping discourses of the construct bipolar mood disorder and therefore required a methodology which could explore the ways in which language, culture, societal and historical factors shape bipolar mood disorder.

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, 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 (Tarnas, 1991). Psychotherapy, in an attempt to place itself legitimately within a scientific discipline, also adopted these viewpoints and assumptions.

It is apparent that this research 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. From a postmodern perspective mental illness is 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).

Method

Participants

For the purposes of this research, purposive sampling and convenience selection was used (Lincoln & Guba, 2000). Participants were selected if they were willing to speak about their experience of bipolar mood disorder, and if they agreed to the demands of the process such as, interviews, and follow-up discussions. The intention of selecting a cross-section of a system (including patients, a psychiatrist and a psychologist) was to generate a holistic understanding of the world of bipolar mood disorder including as many of the role-players as possible. The family members of the diagnosed patients did not want to participate in this research, as they felt that they did not have anything to contribute. This was seen to be a further comment on the pervasive discourse of the disorder being commonly understood as an intrinsic, deficit based phenomenon.

The four co-researchers who did participate in this research were given pseudo-names for the sake of maintaining confidentiality. They were:

- ✘ Marge Polyvocal, a 54 year old married woman with two children. She was diagnosed with bipolar mood disorder (type 1) more than thirty years ago. She has been compliant with her medication and continues to seek psychiatric and psychological help for her diagnosis. The metaphor of polyvocality was thought to be descriptive of this co-researcher. 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). Marge Polyvocal's story is embedded within her lived experience of having the diagnosis of bipolar mood disorder, fraught with contradictions and opposing ways of behaving, and it was therefore thought to be appropriate to name her in this way.

- ✘ Linda Egalitarian, a 44 year old married woman with three children. She was diagnosed fifteen years ago with bipolar mood disorder (type 1). She has had phases of being non-compliant with her medication and she has endured many relapses, although she claimed to be stabilised at the time of the interviews. 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.
- ✘ Faith Semantic, a postmodern psychotherapist with years of experience in working with bipolar mood disorder. Faith Semantic struggled with the overarching influence of the medical model as she worked in a psychiatric setting. She offered both modernist and postmodernist opinions on working with bipolar mood disorder. Her name was chosen to emphasise the trust that patients have in the therapist that they work with, as well as the fact that this co-researcher operated from a postmodern stance and validated many of her suppositions in language, meaning, and contextual descriptions.
- ✘ Professor Medi Caution, the professional psychiatrist. This co-researcher worked in a psychiatric hospital and played a pivotal role in educating and training psychiatrists. Her epistemological position was based on medical model and psychiatric premises. She assumed an expert role and was confident in her treatment approach to bipolar mood disorder. The naming of this co-researcher came about when transcribing the interviews. It appeared that even though she was certain about the benefits and the necessity of medication, she cautioned herself to not over-medicate the patients.

Data collection and analysis

The narrative interview used for this research was understood to be an account or script offered by the research participant in accordance with the nature of the questions asked by the researcher, which reciprocally influenced the researcher's questions (Gubrium & Holstein, 2003). Therefore, any deductions and inferences made from the transcribed data were also reflective of the researcher's interpersonal style and preferences (Mishler, 1986). The 'truth' value of the interview data was co-determined by both the researcher and the co-researcher (Atkinson & Coffey, 2003).

The unstructured interview, or conversation, was the method used to obtain information (verbal and non-verbal) (Mishler, 1986). The questions asked were open-ended and modified according to the co-researcher's unique story. The researcher was an active participant, guiding the story through questions asked, checking her understandings, and reformulating presuppositions according to the demands of each conversation. Each interview was recorded and transcribed. The researcher's careful analysis of the transcriptions allowed 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, was utilised to demarcate pertinent idiosyncratic and common themes.

Once the interviews were transcribed, vignette analysis as described by Miller et al. (1997) was used to convey the richness of the research interviews. This entailed a write-up including both modernist psychiatric stories, and postmodernist contextual accounts. These vignettes were further explored using the coding process described by Pidgeon and Henwood (1997) and the analysis of discourses outline provided by Parker et al. (1995), using the language and words of the co-researchers. This was then thematically analysed according to the framework provided by Hayes (1997) which assisted in clarifying themes of difference and similarity. This process of data analysis required a back and forth process, as the themes were harvested from within and across the interviews.

Lastly, the data analysis made use of matrices, as set out by Miles and Huberman (2001) to assist the researcher in noting patterns, themes, contrasts and comparisons.

These matrices were 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. Process models were then generated to highlight the premises of this research.

Two major objectives of storied research are to describe and analyse both the processes through which social realities are constructed, and also the social relationships through which people are connected to one another. It is within, and through these relationships and processes that culture and society, organisations, and institutions emerge and are sustained (Miller & Dingwall, 1997). Being 'context sensitive' places emphasis on many aspects of social, historical, and physical contexts that shape the way we come to attach meaning to experiences and events (Miller & Glassner, 1997).

The unstructured interview, transcriptions, coding and thematic analyses processes, shaped the emergent discourses. These discourses were grouped together using the language of the co-researcher and were broadly categorised as naming the disorder; causes of the disorder; self-perception/perception of the patient; support systems; religion; symptom expression; and perception of the psychiatrist/psychiatric system. For example, comments on the causes and nature of bipolar mood disorder included:

- ✦ **Marge Polyvocal:** I have this rapid cycling, this emotional and mental wave that cycles very quickly in one day.
- ✦ **Linda Egalitarian:** I got the ability to handle things, but my body wouldn't cooperate.
- ✦ **Faith Semantic:** The bipolar description became a stressor, the family bought into this label, and he started to treat this patient as if he was mad.
- ✦ **Medi Caution:** People abusing substances along with other problems, ja, it complicates matters tremendously.

Following the thematic analysis, emergent discourses were refined and discussed including: the biomedical, psychosocial, cognitive-interpersonal-emotive, and the socio-cultural discourses. After the deconstruction of discourses, emerging themes

were identified and reconstructed along with the existing body of literature on bipolar mood disorder, but will not be discussed in this paper.

Reliability, objectivity and validity

In this research, ‘objectivity’ was 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 & Fraser, 2004).

Reliability of the research data, that is the trustworthiness of the interview transcriptions were context-dependent, and rested upon thorough explications of the contextual backgrounds for each vignette used. The researcher disclosed 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 were shaped by the researcher’s background, which impacted on the outcome of the research inferences.

With regards to validity, meaning trustworthiness of the interpretations (Stiles, 1993), the researcher provided completeness of interpretations (Madill et al., 2000) rather than convergence. This research focused on multi-disciplinary fields within the mental health framework, including that of the patient’s experiences. It is therefore fitting that this research exemplified emergent differences, rather than acquiring knowledge through consensus. It is believed that the permeability, forestructure and interpretative completeness of the research achieved qualitative standards of reliability and validity.

Emergent themes

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 themes were written up from three perspectives, that being themes that emerged across the interviews, themes within the interviews, and then commentary on the pervasive discourses. The following themes will be discussed with reference to each co-researcher:

- ✘ Titrating power relations, distilling relationships.
- ✘ The expert.
- ✘ The therapeutic problem.
- ✘ The problem of therapy.
- ✘ Problem systems: The patient.
- ✘ Problem systems: The psychiatrist and the psychologist (the psy-fraternity).
- ✘ Connection and disconnection.
- ✘ Shifting contexts: Meaning generating systems.
- ✘ Belonging.

These emergent themes (not discussed in detail this paper) were then reconstructed and compared with the existing body of literature on bipolar mood disorder under the following headings:

- ✘ 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.

Titrating Power Relations, Distilling Relationships.

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.

Power was evident in the words that people used to describe how they feel, who they are, and what they experience. It was also instrumental in shaping the social constructions of bipolar mood disorder. It defined the nature of relationships and determined who has the most influential position. Power was also 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 showed 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.

The power differentials that emerged 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 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.

The initial power differential emerged when the patient sought 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.

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 the 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 Expert

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.

Both patients 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. The research indicated that the patients are experts on their own lives and knew which treatment was best for them, when to seek help, and when a relapse was imminent.

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 patient view); the expert on how best to medically treat the disorder (the psychiatrist); the expert on the most effective psychotherapeutic intervention for the disorder (the psychotherapist); the expert on the prognosis and length of the disorder (the psychiatrist); and the expert on the knowledge base informing the disorder (the psychiatrist and psychologist).

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 disorder itself affected every aspect of the person's life and shaped how each person interacted with others, low self-perception, accomplishments in life, as well as the disappointments.

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. 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 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. 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.

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 Therapeutic Problem

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. Several of these problems will now be discussed.

The psychiatrist defined the therapeutic problem as one in which the person is uncontained due to mood disparities. The psychiatrist's objective was to restore normal mood patterns which do not reach extremities of suicidal ideation or wild manic outbursts. This entailed 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 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.

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.

The Problem of Therapy

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. In this research, there were obvious problems of therapy, such as a lack of blood tests to test the therapeutic levels of the drugs; a sense of anger voiced by the patients for the doctors only reaching a diagnosis after much time had passed; the lack of availability and short sessions with the treating psychiatrist; the focus on deficit and problem saturated language; a demanding patient; and a lack of knowledge (of manualised psychotherapies) on the part of the therapist. These aspects of bipolar mood disorder will be briefly explored.

Firstly, identifying bipolar mood disorder requires knowledge of the psychiatric literature and research. This in turn initiates a pharmacological treatment protocol. 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.

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.

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.

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.

Problem Systems: The Patient

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.

Problem Systems: The Psychiatrist and the Psychologist (The Psy-fraternity).

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.

The psychiatrist's 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's 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.

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.

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 coordinate 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.

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.

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.

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. 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.

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.

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.

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 whom 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; 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 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.

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.

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.

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.

Discussion

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). 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. 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).

The existing 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).

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).

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 “(c)linical 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).

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.

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. This is a moral judgement, based on societal and cultural norms and values, enforced through the voices of psychiatry and psychology.

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.

Speed (1991, p. 399), commented that “(h)ow 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.

Conclusion

This article 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.

Bipolar mood disorder can also be seen as 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.

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