

**CLINICAL PSYCHOLOGISTS' EXPERIENCES OF MANAGING  
ADOLESCENTS DIAGNOSED WITH BIPOLAR DISORDER**

by

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## ABSTRACT

Literature notes an increase in the number of children and adolescents diagnosed with bipolar disorder. Several challenges faced by clinicians who diagnose and treat early-onset bipolar disorder have been discussed with particular emphasis being placed on its pharmacological management. The contributions made by psychologists including psychosocial interventions, have been explored in this regard; however, there still exists a paucity of voices in the field of psychology that discuss the experiences surrounding the management of this disorder.

Most studies on early-onset bipolar disorder do not distinguish between childhood and adolescent presentations. Adolescence has been recognized herein, as a distinct developmental and transitional phase and thus, it forms the basis of this inquiry. This qualitative study thus explores clinical psychologists' experiences of managing adolescents diagnosed with bipolar disorder and will be approached from a social constructionist perspective which was selected as a means of exploring the meanings that individuals attribute to their experiences as they engage with others in their environment. A literature review evaluated the current available literature on juvenile bipolar disorder. Clinical psychologists in private practices were interviewed using semi-structured interviews. The participants were selected using purposive sampling. Two pilot studies were used to pre-test the study. One participant took part in pilot study 1 and one in pilot study 2. Thereafter, four semi-structured interviews were held with four participants who took part in the main study. Themes were drawn from the data and were explored using thematic content analysis. An analysis of the themes revealed several shared experiences in clinical psychologists' management of juvenile bipolar disorder which were similar to what is reflected in the current available literature on early-onset bipolar disorder.

*Keywords: Adolescent, bipolar disorder, early-onset bipolar disorder, juvenile, juvenile bipolar disorder, management, pre-pubescent, pubescent, youth.*

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## DECLARATION

I declare that **CLINICAL PSYCHOLOGISTS' EXPERIENCES OF MANAGING ADOLESCENTS DIAGNOSED WITH BIPOLAR DISORDER** is my own work and contains no section copied in whole or in part from any other source unless explicitly identified in quotation marks and with detailed, complete and accurate referencing.

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Karabo Makhafula

JANUARY 2016

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# CHAPTER 1

## 1.1 Introduction

In recent years, research has shown an increase in the diagnoses of bipolar disorder among children and adolescents (Diler & Birmaher, 2012). Questions related to how to distinguish bipolar disorder from other commonly-diagnosed childhood mental disorders (Diler & Birmaher, 2012) as well as suitable treatment interventions (Chubinsky & Rappaport, 2006) have arisen in the literature. The medical fraternity has created guidelines for the pharmacological management of early-onset bipolar disorder (Kowatch, Fristad, Birmaher, Wagner, Findling & Hellander, 2005; National Institute for Health and Clinical Excellence, 2006). Moses (2011) notes that more youths have been exposed to pharmacological treatment. In addition, various psychological interventions have been evaluated (Lovelock, Mathews & Murphy, 2010) in order to manage the effects of this chronic, recurrent, and relapsing disorder. Discussions have focused on the variability of its presentation, its effect on daily functioning, age of onset, associated comorbidities, and other areas of study that have helped to advance our understanding.

However, despite the vast amount of literature relating to bipolar disorder, limited attention has been directed towards advancing our understanding of how the management of early-onset presentations is experienced within the field of psychology. Because of the diversity of contemporary ideas on early-onset bipolar disorder, there is a need for further discussions that give voice to how clinical psychologists experience the management of such a disorder. A discussion of this nature could advance our understanding of what clinical psychologists are faced with when managing juvenile bipolar disorder as well as the considerations that they make when managing this disorder. An evaluation of this experience may induce further discussion about how the global discussion on early-onset bipolar disorder relates to how clinical psychologists manage juvenile bipolar disorder.

## **1.2 Statement of the Problem**

This study is motivated by the emerging discussions on early-onset bipolar disorder. Researchers have directed their focus on the reported increase in the diagnoses of early-onset bipolar disorder, the complexities associated with such a diagnosis and the subsequent management thereof. Smith (2007) declares that “there is no greater controversy in child and adolescent psychiatry than that related to the diagnosis, treatment, and increasing prevalence of childhood-onset bipolar disorder”, alluding to the difficulties that have arisen in this area. Yet in spite of the focus on early-onset bipolar disorder, there are still areas of research that could potentially advance the discussion by clarifying areas of concern and shedding light on some of the existing questions and shortcomings in this regard. While the field of psychology has made some contributions towards the study of early-onset bipolar disorder, the overarching question of how clinical psychologists experience the management of this disorder remains unexplored. Clinical psychologists are closely involved in the management of bipolar disorder in general, however a discussion of the experiences of managing the disorder is lacking. Furthermore, this experience as it relates to the management of juvenile bipolar disorder, is absent. The result is that, in terms of the management of juvenile bipolar disorder, studies do not adequately reflect the perspectives of clinical psychologists in terms of the matters that are significant, and perhaps specific to, the field of psychology.

## **1.3 Purpose of the Study**

The overall purpose of the study is to establish how clinical psychologists experience the management of juvenile bipolarity. Not only is there an absence of discussion in this regard, but it is also noted that a glaring limitation of most sources of literature lies in the grouping of children and adolescents when researching and discussing early-onset bipolar disorder (Cahill, Green, Jaram & Malhi, 2007). This failure to differentiate between childhood and adolescent populations minimises the differences in their cognitive, social, and physical development, and may undermine the generalizability of research findings pertaining to early-onset bipolar disorder. Thus, this study aims to curb this by focusing its attention solely on adolescents. This is to say, that the experiences surrounding the management of children

and adolescents diagnosed with bipolar disorder may differ according to the developmental requirements of the two groups and thus, it seems that a more specific approach to the study is required.

#### **1.4 Significance of the Study**

This study does not undertake to examine the actual interventions and practices employed by clinical psychologists as they manage juvenile bipolar disorder. Instead, it is an attempt at investigating how they make sense of their experiences with regards to their management of juvenile bipolar disorder in order to potentially understand the considerations that they make when managing this disorder. Furthermore, in light of the plurality of voices that have contributed towards the research of early-onset bipolar disorder, this study may assist in reflecting on how the experiences of clinical psychologists relate to the global discussions on juvenile bipolar disorder.

#### **1.5 Research Question**

The predominant question in this study is: What are the experiences of clinical psychologists in managing adolescents who have been diagnosed with bipolar disorder?

The study will explore the following aspects:

- 1) What are clinical psychologists 'experiences of managing juvenile bipolar disorder?
- 2) What considerations do clinical psychologists make when managing juvenile bipolar disorder?

## **1.6 The Aims and Objectives of the Study**

The main aim of the study is to explore the experiences of clinical psychologists in the management of adolescents diagnosed with bipolar disorder. This research study further aims to understand the considerations made by clinicians in this process, and to contribute towards generating discussions in this area of research.

In both the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the International Classification of Diseases, 10<sup>th</sup> edition (ICD-10), bipolar disorder is characterised by recurrent periods of labile moods and is associated with significant impairment in functioning across various domains (American Psychiatric Association, 2013; World Health Organization, 1992). The global impact of this disorder has been discussed broadly, with a significant focus on adult populations and thus, an evaluation of how clinical psychologists experience the management of juvenile bipolar disorder may assist in understanding the intricacies of managing this disorder from the perspective of clinical psychologists.

## **1.7 Research Method**

The study followed a qualitative, phenomenological approach. This approach seeks to understand the meanings that individuals construct around a phenomenon and how they make sense of their experiences (Merriam, 2009, p. 13). This is inherently a subjective process (Becvar & Becvar, 2009) as it represents a truth as seen through the eye of a beholder. The phenomenon was explored in its natural environment, as is consistent with this form of investigation (Ellis, Adams & Bochner, 2011). The study was based on a social constructionist paradigm, which supposes that knowledge is socially constructed (Andrews, 2012, p. 39). Hoffman (1990, p. 1) describes this as a part of the postmodernist movement that is mindful of how reality is established through the lenses with which we view the world. The study involved clinical psychologists in private practices in Johannesburg who were selected using purposive sampling. The data was gathered using semi-structured interviews

which were conducted at their respective private practices. The analysis of the data was done using thematic content analysis. A more detailed description of the data analysis procedure will follow in Chapter 4.

## 1.8 Definition of Key terms

**Adolescent:** refers to an individual aged between 13 and 18 years (Danner et al., 2009).

**Bipolar disorder:** is defined as the experience of recurrent periods of labile moods and is associated with significant impairment in functioning across various domains (American Psychiatric Association, 2013)

**Early-onset bipolar disorder:** the definitional framework used to define early-onset bipolar disorder varies across literature (Meyer & Carlson, 2008). For the purpose of this study, early onset bipolar disorder is defined as bipolar disorder occurring in children and adolescents.

**Juvenile:** in this study, is assumed to refer to that which relates to adolescence, since the term has been associated with adolescence in literature (Hartinger-Saunders, 2008). In the study, the term *juvenile* is used interchangeably with the term *pubescent*.

**Juvenile bipolar disorder:** based on the above definition, and for the purpose of this study, juvenile bipolar disorder will be defined as bipolar disorder occurring in adolescents.

**Management:** in the context of this study, refers psychological care- the direct or consultative services provided by a psychologist (<https://definedterm.com/a/definition/106242>).

**Prepubescent:** is that which relates to the period preceding puberty (Collins English Dictionary- Complete and Unabridged

**Pubescent:** is a term used interchangeably with the term *juvenile* in this study.

**Youth:** is defined as a group of mixed-age individuals with ages ranging from those 12 and younger to those between the ages of 13 and 18 (Danner et al., 2009).

## **1.9 Chapter Outline**

Chapter 2 provides a review of the literature on bipolar disorder with a focus on early-onset bipolar disorder and other key literary aspects of the study.

Chapter 3 describes the epistemological paradigm followed in the study. It will define social constructionism as it relates to the phenomenon of juvenile bipolar disorder and its management.

As mentioned above, chapter 4 will discuss the research design employed in the study.

In chapter 5, the research findings are presented and discussed following the thematic analysis of the semi-structured interviews. Each of the identified themes are discussed in detail and the findings are juxtaposed against the reviewed literature.

Chapter 6 concludes the study and an overall summary is provided. Here, the strengths and limitations of the study are discussed. In this chapter, recommendations are made for future research.

## **1.10 Conclusion**

The following chapter commences with a review of the literature that describes and explores the phenomenon of bipolar disorder in general, and juvenile bipolar in particular. Although this does not exhaust the subject of juvenile bipolarity, it attempts to provide an overview of the available literature as it relates to this study. In an attempt to explore the contribution of this study towards future research, it is essential that an appraisal of the current literature is conducted.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

This chapter explores the phenomenon of juvenile bipolar disorder as it relates to the field of psychology, including the challenges associated with its identification, diagnosis and treatment. The discussion begins with an overview of the historical context of bipolar disorder following which the classification and diagnosis of early-onset bipolar disorder will be discussed. Integrated into this is a discussion about child development and psychopathology. The chapter concludes with a discussion of current psychotherapeutic interventions for the management of juvenile bipolar disorder.

#### **2.2 Bipolar Disorder in its Historical Context**

The origins of bipolar disorder are typified by polemic discussions about its description and presentation and an analysis of early studies suggests that a considerable amount of research has advanced our understanding of the disorder over the years. The first descriptions of the disorder are said to have been contributed by the Greeks and Romans who made use of the terms *mania*, *melancholia*, *insanity*, *dysphoria*, *dysthymia*, *paranoiam frenzy* and *lunacy* (Healy, 2008, p. 1). Historical accounts cite Aretaeus of Cappadocia, a physician, in the earliest descriptions of bipolar disorder which date back as far as the first century (Angst & Marneros, 2001). The author noted that the symptoms of bipolar disorder not only represented a switch between the two mood states but also a mixture of these symptoms (Marneros & Goodwin, 2005, p. 6). He described the symptoms of melancholia as, “*the beginning and a part of mania*” and mania as “*...a worsening of the disease (melancholia) rather than a change into another disease*” (Marneros & Goodwin, 2005, p. 6). He went on to explain that “*...in most of them (melancholics) the sadness became better after various lengths of time and changed into happiness; the patients then developed a mania*” (Marneros

& Goodwin, 2005, p. 6). Mania and melancholia are believed to be two of the earliest descriptions of human functioning and these are said to have been described most definitively by Aretaeus (Marneros & Angst, 2002, p. 2). Aretaeus differentiated between melancholia, which is a biologically caused disease, and reactive depression, a psychologically caused state.

These writings suggest the pivotal contribution played by Aretaeus in the original descriptions of bipolar disorder and in facilitating discussions about the presentation of the disorder. They also began to demarcate the organic causes of bipolar disorder against other causes. Early in the nineteenth century, mania was a general term used to describe insanity and it was diagnosed according to visible signs and symptoms which were said to be flushing, overactivity and maniacal behaviour (Yatham & Maj, 2010).

Later accounts of bipolar disorder include descriptions made by two French psychiatrists, Jules Baillarger and Jean-Pierre Falret, whose descriptions continued to build on the idea of mania and melancholia as the key descriptors of bipolar disorder (Angst & Marneros, 2001). In 1854, Baillarger discussed a type of insanity characterised by depression and a form of excitement, which he proposed to name *folie à double forme*, while Falret described a form of mental disease which presented as successive and regular reproduction of a manic state, a melancholic state and a prolonged lucid interval, which he named "*folie circulaire*" (Pichot, 2006). Falret also made the observation that the disorder has a highly genetic component (Burton, 2012). Both psychiatrists identified in their patients a presentation characterised by the presence of distinct mood states in which the individual would vacillate from one state to another.

The work conducted by Baillarger is said to have influenced the involvement of Emil Kraepelin, who classified bipolar disorders under the group *Manic-Depressive Insanity* (MDI) (Angst & Sellaro, 2000). Kraepelin is credited for being the most important founder of modern psychiatry in that he played a significant role in defining and describing affective disorders (Marneros & Angst, 2002, p. xvi). He played a pivotal role in drawing the distinction between bipolar disorder, *manic depressive insanity*, and schizophrenia, which he termed *dementia praecox* (Zepf & Holtmann, 2012, p. 2). Kraepelin proposed that affective

disorders represented a distinct category and exhibited similarities to *dementia praecox*, a mental disorder characterised by periods of psychosis (Angst & Marneros, 2001). Kraepelin therefore isolated his description of what we have come to call bipolar disorder from other affective disorders in general, and schizophrenia in particular.

Kraepelin's description of manic depression was that of an episodic disorder, which does not lead to permanent brain damage (Ebert & Bar, 2013). He is recognised for describing symptoms of mania in adults and children (Pichot, 1995). For this reason, Kraepelin's work is acknowledged in modern research as having laid the foundation for the current studies on juvenile bipolar disorder. Marneros and Angst (2002) suggest that Karl Kahlbaum introduced Falret's concept of "*folie circulaire*" into German psychiatry. Kahlbaum is also credited for having introduced the concept of cyclothymia, which continues to form a part of the spectrum of bipolar disorders today (Baethge, Salvatore & Baldessarini, 2003). Further studies introduced the concept of mixed states, which Kraepelin categorised into thought disorder, mood and psychomotor activity (Angst & Sellaro, 2000). Angst and Sellaro (2000) concede that a review of two centuries of literature on the history of bipolar disorder indicates that it has always been recurrent and considered to have a poor prognosis.

### **2.3 Historical Overview of the Diagnosis of Bipolar Disorder**

Flores de Apodaca and Burza (2012) examined the history of the over-diagnosing of bipolar disorder, mapping the expansion in how the disorder has been defined over the years and the increase in prevalence rates. The defining components of the bipolar spectrum disorders have remained mood cycles that vacillate between episodic highs and lows (Flores de Apodaca & Burza, 2012). Bipolar disorder has been consistently described in literature as the experience of episodes of mania and depression, of varying duration, which result in marked impairment in functioning. Flores de Apodaca and Burza (2012) outline the classification of bipolar disorder from the DSM-I. A brief summary is provided below:

DSM-I (1952): Bipolar was termed "manic-depressive reaction" which was thought to represent a psychotic state in which a person experienced a loss of touch with reality.

DSM-II (1968): the condition was named “manic-depressive illness” implying a more serious and ongoing illness rather than what was previously described as an episode of brief duration.

DSM-III (1980): The name “bipolar disorder” was introduced, describing a spectrum of phylogenetically linked conditions which ranged from mild disturbance to severe psychosis, with an assertion that the condition may be more prevalent than was originally thought.

DSM-III-R, DSM-IV and DSM-IV-TR (1987, 1994, and 1996 respectively): In these publications, an expansion of the description of the bipolar spectrum disorders followed, with more differentiations being added. It is the contention of Flores de Apodaca and Burza (2012) that it was this very expansion on the definition of the bipolar spectrum disorders that set the stage for the upward trend in the bipolar diagnoses that followed. The authors argue that there was never a professional consensus on what a bipolar spectrum phenomenon is and that, once the disorder was no longer considered rare, more patients were included under its expanding classification (Flores de Apodaca & Burza, 2012). Lieberman and Nemeroff (2004) pose that, while there has been an increase in the prevalence of bipolar diagnoses due to the inclusion of individuals with a milder but still clinically relevant and often disabling form of the disorder, another aspect of this is the increasing focus on the treatment of the depressive phase of the illness.

### **2.3.1 Current Classification of Bipolar and Related Disorders**

Clinicians are presented with various challenges that require much consideration when diagnosing bipolar disorder in younger individuals (Kowatch & Wagner, 2001). Primarily, Parens and Johnston (2010) indicates that, according to international studies, there is a need to understand the symptomatology of bipolar disorder among children and adolescents as well as how this compares to that of adults as a means of improving diagnostic clarity. Identifying bipolar disorder symptoms in children and adolescents poses several challenges because of the characteristic behaviours at various stages of childhood development that may

make the diagnosis of bipolar disorder difficult (Chang, 2007). Determining whether behaviour is age-appropriate and developmentally normal, involves a level of subjectivity (Chang, 2007) that may add to this complexity.

The DSM-5 follows closely from the DSM-IV-TR in its categorisation of bipolar disorder (American Psychiatric Association, 2013). This is to say that the category *Bipolar and related disorders* of the DSM-5 enlist diagnostic groupings according to variations of the experience of manic, hypomanic and/or depressive episodes. These groupings comprise the clusters bipolar I disorder, bipolar II disorder, cyclothymic disorder, substance/medication-induced bipolar and related disorder, and other specified or unspecified bipolar and related disorders (American Psychiatric Association, 2013). It defines the experience of bipolar disorder according to manic, hypomanic or major depressive episodes and explains that these determine the diagnosis of bipolar I, II or cyclothymic disorder. The essential feature of a manic episode is described as a “distinct period during which there is an abnormally, persistently elevated, expansive or irritable mood and persistently increased activity or energy that is present for most of the day, nearly every day for a period of least one week (or any duration if hospitalisation is necessary) (American Psychiatric Association, 2013). A hypomanic episode is distinguished from a manic episode by the shorter duration of symptoms required to make a diagnosis: four consecutive days (American Psychiatric Association, 2013). A major depressive episode is characterised by a depressed mood, which is present most of the day, nearly every day, as well as a loss of pleasure, with associated symptoms that represent a change in eating patterns, sleep patterns, and involvement in daily activities (American Psychiatric Association, 2013). Consistent with the DSM-IV-TR, for a diagnosis of bipolar I disorder, a person must experience at least one manic episode and for bipolar II disorder, one or more hypomanic episodes in combination with one or more depressive episodes (without a manic episode) (American Psychiatric Association, 2013).

Symptoms of cyclothymic disorder are defined as chronic, and characterised by fluctuating mood, with periods of hypomanic symptoms alternating with periods of depressive symptoms (Shen, Sylvia, Alloy, Barrett, Kohner, Iacoviello, Mills, 2008). These symptoms are of an insufficient number, pervasiveness, or duration to meet the full criteria for a diagnosis of a hypomanic episode, and the depressive symptoms are not severe enough to meet the criteria

for a major depressive episode (American Psychiatric Association, 2013). Yet, despite the mild, sub-threshold nature of the symptoms of cyclothymic disorder, an individual may still go on to develop bipolar I or II disorders (Shen et al., 2008). Shen et al. (2008) further elaborate that Social Zeitgeber theory is one way of understanding the process by which cyclothymia may progress to a threshold form of bipolar disorder due to life events that disrupt social rhythms, and which may trigger depressive episodes (Shen et al., 2008). This theory explains how disruptions in sleep-wake cycle, eating or other daily activities may affect circadian rhythms and contribute to the development of mood disorder symptoms. The classification of bipolar disorder has clearly undergone various adaptations in an attempt to refine and operationalize its description. This later included the classification of early-onset bipolar disorder as it was recognised as an increasingly common phenomenon which necessitated its own attention.

#### **2.4 Advances in Early-Onset Bipolar Disorder**

Recent studies have suggested an increase in the number of bipolar diagnoses in adolescents and children over the past decade, with up to 59% of individuals experiencing their first episode *before* the age of 18 years (Merikangas et al., 2011). The worldwide prevalence of bipolar disorder is said to be 2.4% (Merikangas et al., 2011). Locally, the South African Depression and Anxiety Group (SADAG) propose that bipolar disorder affects 3-4 % of the South African population (SADAG, 2013). According to Finding, Kowatch and Post (2003), “If left untreated, it may have a prolonged, highly relapsing course; be less responsive to treatment; and lead to legal difficulties, multiple hospitalizations and increased rates of substance abuse and suicide”. Myrick (2010) cautions that adolescents are prone to non-suicidal self-injury since this is a period of transition and growth. Faedda, Baldessarini, Glovinsky and Austin (2004) assert that despite the growing awareness that early-onset bipolar disorder is more common than previously thought, it remains undiagnosed or misdiagnosed. This is consistent with the views expressed by Taylor, Bressan, Neto & Brietzke (2011) who indicate that the onset of the illness is typically in youth however, in many instances, there are significant delays before the diagnosis is made. Historically, the study of bipolar disorder has focused on the presentation of symptoms during early adulthood as many researchers believed that the disorder could only be positively identified during this

stage (Parens & Johnston, 2010). Yet the onset of bipolar disorder occurs before the age of 20 years (Diler & Birmaher, 2012) with “little gender specificity or gender-by-age variation from adolescence to adulthood” (Costello et al., 2002) as is indicated in the growing number of cases of early-onset bipolar disorder.

Despite the growing number of new diagnoses of bipolar disorder in children and adolescents, Meyer and Carlson (2008) note that there are still several questions regarding definitional issues, valid assessment procedures, effective management approaches and the degree of continuity between early-onset bipolar disorder phenotypes and adult forms of bipolar disorder. Furthermore, a diagnosis of early-onset bipolar disorder may result in a chronic and complex course, with impairments in interpersonal, social, cognitive, academic and vocational domains (Marneros & Angst, 2002, p. 149).

Sullivan & Miklowitz (2010) define early-onset bipolar disorder as a presentation of the symptoms of bipolar disorder occurring before late adolescence, which is often characterised by mixed episodes, rapid-cycling, various comorbidities and treatment-resistant presentations of the disorder. This further illustrates how early onset of the symptoms of bipolar disorder involves different dimensions which may result in various associated complexities. It also indicates the possible reason for the heterogeneity of the findings of studies involving childhood and adolescent presentations of bipolar disorder and also the limited availability of research which delineates the two groups. This is because when describing early-onset bipolar disorder, many studies have not successfully differentiated between the similarities or dissimilarities in the presentations of the disorder in childhood compared to adolescence. This failure to differentiate has mired the accurate description of this phenotype (Cahill et al., 2007) and thus, attempts at further refining its definition continue.

The diagnosis of early-onset bipolar disorder has undergone gradual changes and adaptations. Renk et al. (2014) explain that since the period of the late 1980s, the classification of bipolar disorder became more symptom-driven, with the aim of defining its criteria with greater specificity and that it was during this decade that the DSM criteria specified that adult criteria could be used to diagnose mania in children, with modifications based on age and

developmental stage. Carlson (2012) further asserted that children with mania exhibit hyperactivity, an absence of discrete episodes, more irritability and emotional lability as opposed to the euphoric state characteristic of the adult presentation. The author also explains that children in the depressive phase of the illness display more irritable or agitated behaviour, which is similar in presentation to that of unipolar depression in this population, and that mania in children presents with a relative absence of paranoia or grandiosity. The more classic pattern of symptoms is found from around the age of 9 years, according to Renk et al. (2014). However, the authors concede that further research is required in order to provide clarity on the relative importance of irritability, grandiosity and elation in making a diagnosis of bipolar mood disorder in children.

Clearly, early-onset bipolar disorder presents a challenge for clinicians. Faust, Walker and Sands (2006) suggest that the challenge of diagnosis lies in the frequent comorbidity with other disorders as well as the overlap of symptoms with other common childhood disorders. The critique of the debate on the over-diagnosis of early-onset bipolar disorder is that childhood mental disorders share common features with bipolar disorder and this may, at times, result in inaccurate diagnoses. Gudienė, Leskauskas, Markevičiūtė, Klimavičius, Adomaitienė, (2008) discuss the symptoms of adolescents who present with mania, and they indicate that while irritability is a common feature in adolescence, the presentation of mania in adolescence is frequently accompanied by extremely impairing dysphoric, explosive episodes that are often a daily occurrence and arise without a precipitant. They indicate that these occurrences may last for at least one hour or longer and they may also result in the destruction of property (Gudienė et al., 2008). Faust et al. (2006) describe the presentation of the symptoms of bipolar disorder as periods of moodiness, oppositional behaviours, anger that persists for longer than fifteen minutes, sadness and excessive crying, inattention and impulsiveness. They further state that when the symptoms of bipolar disorder precede or follow the onset of puberty, they are typically experienced as irritability; a pattern of continuous, rapid-cycling, and mixed episodes that may co-occur with disruptive behaviour disorders (Faust et al., 2006).

These descriptions further allude to the idea that the pre-pubertal and pubertal presentations of bipolar disorder may differ. This may be largely attributed to the differences in the

developmental stages of these two groups and it highlights the need for a carefully-considered differential diagnosis that takes these differences into account. Geller, Zimmerman, Williams, DelBello, Frazier and Beringer (2002) state that schizophrenia is one of the main differential diagnoses for adolescent and adulthood presentations, whereas attention deficit hyperactivity disorder (ADHD) appears to be the major differential problem diagnosis of presentations in children and early-adolescent individuals. Holtzman et al., (2015) recommend that considering childhood and adolescent onset bipolar disorder separately rather than in aggregate may be a more effective way of understanding early onset bipolar disorder. The researchers suggest that using a cut-off age of 13 years may "...provide developmentally meaningful differentiation of individuals with very early- versus early-onset bipolar disorder" (Holtzman et al., 2015). Saunders and Goodwin (2010) state that the methods used to determine age at onset include age at first treatment, age at first hospital admission and the age at which diagnostic criteria are first met. Carlson (2012) concurs with the idea of distinguishing between childhood and adolescent presentations of bipolar disorder. The author highlights that the clinician's approach to diagnosis may also colour this picture in that a conservative approach considers the presence of clear episodes that represent a distinct change from the individual's characteristic way of functioning, while a more liberal approach considers the presence of severe temper outbursts or irritability as the diagnostic factor (Carlson, 2012). The presentation of symptoms as well as the person reporting the symptoms should be borne in mind, together with the role of the family in assisting the clinician to make a diagnosis (Carlson, 2012). Carlson (2012) adds to this that children and adolescents may not always be able to describe their symptoms comprehensively, and that this could potentially add to the variations in the descriptions of the presentation of early-onset bipolar disorder.

## **2.5 The Introduction of Disruptive Mood Dysregulation Disorder**

Historically, the challenges associated with the diagnosis of juvenile bipolar disorder have been linked with issues such as a lack of awareness about the presentation of the disorder, diagnostic confusion, clinical bias towards making the diagnosis, comorbidity and symptom overlap with other disorders of childhood and the variability in the clinical presentation of symptoms (Diler, 2007, p.194). According to Chang (2007), many children and adolescents

who present with severe mood dysregulation symptoms are misdiagnosed as having bipolar disorder. The DSM-5 has described disruptive mood dysregulation disorder as a series of severe, recurrent temper outbursts occurring at least three times per week, manifested verbally (e.g. verbal rages) and/or behaviourally (e.g. physical aggression toward people or property), that are grossly out of proportion in intensity or duration to the situation or provocation, and are inconsistent with developmental level (American Psychiatric Association, 2013). Between outbursts, children display a persistently irritable mood (American Psychiatric Association, 2013). Because the symptoms described under this diagnosis are markedly different from those childhood disorders with similar presentations, it is expected to create clearer diagnostic boundaries between the conditions. It may also account for those children who have received a diagnosis of bipolar disorder and have not shown improvement upon treatment.

Despite its intentions, the introduction of this category to the DSM-5 was received with much controversy from healthcare professionals and it was argued by some to be redundant to existing disorders in the DSM-5 because of the dearth of research showing it as a discrete diagnostic entity (Mayes et al., 2015). Zepf and Holtmann (2012) emphasise the symptom overlap between disruptive mood dysregulation and bipolar disorder. They further distinguish bipolar disorder by episodes of distinct changes in mood, and associated changes in behaviour and cognition (Zepf & Holtmann, 2012). Therefore, while disruptive mood dysregulation disorder may assist in reducing the over-diagnosis of juvenile bipolar disorder, it should always be borne in mind that the validity of this diagnosis is unknown in terms of how frequently it occurs independently of other disorders.

## **2.6 Bipolar Disorder, Personality Structure and Emotional Dysregulation**

There are differing views on whether adolescence is an appropriate period for the identification of mental illnesses such as mood and personality disorders. Paris (2014) seems to oppose the view of focusing on adolescent presentations and comments that it should come as no surprise that adolescence is an opportune time for the emergence of various difficulties since it is a period marked by emotional lability and impulsivity associated with biological

and psychosocial changes. However, McKinnon, Cusi and Macqueen (2013) suggest that certain personality features displayed during adolescence and early adulthood may represent the prodromal phases of a mood disorder. They identify the tendency to engage in ruminative thought as one of the features common in the personality of an individual living with bipolar disorder and they indicate that this may be due to the fixation on negative thoughts and events (McKinnon et al., 2013). In this way, the experience of the symptoms of a psychological disorder may serve as a cognitive, behavioural or affective marker preceding the onset of bipolar disorder, and this may be particularly useful in advancing our understanding of early intervention and management of the disorder (McKinnon et al., 2013). Therefore, the researchers propose, clinically significant personality features which occur in adolescents and young adults may signify the onset of bipolar disorder (McKinnon et al., 2013). To this may be added that despite the common presentation of mood dysregulation present in both bipolar and borderline personality, not all adolescents who present with this mood instability will go on to develop bipolar disorder (Paris, 2014).

The diagnostic challenges that impede clinicians from making difficult diagnostic differentiations are discussed by Kernberg and Yeomans (2013). The authors recognise the common errors associated with differentiating between chronic emotional instability compared with bouts of affect dysregulation of personality disordered individuals with associated manic or hypomanic behaviour (Kernberg & Yeomans, 2013). Although this distinction is made easier by the distinctiveness of manic symptoms – a clear loss of reality testing, the presence of hallucinations and/or delusions, and inappropriate social behaviour that usually results in others raising concern about the affected individual – the difficulty still lies in differentiating between hypomanic and borderline personality symptomatology (Kernberg & Yeomans, 2013).

Some studies have reframed borderline personality as part of the bipolar disorder spectrum, since both disorders are associated with emotional lability, impulsivity, irritability, anger, unstable interpersonal relationships, and feelings of emptiness and suicidality (Fonseka, et al., 2014). However, what seems to be prominent in borderline personality disorder is the absence of affective stability, a lack of maturity in relations with others, and a persistent state of instability in various areas of an individual's life, which makes this presentation somewhat

distinguishable from bipolar disorder, even where the two disorders occur comorbidly (Kernberg & Yeomans, 2013).

## **2.7 Adolescence against Adulthood Presentations**

Researchers have previously proposed that children and adolescents present with the symptoms of bipolar disorder in a similar manner to adults (Carlson, 2012). This view has since changed as literature has described the symptoms of bipolar disorder in relation to the developmental stage and environmental influences of the child or adolescent. Clark (2001) details the presentation of the symptoms of pubescent bipolar disorder. The author proposes that the adolescent may present with symptoms of depression, mania, hypomania, a mixed state, or no detectable symptoms at all (Clark, 2001). He identifies the depressive phase as being marked by symptoms of apathy, social withdrawal, or loss of interest or pleasure, and the adolescent may also present with symptoms of irritation (Clark, 2001).

Gudienė, et al. (2008) give an idea of the most frequent symptoms of bipolar disorder presented by adolescents and with this, they suggest that the presentation of the symptoms differs to that of adults because adolescents, like children, are generally more prone to irritability and emotional dysregulation as a result of their developmental stage. These differences are necessary to note as they have a significant bearing on the adolescent's experience of the symptoms as well as the clinician's experience in the management of an adolescent who receives a diagnosis of any form of bipolar disorder.

The periods of mania may be marked by symptoms of an over-inflated sense of self, or grandiosity, or unrealistic feelings of ability and prowess, as well as increased risk-taking behaviour (Clark, 2001). Clark (2001) further ascertains that there may be periods where the adolescent does not experience any symptoms, however these asymptomatic periods may be shorter than in adults. Hauser, Galling and Correll (2013) suggest that the presentation of juvenile bipolar disorder, coupled with the associated developmental changes, may be overwhelming and these include a shorter duration and lack of distinction between moods, fewer intervals where the individual may be described as euthymic between episodes, high

levels of irritability and impulsivity, increased episodes of rapid cycling, mixed presentations, and psychosis. Faust et al. (2006) indicate that the manifestations of bipolar disorder change as a function of the individual's developmental stage, and represent a distinct mood disorder that is different and more severe in its presentation than in the adult population.

## **2.8 A Developmental View**

An important tenet of the study of human development is that understanding what is considered normal development and what comprises normal processes can inform our understanding of abnormal development. For this reason, it is apt to delve into a review of the literature on child development. Keenan (2002) explains that development has been defined as *patterns of change over time which begin at conception and continue throughout the lifespan* and that these occur in different domains, including biological (changes to one's physical being), social (changes in one's social relationships), emotional (changes in one's emotional understanding and experiences) and cognitive (changes in one's thought processes). The various definitions of human development appear to embrace the idea that it encompasses an individual's adaptive functioning over time. It is this adaptive functioning that embodies what Baltes (1987) formulated as a set of key principles that describe development within the framework of lifespan developmental psychology. Despite being somewhat dated, these principles hold salience in that they provide a meta-perspective of the process of development. This approach views development as an interplay of constancy and change in behaviour across the lifespan and it considers development as a lifelong process that does not reach any form of plateau (Baltes, 1987). It also depicts development as being multidimensional, in that it cannot be described as a single criterion, and multidirectional, referring to the notion that there is no single, normal path that describes development (Baltes, 1987). The developmental process in this regard, is also represented by a series of losses and gains in behaviours or functions, which occurs over time, thus not only consisting of growth and progression (Baltes, 1987). It is notable that lifespan developmental psychology shows an obvious regard for the influence of context on the variability and fluctuating process of human development.

Shaffer and Kipp (2010, p. 5) provide a chronological overview of the lifespan as described by others in the field of human development. This overview defines adolescence as the period between the ages of 12 to 20 or, according to other developmentalists, as a life stage which spans until the point at which the individual begins to work and is reasonably independent of parental sanctions. Considering the view of lifespan developmental psychology, this view seems to disregard the role of the context in which these sanctions are applied in families. For instance, it may not be assumed that all children grow up in homogenous environments in which parents or caregivers are available to provide such sanctions. This illustrates the importance of understanding both the similarities and differences involved in the process of human development. To that end, Carr (1999) describes child development as a social process in which the family plays a central role in shaping this progression. To expand on this view, a child develops within a framework or system that is indeterminately nested in another, and each bears an inextricable influence on the child and vice versa.

### **2.8.1 Developmental Theories of Bipolar Disorder**

Research has provided views on the development and manifestation of juvenile bipolar disorder. Studies have illustrated the heritability of bipolar disorder and, as Bradfield (2010) proposes, this heritability is such that one or even both parents are likely to have a diagnosis of bipolar disorder. Developmental psychopathologists have investigated the risks associated with the development and manifestation of mental disorders and have identified resilience as an important aspect in this regard (Miklowitz & Cicchetti, 2010, p. 16). They define resilience as the individual's ability to adapt successfully and to function proficiently despite the experience of long-standing adversity or following exposure to severe trauma (Miklowitz & Cicchetti, 2010, p. 16). In this manner, these researchers propose that the manifestation of the symptoms of psychopathology is predominantly influenced by the individual's ability to negotiate through their experiences.

In the section which follows, child development will be discussed from various psychological paradigms and this will be integrated with a discussion on bipolar disorder as described by each paradigm.

## 2.8.2 Psychoanalytical Theories of Child Development

Psychoanalytical theories have made a significant and much deliberated contribution to our understanding of child development. Beginning with the work of Sigmund Freud, psychoanalytical theory emphasised the importance of childhood experiences on later personality development. Freud detailed various stages through which an individual's personality is formed, placing an emphasis on the psychosocial conflict presented by the sexual drive during early development. His theory delineated stages of psychosexual and psychosocial development which play a pivotal role in the formation of personality, beginning at birth and progressing until adulthood (Corey, 2005). According to Freud, love and trust, the ability to develop a positive acceptance of one's sexuality, as well as the ability to deal with negative feelings, are fixed within the first six years of an individual's life (Corey, 2005). These stages also influence the expression of emotions, behaviours and interpersonal interaction, which are fixed during these early childhood experiences (Birmaher, Bridge, Williamson, Brent, Dahl, Axelson, Dorn and Ryan, 2004). The manner in which a child progresses through these stages determines the ability to trust, fosters independence, results in a positive self-esteem and influences the manner in which the child engages with others (Birmaher et al., 2004). This seems to have long-term implications on how individuals later interact and how they define themselves in relation to others. Simanowitz and Pearce (2003, p. 2) explain that Freud came to understand the major influence on development to be the psychosocial conflict presented by the sexual drive during early development. They elaborate that, according to this view, sexuality is a process, which begins in early childhood and, because of its long and complicated nature, it is prone to distortion (Simanowitz & Pearce, 2003, p. 2).

Although Freud presented a biological basis for the development of personality, his theory also highlighted that the environmental and social context also provide a backdrop for both the form and the expression of the sexual drive (Simanowitz & Pearce, 2003, p. 2). From this approach stemmed various adaptations and developments to psychoanalytical theory that have proposed explanations for the manifestation of psychological disorders. These theories

purport that relationships with significant others, particularly with parents, are critical in the development and shaping of personality (Birmaher et al., 2004).

Anna Freud concentrated on development as it occurs in adolescence and she expanded on Freud's theory in this domain. Her work focused on the interplay between the id and the ego and she explained that physical changes during adolescence are accompanied by an increase in impulses such as the sexual drive (Simanowitz & Pearce, 2003, p. 12). Erik Erikson further advanced the field of child development studies and is said to have been influenced by the work of Anna Freud (Simanowitz & Pearce, 2003, p. 12). He further elaborated on the discontinuous process of child development by defining certain universal developmental phases that unfold in a series of predetermined stages and that play a significant role in moulding the personality of an individual (Ryckman, 2008). He developed a psychosocial theory of development in which he suggested that each developmental stage of an individual's life is marked by certain prerequisites that the individual is required to negotiate through, and that failure to negotiate successfully through either of these stages presents a crisis for the individual which therefore has a negative impact on the individual's psychosocial engagement in later life (Ryckman, 2008). Conversely, the successful navigation of each developmental stage allows individuals to move toward a strong self-identity (Ryckman, 2008). Erikson proposed that adolescence occurs between the ages of 12 and 18 years during the stage that he termed *identity versus role confusion* (Meyer, Moore & Viljoen, 2003). This stage forms the fifth of Erikson's eight stages of development and it is a time during which an individual begins the transition from childhood into adulthood and begins to test limits, becomes more independent, and begins to develop a new identity. Failure to achieve this new identity results in feelings of role confusion (Corey, 2005). It is also this time in which the adolescent strives to develop an identity that the ego endeavours to integrate an older or earlier identification with a new self (Kroger, 2008). The adolescent typically experiments with various adult roles which are modelled on adults with whom the adolescent interacts within their environment, and this experimentation occurs until such time that the adolescent has identified the style of adult interaction that is most suited to their style (Kroger, 2008).

Freud depicted mania and depression, which he termed *melancholia*, in two different ways. While he described individuals presenting with depression as defeated and weighted down by

the heaviness of the symptoms of depression, individuals who present with symptoms of mania were described as indifferent to the experience of mania (Gilbert, 1992, p. 273). According to Freud, mania results from a fusing together of the ego and ego-ideal, resulting in the experience of disinhibition and insusceptibility to criticism, and an abolition of feelings of considerations of others (Kelly, 2011). Karl Abraham, a German psychoanalyst, proposed that mania results from an expression of that which is repressed during depression and that it represents a display of emotion that represents a regression to childhood (Kelly, 2011). During times of depression, the id appears to overpower the ego and superego while periods of mania are characterised by the ego using defence mechanisms to protect itself from the aggression of the id (Gilbert, 1992, p. 273). Freud believed that mania results from the merging of the ego and ego-ideal in such a way that the individual who experiences mania is not inhibited by the ego and can enjoy behaving in a manner that is out of character with the individual's usual functioning (Kelly, 2011).

Much like Freud, Erikson's theory is viewed as being intrapsychic in nature, in that physical and personality development and also psychological distress are believed to result from an individual's internal makeup (Meyer et al., 2003). Therefore, bipolar disorder is likely to be viewed as a maladjustment on the part of the individual, and is likely to be viewed as the result of a poor adjustment to a developmental stage.

Anna Freud specified that it is normal for an adolescent to behave in a manner which is inconsistent with or uncharacteristic with their usual behaviour for a considerable length of time, as this marks the period during which the adult structure of personality is beginning to form (Simanowitz & Pearce, 2003, p. 12). Adolescence, in this regard, is thus characterised as a period of uncertainty regarding the self, and of balancing the instinctual wishes of the id against the social demands placed on it by the ego (Simanowitz & Pearce, 2003, p. 12). Thus, her focus on the appropriate use of developmental assessments of children is notable here. Through her work, she advocated that assessments of children and adolescents should be ongoing, developmental, and integrated with findings from other sources of collateral information, and that they must stipulate the reasons for the referral - a description of the child and the family as well as a description of their current level of development (Aldridge, Kilgo & Jepkemboi, 2014). In this manner, the assessment also considers whether a particular

pattern of behaviour is consistent with what is deemed normal in adolescence. These recommendations have elaborate implications, particularly for the psychological management of children and adolescents in that they indicate the need for caution and comprehensiveness, beginning at the assessment phase. Anna Freud's contribution hints at the idea that, when managing bipolar disorder, particularly in youth, a clinician needs to have performed sufficient clinical investigations in an extensive manner in order to intervene appropriately.

### **2.8.3 Attachment and Relatedness**

The work of John Bowlby and Mary Ainsworth has been extensively covered in developmental psychology in terms of its description of the role and significance of the caregiver-child relationship, as well as on its far-reaching consequences for development. This theory focuses its attention on the relationship between a primary caregiver, usually a mother, and child during the early years of development and how this relationship influenced the psychological functioning of that child in later years (Levy, Meehan, Temes & Yeomans, 2012). Bowlby's focus was on the significance of proximity, which is defined according to a child's tendency to remain close to a mother or primary caregiver (Sadock & Sadock, 2007, p. 216). He elaborated that a sense of security arises within a child who maintains a continuous and close relationship with their primary caregiver and that this need for proximity is biologically driven (Sadock & Sadock, 2007, p. 216). Mikulincer and Shaver (2005) describe the components of attachment theory and its influence on emotional regulation. They indicate that this theory of attachment provides an essential framework for understanding the strategies of emotional regulation employed by an individual as determined largely by the individual's attachment history (Mikulincer & Shaver, 2005). Bradfield (2010) notes that the right brain structures that are primarily responsible for emotional regulation develop within the first eighteen months of life and that the normative development of these structures is further enhanced by a positive, growth-enhancing and nurturing environment of a secure attachment relationship between an infant and their primary caregiver. This therefore highlights the idea that emotional distress and mood disorders may result from poor attachment between children and their primary caregivers. Attachment theory identifies the role of the caregiver as one of providing security to the child which, in turn, reduces the child's level of anxiety in relation to their environment (Sadock & Sadock, 2007, p. 138).

Sadock and Sadock (2007) also define the term *bonding*, which refers to a mother's feelings towards her infant, which usually occurs during skin-to-skin contact between mother and child, or during other forms of contact, such as eye contact. These activities suggest a stronger bonding experience for both mother and child and they contribute towards the experience of attachment which is displayed throughout the infant's life.

Mary Ainsworth elaborated on this theory of attachment by detailing the effects of attachment on the infant's later life and on defining the infant's sense of independence and ability to venture out into new experiences (Sadock & Sadock, 2007, p. 138). Ainsworth described the patterns of attachment which included the following:

- **Insecure avoidant:** This term describes a child who experiences antagonistic parenting and subsequently avoids developing close contact with people, while remaining close in proximity to the primary caregiver as opposed to communicating with the caregiver when feeling threatened (Sadock & Sadock, 2007, p. 138).
- **Insecure ambivalent:** Following inconsistent parenting, the child who displays this form of attachment struggles to explore their environment, even when there is no apparent threat, and clings to their parents instead (Sadock & Sadock, 2007, p. 138).
- **Insecure disorganised:** This term describes a child who has experienced abuse at the hands of emotionally absent caregivers and consequently behaves in a strange and bizarre manner when faced with a perceived threat (Sadock & Sadock, 2007, p. 138).

Ainsworth identified this form of attachment as severe in such a manner that it is likely to result in adolescent and adult presentations of psychopathology (Sadock & Sadock, 2007, p. 138). With this in mind, the presentation of bipolar disorder may be understood as a possible manifestation of the type of attachment between an individual and their significant attachment figures.

#### 2.8.4 An Interpersonal Perspective

The traditional theories of psychology described above have not adequately captured the influence of the patterns of interaction on an individual's psychological functioning. These traditional approaches have largely followed the direction of psychoanalytical theory in that their approach has placed its focus on the individual as the source of psychological distress (Goldenberg & Goldenberg, 1985, p. 90). This approach sought to exclude, as far as possible, the inclusion of family members in the process of therapy (Hoffman, 1981, p.16). The involvement of families was interpreted as a hindrance to the process of an individual's healing. Psychoanalytical theory, and other traditional psychological theories that focus on the individual as the locus of psychological distress. This approach follows what has been described as a *reductionistic* approach, in which an event is marked by an identifiable cause in a linear manner (Goldenberg & Goldenberg, 1985, p. 96). In this manner, the therapist's efforts are directed at assisting the individual to realise the source of their distress.

The 1940s were marked by a change in the field of psychology from a focus from individualistic paradigms of psychological functioning to a framework that described the functioning and interrelatedness of the components of a system (Goldenberg & Goldenberg, 1985). This approach was developed by researchers from different fields of study who viewed their theory on the systems as being applicable to all systems: biological, mechanical or social (Kast & Rosenzweig, 1972). The theory therefore stresses that components or parts of a system do not exist in isolation but rather that each exists in relation to another and therefore a change in one part of the system has an effect on the system as a whole (Goldenberg & Goldenberg, 1985). General systems theory posits that nothing exists in isolation and that systems are nested in other systems (Goldenberg & Goldenberg, 1985). A family system, therefore, is nested in a larger social system.

During the 1950's a plurality of voices began to discuss the importance of viewing individuals within the contexts in which they are embedded, with a great focus being the family, since this was described as a natural social system with an established set of rules,

norms, communication patterns, problem solving strategies, and approved behaviours and rules of interaction (Goldenberg & Goldenberg, 1985, p. 3). Goldenberg and Goldenberg (1985) explain that a family is comprised of members that attempt to organise themselves into a functioning group that strives to interact with each other in ways that foster cooperation and collaboration in meeting the developmental and survival needs of the family. The researchers identify different family constellations which each have a unique manner of interacting. These include, but are not limited to, the nuclear family, blended family (in which there is a combination of nuclear families brought together by marriage, also described as the stepfamily), single-parent families, childless couples, extended families, and three generational units residing together or apart (Goldenberg & Goldenberg, 1985, p. 3). These families each negotiate their own ways of engaging with each other and navigating through what they experience as problems.

Hoffman (1981) elaborates that the family therapy movement emerged when clinicians opted to observe individual behaviours within the context of the family. This movement marked a change in the field of psychology as the family was viewed as a system of interrelated parts in which family members influence and are influenced by each other (Goldenberg & Goldenberg, 1985, p. 3). This approach arose from the contributions of researchers from various disciplines including psychology, psychiatry, anthropology and biology. The theory emphasises that, in order to understand human behaviour, one must view it in the context in which it is embedded (Watzlawick, Beavin, Bavelas & Jackson, 1967). Significance is placed on the patterns of interaction that influence behaviour. Several researchers have contributed to this approach and have studied the communication patterns of members of a system, usually a family system. The family systems perspective considers the relatedness of events, people and things as it posits that nothing and no one exists in isolation but that everything that exists is interrelated. "Entities could be understood not in reductionist isolation from other entities in the observational field but in their relationship and interactions with other elements in the observational field" (Rasheed, Rasheed & Marley, 2011).

According to this theory, psychological problems arise from family interactional patterns, and these sequences of interaction are maintained by the family members over time (Bateson, Jackson, Haley and Weakland, 1956). Although their work included a study of schizophrenia,

the discussion may be extended to the formation of other symptoms, including bipolar disorder, since their argument was that mental disorders may be triggered by communication patterns in which conflicting and confusing messages are given to an individual continuously over a period of time. The researchers proposed the *double bind theory* to explain this pattern of communication (Hoffman, 1981). Gregory Bateson is credited for having played a significant role in the development of the double bind theory which aimed to describe the formation of psychological symptoms (Becvar & Becvar, 2009). This theory identified the following as being the sources of these symptoms and therefore the necessary elements of the double bind (Becvar & Becvar, 2009):

- Two or more persons, with one being identified as the “victim”
- A repeated sequence of communication or experience
- A primary negative injunction, which is usually a command or statement which is directed at the “victim”
- A secondary injunction which contradicts the first at a more abstract level and for which there is an implication that wrongdoing will result in a penalty
- A tertiary negative injunction which prohibits the “victim” from escaping from the sequence of communication
- The “victim” learns to view his/her world of interaction within this context as a series of double bind sequences and therefore develops a manner of interaction that may appear to an outsider as bizarre or nonsensical

This unclear and perplexing form of interaction may be further complicated by the seriousness of the relationship between the people involved in the communication sequence (Becvar & Becvar, 2009). The individual who assumes the role of “victim” therefore endures the complicated burden of inescapability from the sequence because of the importance of the relationship. While this theory was never meant to replace biological and other explanations of psychological disorders, it contributed an alternative dimension to psychological functioning which began to acknowledge the relatedness of human behaviour.

Goldenberg and Goldenberg (1985) state that “the emotionally disturbed person is just one part of a subsystem in the family system, but the entire family system is influenced by and

influences the disturbed person". This suggests that when a family member presents with a symptom, the symptom affects and is affected by the family as a whole. Early research in the area of general systems theory was focused on the area of schizophrenia as researcher sought to understand the interactional patterns of family members in families where a member presents with the symptoms of schizophrenia. These studies on schizophrenia may be expanded to include a view on other symptoms, including bipolar disorder, since the discussion focuses on the emergence of a symptom from the repetitive and continuous interactional patterns between the members of a system. In this way, symptoms resembling bipolar disorder may result when a member of a family is exposed to messages that are constantly being nullified or contradicted by other messages given shortly thereafter. This is likely to result in confusion for the individual to whom the message is given and, because of the nature of the relationship to the person from whom the message is received (e.g. a parent), the individual is not free to comment on the confusing nature of the messages, nor are they able to escape from the injunction (Hoffman, 1981). This perspective suggests that the management of adolescents diagnosed with bipolar disorder is also influenced by the interactional patterns between the adolescent and their family members. General systems theory is not absorbed with descriptions of whether an individual is well or sick, but rather that the development of a symptom is indicative of a system which is in disarray and has become dysfunctional (Goldenberg & Goldenberg, 1985).

Rogers' (1961) person-centred approach further illustrates the significance of inter-relatedness in therapy. This view emphasises that the client-therapist relationship should also be conducive for a successful therapeutic process. According to this approach, the role of creating a therapeutic environment that facilitates the process of self-awareness for the client (Rogers, 1961). This suggests that individuals have the autonomy to effect change in their own lives. In the context of psychotherapy, the symptomatic behaviour provides a rich description of the function of the behaviour. By using this approach, the therapist facilitates an exploration of the client's symptoms in a non-judgemental and non-punitive environment in order to assist the client in the process of self-awareness and to empower the client to change (Rogers, 1961). As with systems theory, this view opposes the idea that the client's presentation is inescapable as it is built on the ideas of the humanistic approach which views individuals as being capable of making the necessary changes in their lives (Rogers, 1961).

## 2.9 Associated Comorbidities

The comorbidities associated with bipolar disorder have a profound impact on the diagnosis and management of the disorder (Diler & Birmaher, 2012). Any comorbid conditions can lead to further complexity resulting from non-compliance, greater suicide risk as well as a less favourable response to treatments from multimodal use (Miklowitz, 2008). A higher risk of suicidal behaviour is exhibited by adults who had an early illness onset of bipolar disorder (Goldstein, Birmaher, Axelson, Ryan, Strober, Gill, Valeri, Chiappetta, Leonard, Hunt, Bridge, Brent, Keller, 2005).

The DSM 5 emphasises the need for a differential diagnosis to distinguish bipolar disorder from other disorders that may have similar presentations of irritable mood (American Psychiatric Association, 2013). Geller and Luby (1997), suggest that bipolar disorder in the adolescent population may have ADHD and/or conduct disorder as initial manifestations, while Zdanowicz and Myslinski (2010) advocate that, in the pubescent presentation of bipolar disorder, hyperactivity and bipolar disorder in the depressive phase are often comorbid. Belsham (2012) indicates that the symptoms shared between bipolar disorder and ADHD include distractibility, hyperactivity and poor impulse control, and further concludes that ADHD is associated with various emotional symptoms that also present in cases of bipolar disorder, which include low frustration tolerance and irritability. Sood, Razdan, Weller and Weller (2005) point out that it is commonplace for ADHD to be confused with juvenile bipolar disorder. They attribute this to the likelihood of aggression, which is a common symptom in both disorders, despite the exhibition of this aggression being different in these disorders (Sood et al., 2005). In ADHD, the aggression stems from the impulsivity associated with the failure to achieve a goal, while the mood between the episodes of aggression is usually not irritable, elevated or expansive as in bipolar disorder (Sood, et al., 2005). Therefore youths who are believed to present with symptoms of ADHD may later be found to be more matched to a bipolar disorder diagnosis, in the same way that a cursory diagnosis of pubescent bipolar disorder may also be made in place of another diagnosis (Sood et al., 2005).

Other studies on the associated comorbidities of bipolar disorder have found a high incidence of substance use disorder, alcohol abuse, anxiety disorder, social phobia, panic disorder, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), personality disorder, and binge-eating disorder, as well as other medical conditions such as hypothyroidism, migraine, obesity and type 2 diabetes (Krishnan, 2005). Concomitant substance use may result in an increase in impulsive behaviour and, in return, a high level of impulsiveness may predispose individuals to substance misuse (Etain, Mathieu, Liquet, Raust, Cochet, Richard, Gard, Zanouy, Kahn, Cohen, Bougerol, Henry, Leboyer, Bellivier, 2013). Myrick (2010) explains that adolescents often resort to self-harming behaviours when struggling to manage difficult or overwhelming emotions. This may be particularly evident in cases of early-onset bipolar disorder considering the increased likelihood of risk-taking behaviour. In childhood and adolescence, studies refer to poor emotional regulation as a prominent feature of bipolar disorder. Juvenile bipolar disorder is said to be associated with mood lability or swings, anxiety, hyperarousal, somatic complaints, behavioural dysregulation, attention difficulties, and school problems (Päären, Bohman, Von Knorring, Olsson, Von Knorring & Jonsson, 2014). In their findings, the authors presented an increased risk of adult bipolar in children and adolescents who had familial histories of bipolar disorder and some link between multiple somatic symptoms, anxiety disorders and disruptive disorder in childhood and adolescence, and the later development of bipolar disorder (Päären et al., 2014). They also reported that anxiety disorders serve as a significant predictor of bipolar and related disorders. Evidently, the interplay between bipolar disorder and its associated comorbidities during adolescence cannot be undermined as this has a direct implication for its nosology and subsequent treatment. It is evident that these impairments may interfere with the process of identity consolidation associated with the period of adolescence.

## **2.10 The Far-Reaching Impact of Juvenile Bipolar Disorder**

The adolescent years are marked by discernible developmental changes where the adolescent begins to function differently in the social and familial context. During this time, new ways of engaging with others are negotiated. Understandably, a diagnosis of bipolar disorder may

complicate this course and its effects may certainly linger until the adult years. Kemner, van Haren, Bootsman, Eijkemans, Vonk, van der Schot, Nolen & Hillegers (2015) posed that life events seem to be associated with an increase in the number of hospital admissions over the life course of an individual who has been diagnosed with bipolar disorder. It seems reasonable therefore, to hypothesise that these repeated hospitalisations may impact negatively on the adolescent's sense of self and agency over time and that this impact may be sustained into later life. The developmental course of early-onset bipolar disorder is said to vary with age and pubertal status, but despite this, the increased risk of suicide and self-injurious behaviours, recurrent syndromal or sub-syndromal mood symptoms, comorbid psychiatric disorders, family dysfunction, academic difficulties and the increased risk of substance abuse, remain (Singh & Chang, 2007). Thus, according to (Hirschfield et al., 2010) when taking a history, it is essential for a clinician to consider various longitudinal issues, such as the number of prior episodes, their average length and severity, average inter-episode duration, as well as the interval since the last episode of mania or depression.

The longitudinal trajectory of juvenile bipolar has been mapped by Birmaher et al., (2014) and they indicate that, despite the often recurrent and chronic nature of bipolar disorder, there is evidence to suggest that this is not always the case, as some individuals have persistent periods of euthymia. The authors present a more optimistic picture of juvenile bipolar disorder in acknowledging that good outcomes are not uncommon (Birmaher et al., 2014). Yet, as important as this knowledge may be in broadening our scope of the course of bipolar disorder, it cannot be ignored that the effects of the disorder are far-reaching, impacting individuals both intra-personally and interpersonally.

### **2.10.1 Its Intrapersonal Bearing**

Bipolar disorder appears to, in some ways, have a profound and pervasive impact on an individual's functional ability. From a neuropsychological perspective, various authors have outlined the impact of bipolar disorder on various functional domains such as attention and several aspects of executive functioning, immediate spatial memory, as well as verbal and visuo-spatial declarative memory (Thompson et al., 2005). It has also been associated with various brain abnormalities and attempts have been made to establish whether there is a

definable characteristic in the structural and functional abnormalities in the brains of individuals who receive this diagnosis. The disorder is often described as a frontal lobe abnormality (Brown, 2005). Hosenbocus and Chahal (2012) indicate that “impairment in some cognitive domains such as visual memory, working memory, and risk-taking behaviour, has been seen to remit during periods of euthymia but impairment in other areas such as selective attention, attentional shifting, verbal planning, verbal memory, perseveration, processing speed, and other elements of executive functioning, such as inhibitory control, response inhibition and strategic thinking, is more likely to persist, regardless of the current mood state”.

Although previous studies have given attention to the study of the neuropsychological effects of bipolar disorder among adults, researchers are now honing their attention on the younger population, with studies focusing more on adolescents (Horn, Roessner and Holtmann 2011), owing largely to the fact that the experience of an affective disorder during the adolescent years may adversely affect the social and educational functioning of the adolescent across various contexts. Horn (2011) ascertains that the neurocognitive effects of bipolar disorder are more pervasive than was suggested in previous studies and although studies are more limited in this area, it is essential to understand its cognitive effects, as these have a detrimental effect on the long-term outcome of the disorder and also on the quality of life of the individual diagnosed with bipolar disorder. McKinnon et al. (2013) discuss the associated impairments in social cognition, the processes by which people understand themselves and other people, as well as the ability to understand and respond to the affect and thoughts of others during social engagement (Beer & Ochsner, 2006). Children are typically taught to adhere to various societal norms and to respect the rights of others. Once they reach the adolescent stage of their development, this adherence to norms is usually tested by the demands of new social encounters and experiences in engaging with various individuals. If executive functioning is compromised in bipolar disorder, this may have a significant influence on the adolescent’s ability to exercise judgement, solve problems, plan, prioritise, reason, and plan various actions required by their changing environment. Hosenbocus and Chahal (2012) seem to support this view by stating that individuals with problems in executive functioning are unable to change their behaviours or plans according to the environmental demands and they have difficulties reconfiguring an alternate plan when they are confronted with new situations or tasks.

Bradfield (2010) adds that early-onset bipolar disorder is associated with an increased risk of suicide, self-harm, substance abuse, an increased risk of sexual exploitation, as well as the associated functional impairments. It is significant to reflect on the seriousness of this risk. In 2010, suicide was quoted by the National Institute of Mental Health as the fourth and third leading cause of death among youths aged 5-14 years and 15-24 years respectively (Hauser et al., 2013). These researchers further add that mood disorders in general and bipolar and related disorders in particular are the most common mental disorders found to be diagnosed in children and adolescents (Hauser et al., 2013). Suicidal ideation and suicide attempts are cited as being relatively common among youths, with the strongest risk factor for these being psychiatric diagnosis (Hauser et al., 2013). This suggests that receiving a diagnosis of a mental disorder has a burdensome effect on a child or an adolescent in such a manner that they are more likely to consider or attempt suicide. Parens and Johnston (2010) highlight that children and adolescents who present with symptoms of irritability, affective aggression or emotional outbursts require urgent intervention and treatment, as these symptoms, especially if left untreated, can have dire consequences, including suicide or homicidal rages. Bradfield (2010) summarises by stating that there is an increased risk of completed suicide among adolescents diagnosed with bipolar disorder, there is an increased risk of suicide in adults who were diagnosed with bipolar disorder during their youth and that suicidal ideation and suicidal attempts occur at an earlier age in youths diagnosed with bipolar disorder compared with youths who are diagnosed with another mental disorder, and that this suicidal behaviour is defined by more lethal and more frequent attempts. He concludes that there is a greater correlation between early-onset bipolar disorder and suicide risk (Bradfield, 2010). Despite the divergent views regarding pubescent and prepubescent bipolar disorder, it seems that when there are affective symptoms that present in children and adolescents, the need for intervention remains both urgent and important.

### **2.10.2 Impact on Interpersonal and Psychosocial Functioning**

Bipolar disorder has been associated with significant impairment in multiple areas of psychosocial functioning. The World Health Organisation (WHO, 1992) has identified bipolar disorder as the sixth leading cause of disability globally (Diler & Birmaher, 2012).

For instance, Vázquez et al., (2011) observed that individuals who have been diagnosed with bipolar disorder may experience a reduced level of functioning and productivity in their occupations and that around 20% of them have a permanent disability in this regard. Birmaher and Axelson (2006) assert that early-onset bipolar disorder increases the risk for academic, social, interpersonal and health utilization. In emphasising the long-term ramifications of early-onset bipolar disorder, the authors indicate that bipolar disorder also increases the risk of suicidal behaviours and completed suicide, substance abuse, conduct and legal difficulties, economic participation as well as overall family functioning (Birmaher and Axelson, 2006).

According to Diler and Birmaher (2012), juvenile bipolar disorder is increasingly being acknowledged as a significant health problem due to the resulting complications in family interactions, peer relationships, academic performance, and chronicity of mood symptoms, and the complexity of its presentation, symptom overlap, associated comorbidities, increased hospitalisations and the risk of suicide. Despite periods of remission, bipolar disorder may continue to affect psychosocial functioning for prolonged periods (Rosa, González-Ortega, González-Pinto, Echeburúa, Comes, Martínez-Àran, Ugarte, Fernandez & Vieta, 2012). The symptoms of bipolar disorder therefore have far-reaching implications, not only for the global functioning of the individual but also on their ability to contribute meaningfully in their environment.

Juvenile bipolar disorder is associated with an increased amount of suicidal ideation and substance use as well as problems with functioning within the contexts of the law, family and academic environment (Diler & Birmaher, 2012). Rucklidge (2006) states that adolescents diagnosed with bipolar disorder have reported more negative life events and a greater number of past traumas compared with those without a diagnosis of bipolar disorder. Further, bipolar disorder results in adolescents having a "...higher risk of lower self-esteem, a greater sense of hopelessness, a more external locus of control, more maladaptive coping strategies, and more difficulty regulating anger..." (Rucklidge, 2006). The author thus asserts that understanding the psychosocial impact of bipolar disorder, particularly in youth, will likely assist clinicians in the identification of triggers and in assisting clinicians with designing effective treatment interventions (Rucklidge, 2006).

The management of various mental disorders seems to hinge significantly on the family environment. This is because the family is the basic social unit to which the adolescent is likely to belong and often plays a significant role in the treatment of the adolescent diagnosed with bipolar disorder. Goldenberg and Goldenberg (2013) describe intact families as likely to experience a life cycle that is consistent across families and over time. These cycles are defined by critical points of change, or transition points, namely, marriage, birth of the first child, the youngest child's departure from home, as well as retirement (Goldenberg & Goldenberg, 2013). Given that the connections shared between family members tend to persist over time, even as the life cycle of the family changes, the experience and trajectory of bipolar disorder is influenced in various ways by the stage in which the family exists. This has direct implications for management in the sense that a successful treatment outcome is also largely dependent on the manner in which the individual and the family as a whole manage the disorder.

## **2.11 Psychotherapeutic Interventions**

The management of bipolar disorder also involves considering the stressors and vulnerabilities in the social, educational, and family environment, including the quality of interpersonal interaction between the individual and their family, as well as the effect of comorbidities such as ADHD and anxiety disorders (The National Institute for Health and Clinical Excellence, 2006). The stigma surrounding bipolar disorder as well as the associated cost of its management often results in poor adherence to the interventions introduced, as individuals are often exposed to varying interventions from the time of diagnosis, and these have diverse outcomes (Vázquez et al., 2010). Coupled with this is the need for caution against the overuse of pharmacotherapy, particularly antipsychotics, to treat children and adolescents diagnosed with bipolar disorder. Healy (2008) tracks several cases in the USA where young children, who were believed to display symptoms of bipolar disorder, were prescribed antipsychotics and suffered serious adverse events, including fatalities. Parens and Johnston (2010) note that the concern is that there is limited data supporting the use of these agents in younger individuals, usually below the age of eighteen years, and research on the side effect profile of pharmacological agents is limited for this population.

Although the indiscriminate use of pharmacotherapy to treat juvenile bipolar disorder warrants this strong warning, Miklowitz (2008) advocates that, where a genuine case of juvenile bipolar disorder exists, treatment must be forthcoming and treated with the urgency it requires, owing to the fact that early treatment intervention may allow for the normative acquisition of skills, including personal autonomy, academics and peer relationships prior to the onset of the cycles of relapses, recurrences and remissions. This points to a better prognosis with earlier intervention since, according to Diler and Birmaher (2012), up to 80% of youths who are diagnosed with bipolar disorder experience a recurrence of their symptoms post recovery, despite the continuation of treatment. Steele and Fisman (1997) support this view of early treatment intervention and add that, due to the complexity of the presentation of juvenile bipolar disorder, clinicians must exercise caution when making this diagnosis by understanding the effects of child development on the presentation of the disorder during adolescence.

A range of psychotherapeutic approaches have been used in the management of bipolar disorder. These include psycho-education, cognitive behaviour therapy, family therapy, interpersonal therapy, and psychoanalysis (Kelly, 2011). Malchiodi (2005) discusses a range of expressive therapies which may be beneficial in assisting individuals to communicate relevant issues “in ways that talk-therapy cannot do”. Within this domain are individual approaches which include art therapy, music therapy, drama therapy, dance/movement therapy, poetry therapy and bibliotherapy, play therapy, sand therapy and integrated arts/intermodal approach in which two or more of the above approaches are integrated. Psychotherapeutic intervention aims to reduce the distress that accompanies bipolar disorder, improve functioning between episodes, and to decrease the likelihood and severity of future episodes (Hirschfeld, Bowden, Gitlin, Keck, Suppes, Thase, Wagner & Perlis, 2002). The treatment of bipolar disorder has been extensively recorded, with an added focus on children and adolescents. Miklowitz (2008) addresses the importance of early intervention, particularly when treating children and adolescents diagnosed with bipolar disorder without which social, intellectual, and emotional development may be hampered. A further suggestion is that a delay in the initiation of treatment may result in greater depressive morbidity (Miklowitz, 2008). Other areas of focus include assisting in the early detection of

symptoms using a structured early warning system, improving treatment compliance with pharmacotherapies, and maintaining morale in light of therapeutic adversity and incomplete response (Fountoulakis, Gonda, Siamouli & Rihmer, 2009).

Kaslow, Broth, Smith and Collins (2012) note that family interventions, including family therapy, have been shown to yield favourable results in the management of juvenile bipolar disorder, either as monotherapy or in conjunction with other modalities. The engagement of parents in the management process assists in enhancing parenting and ameliorates maladaptive family environments (Kaslow et al., 2012). The benefits of family-focused treatments for adolescents were also researched, using a model that centres on psycho-education, communication training, and problem-solving skills training (Kelly, 2011). This model has been shown to be effective in conjunction with pharmacotherapy in the stabilisation of depressive symptoms in adolescents diagnosed with bipolar disorder (Kelly, 2011). Various forms of psychotherapy remain essential components of the management of bipolar disorder, especially in light of the psychosocial consequences resulting from past episodes, the ongoing vulnerability towards future episodes and the burden associated with the longevity of treatment (Hirschfeld et al., 2002). In summary, the core interventions seem to be those that involve the family of the diagnosed individual, interventions that assist in some way with the associated interpersonal relations of affected individuals, and interventions that alter the thought processes and resulting behaviours that impact negatively on the trajectory of the illness.

Duffy (2014) laments that current diagnostic systems focus on the presenting symptoms of bipolar disorder without considering the context as well as important risk factors, and that they also neglect what we have come to know about the natural history of illness development. The author advocates the use of a staging model of bipolar disorder, which presupposes that illness “evolves in an identifiable temporal progression of phases, that early intervention will be more effective aiming to significantly prevent or delay illness progression and that treatments for the earlier phases of illness will be more acceptable to patients and have a higher benefit-to-risk ratio” (Duffy, 2014). Staging models suggest that bipolar disorder moves through a relatively predictable set of stages and thus its management should follow a stage-specific course (Passos, Jansen & Kapczinski, 2015). These models call

for a more attentive response to the management of bipolar disorder, which is inclusive of the remission phase of the illness. These models also allow for therapeutic intervention in the premorbid stages of the illness, thus preventing a more pernicious course of illness (Passos, Jansen & Kapczinski, 2015). As a means of operationalizing the therapeutic process, Passos et al. (2015) call for a greater exploration in the assessment phase of the disorder, not only the symptom presentation, but also an investigation of the stage of the illness, similar to what is standard practice in the fields of cardiology and oncology (Passos, et al., 2015). It certainly appears that the management of bipolar disorder involves an individually tailored approach on the one hand, but also an integration of the developing modalities that are showing themselves to be effective in this regard on the other. Furthermore, the guidelines for the treatment of patients diagnosed with bipolar disorder seem to identify the various issues that plague individuals diagnosed with bipolar disorder and they note that the form, intensity and focus of psychotherapy will vary over time for each individual (Hirschfeld et al., 2002).

## **2.12 Conclusion**

Several ideas pertaining to the complexity of juvenile bipolar disorder have been presented in this chapter. Despite the controversies surrounding this diagnosis, there appears to be a need for an expansion towards the operationalization of the description of pubertal bipolar disorder, which will thus extend to its management.

## CHAPTER 3

### SOCIAL CONSTRUCTIONISM IN BIPOLAR DISORDER RESEARCH

#### 3.1 Introduction

The previous chapter provided an analysis of the available literature on various aspects of bipolar disorder, with a particular emphasis on juvenile bipolar disorder. This chapter seeks to discuss social constructionism as the theoretical framework that is followed herein. The researcher will begin by considering the definition of epistemology from various sources and vantage points. The discussion points to the premise that a theory cannot be born in the absence of an epistemology. Consequently, a discussion of bipolar disorder will be tailored according to this framework and the researcher will define both adolescence and psychotherapy as a social construction.

#### 3.2 Epistemology

Numerous researchers have defined epistemology as the critical component in presenting an approach in literature. Epistemology has been defined, in philosophy, as “how we know” (Tennis, 2008). The Stanford encyclopaedia of philosophy (2005) defines epistemology as being concerned with the conditions of knowledge, its sources, structure and limits. This source directs its attention to exploring the justification of one’s beliefs and on the creation and dissemination of knowledge (Stanford Encyclopaedia of Philosophy, 2005). It questions the prerequisite conditions that are necessary for one to know what they know. Browaeys (2004) expands on this definition by indicating that epistemology provides a basis for scientific reflection and analysis and its definition refers, in one part, to its philosophical definition as the theory of knowledge as defined in contemporary Anglo-Saxon countries. In another sense, and according to French philosophy, it is the theory of science in general (Browaeys, 2004). Epistemology is therefore summarised as “a theory which tries to understand the foundations of the knowledge, its development, its object, its purposes and its objectives” (Browaeys, 2004).

The significance of capturing various interpretations of the meaning of epistemology as it relates to the discussion proposed in this study is to illustrate that the self is pertinent to the generation of knowledge and how this knowledge is communicated and framed within a particular framework. Bateson (Hoffman, 1981) emphasises this view by suggesting that certain, sometimes involuntary, rules assist us in the process of making sense of our realities and that they influence the manner in which we construe the behaviours and views of others. Reality is thus greatly determined by the viewpoint of the observer, as determined by their personal experiences, values, and judgements. Theories are guided by an epistemology and Benjamin (Van Niekerk, 2005) indicates that clinical interventions do not exist in a theoretical vacuum, as each is embedded in an epistemology. Epistemology is also shaped by the use of language, which is a representation provided by the observer. Takács (2003) discusses the role of *positionality*, the uniqueness of one's perspectives, as an integral part of how one comes to know what they know. The author further emphasises that it is for this reason that a correctness in reality can never be attained, as each individual brings a different understanding of phenomena (Takács, 2003). It is also valid to augment this argument by suggesting that there is a certain validity to the various contributions made by different voices. Takács (2003) further surmises that "knowledge does not arrive unmediated from the world; rather, knowledge gets constructed by interaction between the questioner and the world".

Keeney (Hoffman, 1981, p. 343) proposes that symptoms must be considered as a means of communication. This view epitomises the stance of general systems theory in which behaviour is deemed to exist within a particular context, which shapes and is shaped by that behaviour. This suggests that an individual is not blameworthy of any such symptom, as it is the result of an exchange between the individual and the members who interact with the individual within that system (Hoffman, 1981, p. 343). In this manner, realities are co-created through interaction and engagement.

Tennis (2008) illustrates the dynamic nature of epistemology, in which epistemic stances progressively shift over time. This position is embodied in the changes in focus in the study of bipolar disorder. It is some of the current-day views of bipolar disorder that have

culminated in the researcher's interest in the exploration of the experiences of clinical psychologists in the management of bipolar disorder in juvenile populations.

### **3.3 Bipolar Disorder against the Vignette of Modernist and Postmodernist Movements**

Bipolar disorder has often been described from a positivist, reductionist perspective that is consistent with the modernist approach. Modernism and postmodernism represent two movements that have yielded much attention in the field of psychotherapy in recent years. Boston (2000) explains that postmodernism is not separate from modernism but rather that it expands on it. Others depict both as distinct, radically different and identifiable epistemologies. Yet what seems evident is the notion that these approaches have yielded divergent ways of drawing distinctions when observing and describing phenomena.

#### **3.3.1 Modernism**

This has been described as the period between late nineteenth and twentieth century European culture and has been defined as a period that was marked by a distinct form of thinking (Boston, 2000). Authors who describe the distinct phases of its development describe modernism as an approach that assumes a scientific tradition (Becvar & Becvar, 2009, p. 3.). Modernism is marked by a way of thinking that seeks out cause and effect and where all that is known may be validated against that which is observable. This view has been described as Western, Lockean, and scientific tradition (Becvar & Becvar, 2009, p. 3) in as far as it relates to knowledge, which may be proved or disproved, and is objective and distinct from the knower.

Hoffman (1993) provides the example that health insurance is forthcoming inasmuch as disorders are classifiable according to a biological basis. The healthcare profession is guided largely by this principle, described as the "medical model", in which diagnoses are categorised according to an organised structure against which formularies are developed. These formularies may influence the diagnoses given to individuals, as well as the

reimbursement provided by funders to the healthcare professionals. The modernist perspective is therefore motivated by clear diagnoses and an *objective* approach to the management of disorders by healthcare practitioners.

Becvar and Becvar (2009, p. 3) further suggest that individuals exposed to a Western epistemology are socialised into this way of thinking, which defines their way of organising and understanding their world. Hoffman (1993) lists *the five sacred cows of modern psychology*. It is from these that social constructionism strove to deviate, thus encompassing a different approach. They are:

- a) Objectivity: modern psychology emphasised the notion of a singular reality which contributes to the 'knowable' and universal nature of phenomena. Social constructionists argued against this view as this suggests that truth is a finite entity that exists according to very specific and scientific rules.
- b) A restrictive notion of the core self which identifies the self as a fixed, established entity that is shaped by internal processes. The self, according to this approach, is represented by an intricate inner reality.
- c) Modern psychology places stress on the developmental stages as defined by theories of development. This approach suggests that there is a universal process through which people progress and that this determines the manner in which they function and relate to their worlds.
- d) The special status placed on emotions, which are perceived as discrete inner states.
- e) The hierarchy in the levels of structures that delineate human interactions.

While bipolar disorder may be explained from both the modern and postmodern perspective, this study seeks to divert from the traditional explanation proposed by modernism.

### **3.3.1.1. Bipolar Disorder in the Modernist Movement**

Goldberg (2007) has explored the ways in which society has constructed the diagnosis of bipolar disorder with an emphasis on the individual and societal meanings ascribed to the diagnosis. This study illustrated the challenges to the development of identity experienced by the participants and this was described as a difficulty in forming a sense of self due to the meanings imposed by the psychiatric community in their treatment of bipolar disorder (Goldberg, 2007). The imbalances in neurotransmitter release proposed by the medical community appeared to result in participants describing a loss of control over their sense of self as this is attributed to a biochemical imbalance, which implies that the individual is under the control of this biochemistry. These findings are consistent with the modernist perspective which depicts bipolar disorder as a disorder characterised by fluctuating moods and debilitating symptomology. This is punctuated by periods where the individual experiences an exacerbation of their symptoms and other periods where the individual is asymptomatic and is able to perform their daily activities. According to this approach, research on bipolar disorder has traditionally emphasised that, while the exact cause is not known, the most common risk factors include genetic factors, biochemical factors, and environmental influences, although genetic factors are suggested to be far more dominant than environmental bases (Pregelj, 2011).

It has been widely discussed that a family history of bipolar disorder, particularly in combination with stressful life events may precipitate the onset of the symptoms of bipolar disorder. Yang (2011) notes that the significance of family history on the presentation of bipolar disorder has long been recognised as an important clinical feature. This illustrates the magnitude of the genetic burden on bipolar disorder (Yang, 2011). Differences in the brain structures of individuals diagnosed with bipolar disorder may be observed in neuroimaging studies, which indicate lateral ventricular enlargement and white matter changes (Yang, 2011). These views highlight the influence of modernism in modelling the image of bipolar disorder.

### **3.3.2 Postmodernism**

Terre Blanche and Durrheim (2002, p. 482) define postmodernity as “both a critique of modernity and a global cultural phenomenon which is said to have (partially) replaced modernity”. The authors indicate that, where modernity believes in the possibility of a unifying synthesis or whole, postmodernity playfully exposes as sham the apparent coherence in scientific or political programmes, works of art and texts of all sorts (Terre Blanche & Durrheim, 2002, p. 482). Among the ‘grand narratives’ of modernity, which are starting to unravel in postmodernity, is the idea that each individual has a clear-cut identity and that society progresses through the rational application of scientific principles (Terre Blanche & Durrheim, 2002, p. 482). This approach diverged from the positivistic and reductionist orientation of modernism, which sought to deconstruct objects and phenomena of study into their most basic constituents. Boston (2000) attests that the postmodern model was greatly influenced by the ideas of social constructionism as well as the philosophical culture of the hermeneutic approach, which is concerned with interpretation and explanation of phenomena.

In the postmodern model, the therapist interacts in a manner that is unlike that of the modernist therapist (Boston, 2000). According to this approach, the therapist assumes a reflective stance, which involves a shift from the expert role assumed in more traditional approaches to psychotherapy (Boston, 2000). This method of assuming a “not-knowing” stance allows both client and therapist to engage in the construction of a particular reality that emanates from their interaction as defined by their use of language, with the client describing the problem as it is experienced, as well as the meanings ascribed to it, and the therapist engages by using a particular style of communication that stimulates the client to ascribe a different meaning to the identified problem.

#### **3.3.2.2 Situating Bipolar Disorder in the Postmodern Movement**

As previously mentioned, there is a dearth of research in the exploration of postmodern and experiential approaches to define bipolar disorder. Most research assumes a modernist focus,

which emphasises the medical and biological aspects of the disorder. Modernist-driven perspectives have contributed to the large number of asylums being built around the world during the sixteenth century (Foerschner, 2010). Those who were kept in these asylums often endured grim treatment conditions and were abandoned by their families and relatives (Foerschner, 2010). It was during the 1800s that the humanitarian approach to treatment was introduced and this considered the spiritual, moral, and personal development of individuals described as being mentally ill (Foerschner, 2010).

Postmodernism is a gateway for the discussion of the psychosocial issues related to bipolar disorder. These have influenced the manner in which mental disorders are perceived and thus experienced by a particular people. There are different examples of how cohorts of people across various geographical locations and cultures have given meanings to bipolar disorder. Suto et al. (2012) explored the structural, social, and self-stigma experiences of individuals who had been diagnosed with bipolar disorder. The authors defined stigma as “a dynamic, multifaceted social process that has been consistently implicated as a key contributor to poor outcomes for many people who live with stigmatised health conditions, such as mental illnesses” (Suto et al., 2012). They reported that, once an individual experiences the stigma associated with a particular psychological diagnosis, it becomes an impediment to their quality of life and to the recommencement of the activities of daily living (Suto et al., 2012).

In China, a distinction was made between insanity and madness (Ng, 2009). The former describes an individual who experiences symptoms of insomnia, changes in appetite, an inflated ego, arrogance, inappropriate laughter and singing, as well as being constantly active; while madness is described as the feeling of being “unhappy, falling to the ground with eyes looking straight, and the pulse will be strong in three regions at the wrist” (Ng, 2009). These definitions illustrate the notion that language is used to create that which is perceived as abnormal and to demarcate it from that which medicine, and society, will deem acceptable and appropriate. An analysis of the views of youths who had grown up during the post-Mao generation found that their perception of having been diagnosed with bipolar disorder left them with a feeling that they ought to control their illness and that they were to blame for their condition, thus suggesting an internal locus of control for their diagnosis (Ng, 2009).

This was dissimilar to older individuals, who tended to blame external circumstances such as luck (Ng, 2009).

Cross and Walsh (2012) noted that the influence of self-disclosure of bipolar disorder by well-known people and celebrities and describe this as a “risk-laden activity”. The authors reported that when sufficient social support exists, the psychosocial burden of the diagnosis of bipolar disorder is lessened on the individual and it may also elicit the same need for disclosure by other individuals (Cross & Walsh, 2012). The suggestion made by the authors is that through processes such as self-disclosure, the stigma associated with bipolar disorder is reduced and an experience of universality, which is a realisation that our experiences, although personal, are consistent with the experiences of others, is introduced. Therefore, there is a certain shared experience that is socially constructed, which has a connotation for the experience of bipolar disorder. Adopting a postmodern perspective to our understanding of bipolar disorder allows for an exploration of these experiences and insight into the meanings ascribed to them by both therapists and clients.

### **3.4 Defining Social Constructionism**

Social constructionism is defined as the theoretical framework that seeks to analyse how signs and images have powers to create particular representations of people and objects (Terre Blanche & Durrheim, 2002). It is an approach that has been derived from various disciplines, which includes linguistics, philosophy, and sociology (Burr, 1995, p. 1). This approach assumes a critical stance against the notion that the world may be discovered and known with certainty (Burr, 1995, p. 1). This view opposes the Western, Lockean approach discussed previously, in which knowledge is described as being built on that which is observable and distinct from the observer.

Researchers have described social constructionism from various perspectives that accentuate different aspects of construction. Sociologists have emphasised the social construction of various components of society while anthropologists place their attention on the social

construction of culture. Psychology places its attention on the social construction of human interaction and the meanings ascribed through interpersonal exchanges. Brown (2005) defines social constructionism according to medical sociology as a view that has deviated from describing social problems in a definitive and assumed manner towards an approach that pursued the meanings created through everyday interactions. This view supports that proposed by Gergen (1985), in which social constructionism acknowledges that people are the experts of their own experiences and that this knowledge is socially, culturally, and interpersonally constructed. What it proposes is that we create the groupings and categories that we observe in the world (Burr, 1995, p. 3). This implies that reality is largely influenced by the subjectivity of our observations and that our observations change, as we are in a state of constant change and adaptation. This approach introduces the element of personal experience as a determinant of reality. Gergen describes the social constructionist approach as being concerned with the processes through which people come to describe and explain events in their world, as well as how they describe their positions in their world and how these are influenced by their interpersonal, cultural, and social influences and contexts. Social constructionist methods are qualitative, interpretive, and concerned with meaning (Terre Blanche & Durrheim, 2002).

The stance assumed by social constructionism, that we create the groupings that we perceive in the world, acknowledges that these perceptions are embedded within a historical and cultural context. The roles ascribed to male and female children, in which males are discouraged from displaying the feelings associated with femininity, such as fear, anxiety and depression, often influences the manner in which males interact socially. The perception of these roles has since shifted in some cultures, where a display of emotion by males is now considered as sensitivity, warmth, and kindness. These changes suggest that epistemology is influenced by the particular period in a culture and, because this is not static, epistemology may be described as evolutionary in nature, and that it represents an artefact of that culture (Burr, 1995, p. 4).

Burr (1995) documents that knowledge is generated through the discourses and interactional exchanges that occur between people. Social engagement is therefore critical in the process of determining how we know what we know. The implication of this is that the discourses

which create and shape our reality in the present day largely influence the manner in which outcomes are decided upon. If, for instance, a child is described as overactive in such a way that their functioning across multiple contexts is impaired, the current approach to the management of this condition has shifted away from punitive measures to psychotherapeutic interventions and pharmacotherapy. Social constructionism, as a domain of the postmodernist approach, endeavours to explore how alternative meanings and interpretations give rise to different realities.

### **3.4.1. The Role of Language in the Construction of the Self**

The use of language remains paramount to the views of social constructionism, which weaves its principles around the meanings created through the use of language. The modernist focus of emerging theories in psychology sought to define psychopathology in ways that resulted in labels being ascribed to those who received various diagnoses. Stryker and Burke (2000) denote that the description of the self has been offered by various disciplines, including psychology, sociology, history, and political science. Jaspal (2009) indicates that language is not only a vehicle for communication, but that it also provides a means of defining one's identity, and differentiates an individual from others. This depiction of the self exists in relation to the context in which one lives, as it is influenced by sociocultural matters. Jaspal (2009) explains that identification with a particular ethnic group sculpts the creation of identity. Stets and Burke (2000) explain that, according to social identity theory, through the process of social participation, engagement with one's environment and with others, the individual develops their self-concept. This is to say that the development of the self occurs as one interacts with their environment. The authors depict the self as an entity that exists independently and in relation to a social context (Stets & Burke, 2000). In this regard, the relationship between the self and society is a reciprocal one, marked by an influence of both agencies on and by the other. The authors cite Hogg and Abrams, 1988, who describe a social identity as "a person's knowledge that he or she belongs to a social category or group" (Stets & Burke, 2000).

The modernist depiction of the self defines a common path followed by all humans in their personal growth and development. Boston (2000) states that the Western notion of the self is characterised by the picture of an individualistic and independent self as suggested in the Greek dictum, *to thine own self be true*. This suggests that according to this approach, the self is an entity that seeks to behave in ways that are self-beneficial and towards a way of becoming self-sufficient in the way in which it negotiates its way through the world. This contrasts with the postmodern description of the self, which is ever-evolving and fluid (Boston, 2000). These models are also portrayed in the context of psychotherapy, where, according to the former, language comprises a fixed structure which is representative of “reality” while the postmodern approach sees people as being in conversation with each other, using language that bears the same or a similar significance to both parties (Boston, 2000). These explanations suggest that the modernist perspective portrays a fixed, permanent self, while the postmodern approach proposes a malleable, more flexible self.

In the context of psychotherapy, a postmodernist approach enables the therapist to explore how clients view themselves in relation to their diagnosis as a means of understanding how the client makes sense of the diagnosis. The therapist is also able to borrow from previous experiences in psychotherapy with different clients, as well as from personal experiences as a means of co-creating and coordinating the meanings derived from the divergent rationalities that emanate from the therapeutic encounter. Anderson and Goolishian (1988) define the role of a conversational artist who is a participant-observer and a participant-participator in the therapeutic conversation. In this way, the therapist facilitates the therapeutic conversation in such a manner that the client begins to consider other possible realities and ways of viewing a situation. Both the therapist and client define themselves in the context of psychotherapy while engaged with each other. This is a fluid process of continual co-creation and is recursive as it involves both participants.

### **3.4.2. The Social Construction of Psychotherapy**

If language is involved in the construction of the self, what is the role of discourse in creating meaning and shaping the experience of psychotherapy? The question posed suggests that

therapy is no longer viewed as the expression of a problem by a client while the therapist assumes the position of an expert, but rather that both parties influence and are influenced by the language that they use to describe a problem. A problem therefore assumes that status if it is defined as such.

The course of psychotherapy has transformed in its definition of the client-therapist relationship as well as in how problems are defined in the context of therapy. According to earlier approaches which arose from psychodynamic theory, the therapist played a significant role in defining the client's problem. Goldenberg and Goldenberg (1985) encapsulate the view of these approaches, which suggest that a parent who struggles with interpersonal conflicts from their childhood may project this onto their child, who then introjects the parent's childhood conflicts and subsequently develops an identity crisis. This view therefore examines the inner lives of individuals and how conflicts arise herein. A shift proposed in later years assumed a different approach to this perspective (Goldenberg & Goldenberg, 1985). Nathan Ackermann, having trained as a psychoanalyst, became a pioneer who sought to merge psychoanalytical approaches with a systems approach in which behaviour is viewed both as emanating from intrapsychic processes and as a result of the interpersonal transactions between members of a family (Goldenberg & Goldenberg, 1985). This introduces the notion that an individual influences, and is influenced by, the various systems in his or her environment. The introduction of this systems approach in the field of psychology saw theorists attempting to integrate these two approaches (Goldenberg & Goldenberg, 1985). The focus shifted away from a theory of pathology to an approach which emphasizes the role of context in the presentation of psychopathology (Goldenberg & Goldenberg, 1985).

It was at the beginning of the twenty-first century that the field of family therapy redirected its focus on the relationships between individuals in families. Minuchin, Nichols and Lee (2007) track the evolution of the family therapy movement and explain that its focus has evolved from family interactions to the narrative construction of the experiences of individuals within the family. In their discussion of constructionism and its role in therapy, McNamee and Gergen (1992) suggest that it is not as a therapeutic approach, *per se*, but a philosophical stance that facilitates the creation of a therapeutic dialogue between therapist

and client. The therapeutic process is thus co-created through dialogue. In therapy, the focus of the therapist is thus on how the client uses language which constrains them and prevents them from change (McNamee & Gergen, 1992). The role of the therapist is therefore to assume a stance of intense curiosity which enables engagement with the client in a manner which entices the client to think about alternative solutions (McNamee & Gergen, 1992).

What the authors further indicate is that the role of the therapist is not to create a shared meaning whereby both client and therapist agree on shared meanings attributed to discourses, but rather to co-create meanings which focus on bridging incommensurate discourses (McNamee & Gergen, 1992). In this manner it becomes possible for the therapist and client to engage and to relate despite attributing different meanings to events. The therapist merely creates a space in which a comment or action within a given conversation may become an opportunity or opening to a different alternative. The therapist who assumes a constructionist approach is not concerned with debating what is right or wrong, healthy or unhealthy, but rather on the reality which is created through the therapeutic process (McNamee & Gergen, 1992). In this way, the field of psychology introduced the role of language in therapy and placed the therapist and client in the process of co-creation of new realities as defined within the context of psychotherapy.

Anderson and Goolishian (1988) identify properties that characterise human systems that also bear relevance in the context of psychotherapy. The authors provide a view of human systems in which the members of a system are actively involved in generating meaning in their communication through the manner in which they use language. A system is therefore created through the use of language. According to these properties:

- Human systems are language-generating and meaning-generating entities in that the context in which a system exists is set about by language and the meanings derived from the communication shared therein.
- It is through dialogue that the meaning and understanding of discourse is created and is therefore said to be intersubjectively constructed.

- This dialogue allows for flexibility in the adaptation and renegotiation of those meanings as these are not fixed.

What is proposed has very specific implications for the process of psychotherapy. In therapy, a system is defined between a client and therapist through the process of linguistic exchange, with a form of communication that bears relevance to and for that system (Anderson & Goolishian, 1988). Change in therapy is therefore the result of a conjoined effort between therapist and client in which, through discussion, the meaning or significance given to a problem is altered. In the same manner that the self is fluid and ever-evolving, so too is the process of therapy, which shifts as the members of the system shift. While social constructionism offers no specific techniques or set of methods, it makes allowance for those who work together to define the process of therapy in a manner which develops spontaneously in response to the discourse offered by both participants.

### **3.5 Adolescence as a Social Construction**

In delineating views about the development of the self, researchers have introduced various perspectives which range from individualistic views to perspectives that place emphasis on the contextual processes that influence its development, with later perspectives focusing more on the latter. Schwartz, Mason, Pantin, and Szapocznik (2008) note that “a cohesive and well-functioning family environment, including involved and supportive parents, is associated with a positive and coherent sense of self and identity”. Schwartz (2008) elaborates that self-concept is identified as a protective factor against behavioural problems during adolescence. This, in part, hints at the social constructionist view of adolescence.

Elton (2008) lists the significant contributions made in the field of sociology in the recognition of adolescence as a separate life stage. According to Mills (Elton, 2008) adolescence is a recently accepted phenomenon. Miller ( Elton, 2008) believed that the social acknowledgement of adolescence occurred during the 1800s, while Nichols and Good (Elton, 2008) indicate that it was during the 1900s that it became acknowledged as a subculture.

The concept of adolescence did not appear to be conceived in the medieval era, due largely to the labour requirements of the time (Elton, 2008). This was an era of ignorance of adolescence as a life stage that connected childhood to adulthood (Elton, 2008). During this period, medieval societies did not place much emphasis on childhood as a significant stage of human development and, as such, children were provided with the responsibilities of adults, often being required to learn to perform the trades of their parents from a young age (Elton, 2008). The responsibilities placed on girls and boys, more often than not, plunged them into the respective roles created for adulthood by the age of around thirteen or fourteen years (Elton, 2008). This suggests that the expectation would be for children to make a swift transition into the stage of adulthood, by means of responsibility, from an early stage, without the evolutionary process that occurs in between.

Elton (2008) further discusses the role of the industrial revolution on the definition of adolescence. According to this view, social norms were largely influenced by the introduction of mass marketing at the time, and this consumerism was directed at those who were no longer children but still had not received the privileges, rights and responsibilities that were synonymous with adulthood (Elton, 2008). This suggests that the political climate played a hand in the distinction of the life stage of adolescence and how it is understood in the present day. Fasick (1994) confirms the view that the recognition of adolescence was brought about by the urban-industrial society and indicates that the most powerful structure in this regard is the educational system. Fasick (1994) depicts adolescence as a time during which the educational structures maintained the dependency of this population on their parents while also depriving them of the increasingly obvious adult roles that become imminent during this time. Elton (2008) seems to illustrate this as the source of challenges which arose when those adolescents who continued to be initiated into the world of work were elevated by society to the status of men while those who pursued academia were cast into the role of children and described as “youngsters”. This denotes that the transition into adolescence marks a period that is unique in its demands as well as its limitations. Fasick (1994) further identifies that, with the improvement in food quality as well as the quality of health during the nineteenth century, the life expectancy of people increased drastically, and contrary to what was customary in the eighteenth century, more people have come to survive the period which has

now been identified as adolescence. This increase in life expectancy became a marker for a change in the thinking of academics and researchers, who came to distinguish that there exists in all people a period during which an individual transitions into the stage of adulthood.

These are but some of the views that illustrate the social constructionist view of adolescence. These views suggest that adolescence has not always been recognised as a distinct period of development and transition into adulthood. Hurrelmann and Engel (1989) reiterate that social history has shown how adolescence was identified as an autonomous life stage since the second half of the nineteenth century and that this change has been linked to the introduction of compulsory secondary schooling, as well as economic, political, and cultural changes in the milieu of the time. Since more adolescents have been diagnosed with bipolar disorder in recent years, the experience of this diagnosis, according to the social constructionist approach, is a matter of the meaning which the adolescent ascribes to the diagnosis. This meaning is shaped by the adolescent's environment and, in turn, shapes the manner in which adolescents understand themselves within their context.

### **3.6 Bipolar Disorder as a Social Construction**

Mental disorders have undergone changes in the ways in which they have been described at various points in history. Askanasky (Gove, 2004) provides a historical account of how mental disorders have been described and understood. The author records the term “nervous breakdown” as the term that was used in society to describe those that were in need of psychiatric treatment and explains that this is the manner in which they were viewed. In the nineteenth century, the term *neurasthenia*, which was used to describe a physical disorder believed to arise from high levels of stress, was introduced as a diagnosis in the field of psychiatry (Gove, 2004). This term was identified by George Beard in 1869 as a presentation of excessive physical and mental fatigue which manifested as insomnia, lack of concentration, depression, fears, and irritability (Taylor et al., 2011). Beard further ascribed this condition to the stresses endured by the affluent, educated, or those in business, and came to be described as a “fashionable disease” (Taylor et al., 2011). From these views, one is able to understand that mental disorders have previously been ascribed to stress, and terminology

has been created to reflect the meanings attributed to these as a reflection of the times from which they emanated.

Gove (2004) further describes the advent of institutionalisation as having been a prominent means of intervention in past decades, for those who presented with symptoms of mental disorders. This suggests that, at that stage, mental disorders were viewed as a burden and as unmentionable, hence the drive to isolate those who presented with symptoms of such. Although this has changed over time, and the treatment of psychological dysfunction occurs in a variety of settings such as outpatient facilities, we are able to get a sense of some advancement in the approach to psychological disorders over the years. These changes have been influenced by the societal changes that have shifted the focus of psychologists in their therapeutic interventions. Social constructionist theory has therefore contributed towards shaping our understanding and treatment of mental disorders. The manner in which psychological disorders have been described has shaped the manner in which they have been treated. Despite the role of the medical model in the diagnosis and treatment of mental disorders according to specified categories, a social constructionist understanding of bipolar disorder influences the manner in which the therapist and client mould the therapeutic conversation in such a manner that neither ascribes blame to the other, nor assumes a pejorative role during the therapeutic process.

### **3.7 A Social Constructionist Exploration of Clinical Psychologists' Experiences in the Management of Juvenile Bipolar Disorder**

A social constructionist approach to this study allows for a broad discussion of the experiences of the participants in the management of juvenile bipolar disorder. Constructs of the disorder require that we examine topics such as societal responses toward the individual diagnosed with the disorder, issues of stigma, the role of family support, and matters related to treatment. In terms of the actual diagnosis, it is pertinent to explore the role of funders in the diagnosis of bipolar disorder in the adolescent population. A social constructionist approach facilitates a discussion about the experiences that enhance and comprise the reality of the participants as they engage with their clients. Social constructionism proposes that

these experiences are dynamic and ongoing, being influenced by the ever-evolving context in which the participants function. This reality is further shaped by the participant's interpretation thereof, as well as how they resolve possible challenges and conflicts. The researcher endeavours to derive a multitude of realities as a means of generating an understanding of the management of juvenile bipolar disorder by psychologists. The study thus does not purport to discover a particular "truth" in this regard, but rather to create a rich understanding for the reader relating to those aspects of management which are currently relevant to clinical psychologists. In summary, it seeks to provide context-specific insight into how clinical psychologists experience the management of juvenile bipolar disorder.

### **3.8 Conclusion**

In concluding this discussion about social constructionism, some of the pragmatic issues related to the experience of bipolar disorder have been offered. The discussion has addressed the description of bipolar disorder using various perspectives that provide formulations that emphasise external and interpersonal influences rather than placing an emphasis on the internal processes accentuated by biological and medical formulations. This emphasises the broadness and multidimensional approach that is necessary in the interpretation of bipolar disorder with a specific focus on the adolescent population, whose life stage and thus experience of bipolar disorder has been purported to differ to that of adults.

## **CHAPTER 4**

### **RESEARCH DESIGN AND METHOD**

#### **4.1 Introduction**

The research design process in qualitative research is described as beginning with philosophical assumptions undertaken by the researcher which encompass the researcher's worldviews, paradigms, and beliefs (Creswell, 2007). Thus, the researcher is always a part of the described phenomena.

In the forgoing chapter, the reader was introduced to the theoretical framework assumed in this study. This chapter seeks to explain the research design and method, as well as the process of data collection that will be employed by the researcher in this study. The researcher will begin with a discussion of qualitative data, followed by a discussion of the data collection methods, sampling procedure, and data analysis method.

#### **4.2 Research Design**

There exists an association between research design and the research question. This association is such that the quality of research may be compromised if an inappropriate research design is used to answer a research question. Durrheim (2002, p. 29) defines research design as "a strategic framework for action that serves a bridge between research questions and the implementation of research". The author further explains that research designs play a bridging role between the research question and the execution of the research (Durrheim, 2002, p. 30). According to Draper (2004) this plan includes "a description of how the sample is to be identified and recruited, ethical considerations, confidentiality, anonymity, access to the research site, how the data are to be collected and analysed, and plans the researcher has for disseminating the findings of the study. A research question therefore needs to be matched to a research design.

### **4.2.1 Qualitative Research Design**

This study will assume a qualitative approach in an attempt to determine the uniqueness of each study participant's experience. "Qualitative research is defined as an umbrella term covering an array of interpretative techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world" (Al-Busaidi, 2008). Mack, Woodsong, Macqueen, Guest and Namey (2005) explain that some authors define qualitative research in terms of its purpose and focus: "Qualitative researchers are interested in understanding the meaning people have constructed, that is, how people make sense of their world and the experiences they have in the world" (Merriam, 2009, p. 13). They further explain that other researchers describe qualitative research from an epistemological perspective: "[Qualitative research is] research using methods such as participant observation or case studies which result in a narrative, descriptive account of a setting or practice" (Parkinson & Drislane, 2011). A qualitative research design will allow the researcher to gain insight and explore the circumstances within which the study participants operate, and it allows the researcher to collect and analyse data that is based on the lived experiences of those who partake in the study (Denzin & Lincoln, 2000).

### **4.2.2. Phenomenology**

When choosing a research design, it is essential that a researcher selects one that is relevant to and will answer the research question appropriately. In this study, the researcher will use phenomenology as qualitative research design aimed at allowing the researcher to gain insight into the context of the study participants. It also allows the researcher to collect and analyse data which is based on the lived experiences of the study participants and, as Polit and Beck (2010, p. 267) explain, to ascertain critical truths about reality and study phenomena that are subjective to individuals. Phenomenology is described as an interpretive approach in which researchers begin by assuming that reality is socially constructed through language, consciousness, and shared meanings (Maree, 2007, p. 59). This approach may also be defined as "the study of lived experiences through understanding the structure, essence

and context of the subjective experience of the individual” (Beck, 1990). As opposed to a narrative approach, which explores the experience of a single individual, a phenomenological approach is concerned with the experiences of several individuals of their lived experiences with regard to a particular phenomenon (Creswell, 2007, p. 57). Creswell (2007, p. 58) further explains that the purpose of this approach is to extrapolate from individual experiences to a description of the universal essence. As an interpretive perspective, Maree (2007, p. 59-60) outlines that the phenomenological approach is based on the assumption that:

- i. Human life can only be understood from within: it focuses on subjective experience
- ii. Social life is a distinctly human product: reality is viewed as a social construct
- iii. The human mind is the purposive source or origin of meaning: people impart meanings to phenomena and their social contexts
- iv. Human behaviour is affected by knowledge of the social world: realities related to phenomena differ across time and space
- v. The social world does not “exist” independently of human knowledge: researchers are influenced by their own knowledge and understanding of phenomena in terms of the manner in which research is conducted, based on their experiences.

This study assumes a phenomenological design, which is a way of examining people’s lived experiences to ascertain critical truths about reality and study phenomena, which are subjective to individuals (Polit, 2010). It aims to gain an understanding of the experiences of the study participants and considers the variances in these individual experiences. In phenomenological research, information is usually gathered by way of interviews (Creswell, 2007, p. 61), which allows for participants to describe their experiences as they perceive them, and the researcher will assume such an approach in data gathering.

### **4.3. Data Collection Method**

Creswell (2007) proposes that there are four basic means of collecting information in qualitative research, namely observations, interviews, documents, and audiovisual materials. In the interest of this study, interviews will be discussed in more detail so as to introduce the reader to the data collection method followed herein.

#### **4.3.1. Interviews**

Interviews are used across various disciplines and contexts as one of a variety of ways of gathering information. Kvale (1996) describes the qualitative research interview as one that seeks to understand the meanings of the central themes in the life world of the participants. Most qualitative literature identifies three types of in-depth interviews, namely unstructured interviews, semi-structured interviews, and structured interviews as the major interview structures.

Individual in-depth interviews are widely used by health care researchers to co-create meaning with interviewees by reconstructing perceptions of events and experiences related to health and health care delivery (DiCicco-Bloom & Crabtree, 2006). A key feature of this form of interview is their deep focus on the individual (Ritchie & Lewis, 2003, p. 58). This type of interview allows for in-depth discussions and thorough engagement with the study participants regarding their specific experiences concerning the study topic, and this form of interview enables study participants the opportunity to reflect on their experiences. The nature of this type of interview allows for research participants to provide broad information on a given topic, based on their experiences. As such, the interviewer must be flexible in their approach by allowing for interviewees to digress somewhat from rigidly answering questions, as this may be a productive means of gathering other related information that may be pertinent to the study.

### **4.3.2 Interview Structure Employed in this Study**

In this study, semi-structured interviews were conducted as a method of data collection. DiCicco-Bloom and Crabtree (2006) denote that the semi-structured interview is the most commonly used form of interviewing in qualitative research, and state that it may be conducted with individuals or with groups, as is the case in focus groups whereby multiple individuals in a group context share their experience on a given subject. This form of interview entails a set of predetermined, open-ended questions from which other questions emerge during the dialogue between interviewer and interviewee (DiCicco-Bloom & Crabtree, 2006). Semi-structured interviews consist of several key questions that help to define the areas to be explored, and it also allows the interviewer or interviewee to digress in order to pursue an idea or response in more detail (Britten, 1999), thus allowing for greater flexibility in the interview process.

The researcher finds that the use of semi-structured interviews allowed for a rich collection of data on the unique experiences of the participants in the study topic. This form of interview allows for flexibility in that the researcher can probe for further discussion arising from issues that are identified as broad themes (Burnard, Gill, Stewart, Treasure, Chadwick, 2008). The semi-structured interviews that were held were each recorded separately. Open-ended questions were asked and the researcher requested that the participants elaborate on their responses, where necessary. This approach to the interviews allowed the participants to express themselves comprehensively and enabled the researcher to obtain rich responses.

### **4.4 Selection of Participants**

Context is said to be an important aspect of any qualitative study (Ritchie & Lewis, 2003, p. 57). The selected participants in this study have enabled the researcher to explore the research question in the various contexts of the research participants. This allows participants to discuss their experiences in a forthright and explicit manner and to share their interpretations of these experiences. The participants for this study consist of clinical psychologists who were selected based on their experience in the management of adolescents diagnosed with bipolar disorder. The psychologists were selected from private practices in Johannesburg and

they were purposefully selected based on their experiences with the management of adolescents who had been diagnosed with bipolar disorder.

#### **4.4.1 Sampling**

Sampling is a critical aspect of research as it ascertains the suitability of research participants for the research project. Sampling for qualitative research relates to “the selection of individuals, units and/or settings to be studied”. Coyne (1997) denotes that, in qualitative research, sample selection bears a direct impact on the ultimate quality of the research and that, consequently, there exists an opportunity for qualitative sampling methods to be more clearly defined.

#### **4.4.2 Procedure**

Purposive sampling was used to recruit the participants in the study. This form of sampling is considered one of the most common forms of sampling in qualitative research, and serves as a useful means of grouping participants according to preselected criteria (Mack et al., 2005). These participants are deemed to be a useful and rich resource of information, based on their expertise (Russell & Gregory, 2003). According to Marshall, (1996), the optimum sample size depends upon the parameters of the phenomenon under study. In keeping with the sampling procedures of qualitative research, the researcher conducted interviews until saturation was reached. Patton (1990) captures the intricacies of qualitative sampling methods. The author states that qualitative sampling methods focus “in-depth on relatively small samples, even single cases (n=1) selected *purposefully*” (Patton, 1990, p. 169). “A qualitative inquiry sample only seems small in comparison with the sample size needed for representativeness when the purpose is generalising from a sample to the population of which it is a part” (Patton, 1990, p.184). Therefore, saturation will be established once the research question has been adequately answered, as determined by there being no new information provided by the participants.

An email was sent to prospective participants requesting their involvement and informing them of the selection criteria. An appointment was then scheduled with those who responded affirmatively. The participants were requested to sign a consent form prior to the commencement of the interview. Before the actual interviews could be conducted, two pilot studies were conducted as a means of pre-testing the study. From this, the interview questions would be revised, where appropriate.

The study procedure is summarised as follows:

- Permission was obtained from the research participants by email
- Participants were required to have experience in the management of adolescents diagnosed with bipolar disorder
- An interview appointment was scheduled
- Informed consent was obtained prior to commencement of the interview and the purpose of the study was explained to the participant
- A semi-structured interview was conducted
- Interviews were recorded using a tape recorder
- Data was stored in a safe storage area

#### **4.4.3 Pilot Study**

In the current research, a pilot study was used as a means of testing the application of the semi-structured interview questions that were to be used to explore the experiences of clinical psychologists in managing juvenile bipolar disorder. A pilot study is a small-scale version of a larger study which provides the researcher with useful information pertaining to the proposed data collection methods to be employed in the actual study. This serves the purpose of enabling the researcher to test study procedures, confirm the validity of tools and to estimate the recruitment rate (Arain, Campbell, Cooper & Lancaster, 2010). In addition, the pilot study allows the researcher to familiarise themselves with the research instrument to be employed in the study. If necessary, the pilot study may be adapted to better suit the questions and aims of the research and, in this way, it serves the purpose of circumventing potential practical pitfalls.

In this study, the researcher used the same selection criteria for the participants as in the main study which is discussed later in the chapter. During the pilot study phase of this study, the researcher applied the questions of the semi-structured interview to two participants. Both participants were clinical psychologists in separate private practices in Johannesburg. The details of the participants were obtained from internet searches and they were both purposively selected based on the researcher's idea that they shared characteristics that were most relevant to the research question. One participant was in full time practice at an inpatient and outpatient private psychiatric facility while the other participant's practice in a residential area in close proximity to an inpatient psychiatric facility. Appointments were scheduled with the participants by electronic mail. The participants were seen individually in their respective practices. Informed consent was obtained from the participants before the study commenced and the pilot studies were recorded as per the study procedure. The pilot study was used to ascertain the feasibility and representativeness of the interview questions. By collecting this preliminary data, the researcher was able to consider making adjustments to the interview questions. The interviews each took approximately 45 minutes.

The motivation to use two pilot studies was to assess and confirm the feasibility of the research tool. To replicate, Kirk and Miller (1986) asserted that asking the wrong questions is the source of most validity errors. The researcher sought to guard against this and, in so doing, to further reduce the potential for validity errors. From the second pilot study, the researcher was able to further ascertain whether the research questions were indeed appropriate to answer the research question. The pilot studies served the purpose of identifying whether there were any attributes of the study that required further refinement or redefinition. For the purpose of clarity, the participants' responses are differentiated as *pilot study 1* and *pilot study 2* and are referred as such herein.

#### **4.5 Data Storage**

Creswell (2007) purports that the approach to the storage of information will reflect the type of information collected, which varies by tradition of inquiry. Good quality audio recording

equipment was used during interviews. The names of participants were protected at all times by masking their names in the data. Audio tapes were stored in a locked cupboard and destroyed once appropriate.

#### **4.6 Data Analysis Procedure**

The analysis of qualitative data is said to begin in the field, during observation and/or interviewing, as the researcher identifies details that may possibly assist in understanding the topic of research (Schutt, 2004). Maree (2007) argues that qualitative data analysis is aimed at examining meaningful and symbolic content of qualitative data. This means that this form of data analysis attempts to establish how participants make meaning of a specific phenomenon by analysing their perceptions, attitudes, understanding, knowledge, values, feelings, and experiences in an attempt to approximate their construction of the phenomenon (Maree, 2007). Data analysis involves reading through data repeatedly, and engaging in activities of breaking the data down (thematising and categorising) and building it up again in novel ways (elaborating and interpreting) (Terre Blanche & Durrheim, 2002). Due to the qualitative nature of this study, data analysis was ongoing and combined data collection, analysis, and interpretation. The original field notes and data were revisited in order to confirm conclusions.

Clarke and Braun (2013) demarcate the uses of thematic content analysis and they indicate that it is a phenomenological method for identifying and analysing patterns of qualitative data. The researcher will follow the steps outlined by Clarke and Braun (2013) in identifying and analysing the patterns that emerge from the proposed study. Clarke and Braun (2013) list six of these steps. These include:

- Familiarisation with the data: this refers to researchers becoming immersed in and familiarising themselves with the data
- Coding: generating labels for the important features that emerge from the data
- Searching for themes: this involves searching for meaningful and relevant patterns that emerge from the data
- Reviewing themes: checking that the themes are consistent with and relevant to the

research being conducted

- Defining and naming themes: writing a detailed analysis of each theme as well as providing a name for each theme
- Writing up: the researcher combines the analytic narrative and data extracts in creating a comprehensive, detailed, and persuasive story

In this study, data was organised into themes using thematic content analysis. This is because it is an appropriate means of systematically analysing message content and is suitable for use when analysing subjective responses to open-ended, qualitative questions that arise from interviews. Thematic analysis is a method of reporting themes which emerge from data and it provides a means of identifying, analysing, and reporting patterns within data (Braun & Clarke, 2006). The researcher read through the participants' responses in order to transcribe the data to establish the general ideas presented. Significant statements were extracted and meanings formulated from those responses. These meanings were organised into themes and sub-themes or categories. From this, the researcher formulated a description of the phenomena.

#### **4.7 Ethical Considerations**

The research process involves the consideration of ethical issues that are pertinent to the study. These issues include confidentiality, informed consent, and feedback regarding the research outcomes. Research ethics is a process which involves identifying the potential ethical challenges anticipated from the research process and circumventing these by creating research guidelines to be followed in order to protect those who will be involved in the study. This is an explicit prerequisite for research. Ritchie and Lewis (2003, p. 66) state that ethical considerations are the final aspect of the negotiation of research relationships and the authors further explain that any research study raises ethical considerations.

A researcher has an ethical responsibility to protect the participants from maleficence and to uphold ethical principles of respect for participants in ensuring their anonymity and protecting any individuals partaking in the study from exploitation; beneficence in

minimising the risk of exposure of patient information. There is also a responsibility display respect for individuals.

#### **4.7.1 Confidentiality**

The general rule in research is that confidentiality cannot be breached without the participant's consent (Orb, Eisenhauer, & Wynaden, 2000). Confidentiality was discussed thoroughly with study participants before the commencement of the study. Confidentiality in research is not without its challenges, since researchers have a duty to report on their findings, which, by its very act, presents a conflict against the notion of confidentiality (Wiles, Crow, Heath & Charles, 2006). This places researchers in a rather challenging position. What researchers can do is to ensure that they do not disclose identifiable information about participants and try to protect the identity of research participants through various processes designed to anonymize them (Wiles et al., 2006).

The researcher considered the confidentiality of the participants as well as those that the participants reported on. For this reason, the privacy and confidentiality of the participants was upheld and their names were not used on the data recording form. Instead, codes were used when handling the data in order to ensure anonymity. The researcher is aware of the sensitive nature of the discussion of patient information and thus, the names of patients that formed the basis of the participants' experiences were also not disclosed to the researcher.

#### **4.7.2 Informed Consent**

Informed consent is a critical aspect of any research study. It includes informing the study participants of the purpose of the research as well as other issues, such as what is expected of the participants, the amount of time required from them, the expected risks and benefits of the study, the voluntary nature of their participation, confidentiality, as well as the name and contact number of the researcher and supervisor of the study in the event that they may have questions pertaining to the study. The language in which the study was conducted was English, so as to ensure uniformity in the research procedure. Informed consent was obtained

in written form for record purposes. This was done in the form of a letter requesting participation in the study as well as a letter of informed consent for participating in the study. Informed consent was also obtained from participants prior to the audio recording of the interviews.

#### **4.7.3 Withdrawal from the Study**

Before the commencement of the study, the participants were made aware of the reason for the study as well as the study procedure. They were also to be informed of their freedom to terminate their involvement from the study at any point without the fear of repercussions.

#### **4.7.4 Protection of the Participant**

The researcher did not utilise the information discussed by the participants in any interviews with other participants. The participants were made aware that the information was made available to the researcher's supervisor for supervisory purposes only.

#### **4.7.5 The Researcher's Primary Responsibility**

The protection of participants is the primary responsibility of the researcher. This entails protecting them from physical and psychological harm. The participants were therefore made aware upfront that therapeutic support was put in place and was readily available for participants where necessary during the course of the data collection process.

### **4.8 Issues of Reliability and Validity**

Golafshani (2003) discussed the relevance of reliability and validity in qualitative research design. Since qualitative research does not seek to demonstrate the repeatability of results in an attempt to claim the generalisability of those results to the general population, many

researchers have questioned its reliability and validity. Qualitative analysis results in a different type of knowledge than quantitative inquiry because one party argues from the underlying philosophical nature of each paradigm, enjoying detailed interviewing, and the other focuses on the apparent compatibility of the research methods, “enjoying the rewards of both numbers and words” (Glesne & Peshkin, 1992). Creswell (2007) explains that, according to the positivist approach, reliability, the consistency with which results may be reproduced by similar research methods; and validity, a measure of whether an instrument measures what it purports to measure; are critical elements of quantitative research, which are increasingly being spread out into all areas of research. However, if we see the idea of testing as a way of information elicitation then the most important test of any qualitative study is its quality (Golafshani, 2003). Therefore, this places an emphasis on the effort and input of the researcher.

Lincoln and Guba (1985) argue that sustaining the trustworthiness of a research report depends on the issues of validity and reliability discussed above. Braun and Clarke (2006) explain trustworthiness as the process of ensuring rigor in qualitative research. This is to say that it is a process of ensuring the accurate capturing of transcripts, and that the themes are coherent and congruent (Braun & Clarke, 2006). In this study, the researcher made use of audio recordings of the interviews that were conducted. These interviews were then transcribed verbatim. All similar themes were grouped together and given a theme and a title, and similar themes were grouped together. This process required that the researcher be immersed in the data and that the data be revisited so as to ensure *credibility*, which refers to the researcher’s representation of the participants’ realities as adequately as possible (Krefting, 1991).

Kirk and Miller (1986) state that asking the wrong questions actually *is* the source of most validity errors. Devices to guard against asking the wrong question are critically important to the researcher. This requires of the researcher careful consideration to the specific questions asked of the participants to ensure that they are not asked aimlessly but that they are relevant. In qualitative research, issues of reliability and validity involve careful consideration of the questions asked by the researcher as well as the manner in which these questions are asked. Because of the conversational and semi-structured nature of the interviews in this study, the

researcher remained mindful of the potential to lose sight of the purpose of the study while engaging in an over-inclusive and broad discussion on the topic.

#### **4.9 Conclusion**

This chapter provided an overview of the research design and method that was used in exploring clinical psychologists' experiences in the management of adolescents diagnosed with bipolar disorder. In addition, the data collection techniques as well as the data analysis method was discussed. Ethical considerations were elaborated on in an attempt to highlight the potential ethical challenges that may have been pertinent in this study. Furthermore, issues of reliability and validity were elaborated on to address potential questions related to reliability and validity in qualitative research. The following chapter presents and discusses the findings of the study.

## CHAPTER 5

### PRESENTATION AND DISCUSSION OF THE FINDINGS

#### 5.1 Introduction

The research design and methods of data analysis have been previously discussed. In this chapter, themes extracted from the interviews conducted are discussed and the significant themes highlighted. Through the emerging themes the research looked at how the participants described their management of juvenile bipolar disorder. The discussion and the themes discussed do not exhaust the subject but add a voice to the study of clinical psychologists' experiences of managing juvenile bipolarity. They are also a co-construction between the researcher and participants. Burnard, et al. (2008) put forth the notion that social scientists share a common belief that "a definitive, objective view of social reality does not exist". The themes identified were sorted accordingly by grouping together similar experiences shared by the different participants and thereafter the themes were explored more closely in order to capture the meanings ascribed to them.

#### 5.2 Data Analysis Procedure

Thematic content analysis was utilised to organise the data into themes. Guidelines for the analysis of the data were obtained from Braun and Clarke (2006) and have been previously outlined in the section entitled *Data Analysis Procedure* in Chapter 4 (Research Design and Method). The researcher began by transcribing the recorded interviews verbatim. Interview transcripts provide a descriptive account of the study but they do not provide explanations thereof (Burnard et al., 2008). In the process of familiarisation with the data and in identifying the themes, the transcripts were read repeatedly. Data analysis involves reading through data repeatedly, and engaging in activities of breaking the data down (thematising and categorising) and building it up again in novel ways (elaborating and interpreting) (Terre Blanche & Durrheim, 2002). Due to the qualitative nature of this study, data analysis was

ongoing and incorporated data collection, analysis, and interpretation. The original field notes and data were revisited in order to confirm conclusions.

The researcher systematically clustered the data for each participant into main themes and sub-themes by extracting significant statements from the data and generating meanings from those responses. Themes that captured an important idea were identified in relation to the research question. The researcher referenced the emerging themes against the purpose of the study so as to establish whether these were reflective of what the study aimed to explore. Quotations from the interview transcripts were included in the text as a means of illustrating, highlighting and substantiating the themes. The tables attached in the appendices indicate the themes, sub-themes, quotations and line numbers that were included, for ease of referencing.

### **5.3 The Participants**

Clinical psychologists were the participants in this study. The psychologists interviewed practiced in different private inpatient and/or outpatient. All were independent practitioners who were not affiliated to the facilities at which they were practicing. To emphasise the words of Marshall (1996), an optimal sample size depends on the parameters of the phenomenon under study. A small sample was selected with the aim of obtaining detailed information about the phenomenon being explored since qualitative research is concerned with focusing “in-depth on relatively small samples” (Patton, 1990) as stated previously. The researcher considered this in the selection of the participants in this study. The participants were purposively selected in relation to the research question. The point at which the research question had been adequately answered was determined as being the point at which no new information was elicited by the researcher or reported by the participants. At this point, saturation had been established according to what was stipulated by Patton (1990) and discussed in chapter 4. A brief presentation of the demographic information of the participants is presented in table 5a below:

*\*Table 5a: Overview of the participants*

	<b>No of years in private practice</b>	<b>In/outpatient facility</b>
<b>Pilot study 1</b>	6	Inpatient and outpatient
<b>Pilot study 2</b>	8	Outpatient
<b>Participant 1</b>	12	Outpatient
<b>Participant 2</b>	7	Outpatient
<b>Participant 3</b>	5	Inpatient and outpatient
<b>Participant 4</b>	9	Inpatient and outpatient

### **5.3.1 Eligibility Criteria**

Clinical psychologists who were in private practice in Johannesburg were approached to participate in the study. For inclusion into the current study, the participants were required to have been in private practice for a minimum of three years and had to have experience with the research topic. That is to say that the participants were required to have managed adolescents who had been diagnosed with bipolar disorder. The participants were not required to have made the diagnosis themselves but, in order to be included in the study, they had to have managed at least one adolescent who had been diagnosed with bipolar disorder. The participants were also required to be willing and to give consent to taking part in the current study. No specifications were made by the researcher regarding the type of facility that the participant was required to be working in and the researcher considered those participants who were in both private inpatient and outpatient facilities. The exclusion criteria included clinical psychologists who had not managed adolescents diagnosed with bipolar disorder, clinical psychologists who had been in private practice less than three years and clinical psychologists outside the Johannesburg area. For the purpose of homogeneity in the sample, clinical psychologists practicing in the state sector and non-governmental organizations were also excluded from the study.

### 5.3.2 The Enquiry

The current study was aimed at exploring the management of juvenile bipolar disorder by clinical psychologists. In order to identify potential participants, the researcher conducted an internet search of clinical psychologists who fulfilled the abovementioned criteria. This involved directing attention at those whose list of services included working with adolescents. The researcher also approached the relevant gatekeepers at two private inpatient and outpatient psychiatric facilities in order to obtain permission to recruit potential candidates for the study. The researcher then communicated with these participants through electronic mail and some were contacted telephonically on their office telephones. Those members who did participate in the study did so of their own volition and consent.

The enquiry was centred on adolescents that were aged between thirteen and eighteen years who had been diagnosed with bipolar disorder. The experiences shared by the participants were related to cases of juvenile bipolar disorder that they were managing at the time of the interview or that they had managed previously. The participants did not disclose the identities of the adolescents and no information was shared with the researcher that compromised their anonymity. Face to face semi-structured interviews were conducted with the participants. All interviews were conducted in English and were held at the practices of the participants. The interviews took, on average, forty-five minutes to an hour.

With the aim of exploring clinical psychologists' experiences of managing adolescents diagnosed with bipolar disorder, the following questions were posed to the participants:

- How do adolescents diagnosed with BMD present clinically?
- What is the prevalence of adolescents diagnosed with bipolar disorder?
- What are your experiences in the management of adolescents diagnosed with BMD?
- What are your suggestions regarding the considerations when managing adolescents diagnosed with BMD?
- Do you think that we can stick to this interview structure?

These formed the core questions that comprised the semi-structured interviews. These questions allowed the participants the flexibility to report their experiences of managing juvenile bipolar disorder from their own perspectives and they gave rise to further questions which were then incorporated into the discussions. The participants were each asked if they would like to include further questions to the interview structure and these suggestions were further integrated into the interview structure.

## **5.4 Discussion of the findings**

The following section outlines the findings of this study. In the presentation of the findings, the basic themes are presented under their respective headings and the sub-themes are discussed under each of the main themes. An illustration of each theme and subtheme is provided using non-hierarchical, diagrammatical illustrations. These may be found in figures 1,2 and 3. The results of the two pilot studies are presented and discussed first, followed, in a new section, by a discussion of the findings from the main interviews. In the pilot studies, the participants gave detailed descriptions of their experiences of managing adolescents diagnosed with bipolar disorder. Both of the participants stated that they had managed more than one case of the above. Their experiences are discussed according to the relevant themes and subthemes outlined in the section that follows. The themes and subthemes related to the pilot study will form part of *Section A*.

### **5.4.1 Section A: Presentation and Discussion of Identified Themes that Emerged from the Pilot Studies**

The section that follows presents and discusses only the results of the pilot studies. As discussed in the preceding chapter. The pilot studies were held in order to pre-test the study and to ascertain the appropriateness and comprehensiveness of the interview questions. The participants of the pilot studies were selected on the basis of the eligibility criteria discussed previously in the study. From the pilot studies, the researcher was able to draw various themes that related to the experiences of clinical psychologists in the management of juvenile

bipolar disorder. Again, the interviews were not meant to focus on the actual management practices of the participants (although this information was volunteered in the interviews), but to draw attention to the experiences of the participants in relation to their management of juvenile bipolar disorder. The questions asked in the pilot studies were found to be an adequate representation of the areas that the study sought to focus on. The following common emergent themes represented in *table 5B* below encompass the basic themes that emerged from the pilot study.

*\*Table 5b: Basic Emergent Themes from the Pilot Study*

A1	Diagnosis and Classification
A2	External Influences
A3	Management and Interventions
A4	Therapeutic Relationship

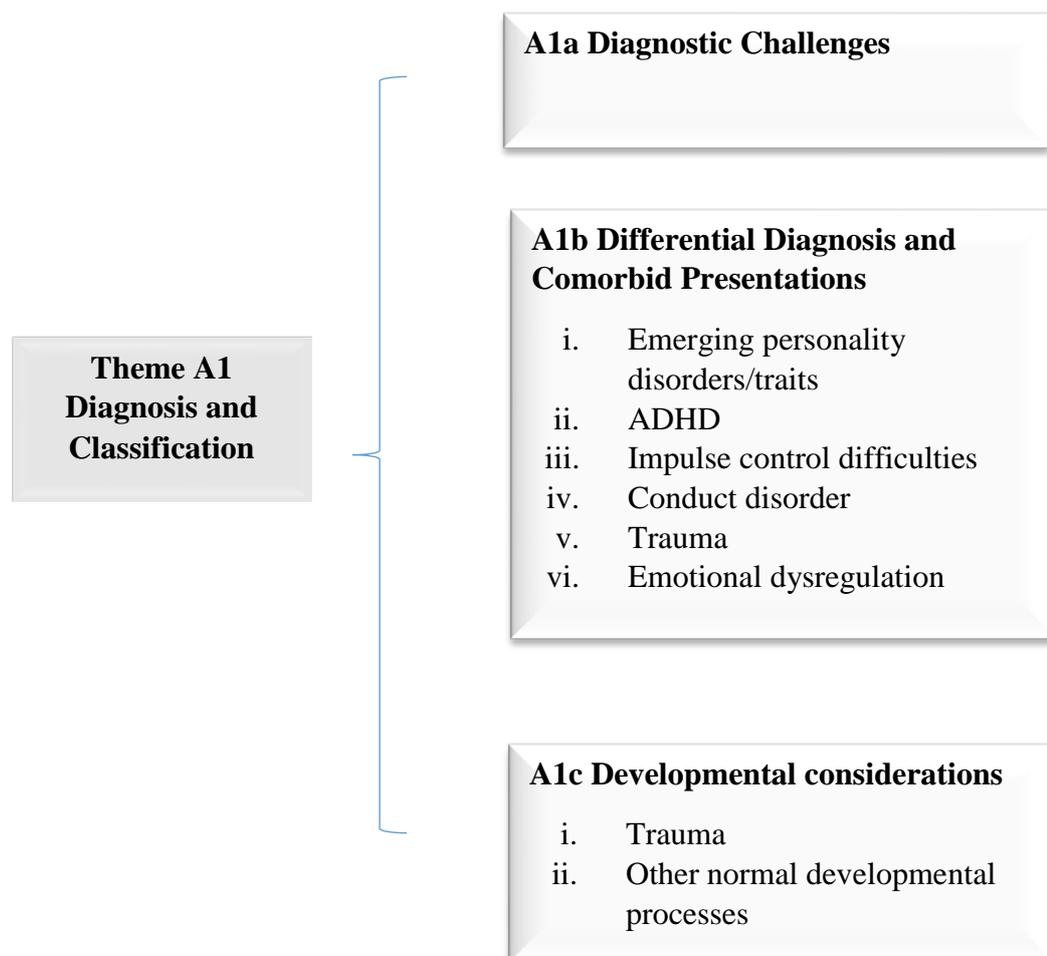
In the section below, the basic themes and their subthemes are presented and discussed in relation to the literature presented in chapter 2. Extracts from the participants' responses are also included in the discussion. The pilot study revealed that there are certain considerations that are made when making a diagnosis of bipolar disorder in adolescents and it seems that there is some overlap in these. The diagnosis of juvenile bipolar disorder appears to be a contention in clinical practice, according to what emerged in both interviews. Both participants discussed the variability of the presentation of bipolar disorder among adolescents. The complexities involved in making a bipolar diagnosis during this developmental stage were elaborated on by both participants. There were some slight variations in the participants' experiences.

### **A1. Diagnosis and Classification**

The *Diagnosis and Classification* theme refers to whether participants consider that a diagnosis of juvenile bipolar is an accurate and useful one. The theme and its related sub-themes is presented in *Figure 1*. It encompasses the idea that there are diagnostic challenges

associated with making this diagnosis and that developmental considerations are paramount in this process. Under this heading, various comorbidities that often coexist with juvenile bipolar disorder are also discussed. The participant in the first pilot study highlighted that, because clinical psychologists often work in conjunction with other healthcare practitioners, discrepancies in the diagnoses may arise. This difficulty is related to the insufficient direction given by the DSM regarding the diagnosis of early-onset bipolar disorder. This participant stated, “There’s *no diagnosis to accommodate it in the DSM so where do we place them, especially when one is working with a multidisciplinary team?*” The suggestion made by this participant is that, at times, there may be a gap between what is prescribed by the DSM and the interpretation made by different clinicians.

**Figure 1: Diagnosis and Classification**



### *A1a. Diagnostic Challenges*

The participants expressed their concern about the complexity of diagnosing adolescents with bipolar disorder and they indicated that this contributes significantly towards the complexities associated with their experiences of managing juvenile bipolar disorder. The first participant spoke about the obscurity of the DSM-5 classification of bipolar disorder and how it does not make adequate provision for the classification of juvenile bipolar disorder as is evidenced in the statement, *“There’s no diagnosis to accommodate it in the DSM so where do we place them?”* Bradfield (2010) emphasises this difficulty by explaining that, while the DSM provides a comprehensive description of bipolar disorder in general, the description of paediatric bipolar disorder, which manifests as a rapid cycle of fluctuating moods, falls into a nosological gap. Thus, while the participants had managed adolescents diagnosed with bipolar disorder in their practices, they questioned the accuracy of this diagnosis.

When reporting on the actual incidence of juvenile bipolar disorder, the first participant stated, *“the number of children and teens diagnosed with bipolar disorder isn’t that high”*. This view is similar to that held by the second participant who reported to have never *“seen a case that purely fits the bill”*. The participants commonly reported that the incidence of pure juvenile bipolar disorder is actually rare, despite the growing number of adolescents being diagnosed with mental illnesses in general (participant 2), and in spite of the incidences of diagnosed cases of juvenile bipolar disorder that each participant had reportedly managed. Danner et al. (2005) state that, despite the growing number of children and adolescents who are being diagnosed with bipolar disorder in inpatient, outpatient and primary care settings, this diagnosis remains difficult to make, particularly in youth.

The participants cited various reasons for the diagnostic challenges associated with juvenile bipolar disorder. Participant 1 noted that the difficulty in making an accurate diagnosis is that there are no blood tests that can confirm such a diagnosis. Thus, juvenile bipolar disorder was shown in both pilot studies to involve a complicated diagnostic process which bears influence on the management of the disorder. The diagnostic process has been depicted as an integral

part of the management of juvenile bipolar disorder (Danner et al., 2009; Renk et al., 2014) which requires a degree of clinical acumen in which the developmental aspects of adolescence are carefully considered.

### ***A1b. Differential Diagnosis***

The participants each identified the importance of making a differential diagnosis in which the clinician rules out comorbidities and analogous presentations when considering a diagnosis of juvenile bipolar disorder. Central to this is that there may be a symptom overlap between bipolar disorder and other presentations and thus a focus on the diagnosis may disregard other important areas that may also require appropriate intervention. Both participants noted that it is necessary to rule out related comorbidities. Gellar et al. (2002) suggest that this is crucial in curbing the over and under-diagnosis of early-onset bipolar. In their experience, the participants had encountered presentations in which it was unclear whether an adolescent was presenting with bipolar features or whether the presentation was of another disorder. According to the first participant, there may be instances where, “...*the child is diagnosed with ADHD, [and] they later get a diagnosis of bipolar disorder*” which raises an important aspect related to the management of juvenile bipolarity in that it points to the importance of having a working diagnosis. Renk et al. (2014) refer to a study conducted by Birmaher et al. (2014) which sought to examine the four-year longitudinal course of bipolar symptoms in children and adolescents. The results of this study showed a variability in the outcomes of bipolar diagnoses in the children and adolescents that were examined whereby 81.5% experienced a complete recovery of their symptoms while 62.5% experienced a recurrence of syndromal symptoms at the time of their respective follow-ups. Participant 2 added that, at times, the adolescent will be admitted to an inpatient facility “...*for behavioural problems related to maybe substance abuse, ADHD, and other things*” which further adds to the notion that, in diagnosing bipolar disorder in adolescents, clinicians ought to remain vigilant when examining the constellation of symptoms and comorbidities.

Despite having seen a few cases where adolescents have been diagnosed with bipolar disorder, the participant in the second pilot study highlighted that these could be cases of personality disorder traits which also share much of the symptom presentation of bipolar

disorder. Another presentation that may mimic bipolar disorder is that of GAD. Added to this is the high incidence of trauma which many young children and adolescents are exposed to in our current time and context (participant 1). Given these considerations, the management of juvenile bipolar disorder seems to require active engagement.

### ***A1c. Developmental Considerations***

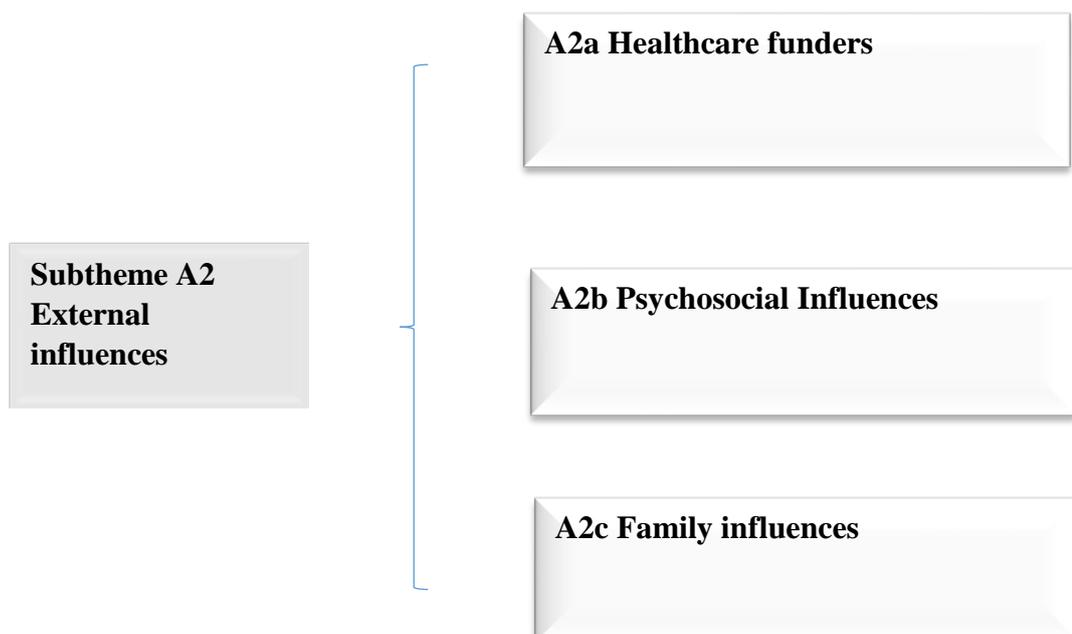
In the first pilot interview it emerged that the adolescent's behaviour should be evaluated in context, in the sense that, at times, it may be a part of the normal developmental process. Therefore, the clinician should differentiate between normal and pathological behaviour. Renk et al. (2014) indicate that emotional dysregulation is a common occurrence and a typical part of child development. This participant stated, *"It's just part of that life stage where they're trying to define who they are in their environment and they end up wanting to know how far rules can be pushed"*. This is also in line with what was pointed out by Danner et al. (2009) who explained that one of the reasons why early-onset bipolar disorder is difficult to diagnose is because the clinician must consider the impact of the child's developmental level on the presentation of their symptoms. The participant indicated that the adolescent's presentation could be a manifestation of, or exacerbated by difficulties associated with the challenges of adolescence as a developmental stage. From this it appears that the adolescent's level of development bears some influence on the management of juvenile bipolar disorder and, as explained by Diler and Birmaher (2012) the clinician ought to have a comprehensive understanding of the child's normative cognitive, behavioural and emotional development and whether this is expected or pathological according to their developmental level.

### **A2. External influences affecting the Management of Juvenile Bipolar Disorder**

Literature depicts the extensive impact that a diagnosis of bipolar disorder may have on youths. The psychosocial influences associated with bipolar disorder are commonly reported and, with reference to the present study, these may influence the experiences of clinical

psychologists in managing youths diagnosed with bipolar disorder. In order to ascertain how the disorder impacts on the adolescent, it is important to gain an understanding of their psychosocial circumstances. This theme encompassed various influences that were considered to be external to the therapeutic relationship and context but that impacted on the participants' experiences of managing adolescents diagnosed with bipolar disorder. The participants thus depicted their experience of the management process on a broader scale which consists of events that occur in different contexts outside of the therapeutic space but that have an impact on how the participants experience the management of juvenile bipolarity. Birmaher and Axelson (2006) note that early-onset bipolar disorder has a considerable impact on the normal psychosocial development of a child. Thus, it seems logical that the adolescent's unique circumstances must assume a role in allowing for a more holistic understanding of the impact of the disorder on the youth and on how the disorder is managed. Following from this, the discussion that follows centres on healthcare reimbursement, family and interpersonal influences and other psychosocial influences that were found to have an impact on the management of juvenile bipolar disorder.

*Figure 2: External influences affecting the management of juvenile bipolar disorder*



## ***A2a. Healthcare Funders***

The chronic and complex course of early-onset bipolar disorder was highlighted in chapter 2 (Marneros & Angst, 2002). With this, healthcare funders play a critical role in many instances where an adolescent is diagnosed with bipolar disorder or any condition requiring long term reimbursement. Miklowitz (2008) advises healthcare practitioners against the indiscriminate use of pharmacological agents to treat early-onset bipolar disorder but adds that, where a genuine case warrants the use of these agents, treatment should be forthcoming and prompt. Hence, in many instances, the role of healthcare funders is pivotal in this process since it appears that the time taken for treatment to be initiated is significant. As explained by participant 1, *“When they’re diagnosed, it’s important to get them onto medication so as to stabilise them”* alluding to the idea that, since psychotherapy is part of a multimodal approach to the management of juvenile bipolar disorder (Weintstein, West & Pavuluri, 2013), clinical psychologists’ experiences of managing juvenile bipolar disorder may also be influenced by this process. The participants discussed the stance assumed by healthcare funders regarding the reimbursement of mental disorders and how this impacts on the clinician’s management of juvenile bipolar disorder. The first participant noted that, at times, because a medical aid will not reimburse for disorders such as conduct disorder, a diagnosis of bipolar disorder is made so as to obtain reimbursement for treatment: *“so then a child will get a diagnosis of bipolar because the medical aids won’t reimburse us if it’s a conduct disorder...”* This is in contrast with the literature presented in chapter 2, in which it was posed that the over-diagnosis of juvenile bipolar disorder is influenced by the commonality of the features that are shared by mental disorders of childhood (Sands, 2006). Thus, the core reason for the rise in bipolar disorder diagnoses in adolescence has been chiefly attributed to the complexity of the diagnosis as a result of the symptom overlap between bipolar disorder and other mental disorders (Sands, 2006) and various authors describe the symptoms of early-onset bipolar disorder in detail (Renk, 2014; Carlson, 2012). The findings of pilot studies suggest that the diagnosis and management of juvenile bipolar seems, in part, to be directed by the dictates of external bodies such as healthcare funders. The second participant added that, in an inpatient context, the difficulty of making an accurate diagnosis is further complicated by the significant time it takes for the symptoms present at admission to resolve, contrasted with the duration of hospitalisation that is permitted by healthcare funders, who require that the clinician’s management is rapid and brief. This is illustrated by the statement,

*“there are instances where the circumstances kind-of influence the hastiness of the clinician”*. Thus the period of hospitalization and inpatient treatment that is reimbursed by funders, seems to be experienced as inadequate at times and this may impact negatively on clinicians’ the management of the disorder.

From the pilot study, it emerged that healthcare practitioners are influenced by the policies of medical aids and this largely influences their management of juvenile bipolar disorder. Hoffman asserted that health insurance is forthcoming inasmuch as disorders are classifiable according to a biological basis (Hoffman, 1993) and this is in line with the experiences of both participants. The second participant discussed the urgency with which patients are treated in inpatient facilities. This participant stated, *“We’re under so much pressure from all sides to get the patient treated and out”*. This participant further added that often the period of inpatient treatment that is reimbursed by the funders is inadequate for a therapeutic intervention to take place effectively. This approach calls for brief interventions to manage juvenile bipolar disorder and this may be a contrast when considering the chronicity of bipolar disorder and the complexity of associated with making such a diagnosis which has been reviewed in the literature in chapter 2. However, this view does not prohibit the clinician from continuing with management as necessary on a more long term basis. These reports once again draw attention to the prevalence of actual incidences of juvenile bipolar disorder. They also raise the concern that adolescents may be exposed to certain treatment interventions prematurely following a brief assessment, and this may bring about the situation described by Vázquez et al. (2010) where there is poor adherence to prescribed interventions. Yet the considerable cost of managing mental health conditions has been outlined in the literature (Vázquez et al. 2010). As such, early and accurate identification of bipolar disorder also appears to bear significance for healthcare funders. Reimbursement for mental disorders is thus significantly dependent on how the various disorders are classified according to the policies and formularies of funders.

## *A2b. Psychosocial Influences*

In discussing the external influences of various systems that may affect their experience of managing adolescents diagnosed with bipolar disorder, the participants focused on the psychosocial elements that play a role in this regard. Diler (2007) acknowledges the expansiveness of early-onset bipolar disorder. The author states that the illness is now increasingly recognised as a significant public health problem affecting youth and that it is often associated with impaired family and peer relationships, poor academic performance, high rates of chronic mood symptoms and mixed presentations, psychosis, disruptive behaviour disorders, anxiety disorders, substance use disorders, medical problems (e.g. obesity, thyroid problems, diabetes), hospitalizations, and suicide attempts and completions” all of which carry their associated costs (Diler, 2007). In the pilot study, the participants’ gave accounts of how psychosocial variables had impacted on their management of juvenile bipolar disorder. The second participant observed an increase in the number of adolescents being hospitalised for the treatment of various mental disorders, which the participant attributed to, on the one hand, an increased awareness of mental illnesses on the part of the parents and, on the other, to the possible de-stigmatization of mental illness. This participant offers an alternative view to what is suggested in the reviewed literature, in which Suto et al. (2012) explored the self-stigma experiences of individuals who had been diagnosed with bipolar disorder and they found that, once an individual experiences the stigma that is associated with having a mental illness, they are more likely to have a poorer quality of life and this is likely to have a negative impact on their ability to perform their activities of daily living. The stigma associated with juvenile bipolar disorder was also related to the adolescent consulting a clinical psychologist: “...*they’re already stigmatized for seeing a psychologist*” which suggests that clinicians may be faced with resistance when managing juvenile bipolar disorder. This may pose a difficulty for the adolescent as they strive for a sense of belonging and acceptance among their peers. In Suto et al. (2012), the authors describe the experiences of individuals who had been diagnosed with bipolar disorder who recounted how they had been excluded from participation in various contexts as a result of the stigma associated with bipolar disorder. The authors describe this as *structural stigma* and they explain that the stigma associated with bipolar disorder may culminate in restrictions being placed on those diagnosed with the disorder from engaging in activities in the same manner as others (Suto et al., 2012). Participant 2 emphasised the need for clinicians to be aware of ways that they can

provide additional support to the adolescent: “...so it’s important to be vigilant to other ways that support can be provided...” In relation to the concern around the stigmatization that sometimes results when others learn that the adolescent is consulting a clinical psychologist, it appears that the issue of disclosure may, at times, impede the therapeutic process. In exploring this issue, Suto et al. (2012) explain that the circumstances under which this occurs are crucial. The implication made by the participants is that, in managing juvenile bipolar disorder, clinicians ought to provide a containing environment in which such difficulties may be explored and worked through.

### ***A2c. Family Influences***

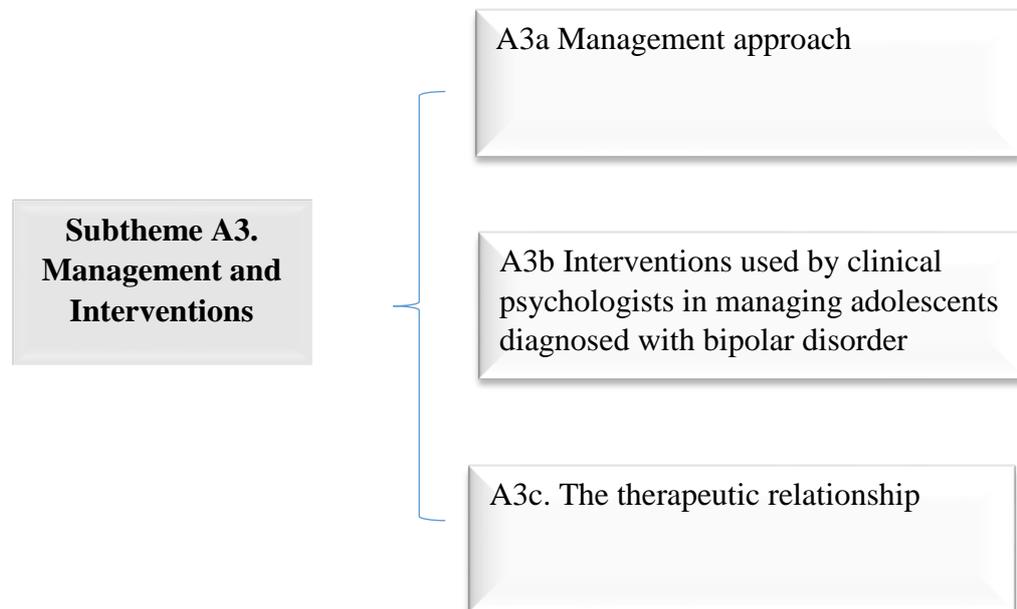
This sub-theme encompasses the relationship and communication patterns between the members of a family that may impact on how the adolescent responds to psychotherapy. The participants explained that, when an adolescent is diagnosed with bipolar disorder, this impacts on the functioning and communication patterns of the family. The second participant stated that the family could, at times, begin to identify the adolescent as being the problem in the family. This idea is illustrated by the statement, “*when a teen is diagnosed with a mental illness, especially bipolar disorder, the family is plunged into crisis, problems develop in the family, the teen becomes the IP and the problem just worsens over time*”. Hoffman (1981) explains that, individuals do not exist in a vacuum but are embedded in systems and that, because of this, events occur as a result of an exchange that exists when an individual interacts with others. This is to say that that events that occur are the result of an exchange between an individual and the members who interact with the individual in a system (Hoffman, 1981). When proposing that it is necessary for the clinician to explore the family dynamics, the second participants stated, “*it gives you a chance to see what the family dynamics are in that family and whether there aren’t also issues where people are getting along*”. The participants thus described the concept of circularity which is central to systems theory: that an individual, through their interaction with a system, influences and is influenced by, the system (Goldenberg & Goldenberg, 1985). Individuals within a given system affect each other in a self-regulating and recursive manner (Nichols & Schwartz, 2006). Thus, in any system, information about past behaviours (feedback) is continuously fed back into the system in a circular manner thus creating a feedback loop (Becvar & Becvar,

2009). In this manner, and according to the cybernetics of cybernetics, the therapist is understood to be a part of the therapeutic relationship and is not an outsider that is exerting influence on the client in a type of one-up, one-down relationship (Hoffman, 1981). Thus the clinician's experience of managing juvenile bipolar disorder appears to be shaped by the interaction across different systems and subsystems.

### **A3. Management and Interventions**

This theme encompasses the participants' experiences and insights related to the management of juvenile bipolar disorder. In the pilot studies, both participants discussed the approaches that they have found useful in this area. Although this study does not seek to evaluate the specific interventions used by clinical psychologists in managing early-onset bipolar disorder, these will be outlined in the discussion as they form part of the rich experiences shared by the participants in this regard. Some of the interventions outlined herein reflect the current scientific approaches outlined in sections of the literature reviewed in chapter 2, however others are disparate and represent the relational clinical experiences of the participants. These experiences raise some salient points to be borne in mind by other colleagues when managing juvenile bipolar disorder across different contexts. The views shared herein suggest that there are a number of diverse approaches and interventions that are employed in the management of early-onset bipolar disorder and it also hints to the idea that this represents a dynamic area of mental health that is still in its early stages of development. Horn (2011) indicated that researchers are giving increased attention to the area of early-onset bipolar disorder and this is based on the understanding that the experience of an affective disorder during adolescence may adversely affect the social and educational functioning of the adolescent across different contexts. This theme and its related subthemes are illustrated in *figure 3 below: Management and interventions*.

**Figure 3: Management and Interventions**



### ***A3a. Management Approach***

Literature on the management of bipolar disorder points towards a multimodal and multidisciplinary approach (Weinstein, West & Pavuluri, 2013) that seeks to understand the client’s presentation in a holistic manner. In the pilot study, both participants highlighted the interventions that they have found to be effective when managing juvenile bipolar disorder. They suggested that a collaborative approach to management seems to be beneficial. This approach allows for greater integration of treatment interventions introduced by the multidisciplinary team which could potentially enhance treatment outcomes. For instance, the participant of the second pilot study stated, *“If they start becoming sleepy on the meds you can adjust the time that you see them for therapy or if you are aware their meds are being changed then you know you can expect that they may need some time to adjust sometimes”*.

Specific to this subtheme, participants suggested specific interventions that they had found to be useful when managing juvenile bipolar. This may support the idea of exploring current evidence-based interventions that are being discussed in the literature which may provide the therapist with guidelines on the current management strategies being employed by other

clinicians who manage juvenile bipolar disorder. This view is consistent with what was posed by participant 1, “*What I like about the literature though is that it supports this kind of thinking in juvenile bipolar ...*” In chapter 2, the call for pragmatic and evidence-based interventions in the management of bipolar disorder was discussed (Miklowitz, 2008). Miklowitz (2008) suggests that it may be useful to use an approach to therapeutic management that borrows from the medical model in its focus on well researched, evidence-based interventions with demonstrated efficacy (Miklowitz, 2008). During the interview, the participants explained that the most effective approach to managing juvenile bipolar disorder is to have a comprehensive understanding of the adolescent by consulting with the relevant healthcare practitioners that are part of the treating team and by referring to relevant literature sources that may assist in providing the most appropriate and effective treatment methods. In pursuing evidence-based therapy, Kowatch et al. (2005) suggest the use of psycho-education, skill building (especially related to communication and skills related to problem-solving in regard to symptom management, emotion regulation and impulse control) as effective means of assisting the adolescent once they are stable on medication.

### ***A3b: Interventions used by Clinical Psychologists in Managing Adolescents Diagnosed with Bipolar Disorder***

The aim of the current study was not to assess the specific interventions used by clinical psychologists in managing juvenile bipolar disorder but rather to explore their experiences in managing the disorder. Therefore, an in-depth analysis of the proposed interventions used by the participants in managing this disorder is not provided. Rather, the discussion which is presented in this section represents a partial arc of the overall experiences of the participants in managing juvenile bipolar disorder.

In discussing the study topic, the participants shared experiences of managing juvenile bipolar disorder in their specific contexts. Participant 1 found it beneficial to use both behavioural and systems approaches when managing juvenile bipolar disorder. The goals established by this framework are that cognitions, feelings and behaviours influence each other in a circular manner and thus, the therapist plays a role in identifying unhelpful thought patterns and facilitating a more functional and helpful way of thinking in certain situations (Australian Psychological Society, 2010). Studies have suggested that the use of behavioural

approaches may be useful in the management of bipolar disorder, and Hirschfield et al. (2002) suggest that this approach is particularly useful in the management of the depressive episodes in bipolar spectrum disorders when used in conjunction with pharmacotherapy. For participant 2, behavioural approaches, including DBT were found to be useful in that the adolescent “*can start to identify the problematic thoughts that then influence their behaviour and if they can identify those, it can have a positive impact on how they manage those*”. Having originally been designed for the therapeutic management of borderline personality disorder, Renk et al. (2014) suggest that DBT may prove to be an effective approach to managing juvenile bipolar disorder. Renk et al. (2014) discuss a one year, open-trial conducted by Goldstein et al. (2005), in which DBT with family skills training and individual therapy was demonstrated to be highly efficacious in the management of juvenile bipolar disorder in that it improved symptoms such as suicidality, self-injurious behaviour, emotional dysregulation, and depressive symptoms. Here, distraction techniques are taught as a means of managing overwhelming emotions (Myrick, 2010). The four basic skills taught in DBT include mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness (Australian Psychological Society, 2010). This approach was found to assist adolescents to be more vigilant of their symptom presentation, as was highlighted in the second pilot study. Participant 1 considered CBT to be an effective approach that assists parents to become more containing for their child and for themselves when the child experiences a manic episode.

The implementation of interventions that focus on the interaction between parents, family members and members of other systems with which the adolescent is in contact, is consistent with the suggestions made by Kaslow et al. (2012) in chapter 2. The participants noted that, in their experience, it is useful to involve the family in the management of juvenile bipolar. This approach acknowledges bipolar disorder as not only impacting on the individual but the family as a whole. Typically, this would include the adolescent’s family of origin, caregivers and/or extended family and generally, those individuals with whom the adolescent is in a continual and recursive interaction. With that, the first participant mentioned that a systems approach which takes into account the interaction of the different family members and the impact that this has on the bipolar presentation of the diagnosed adolescent, is integral.

The use of expressive arts therapies is supported in various texts on the management of various mental disorders affecting adolescents. In this study, it was proposed that art therapy may be used as a means of allowing the adolescent to define their experiences of bipolar disorder from their own worldview. One participant stated, *“I also do art therapy to help them express their pain and I encourage them to use it in their own space”*. Malchiodi (2005, p. 72) explains that, *“At a basic level, making an image concretizes and externalizes a problem”*. The author explains that art therapy focuses less on the artistic product that is created and more on the therapeutic process (Malchiodi, 2005, p. 1), and that this is an effective means of managing various mental illnesses, including bipolar disorder. In addition, it appears that the participants also found narrative therapy to be a useful means of facilitating self-expression in therapy. This approach is concerned with the narratives that individuals use to describe their experiences (Australian psychological society, 2010) and was found, by participant 2, to be helpful in assisting the adolescent and therapist to externalise the illness and thus communicate about it in a less pathological manner.

The Australian Psychological Society (2010) explains that psycho-education- although not a form of therapy- involves the dissemination and explanation of information to clients regarding illnesses and it includes information that is aimed at enhancing their understanding of the illness and other aspects related to its causes, effects and implications. The participants found this to be beneficial in assisting the adolescents to play an independent and responsible role in the management of their illness (participant 2). An example of where this could be useful is provided by participant 1: *“I also teach them to recognize the prodromal symptoms”* which allows the adolescent to be more accountable for their own wellbeing by taking the necessary steps to seek help when certain symptoms present. The participants also spoke about the use of psycho-education to inform parents about the complexities of the disorder and also on ways that they can provide support for the adolescent. Participant 1 cautions, *“they must also be aware of the changes that can happen in their own relationships”*, thus emphasising the possible impact of bipolar disorder on the family as a whole.

Phase-specific interventions were discussed as an effective approach to managing specific episodes. The first pilot study revealed that this approach may be an effective means of management as it is sensitive to the current episode of bipolar. This is consistent with the recommendations made by Miklowitz (2008) who suggests that *“management protocols may*

differ depending on the stage of the patient's disorder". The first participant noted that interventions tend to be more effective if introduced during the depressive phase of bipolar or when the individual is euthymic, as this is likely to improve their response to the intervention. Miklowitz (2008) also calls for practical trials that establish whether "for example, that acutely manic patients need to be adequately stabilized with pharmacotherapy prior to the initiation of psychosocial interventions, whereas acutely depressed patients may benefit from the simultaneous initiation of drug and intensive psychosocial treatments". An approach that is sensitive and specific to each episode and phase of the disorder may thus be beneficial.

### ***A3c. The Therapeutic Relationship***

The participants highlighted the significance of the therapeutic relationship and how this influences their experience of managing adolescents diagnosed with bipolar disorder. At the beginning of the active phase of the illness, the second participant explained the need for the adolescent to be in a contained, unthreatening environment, and that it is usually not useful to challenge the adolescent at this time. The participant described the importance of exploring what living with the bipolar disorder label means to the adolescent. This allows the therapist to understand the adolescent's self-perception as described from their worldview. Rogers (1980) explains that this fosters a sense of empathy in the therapeutic relationship, as the therapist listens sensitively and actively to the client and senses the client's feelings. The first participant added, "*Letting them know that in your experience you've seen how difficult it is for patients to comply with their treatment*", which emphasises the importance of assuming an empathic stance toward the adolescent. This approach also allows the adolescent to know that there is a shared experience among others who receive this diagnosis. The therapist also seeks to understand how the adolescent is affected by the ongoing and multifaceted management of their illness.

## **5.4.2 Integration of Results from the Pilot Study**

In summary, the pilot studies were found to adequately represent what the researcher was exploring and thus, further interviews were conducted. When asked about potential questions that could be used to adapt the structure of the interviews, one participant mentioned the

importance of identifying the role of trauma in the diagnosis of juvenile bipolar disorder. This was based on the participant's experience of adolescents who had been exposed to traumatic experiences and presented with mood symptoms that appeared similar to those of juvenile bipolar disorder. This suggestion was considered by the researcher however it was not included in the interview structure, since this would have compromised the open-ended and non-directive structure of the interviews.

#### **5.4.3 Section B: The Main Study- Presentation and Discussion of Identified Themes**

Following the pilot studies, four participants were interviewed. For the sake of clarity and ease of referencing, this section, and the information that was derived from it, will be referred to as the main study. The main study focuses on the experiences of four clinical psychologists in managing adolescents diagnosed with bipolar disorder. The discussion that follows forms part of *Section B* of the study.

The four clinical psychologists that formed part of the main study were recruited from private practices in the Johannesburg area. The participants were interviewed individually in their respective practices. As discussed in chapter 4, this study followed a qualitative approach and utilized thematic analysis to organize the information obtained from the participants into their relevant main themes and subthemes and these are presented and discussed in the sections that follow below. The themes and subthemes were extrapolated using the methods outlined by Braun and Clarke (2006) which were discussed in greater detail in chapter 4.

Under the headings of each of the main themes, their respective sub-themes are integrated and discussed. Diagrammatic illustrations of the themes and subthemes are provided in *figures 4, 5 and 6*. The participants had each been exposed to cases of juvenile bipolar disorder although the extent of this was varied. Each presented their ideas about the management of this disorder as it relates to their specific context. There were several commonalities among the experiences shared by the participants with few unique findings. In

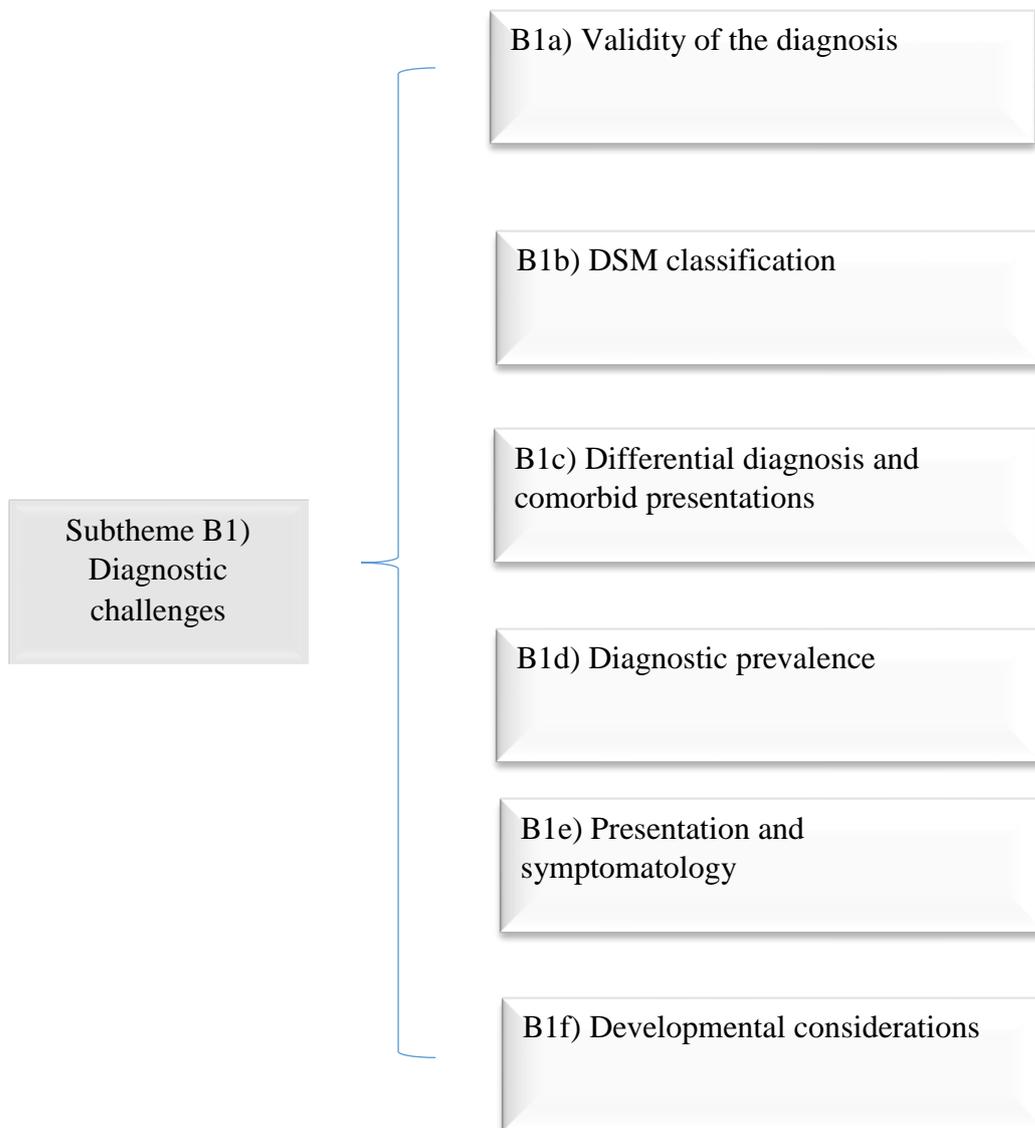
this regard, the main themes comprised of the following aspects: *Diagnostic challenges, external influences and management and interventions.*

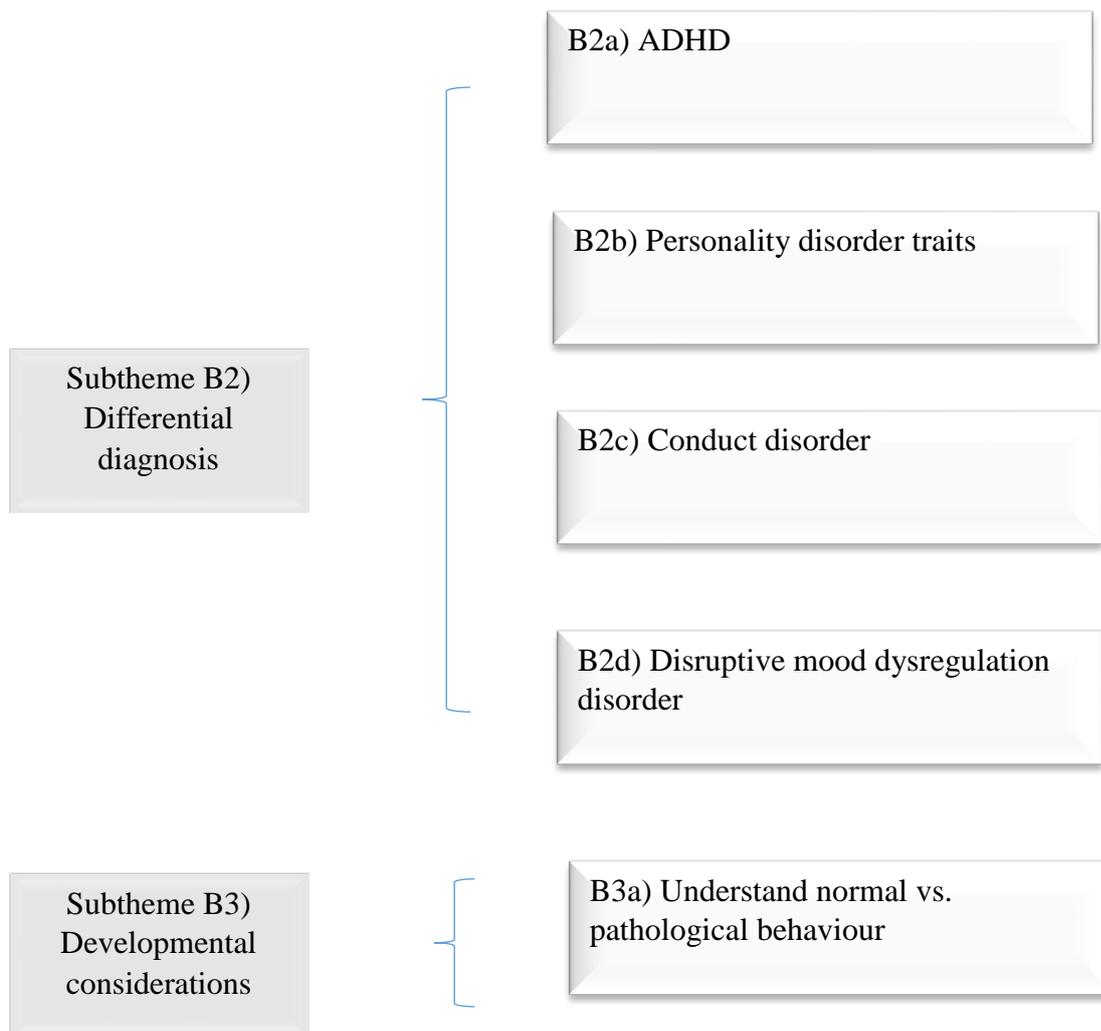
## **B1. Diagnostic Challenges**

The first superordinate theme is concerned the participants' experiences of diagnosing early-onset bipolar disorder. This study yielded similar findings to those presented in chapter 2 regarding the conceptual challenges related to the classification and definitional problems associated with early-onset bipolar disorder. The study supported the notion that juvenile bipolar disorder may be difficult to diagnose accurately and this was attributed to various influences. This theme was identified as a significant component of the management process by the participants as it was related to the operationalization of early-onset bipolar disorder. The participants indicated that, because of the challenges associated with making a diagnosis of bipolar disorder in adolescents, this has some bearing on how they manage adolescents who present with bipolar-type features. This seems to be of relevance particularly in instances where a participant works in conjunction with a multidisciplinary team in contexts such as inpatient facilities where, at times, there may be differences among members of the treating team in terms of their approach towards juvenile bipolar disorder. Under this theme, participants' reflections regarding the diagnostic challenges associated with juvenile bipolar disorder are discussed. In chapter 2, the classification of bipolar disorder was discussed according to the different publications of the DSM and the changes were mapped from the period of its description as a loss of touch with reality to the period where its description was expanded to include more differentiations (Flores de Apodaca and Burza, 2012). These changes suggest an increasingly identified complexity associated with making a diagnosis of bipolar disorder across all age groups. Flores de Apodaca and Burza (2012) share the view that there has been an overexpansion of the diagnosis of bipolar disorder as a consequence of managed healthcare and its economic incentives to some remunerable diseases/conditions. With these challenges, Parens and Johnston (2010) elaborate that international studies make a call for clinicians to have a greater understanding of the symptomatology of bipolar disorder among children and adolescents in order to have diagnostic clarity and, in so doing, to curb the scourge of inaccurate or invalid diagnoses.

The difficulties associated with making a diagnosis of juvenile bipolar disorder were highlighted by all of the participants as each shared their ideas about the considerations to be made when making such a diagnosis. The uncertainty surrounding the accuracy of making a bipolar diagnosis in adolescents was evident in the statement, “*Because while I have a fair number of bipolar cases in adolescents I mean, I often ask myself how accurate that is*” (Participant 2). This speaks to the definitional issues related to early-onset bipolar disorder that were raised in the study. In defining early-onset bipolar disorder, Sullivan and Miklowitz (2010) indicate that its associated symptoms present prior to late adolescence and that these are often characterised by mixed episodes, rapid-cycling, various comorbidities and treatment-resistant presentations of the disorder. In chapter 2, it was presented that these different components may account for the numerous complexities associated with making a diagnosis of bipolar disorder among youths. Participant 1 cautioned against making a hasty diagnosis of juvenile bipolar disorder and this is illustrated by the statement, “*...until you can decide definitively over time what’s happening*”. Thus, the suggestion made by this participant is that of a provisional diagnosis in cases where there are bipolar disorder features present but where there is insufficient information to make a more accurate diagnosis. The participant also makes a call for clinicians to reassess their evaluation periodically. In describing some of their diagnostic considerations, the participants discussed various features that share commonalities with early-onset bipolar disorder. Participant 3 stated, “*and obviously you have to make sure that the irritability isn’t caused by something else*” and it was further explained that, “*...you must be aware that when a child has ADHD they will often become irritable*”. This highlights the symptom overlap shared by a number of childhood mental disorders. These are discussed further under the main theme *differential diagnosis*. Figure 4 illustrates this theme and its related subthemes which are discussed in the section that follows.

*Figure 4: Sub-themes related to the main theme: Diagnostic challenges*





The subthemes that will be discussed under the main theme *Diagnostic challenges* include: validity of the diagnosis, DSM classification, differential diagnosis and comorbid presentations, diagnostic prevalence, presentation and symptomatology and developmental considerations.

### ***B1a) Validity of the Diagnosis***

This subtheme refers to whether the participants consider their diagnoses of juvenile bipolar to be accurate in light of the possible comorbidities other mental disorders as well as other related presentations that are common in adolescents. In the cases of some participants, there appeared to be some doubt related to whether the cases of juvenile bipolar disorder that they

were managing or had managed previously fulfilled the criteria for such a diagnosis. They gave various examples related to this. Participant 2 stated, “*Because while I have a fair number of bipolar cases... in adolescents... I often ask myself how accurate that is*”. With this, the third participant identified that there may be instances where the most symptomatic behaviour will be seen by the adolescents’ families and that this may lead to an inaccurate diagnosis being made initially. The statements, “*I think a lot of the time, the more manic behaviour will be seen by families as the child being wild*” and “*one of the other challenges is that unfortunately a lot of the time, they will first be diagnosed as depressed before the bipolar is identified*” (Participant 3) suggest that the presentation may differ between contexts and that, owing to this, the features of bipolar disorder may be missed resulting in an initial diagnosis of depression. Kernberg and Yeomans (2013) note that, while the distinctiveness of manic symptoms make the differentiation of bipolar disorder from other mental disorders easier, differentiating between hypomanic and borderline personality symptomatology remains a challenge. With this, the authors reflect that there are common errors made by clinicians in distinguishing between chronic emotional instability and bouts and affect dysregulation (Kernberg and Yeomans, 2013). It therefore appears that, in their experiences of managing juvenile bipolar disorder, clinicians may be presented with similar diagnostic challenges that have impeded clinicians from making these diagnostic differentiations as was presented in the review of the literature in chapter 2.

### ***B1b) DSM Classification***

The classification of juvenile bipolar disorder was described by the first participant as being vague. This vagueness is evident in the statement, “*The DSM seems to...not be as clear*” which is later contradicted by the statement, “*I think there’s some cases that are very clear*” (Participant 1).

The participants indicated that working within a multi-disciplinary team in which the ideas of one clinician may supersede those of the other, may present a challenge. The National Institute for Health and Clinical Excellence (NICE) guidelines (2006) recommend that, when diagnosing bipolar disorder in adolescents, the same criteria should be used as when diagnosing adults. However, because the diagnostic criteria are not well established for the

diagnosis of bipolar II in children and adolescents, such a diagnosis should not be made routinely. The experience of managing juvenile bipolar disorder may thus be complicated by differences in clinical opinion and judgement. Presently, it seems that this challenge of making a diagnosis of bipolar disorder in youths remains (Renk et al., 2014).

### ***B1c. Differential Diagnosis and Comorbid Presentations***

In their experiences of managing juvenile bipolarity, the participants had each encountered instances of unclear bipolar-type features that could potentially be attributed to another mental condition or due to psychosocial factors or other stressors. Geller et al. (2002) maintain that ADHD has been a major differential problem in early-onset bipolar disorder. This differential challenge was described by the first participant who stated, *“it could fall under all sorts of difficulties... sort of hypermanic could be an ADHD”* and, added to this, *“a very anxious child can...sometimes present as being sort of quite agitated and manic.*

The participants discussed the importance of ruling out other possible diagnoses when considering a diagnosis of early-onset bipolar disorder due to the common symptoms shared by various mental illnesses. All of the four participants mentioned that personality disorder traits often mimic the presentation of bipolar features in youths. Commonly, cluster B personality disorder traits were mentioned in this regard, with borderline personality traits being the most commonly discussed personality features and with a mention of histrionic personality features that may also present in a similar manner (*“predominantly the borderline but also the histrionic”*, Participant 2). This is not different from what was noted by Fonseka et al. (2014), that the borderline personality and bipolar disorders share common features which include emotional lability, impulsivity irritability, anger, unstable interpersonal relationships and feelings of emptiness and suicidality which may account for why some studies have reframed borderline personality as part of the bipolar disorder spectrum. Bradfield (2010) also highlights the connection between borderline personality disorder and the experience of trauma in the early attachment years and how, in the first 18 years of life, a failure to develop those right brain structures that are involved in the regulation of emotion may result in the poor emotional regulation that is typically observed in a borderline or bipolar presentation. This is closely related to the experiences of participant 4 who stated, *and*

*it could also be trauma-related. So as a result of some or other trauma that the teenager experienced as a child or more recently*". In chapter 2, psychoanalytical theories of child development were discussed. Herein, Freud's view that the ability to deal with negative feelings is fixed within the first six years of an individual's life (Corey, 2005), is central to the ideas posed by participant 4. This illustrates the pivotal role played by childhood experiences in the display of emotional dysregulation during adolescence as was described by the participants.

Although irritability is a common feature in early-onset bipolar disorder (Gudienė et al., 2008; Faust et al., 2006), it is not a unique feature of the disorder. In chapter 2, it was stated that Faust et al. (2006) suggest that when the symptoms of bipolar disorder precede or follow the onset of puberty, they may occur concomitantly with disruptive behaviour disorders. Participant 2 alluded to the idea that there may be presentations of ADHD which share common features of early-onset bipolar disorder. This participant stated, "*so you must be aware that when a child has ADHD they will often become irritable, or if they have another disorder like oppositional defiant disorder which is there as well or conduct or something*". The participant went on to say, "*so if irritability is there you know you should start looking more at personality traits and possibly a personality disorder at a later stage*". The third participant cautioned that it is important to explore the cause of that irritability as it may not necessarily be a symptom of bipolar disorder. It is also essential that the clinician monitors the pervasiveness of the irritable mood as it may be an indication of, for instance, a personality disorder feature such as a borderline or histrionic personality structure, or neurological difficulty. This is depicted by the statement, "*if, in sort-of middle to late adolescence, the mood is still predominantly irritable then I would consider something else like a neurological problem or some other psychiatric disorder rather than a bipolar*". Here, the pervasiveness of the symptoms is another feature that it added to the considerations that the clinicians seem to make when managing adolescents diagnosed with bipolar disorder. Monitoring the duration of the symptoms may also be useful in ascertaining if the mood is caused by the effects of a substance, in which case the symptoms should resolve following the alleviation of the effects of the substance.

In describing the similarities between personality disorders and bipolar disorder presentations, participant 1 indicated that, at times, an adolescent with emerging borderline personality disorder traits may present with features similar to bipolar disorder. This participant cautioned that such cases may actually be indicative of affect dysregulation difficulties rather than bipolar disorder. However, it has been previously posed that clinically significant personality features occurring during adolescence and young adulthood may, in fact, be indicative of the onset of bipolar disorder (McKinnon et al., 2013) and thus, a clinician may require a more conservative approach to identifying the symptoms of bipolar disorder, more so in this population group. The first participant suggested: *“I think under the circumstances the best thing is to make a provisional diagnosis”*. These experiences point to the idea that early-onset presentations of bipolar disorder continue to present a diagnostic and treatment challenge.

### ***B1d) Diagnostic Prevalence***

The diagnostic prevalence of early-onset bipolar disorder is discussed in the literature. According to the findings of Merikangas et al. (2011) presented in chapter 2, there has been a global increase of bipolar disorder diagnoses among adolescents, with up to 59% experiencing their first episode before the age of 18 years. The findings of this study indicate that the participants' ideas around the prevalence of juvenile bipolar disorder were varied. Participant 2 seemed not to agree with the statistics reported in recent literature indicating the increased number of new diagnoses of early-onset bipolar disorder (Meyer & Carlson, 2008). According to this participant, *“I'm guessing they'll agree that, in its purest form, maybe not as high as some of the studies are showing”*. In accounting for this discrepancy, Flores de Apodaca and Burza (2012) suggest that this increase results from the over-diagnosing of the disorder among youths. This is more in line with what the participants of the current study described: that while there has been a relative increase in the number of early-onset bipolar cases that they have managed, this results from the over-diagnosis of the disorder and the reasons for this are dealt with throughout this study. In the experience of participant 3, *“I am seeing more cases of bipolar in adolescents and very few in children but it's there”*. The participant elaborated that there has *“definitely been an increase in the number of cases of children and adolescents with bipolar in the past few years”* and that this spans across gender

and race. This view is in line with that of those researchers who suggest that the onset of bipolar disorder is predominantly before the age of 20 years (Diler & Birmaher, 2012) with little specificity for or variation in gender (Costello et al., 2002). Participant 4 reported a distinct increase in the number of juvenile bipolar cases: *“I must say, I do see it in my practice and relatively prevalently so I would say if I see 10 teens, 3 or 4 have bipolar”*. This raises the question whether the context plays a role in the identification and prevalence of early-onset bipolar since the increase in early-onset bipolar cases was reported by those participants whose practices exposed them to a combination of inpatients and outpatients. The findings of the study seem to raise more questions about the incidence of juvenile bipolar disorder in South Africa and whether the findings in different clinical contexts represent the increased prevalence reported in the literature or whether this is due to the over-diagnosis that results from inaccurate diagnoses.

### ***B1e) Presentation and Symptomatology***

During the interviews, each participant shared their views regarding the presentation of juvenile bipolar disorder. With this, they discussed the symptom clusters of early-onset bipolar disorder as well as how these are likely to present. In chapter 2, different views were offered by a number of authors who delineated the presentation of the disorder across age groups. The contention of some of these authors is the age at which the symptoms of early-onset bipolar disorder begin to resemble those of adult presentations. In this study, the participants' ideas about the stage at which the classic bipolar disorder symptoms typically present, was varied. For participant 2, *“...the older adolescents, sort-of 17 or 18 will start to present with the classic manic and depressive episodes”*. In contrast, participant 4 stated, *“I'd say it's prominent in the pre-teen phase to...early adolescence, so from around age 11/12 to around 15, 16 in some. But in many instances it starts from a young age”*. These views begin to depict the discrepancies represent the lack of a tangible definition of early-onset bipolar disorder in the literature. Renk et al. (2014) proposed that the more classic pattern of symptoms is observable from the age of around 9 years however, participant 4 indicated that, when this presentation occurs at a young age, *“they could have had some kind of psychological problem or mental disorder from a young age or a mood disorder that presents with irritability or just some other difficulty...”* Participant 3 suggested that the

clinician should monitor the pervasiveness of the symptoms and that a diagnosis of bipolar disorder should be made only once the behaviour has been shown to be pervasive later into puberty and that it has been shown to extend across contexts while, in chapter 2, Saunders and Goodwin (2010) emphasise the importance of the age of the first hospitalization in determining the age at onset of early-onset bipolar disorder. These views highlight the variability in the clinical presentation of the symptoms of early-onset bipolar disorder.

When describing the features of early-onset bipolar, the first participant suggested that, in most instances, “...*the presentation is with depression first*”. This participant remarked that it is uncommon for adolescents to present first with manic symptoms: “...*it’s very unusual they’ll initially present with a manic phase which is often the way that mania displays itself in adolescence not so much the sort-of ebullient high, sort-of laughing, joking picture of mania but more... irritability and agitation*”. Not uncommon to the experience of a depressive episode, the adolescent is likely to experience anhedonia which, according to participant 4, is usually associated with, “*the child...isolating themselves from others or they will lose interest in their sporting or school activities...*”

In addition, the significant impact on the adolescent’s neurovegetative functioning was highlighted: “*generally they will start off ...poor concentration, changes in appetite, changes in engagement in terms of their interests*” (participant 1). Gudienè et al. (2008) suggest that, when adolescents do present with manic symptoms, these usually involve irritability as a common feature. They further elaborate that these manic symptoms are usually associated with extremely impairing, dysphoric, explosive episodes that are often a daily occurrence and arise without a precipitant. Participant 4 alluded to these explosive episodes, stating that the more prominent, frequent and impactful these are, the more indicative they are of “...*bipolar or at least a mood disorder*”. Faust et al., (2006) extend this discussion by suggesting that, when bipolar disorder symptoms precede or follow the onset of puberty, they are also often associated with periods of continuous, rapid-cycling and mixed episodes that may co-occur with disruptive behaviour disorders. This behaviour, according to participant 4, becomes “...*prominent across various contexts*” and is more likely to be reported across different contexts including the home and school environments. Participant 4 added that the “*frequency of the mood swings and the intensity as well as...how it impacts on their daily*

*functioning is what gives an indication of whether you're dealing with bipolar or at least a mood disorder".* The third participant explains, *"during an episode they will start with eccentric behaviour like they will start staying up, so a reduced need for sleep... they will start misbehaving, doing things are out of the ordinary behaviour..."* In chapter 2, Carlson (2012) proposed that the clinician's approach impacts on the management of juvenile bipolar disorder in that a more conservative approach considers the presence of clear episodes that are distinguishable from the individual's usual functioning, while a more liberal approach looks at severe emotional dysregulation or temper outbursts or irritability as a diagnostic factor.

The views expressed both in the literature and by the participants of this study suggest a broadness in the ideas surrounding the presentation of early-onset bipolar disorder. They also seem to illustrate the call made by numerous authors for greater attempts to further operationalize and refine the definition of early-onset bipolar disorder so to better identify those behaviours that are typical of early-onset bipolar. With this, Carlson (2012) advised that it should be borne in mind that children and adolescents may not be able to provide an adequate or comprehensive description of their symptoms and that this could also account for the discrepancies in the symptom clusters described herein.

### ***BI(f) Developmental Considerations***

As stipulated by Keenan (2002), the term *development* has been used to describe patterns of change over time beginning at conception and continuing throughout the lifespan. These changes occur in biological, social, emotional and cognitive domains (Keenan, 2002).

Definitions of human development which are provided in more detail in chapter 2 of this study, define adolescence in terms of age and relative independence from parental sanctions (Saffer & Kipp, 2010) and as a social process in which the family is an integral part (Carr, 1999). The stages of development are described along a continuum in which specific skills that enable an individual to navigate successfully through life, ought to be acquired (Corey, 2005). Findings from this study indicate that all four of the participants considered adolescence as a developmental stage that is critical in the definition of juvenile bipolar

disorder. With this, the participants recognised the importance of differentiating pathological behaviours from those that may be attributed to developmental factors. The role of attachment in the development of affect regulation is described in chapter 2. A secure attachment results when the biologically-driven need for a continuous and close relationship with a primary caregiver is adequately met (Sadock & Sadock, 2007). The importance of attachment relationships was raised by two participants in the present study. Participant 1 mentioned, “*were there attachment difficulties; was there separation anxiety, is there trauma, is there a history of abuse...*” suggesting that a presentation of bipolar-like features in adolescence may result from a deficiency in this area. The participant added that, at around the age of 20, the difficulties with emotional regulation may, at times, resolve. Participant 2 illustrated that, the adolescent may, at times, adopt a defensive stance when faced with life challenges during which they “*become suicidal, thinking that the whole world is against them*” and this may result in impulsive reactions in certain circumstances during which the adolescent is in distress. In this case, the participant suggests a more conservative management approach which considers that an adolescent’s behaviour may be coupled with their inadequately developed coping skills. Participant 2 suggested that the clinician is better able to gauge the adolescent’s personality at around the age of 15 years and thus should be allowed time to transition into puberty before a diagnosis of bipolar disorder is made.

The participants raised the idea that, because adolescence is an integral part of the manifestation of an individual’s personality, difficulties in this regard are likely to emerge during this developmental phase. In this regard, salient aspects of both developmental psychology and psychopathology must be considered when managing this disorder. Each participant alluded to the idea that adolescence is a period that is characterised by the definition of oneself in relation to one’s environment and that it is during this time that the adolescent tests boundaries. In addition, according to participant 4, “*the girls I get referred come to me at around 14 ...and the boys is more 16... is the difficult period*”. However, this may not necessarily represent the onset of symptoms but it may point to psychological help-seeking behaviours across genders as well as family and social environments.

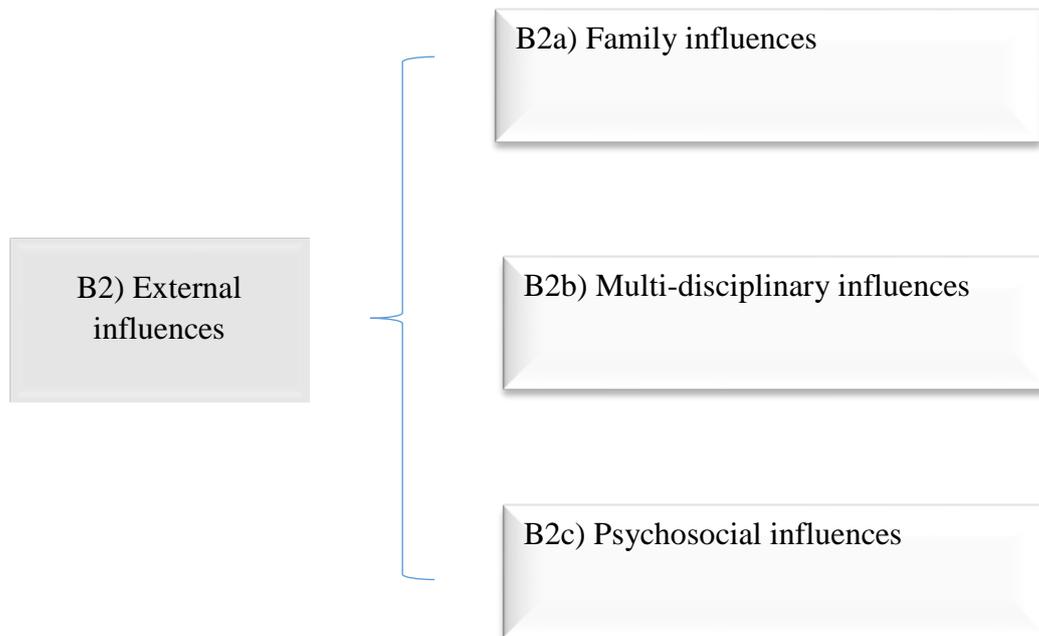
Overall, this theme and its subthemes outline the developmental considerations and definitional challenges related to early-onset bipolar disorder. The participants appear to

make various considerations regarding the validity of their diagnoses when managing early-onset bipolar disorder and this is associated with taking the necessary steps to differentiate this disorder from others which may present in a similar manner.

## **B2. External influences**

Considering the impact of juvenile bipolar disorder on the adolescent's global functioning, researchers have sought to explore the role played by life events on the course of the illness (Kemner et al., 2015). Life events are related to environmental factors that play a role in the onset and course of mood disorders (Kemner et al., 2015). In the current study, the impact of environmental factors that may influence the management of juvenile bipolar disorder were discussed by each of the participants. These are referred to as *external influences* for the purpose of this study and are illustrated in *figure 5* below. This theme encompasses peripheral elements and the interplay between the clinical psychologist and the systems with which the clinician interacts while managing adolescents who have been diagnosed with bipolar disorder. These elements include the role of healthcare funders, family, multidisciplinary teams and other psychosocial variables that may have a bearing on how clinical psychologists experience the management of juvenile bipolar disorder. The participants alerted that clinicians must be sensitive to these influences as they may further obscure the management process. Some of the complexities related to juvenile bipolar disorder that were raised in chapter 2 include the complications in family interactions, peer relationships, academic performance, chronicity of mood symptoms, the complexity of its presentation, symptom overlap, associated comorbidities, increased hospitalizations and increased risk of suicide (Diler & Birmaher, 2012). These influences hold salience in this section. The insights gained from the subthemes that emerged from this theme are that the impact of bipolar disorder extends beyond the individual who is diagnosed with the disorder and thus, it seems mandatory for clinicians to hold this in mind when managing juvenile bipolar disorder.

**Figure 5 External Influences**



***B2a. Family influences***

The participants acknowledged the potential impact that a diagnosis of juvenile bipolar may have on the family and how this may, recursively, impact on the therapeutic process. This, according to the first participant, may, *“have quite a knock-on effect”* in the sense that the parents may experience other difficulties which are related or unrelated to the diagnosis, which may impact negatively on the manner in which they provide support to the adolescent. The participants indicated that it is beneficial for the therapist to understand these potential influences and how they may potentially influence their management of juvenile bipolar disorder. Participant 3 stated, *“You must step into the worldview of the family as a system and that is when you understand it better,* which illustrates the importance of this awareness.

The first participant suggested that it is important to identify where a caregiver is experiencing difficulties that may impact negatively on the adolescent's therapeutic process and to be able to refer the caregiver for their own therapy or treatment elsewhere. The participants noted the potential struggle that parents may have in accepting the adolescent's diagnosis as well as the impact of such a diagnosis on the family as a whole and they indicated that it is helpful for the therapist to acknowledge the difficulty of this diagnosis when speaking to the parents and families so as to facilitate a sense of acceptance and a level of reassurance.

### **B2b. Multi-disciplinary influences**

The influence of the context in which the therapist functions has been highlighted previously. Participants identified that working within the context of a multidisciplinary team may have a bearing on how the therapist navigates through the process of diagnosis and management of juvenile bipolar disorder. In this regard, it emerged from the study that there are times when clinicians' approaches to juvenile bipolar disorder may vary considerably.

Another view presented by the participants is that, in their experience, it is necessary to work together with other healthcare professionals in the management of juvenile bipolar disorder. This approach ensures that the management process is a well-integrated one that seeks to provide the most benefit to the adolescent.

### **B2c. Psychosocial Influences**

The participants indicated that, because the period of adolescence is marked by various psychosocial challenges, it is useful for the therapist to understand how these could potentially influence how the adolescent responds to the management process. The fourth participant illustrated the extent of these challenges in the statement, "*...because that's the thing is the burden of it. On them, on their academic lives, on their families their*

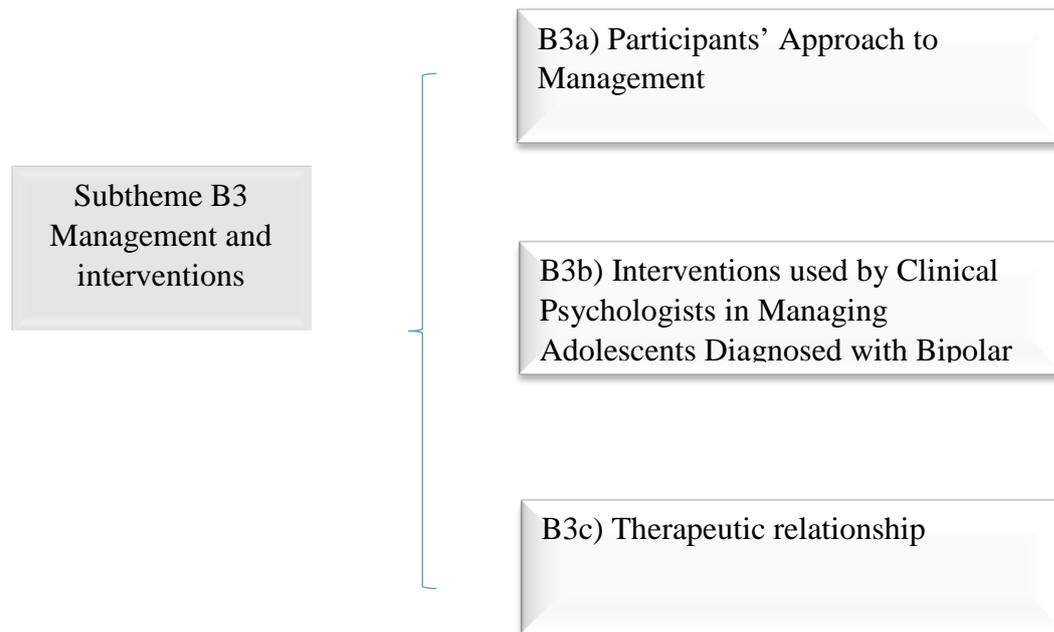
*relationships with others*". This indicates that the management of juvenile bipolar disorder requires a holistic approach that considers the different areas of the adolescent's life.

Psychosocial interventions also play a role in curbing the impact of environmental influences, which are essential in "determining whether an individual at risk develops bipolar disorder, and the timing, frequency, and polarity (depressive vs. hypomanic/manic) of his/her bipolar episodes" (Ellicott, Hammen, Gitlin, Brown, & Jamison, 1990; Nusslock, Abramson, Harmon-Jones, Alloy, & Hogan, 2007). Thus, numerous texts have emphasised the role of effective psychotherapeutic interventions to be used as adjunctive interventions in the management of bipolar disorders.

### **B3. Management and Interventions**

It is important to echo that the current study did not purport to evaluate the methods employed by clinical psychologists in managing juvenile bipolar disorder but rather to gain a comprehensive understanding of their *experiences* of managing the disorder. Thus, comprehensive guidance of the management of juvenile bipolar disorder is beyond the scope of the current study. This section follows the experiences shared by the participants on the interventions that they have found to be of benefit when managing juvenile bipolar disorder. The basis of this discussion was not to discuss the merits of these intervention but to situate them within the context of the overall experiences of the participants. The participants discussed their preferred approach to managing juvenile bipolar disorder and the findings suggest that there are various similarities between the participants' responses and what is stipulated in the reviewed literature in chapter 2. The sub-themes that comprise the *Management and interventions* theme include: *Participants' approach to management and interventions used by clinical psychologists in managing adolescents diagnosed with bipolar disorder* and are illustrated in *Figure 6*.

**Figure 6: Management and Interventions**



***B3a. Participants' Approach to Management***

This sub-theme encompasses the participants' approach to managing adolescents diagnosed with bipolar disorder. It is related to the stance assumed by clinicians when managing this disorder. With this, the third participant spoke about a collaborative approach in which the clinician works together with family members and other individuals that may play a significant role in enhancing the management process for instance, by providing relevant collateral information that may assist the clinician. This is closely linked with the suggestion made by participant 4 in which the participant referred to the significance of working together with other members of the treating team. This is illustrated by the statement, *“Talk to other psychologists who see teenagers with bipolar and find out how they are managing them”*. In

addition to this, the participant suggested, “...start some sort of journal club where these issues can be discussed”. This points to the need for continuous re-evaluation of the practices employed to manage this disorder. Related to the suggestion that the clinician work with other members of the treating team, the first participant added that, in addition to consulting with other professionals, the clinician may also consult with teachers and family members who would also be able to provide useful collateral information about the adolescent when necessary. The participant explained, “...if the child has been assessed previously, to see those reports, so to have a sense of looking at the child, where they’ve come from, where they are now...” This collaborative and multidisciplinary approach allows for a more comprehensive intervention strategy which allows for a greater level of cooperation in the management process, early detection and management of symptoms and more efficient sharing of relevant information. The participants advocated the use of this approach as it engages the adolescents and their parents in the management process as a means of assisting them to independently identify the warning signs during the active phase of the illness. The therapist is also able to alter their management in response to, for instance, the adolescent’s response to pharmacological intervention and thus it involves constant interaction with the adolescent, their families, and other professionals.

The role played by the family in the management process was considered by the third participant who indicated, “So periodically I will discuss ways that they can continue assisting their teen at home...” This participant emphasised the importance of working together with the family to enhance the therapeutic benefit for the adolescent. The participant also indicated that it is essential to partner with families as this facilitates a more integrated therapeutic process. The participant stated, “The families to provide you with feedback...” which illustrates the important role played by family members in providing the necessary supportive structure and containment for the adolescents. In this regard, the family members are able to give necessary information to the clinician related to the changes in the adolescent’s behaviour that may be evident at home and in other contexts such as school. The information provided by families was perceived by this participant as being a reliable source of collateral information. The statement, “and the parents will tell you, I find they are such a reliable source of information that I can’t imagine working without them” illustrates this position. With regard to the information supplied by family members, participant 3 stated, “parents and caregivers are so important in telling you if the mood symptoms and subsequent

*behavioural problems are pervasive, if they happen only in certain instances, or if they are transient*” The views of this participant are consistent with the family systems perspective introduced in chapter 2, which considers interrelatedness of people and things (Rasheed, Rasheed & Marley, 2011). In addition, Kowatch et al. (2005) pose that information supplied by the family is crucial in assisting the clinician in the diagnostic process and in identifying if there are other untreated and often undiagnosed comorbid disorders. The authors advocate that a therapeutic alliance is essential when working with adolescents diagnosed with bipolar disorder and their families (Kowatch, 2005).

Participant 3 also indicated the importance of relieving parents of the guilt that often arises when a child is diagnosed with bipolar disorder. The participant stated, “...*to help them find a way to remove the guilt and shame that comes with the diagnosis sometimes and also lessen the burden of the illness on the person and the family...*”. According to this participant, parents can, at times, inadvertently influence the adolescent’s therapeutic process because of their own struggle to accept that the adolescent has received this diagnosis and this also illustrates the interrelatedness of family members and the impact that each has on the other.

### ***B3b. Interventions used by Clinical Psychologists in Managing Adolescents Diagnosed with Bipolar disorder***

As mentioned above, the participants discussed various interventions that they have found to be useful in the management of adolescents diagnosed with bipolar disorder. These interventions are were further broken down into organizing themes as they encompassed a range of interventions. These include *psycho-education, behavioural approaches, group therapy, expressive arts therapies* and *narrative therapy* as well as *family and systems interventions* and will be discussed below.

#### ***i. Risk Assessment and Screening***

According to Taylor et al., (2011), an approach to management that provides a structure for the appropriate assessment of risk, could provide early identification of prodromal symptoms

of bipolar disorder in which case, preventative measures may be put in place. This, not only requires that the clinician remain vigilant, but that the adolescent and the family members are empowered to identify these prodromal symptoms. Participant 1 seems to advocate this view strongly in the statement, “...differentiate between, is it a circumstantial something that’s gone on or triggered what’s going on that requires them to get help...” The fourth participant identified the increased risk of suicidal ideation and attempts which occur during adolescence, and indicated that it is essential for the therapist to be vigilant to such risks and to incorporate the necessary risk assessments. This participant explained that, at times, the symptoms are not overtly visible and that the family may normalise some of the symptoms as being part of the adolescent’s development and that, for this reason, the therapist must be vigilant and comprehensive in their assessment in order to elicit this information.

## **ii. Psycho-education**

Filaković et al. (2013) propose that psycho-education be introduced as soon as the patient’s state allows it and that it should be continued during therapy. The participants all identified psycho-education as a useful intervention that is used to inform the adolescents and their families about bipolar disorder. This approach was also used to facilitate a more effective means by which family members may assist the adolescent during mood episodes. The second participant went on to state that when the adolescent assumes a passive role in the management process, it worsens the prognosis and outcome. To this end, adolescents are coached to identify the prodromal symptoms. In addition, the participant indicated, “... *I teach the parents about bipolar*” which suggests that the participants extend their approach towards managing juvenile bipolar disorder to the families of the adolescents. Individual and multi-family psycho-education groups have been identified as potentially useful approaches to the management of juvenile bipolar disorder. They include education about bipolar symptoms and symptom management, the improvement of communication skills among family members, and the increase of support among family members (Renk et al., 2014).

Filaković et al. (2013) urge that psycho-education should not only involve informing the patient about their illness but also on how to cope with a chronic illness and other frequently occurring comorbidities; lifestyle regulation; acquiring healthy, functional habits; recognizing

prodromes; and the importance of treatment compliance. Participant 4 stated, “*I just involve the parents from an educational point of view*” which emphasises the important role played by psycho-education in empowering parents who have a child that has been diagnosed with bipolar disorder. Participant 1 went on to explain that parents must be able to distinguish actual symptoms from age-appropriate malingering behaviour which may occur at times during adolescence. The role of the parents in creating a containing environment during the mood episodes was identified. This means that both parents are coached to become more sensitive to identifying mood changes and in recognising the prodromal symptoms. The effectiveness of life-charting has been noted by various authors as an effective means managing bipolar disorder. Using this approach, the client and therapist identify times during which the mood symptoms were experienced and the events that occurred around that time (Myrick, 2010). This is useful in identifying the associated signs, triggers, and patterns of symptomatology (Myrick, 2010) and may be a useful means by which the adolescent may further track their mood symptoms and behaviours.

In describing the benefit of psycho-education for the family of the adolescent, the first participant stated, “...*talk to the patients about helping the child manage their moods, helping them identify the patterns in terms of what can trigger or exacerbate the sort of bipolar mood swings...*” indicating the importance of empowering the family to assist in the management process. This highlights the significant role that families seem to play in the trajectory of the therapeutic and management process.

This is linked with the systems approach discussed in chapter 2 in which it was stated, “the emotionally disturbed person is just one of a subsystem in the family system, but the entire family system is influenced by and influences the disturbed person” (Goldenberg & Goldenberg, 1985). In light of this, the approach taken by participant 3 is similar: “*a broader view of the diagnosis in the sense that it doesn’t affect...just...the individual with the illness...*” Systemic approaches, like the group therapy approach suggested by participant 1, serve the purpose of exploring interactional and communication patterns and how these impact on the adolescent’s symptom presentation.

### **iii. Behavioural Approaches**

Two of the participants discussed the benefit of behavioural approaches in altering dysfunctional thought patterns that may impact on the adolescent's ability to function in different contexts. In light of this, participant 2 stated, *"I use CBT to challenge the way they think about themselves, their diagnosis and their experiences of their world"*. This approach was found by the second participant to be an effective means of challenging the cognitive and behavioural patterns between parents and the adolescents, particularly where the adolescent experiences episodes of mania. Cognitive behavioural therapy is described as a focused approach that is based on the cognitive processes that influence feelings and behaviours, and that the resultant emotions and behaviours can influence cognitions (Australian Psychological Society, 2010). The role of the therapist in this is to assist the client to identify problematic or unhelpful thoughts, emotions and behaviours (Australian Psychological Society, 2010). In addition to these behavioural approaches, Participant 1 discussed other behaviour modification approaches that include advising the adolescent to maintain a sense of structure and consistency in their routine, as is illustrated by the statement, *"some of the things are they shouldn't have lots of caffeine...there should be a lot of stuff around hygiene...structure is very important..."*.

### **iv. Expressive Arts Therapies**

Malchiodi (2005) discusses alternative forms therapy that facilitate self-expression in a manner that is different from strictly verbal means and these have been outlined in chapter 2. These expressive therapies are defined as the use of art, music, dance or movement, drama, poetry, creative writing, clay, and sand trays as part of psychotherapy and as part of other forms of intervention. The premise behind this form of "non-traditional" approach is to facilitate other forms of expression using a different method of exchange where verbal communication is less effectual. The third participant found this approach to be a useful when working with adolescents. This is illustrated by the statement, *"I get to know what type of music they like and that becomes an entry point into building a therapeutic relationship because generally teenagers like music"* and it points to the notion that this type of

intervention may be perceived by the adolescent as being non-threatening and so, it may assist in facilitating easier communication and engagement in therapy. Through this, the participant explained that the therapist may begin to understand the adolescent from their worldview by understanding their interests. When discussing the use of art therapy when managing juvenile bipolar disorder, participant 3 went on to say, “...*where the adolescent has difficulty speaking. Sometimes males struggle to discuss their emotions openly...although this isn't strictly the case*”, suggesting that this may be a useful means of facilitating emotional expression, particularly in cases where the adolescent experiences difficulties to express themselves verbally. Malchiodi (2005) explains that, through the use of this form of therapy, a therapist is also able to facilitate self-expression, active participation, the use of imagination and mind-body connections.

#### v. *Narrative Therapy*

Narrative therapy was found to assist the clinician to “...*see how they speak about themselves and their problems so you're also able to build a different narrative together*” (participant 4). Participant 4 found this approach useful for facilitating a discussion about bipolar disorder with the adolescent in a non-condemnatory manner by not situating it as an intrapsychic problem which the adolescent can do nothing about. The participant further added, “*I don't... want to make the bipolar the centre of attention in therapy because I always try and remember that this is a whole human being with other difficulties, aspirations, goals...so what's happening not just as a by-product of the bipolar but in addition to it?*” In line with the assumptions of this approach, the therapist listens to how the adolescent describes their problem and identifies those narratives that may restrict them in resolving their difficulties (Australian Psychological Society, 2010). The premise is that the adolescent becomes less likely to internalise the diagnosis of bipolar disorder, and is thus mobilised into becoming involved in the therapeutic process. In this way, the therapist and client are able to co-create an alternative narrative regarding the disorder.

## **vi. Pharmacological Management**

It has generally been accepted that pharmacological management is an essential feature of bipolar disorder treatment (Hirschfield et al., 2010; Taylor et al., 2011) and this view is consistent with what the current study revealed. During the interviews, the participants spoke about the use of pharmacological agents in the management of juvenile bipolar disorder in the sense that it is useful to have a holistic understanding of how the adolescent is being managed by other clinicians. With this awareness, the fourth participant stated, *“I make sure that I am aware of how the medication is working because it makes sense that I would want them to be stable as soon as possible so that my own work can be productive”*. This implies that the management of juvenile bipolar disorder by clinical psychologists is inextricably linked with the control and stabilization of the medical symptoms. This finding is not new as the link between the psychiatric and psychosocial aspects of the disorder have formed the basis of the bulk of the research in this area. Hirschfield et al. (2010) summarise this idea by explaining that individuals who are diagnosed with bipolar disorder are often affected by the psychosocial consequences of past episodes, their ongoing vulnerability to future episodes, as well as the burden of adhering to a long-term treatment plan with possible undesirable adverse effects.

## **vii. Referrals for Further Management**

There are times when a therapist may encounter situations in which other family members may require further management. The third participant gives an example of this in which parents may experience their own difficulties which may impact on the adolescent's experience of therapy, and they may need to be referred to another therapist for further management while the adolescent continues with their own therapy concurrently. The fourth participant states that, in cases where the therapist is not fully competent in a particular modality which is a suitable intervention in a particular instance, the therapist needs to refer the family for further management: *“...to refer them to someone who can do family therapy or something if it would be more useful for them to be seen together”* which addresses the idea that clinicians have a responsibility to be forthcoming when making referrals to other clinicians when an approach that falls outside of the clinician's competence could potentially benefit the client.

### **B3c. Therapeutic relationship**

This sub-theme encompasses the nature of the therapeutic relationship. This was identified as being a critical vehicle for change in that it plays a critical role in creating a context where the adolescent may explore their presentation and start to find ways to deal with the challenges associated with a diagnosis of bipolar disorder. All four participants commented on the significance of the therapeutic relationship, emphasising that it is important for the nature of this relationship to be conducive and containing so that the adolescent may explore their difficulties. Kowatch et al. (2005) remark that, in order for a child to benefit from therapy, it is essential that they are comfortable talking to the therapist and that they are not forced to attend therapy as this may potentially do more harm than good to the process of therapy. It is reasonable to assume that a therapeutic environment in which the adolescent perceived themselves as being the target of blame or where they perceive that they are being coerced into therapy is likely to be counter-therapeutic. This aspect of the process of management was important to all four participants. As discussed in the reviewed literature in chapter 2, Rogers (1961) approach identifies the significance of the therapeutic relationship in bringing about change in the client's life. Rogers states, "If I can provide a certain type of relationship, the other person will discover within himself the capacity to use that relationship for growth, and change and personal development will occur". Rogers (1961) posits that the client has the capacity and is an agent for self-change. Thus, once a trusting therapeutic relationship has been defined by the therapist and the adolescent, the management process tends to become more effective. It is the nature of this relationship that strongly influences and is a prerequisite for effective therapeutic management. The fourth participant explains that, by assuming a non-pejorative stance in therapy, the therapist is able to create a context where the adolescent may discuss their experiences openly. Participant 2 captured the significance of this relationship: "*you have to build a strong enough therapeutic relationship that the teenager is able to find therapy as a safe enough space to say if there is any of this going on because these are those invisible things that can sabotage your work*". The difficulties associated with juvenile bipolar disorder have been highlighted in chapter 2. These may ultimately affect the psychosocial functioning of the adolescent for prolonged periods (Rosa et al., 2012). It follows from this that, in the absence of a containing therapeutic environment,

the adolescent may feel discouraged from discussing sensitive information related to the impact of the illness on their ability to perform their daily functions.

#### **5.4.4 Integration of the Main Study Findings**

The study indicated that clinical psychologists experience the management of juvenile bipolar disorder as a complex, multi-faceted and dynamic process. Of the four participants interviewed in the main study, two indicated that the incidence of juvenile disorder is rare while the other two indicated that they were seeing more cases of juvenile bipolar disorder in their practices. The participants each discussed the challenges associated with making a diagnosis of this nature and they attributed this to the high incidence of symptom overlap that exists between bipolar disorder and other clinical presentations. The participants thus advise that the process of diagnosis should be a carefully considered one and they caution against making an impulsive diagnosis. Bradfield (2010) discusses the variability that emanates from the available literature on the classification of the disorder in that there is, for starters, a methodological inconsistency in the term “childhood onset” which “is relative, since the index episode could occur anywhere between early infancy and late adolescence”. The definition and operationalization of such a diagnosis has proved to be challenging to clinicians.

The participants discussed various external influences that impact on their experience of managing adolescents diagnosed with bipolar disorder. The significance of these to this study was that they illustrated how the psychologist’s experience of the management process may be linked to other events that occur in various contexts outside of therapy. Hence, the participants indicated that, as part of their management, it is helpful for the therapist to facilitate a discussion of how the adolescent experiences these challenges.

The participants shared their experiences related to the psychotherapeutic interventions that they have found to be useful when managing juvenile bipolar disorder. These include psycho-education, expressive art therapies, behavioural therapies, systems approaches and narrative

therapy. They also note that it is useful for the therapist to have a more integrated collaborative approach that works together with other healthcare professionals when managing the adolescent and to identify instances where it is necessary to refer clients and/or their family members to other professionals.

## **5.5 Conclusion**

This chapter presented and discussed the findings of the study. An overview of the emerging themes indicates that clinical psychologists' experience the management of juvenile bipolar disorder as a complex process that requires much consideration. The themes that emerged were linked to the relevant literature as a means of validating the findings of the study. The following chapter provides a critical analysis of the study by discussing the strengths and limitations of the study as well as recommendations for future research.

## **CHAPTER 6**

### **CONCLUSION**

#### **6.1 Introduction**

This chapter will serve to provide a general overview of the central ideas that emerged from the study. An evaluation of the study will then be conducted and this will address the study's strengths and limitations. Thereafter, recommendations will be made for future research.

#### **6.2 Evaluation of the Study**

This qualitative study was a phenomenological enquiry into the experiences of clinical psychologists in the management of juvenile bipolar disorder. The study further aimed to understand the considerations made by clinicians in this process, and to contribute towards generating further research in this area. In order to achieve these aims, the participants' responses were recorded and analysed using thematic content analysis. Social constructionism served as the theoretical framework of this study as it was found to be an adequate means of reflecting the meanings that each participant attributed to their experiences. The themes that emerged from these responses were subsequently discussed.

The ethical considerations discussed earlier in the study were fulfilled. The study protocol followed the requirements of the Unisa Ethics Committee. Informed consent was obtained from each of the participants. The confidentiality of the participants was also maintained.

### **6.3 Strengths of the Study**

This study followed a social constructionist paradigm as it was deemed suitable to reflect the participants' experiences as they have been shaped by various situations and circumstances. The participants were able to express their opinions experiences in the familiarity of their working context so as to allow for a greater sense of ease. The researcher and participant were able to co-create a context in which rich discussions of the research topic could be explored.

The literature reviewed in chapter 2 illustrates that there is an absence of literature which reports on the experiences of clinical psychologists in managing juvenile bipolar disorder and, through this present study, the researcher was able to initiate a discussion in this regard. While this does not exhaust the present discussion, it provides a platform for further exploration in this area.

The qualitative design of the study allowed the researcher to engage with the participants about the nature of the study, as opposed to a quantitative study in which the researcher provides minimal disclosure. The researcher opted to use semi-structured interviews as they are less restrictive in that the participants are able to share their experiences in a manner which is less restrictive than with structured interviews. Burnard et al. (2008) explain that semi-structured interviews allow the researcher more flexibility in that they may probe for further elaboration and discussion where necessary in an interview. By informing the participants about the nature of the study, the participants were able to make an informed decision with regards to their participation in the study.

### **6.4 Limitations of the Study**

Although the study was considered to be valuable in that it initiated a discussion about the experiences of clinical psychologists in managing juvenile bipolar disorder in the South African context, the limitations need to be recognized. One of the limitations of the study was

its small sample size and thus, findings cannot be generalised to other contexts. Although it is acknowledged that the objective of qualitative research is not necessarily to generalise findings to populations as with quantitative enquiry, the present study could have been extended to other geographical regions so as to add to the representativeness and the richness of the data findings. Of the clinical psychologists who were approached, not all had the necessary experience of having managed an adolescent diagnosed with bipolar disorder and thus, not all could participate.

The focus on participants from the private sector disallowed those views from participants who manage adolescents in the public sector.

## **6.5 Recommendations**

In light of the gaps that have been identified in both the literature and the present study, it may be useful for future research on this subject. Considering the disparities of available resources that exist in the private and public sector, it may be useful for the study to be conducted on a broader scale that explores the experiences of clinical psychologists who manage juvenile bipolar disorder in the private sector. The challenge related to the cost of managing bipolar disorder was raised by some of the participants of this study, and thus, it may be useful to further explore this phenomenon with this in mind.

This study delineated adolescence as a distinct developmental and transitional phase. Thus, this inquiry remained specific to the experiences of clinical psychologists in managing adolescents who were diagnosed with bipolar disorder. Future research in this area could explore the experiences of managing pre-pubertal populations and juxtapose this against the findings of the current study. In this way, a more comprehensive understanding of this experience may be gained.

In order to assist in reducing the number of instances where inaccurate diagnoses are made, it may be useful for clinicians to make use of a provisional diagnosis where a juvenile bipolar

disorder is suspected. It may also be of benefit for clinical psychologists to engage with healthcare funders in a greater attempt at finding a more efficient balance between psychotherapeutic management, on the one hand, and reimbursement challenges on the other. The findings of the study indicated that the management process does not only involve the therapist and the client, but that there are external influences such as the role played by the healthcare funders in the management process. This role is one that results in clinical psychologists often feeling pressured towards acute interventions when managing juvenile bipolar in an inpatient setting. This raises a prospect for future studies to delve into this area in a qualitative inquiry into the extent of these external influences on the psychotherapeutic management of juvenile bipolarity. It provides a basis for a future inquiry that is punctuated more broadly to involve a more holistic view of the various networks involved in the management of juvenile bipolar disorder.

## **6.6 Concluding Remarks**

The study explored the experiences of clinical psychologists in managing adolescents diagnosed with bipolar disorder. Various considerations involved in this process were identified. The study highlights the complexity of managing juvenile bipolarity and it gives voice to the experiences of clinical psychologists in this regard. This study may serve to facilitate further understanding of this disorder, as it relates to the field of psychology.

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## APPENDIX A

### Invitation to participate in the study entitled:

### “Clinical Psychologists’ Experiences of Managing Adolescents Diagnosed with Bipolar Disorder”

Dear Potential Participant,

My name is Karabo Makhafula, a MA student at The University of South Africa (UNISA). I am conducting a study on the experiences of clinical psychologists in managing adolescents who have been diagnosed with bipolar disorder.

If you are a clinical psychologist in private practice who manages adolescents diagnosed with bipolar disorder, I would like to invite you to participate in this study.

To participate:

- You should be a practicing clinical psychologist who has registered with the HPCSA
- You should be in private practice currently
- You should have managed an adolescent who has been diagnosed with bipolar disorder in your practice
- You should have been in private practice for at least two years

Kindly read through the attached letter of informed consent before you decide whether you would like to participate or not.

Yours Sincerely,

Karabo Makhafula

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MA in Psychology Student

University of South Africa

***N.B. Please feel free to share this information with other clinical psychologists who fit the above criteria and who you think might be interested to participate in this study.***

## **APPENDIX B**

### **Letter of informed consent for participating in the study entitled:**

#### **“Clinical Psychologists’ Experiences of Managing Adolescents Diagnosed with Bipolar Disorder”**

Dear Potential Participant,

My name is Karabo Makhafula, a MA student at UNISA and I am conducting a study on the experiences of clinical psychologists in the management of adolescents diagnosed with bipolar disorder. The purpose of this study is to conduct interviews with you in order to explore and describe to explore the experiences of clinical psychologists in the management of pubescent bipolar disorder by clinical psychologists. My aim is to contribute towards the body of knowledge of research in the area of bipolar disorder in adolescents.

The interviews will take the form of a natural, free flowing dialogue or conversation to provide you with an opportunity to express your opinions freely without restrictions. I will be interviewing each participant individually at a pre-arranged time.

Due to the sensitive nature of therapy the interview has the potential to evoke intense emotions and unfinished issues for both of you. However, I will ensure that backup therapeutic support is put in place and is readily available for you whenever there is a need during the course of the data collection process.

All the interviews will be audio recorded. Audio recording has been selected as a means of accurately capturing the information that you provide. This information will be safeguarded and protected. Your privacy and confidentiality will be upheld at all costs and your names will not be used on the data recording form. Instead, codes will be used when handling your data. This is an attempt to ensure that your data is not linked directly to your names. No one

will have access to the recordings except me and my supervisor. The tapes will be destroyed as soon as the study has been completed.

Your participation in this study is voluntary and although it would be beneficial for you to complete the interview sessions for my data collection process, you are free to withdraw from the study whenever you wish to do so.

You will be compensated accordingly if there is a need for covering your transportation costs to and from the research setting. There are no other anticipated costs apart from the time that will be spent during the interview sessions which will be incurred by you as a result of your participation in this study.

The proposal has been sent study has been approved to The Ethics Committee of the Department of Psychology at UNISA for approval and a copy of the Ethical Clearance will be forwarded to you as soon as I have received it.

Should you need further information pertaining to the study, you are welcome to phone me, Karabo Makhafula, at 076 880 4121 or send me an e-mail at [krbmakhafula@gmail.com](mailto:krbmakhafula@gmail.com).

Yours Sincerely,

Karabo Makhafula

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MA in Psychology Student

University of South Africa

## Ethical Clearance for M/D students: Research on human participants

*The Ethics Committee of the Department of Psychology at Unisa has evaluated this research proposal for a Higher Degree in Psychology in light of appropriate ethical requirements, with special reference to the requirements of the Code of Conduct for Psychologists of the HPCSA and the Unisa Policy on Research Ethics.*

**Student Name:** Karabo Makhafula

**Student no.** 34776451

**Supervisor:** Mrs. Khumo Modutla

**Affiliation:** Dept. of Psychology, Unisa

### Title of project:

Clinical Psychologists' Experiences of Managing Adolescents Diagnosed with Bipolar Disorder

The proposal was evaluated for adherence to appropriate ethical standards as required by the Psychology Department of Unisa. The application was approved by the Ethics

Committee of the Department of Psychology on the understanding that –

- All ethical requirements regarding informed consent, the right to withdraw from the study, the protection of participants' privacy of the and confidentiality of the information will be met to the satisfaction of the supervisor;
- Clearance is to be obtained from the institutions from which the participants are to be drawn, and all conditions and procedures regarding access to staff for research purposes that may be required by these institutions are to be met.

Signed:



**Prof. M Papaikonomou**

Date: 2014-10-14

[For the Ethics Committee ]

[ Department of Psychology, Unisa ]

***The proposed research may now commence with the proviso that:***

- 1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*
- 2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Psychology Department Ethics Review Committee. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*
- 3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

**Table 1: Pilot Study 1**

THEME AND SUB-THEMES	LINE NUMBER	QUOTE
<p><b>1.Diagnosis/classification</b></p> <p><i>Diagnostic Challenges</i></p> <p><i>Differential diagnosis and Comorbid Presentations</i></p> <p><i>Developmental considerations</i></p>	<p>L38</p> <p>L105</p> <p>L47</p> <p>L44</p> <p>L289</p>	<p>There’s no diagnosis to accommodate it in the DSM so where do we place them- especially when [<i>cough, excuse me</i>] someone is working with a multidisciplinary team?</p> <p>there are no blood tests or any definitive tests so it’s hard to tell true BMD</p> <p>P5: the number of children and teens diagnosed with bipolar disorder isn’t that high</p> <p>Because that’s what I see: in cases where the child is diagnosed <b>ADHD</b>, they later get a diagnosis of bipolar disorder</p> <p>some will have ADHD and <b>GAD</b>, or severe mood dysregulation or trauma</p> <p>It’s just part of that life stage where they’re trying to define who they are in their environment and they end up wanting to know how far rules can be pushed</p> <p>Teens can push boundaries you know, so the parents must know how to identify manipulation and be able to distinguish manipulation from actual symptoms</p>

<p><b>2. External influences</b></p> <p><i>Healthcare/Reimbursement</i> L58</p> <p><i>Psychosocial Influences</i> L298</p> <p><i>Family influences</i> L138</p>		<p>So then a child will get a diagnosis of bipolar because <b>the medical aids won't reimburse us if it's a conduct disorder you know</b></p> <p>...and other things like school problems and problems functioning in society so it's important to be vigilant to other ways that support can be provided in order to curb this.</p> <p>When a teen is diagnosed with a mental illness, especially BMD, the family is plunged into crisis, problems develop in the family, the teen becomes the IP and the problem just worsens over time</p>
<p><b>Management/ Interventions</b></p> <p><b>Management approach</b></p> <p><i>Collaborative approach</i> L110</p> <p><i>Evidence-based interventions favoured</i> L113</p> <p><b>Interventions used by clinical psychologists in managing adolescents diagnosed with bipolar disorder</b></p> <p><i>Behavioural approaches: CBT and systems</i> L189</p>		<p>as a therapist...or even as a parent, you cannot do it alone</p> <p>What I like about the literature though is that it supports this kind of thinking in juvenile bipolar because a lot of the approaches speak about doing a systemic type of therapy and also family interventions</p> <p>So just to come back to CBT, what I do is to teach parents how to hold the space when their child is actively manic...so they learn to just simply hold their</p>

		child. When they hold the space then they also hold themselves
	L131	I take on a CBT and a systems approach
<i>Psycho-education</i>	L193	I also teach them to recognize the prodromal symptoms
	L279	Important that the therapist lets parents know that it's not their fault because they can end up blaming themselves. They must also be aware of the changes that happen in their own relationships
<i>Art therapy</i>	L206	I also do art therapy to help them express their pain and I encourage them to use it in their own space. It's important to note what phase the patient is in because I find that you can't manage the phases as one
<i>Phase-specific approach</i>	L263	I intervene the most when the patient is euthymic and/or during the depressive phase because then I find the manic phase needs to settle before they can become responsive to treatment
<i>Pharmacological management</i>	L271	When they're diagnosed it's important to get them onto medication so as to stabilise them
	L145	Then there's usually a vicious cycle, there's no compliance and that messes with treatment

**Table 2: Pilot Study 2**

THEME AND SUB-THEMES	LINE NUMBER	QUOTE
<p><b>1. Diagnosis and Classification</b></p> <p><i>Differential Diagnosis and Comorbid Presentations</i></p>	<p>L9</p> <p>L13</p> <p>L34</p> <p>L29</p> <p>L35</p>	<p>I must say, I haven't seen a case that purely fits the bill</p> <p>P3: we're seeing more cases of adolescents across all racial lines that are diagnosed with various illnesses</p> <p>P4: So, in a nut shell I'd say that bipolar does exist in kids but I'm just not convinced it's to a great extent</p> <p>p3: Most of the time they are admitted for behavioural problems related to maybe substance abuse, ADHD, and other things</p> <p>P4: I have mostly seen emerging personality disorders, teens with other cluster B traits, ADHD, impulse control issues, and emotional regulation, I mean, problems with emotional regulation</p> <p>P5: unfortunately this doesn't mean that I don't have cases of teens that have been diagnosed as bipolar</p>
<p><b>2. External Influences</b></p> <p><i>Psychosocial influences (stigma)</i></p>	<p>L20</p>	<p>P3: Okay, so there are more adolescents being admitted, which means that on the one hand, parents are becoming more aware of mental illness and maybe (coughs) this speaks to the stigma</p>

<p><i>Healthcare/Reimbursement</i></p> <p><i>Family Influences</i></p>	<p>L108</p> <p>L183</p> <p>L243</p> <p>L83</p> <p>L57</p>	<p>starting to wear off.</p> <p>P12: Especially in cases like these where you're diagnosing a bipolar in a teenager and I mean, they're already stigmatized for seeing a psychologist</p> <p>P7: we're under so much pressure from all sides to get the patient treated and out</p> <p>P7: there are instances where the circumstances kind-of influence the hastiness of the clinician</p> <p>P22: It also gives you a chance to see what the family dynamics are in that family and whether there aren't also issues where people aren't getting along</p> <p>P23: Because that could also result in teens displaying mood and behavioural problems</p>
<p><b>3.Management/Intervention</b></p> <p><b>Management approach</b></p> <p><i>Collaborative approach</i></p>	<p>L210</p> <p>L127</p> <p>L136</p>	<p>P15: have more information on what's happening with your patient</p> <p>P14: So I think it's also important to work as a team and communicate with the psychiatrist and vice versa</p> <p>P15: if they start becoming sleepy on the meds you can adjust the time that you see them for therapy or if you are aware their meds are being changed then you know you can expect that they may need some time to adjust sometimes</p>

<p><b>Interventions used by clinical psychologists in managing adolescents diagnosed with bipolar disorder</b></p> <p><i>Psycho-education</i></p> <p><i>Narrative Therapy</i></p> <p><i>Behavioural therapies</i></p>	<p>L158</p> <p>L275</p> <p>L263</p> <p>L278</p> <p>L278</p>	<p>P17: they become more independent and involved in their own treatment</p> <p>P26: If you manage the expectations of the patients and their families then treatment is likely to become more successful</p> <p>P25: narrative therapy helps a lot</p> <p>P26: DBT works well for bipolar</p> <p>P26: CBT in general is a great intervention here because they can start to identify the problematic thoughts that then influence their behaviour and if they can identify those, it can have a positive impact on how they manage those</p>
<p><b>4. Therapeutic relationship</b></p> <p><i>Empathy</i></p>	<p>L271</p> <p>L273</p>	<p>P26: letting them know that in your experience you've seen how difficult it is for patients to comply with their treatment</p> <p>P26: It really is like you give them a sense of being understood</p>

	L232	P23: But initially, if they are still symptomatic, I will just contain them though
	L233	P23: It's important not to challenge in the initial stages
	L261	P25: We also talk about the meaning of living with the label



<p><i>Developmental Considerations</i></p>	<p>L28</p>	<p>predominantly the borderline but also the histrionic that can sort of present in that sort of , in that sort of way; you find the more sort of cluster C don't present in this way, um and narcissists also don't... you find that there are</p>
	<p>L250</p>	<p>and in that you need to have a look at what, were there attachment difficulties was there separation anxiety, is there trauma, is there a history of abuse, all of that sort of stuff</p>
	<p>L279</p>	<p>You know what I find is they generally... the girls I get referred come to me at around 14 (laughs) is when the wheels fall off, and the boys is more 16, sort of more 16 is the difficult period</p> <p>I think once they're through that phase I find, sort of 19/20 they are sort of settling and there's clarity about what's going on</p>
<p><b>2. Presentation</b></p>	<p>L39</p> <p>L40</p> <p>L62</p>	<p>in terms of children and adolescents generally the presentation is with depression first</p> <p>It's low mood, down... it's very unusual they'll initially present with a manic phase</p> <p>which is often the way that mania displays itself in adolescence, not so much the sort of ebullient</p>

	L44	<p>high, sort of laughing, joking picture of mania but more... a lot more irritability and agitation</p> <p>P9: Um, so generally they will start off sort of poor concentration changes in appetite, changes in engagement in terms of their interests</p>
<p><b>3. External Influences</b></p> <p><i>Multidisciplinary influences</i></p> <p><i>Family Influences</i></p>	<p>L59</p> <p>L84</p> <p>L135</p> <p>L139</p>	<p>and then you discover that bipolar because they react really badly to the SSRI which is a treatment for depression</p> <p>how under control is their condition and that will then impact in terms of their parenting style, how containing they can be for the child, how consistent. So it can have quite a knock-on effect</p> <p>I think that the difficulty is if you could picture parenting a bipolar adolescent sometimes they could be reckless, silly, destructive, interpersonally, like, damaging (laughs) things.</p> <p>what I try and do...is...have a look at how there might be a knock-on effect.</p>
<p><b>4. Management/Intervention</b></p> <p><b>Management approach</b></p> <p><i>Multidisciplinary/collaborative approach</i></p>	L226	<p>to try and have a coherent approach in conjunction with the MDT and also dealing with the child together with everyone involved and trying to get everybody on the same page getting collateral information from other professionals or other people involved with the children so, for example teachers...If the child has been assessed previously, to see those reports, so to have a sense of looking at the child where they've come from, where they are now,</p>

<p><i>Feedback</i></p>	<p>L240</p>	<p>have there been traumas or stressors or major changes, substance abuse or a whole range of things that could be causing the child to present how they're presenting at this moment in time</p> <p>So when I'm working with the adolescent (pause) it's important that I generally see the parents every 4-6 weeks for a feedback session I've found that working with parents and parenting, doing sort of parenting stuff and a lot of what you tell people is they want concrete factual stuff to hold onto, they want some clear guidance as to what can we do, what can you think about (cough) in these situations</p>
<p><b>Interventions</b></p>		
<p><i>Behavioural modification</i></p>	<p>L101</p>	<p>some of the things are they shouldn't have lots of caffeine, you know, there should be a lot of stuff around sleep hygiene,</p>
	<p>L111</p>	<p>structure is very important just to try and contain and manage things manageable</p>
<p><i>Psycho-education</i></p>	<p>L99</p>	<p>what I will do then is to talk to the parents about helping the child manage their moods, helping them identify the patterns in terms of what can trigger or exacerbate the sort of bipolar mood swings and um, encourage them around consistency, um being careful about diet um but also how to identify, or if they think something is changing with the child and if there's sort of intervention that's needed around that</p>
	<p>L279</p>	<p>to have a look at what are the things that aid and perhaps trigger an incident</p>
	<p>L304</p>	
<p><i>Group therapy</i></p>	<p>L341</p>	<p>differentiate between, is it a circumstantial something that's gone on or triggered what's going on that requires them to get help they might benefit from being in group therapy</p>

<i>Therapeutic relationship</i>	L193	so generally I find that they are quite trusting of me that I will represent things and be clear with them about what I'm going to say
	L223	I won't go into detail about confidentiality and stuff like that but sort of broad brush strokes stuff in terms of the management and my areas of concern and their areas of concern

**Table 4: Participant 2**

THEME AND SUB-THEMES	LINE NUMBER	QUOTE
<p><b>1. Diagnostic challenges</b></p> <p><i>Validity of the diagnosis</i></p> <p><i>Developmental Considerations</i></p> <p><i>Diagnostic Prevalence</i></p>	<p>L20</p> <p>L93</p> <p>L98</p> <p>L21</p> <p>L25</p>	<p>Because while I have a fair number of bipolar cases...in adolescents I mean, I often ask myself how accurate that is.</p> <p>Usually, mixed with the difficulty of adolescence, they become suicidal, thinking that the whole world is against them. And you must remember this is a critical time for them.</p> <p>Ya, I mean, that's when they're trying to discover who they are.</p> <p>I think it's obvious that there are sufficient cases of bipolar that we see in private but not so many of us see the young cases</p> <p>but I'm guessing they'll agree that, in its purest form, maybe not as high as some of the studies are showing.</p>
<p><b>2. Presentation and symptoms</b></p>	<p>L40</p>	<p>Okay, so on the whole, the symptomatology is usually a bit different depending on the age of the adolescent.</p>

	L123	What I mean is that, um in my experience, the older adolescents, sort-of 17/18 will start to present with the classic manic and depressive episodes.
	L124	ADHD and conduct...mmm, ya I'd definitely say those are the main ones
	L75	There's that emotional dysregulation disorder in the DSM-5 or also the um...pause... the temper tantrum disorder. I forget the name...[disruptive mood deregulation disorder]
	L79	So ya I find that...um, as they approach and enter into late adolescence (coughs) they tend to display the classic manic behaviour.
		which is acting irresponsibly, like, taking risks. In teens, a lot of the time this means experimenting with substances and sexual behaviour
<b>3. External influences</b>		
<i>Psychosocial influences</i>	L164	think of how many kids out there are bullying others and being bullied as well I mean... that's enough to make you so sensitive to their challenges Kids really grow up in more difficult times. And if they don't have a strong self-concept, they can end up really ...well, basically being the type of patients that are more difficult to manage
	L162	And they face peer pressure
<i>Family Influences</i>	L163	in some families difficulties aren't really discussed, especially difficulties that affect the children
	L217	P37: Like that they need to watch what they say to and around the patient. It's so easy to...because of pressure and stress let's say, to...to end up in a screaming

<b>4.Management and interventions</b>		
	L111	.I'd rather manage the patient or client as though they have bipolar than to apply a wait-and-see approach
	L112	I would rather then change my intervention as and when it becomes necessary.
<i>CBT</i>	L140	I use CBT to challenge the way they think about themselves, their diagnosis and their experiences of their world
<i>Psycho-education</i>	L214	So periodically I will discuss ways that they can continue assisting their teen at home, you know?
	L210	P21: So parents and caregivers are so important in telling you if the mood symptoms and subsequent behavioural problems are pervasive, if they happen only in certain instances, or if they are transient
<i>Referrals</i>	L203	P34: Well, basically, I just make sure that if they need to see someone I refer them
<i>Feedback</i>	L231	P36: And what I also do is I teach the parents about bipolar
<i>Evidence-based interventions</i>	L255	so read constantly and update your knowledge in terms of how best to intervene and assist your patient. There's more research being done on um, bipolar so now take the time to really read that and invest in the patient that way.
<i>Therapeutic Relationship</i>	L171	you have to build a strong enough therapeutic relationship that the teenager is able to find therapy as a safe enough space to say if there is any of this going on because these are those invisible things that can sabotage your work
	L233	Ya and so to basically I work to create a containing environment in therapy and so I help the parents to do the same at home.

**Table 5: Participant 3**

THEME AND SUB-THEMES	LINE NUMBER	QUOTE
<p><b>1. External influences</b></p> <p><i>Psychosocial challenges</i></p> <p><i>Family Influences</i></p>	<p>L23</p> <p>L185</p> <p>L198</p> <p>L274</p>	<p>There are many cases where parents are getting divorced and the children struggle you know? P18: like... family problems, school or academic difficulties, are they being bullied or rejected by their peers?</p> <p>But now because they are teenagers they're also prone to feelings of suicidality</p> <p>P30: Ya, like, someone will become difficult or they'll have some kind of problem and unfortunately it's usually the kids in the family that suffer the most, I'd say.</p> <p>How does the child then know how to behave appropriately or how do they learn how to regulate their own feelings and emotions? I mean, we learn from our families</p> <p>I have seen too many instances where people in families talks to each other in such a way that problems become so much harder for them to deal with and the difficulty starts just in the way they speak to each other.</p>

<p><b>2. Presentation and Symptoms</b></p>	<p>L51</p> <p>L45</p> <p>L101</p> <p>L117</p>	<p>P9: So what I'm saying is that once they get to around age 15 you can see how pervasive into puberty the mood has been.</p> <p>But then you'll also get those that also seem so irritable around that age and this irritability happens at school and at home and other places.</p> <p>During an episode they will start with eccentric behaviour like they will start staying up, so a reduced need for sleep... they will start misbehaving, doing things that are out of the ordinary behaviour,</p> <p>P22: When depressed they typically will lose interest in things they usually enjoy and will have the classic low mood, lethargy and feelings of helplessness.</p>
<p><b>3. diagnostic challenges</b></p> <p><i>Differential Diagnosis and Comorbid Presentations</i></p> <p><i>Developmental</i></p>	<p>L61</p> <p>L64</p> <p>L69</p> <p>L79</p>	<p>So what I'm saying is that your challenge would probably be the more younger teen</p> <p>P11: And obviously you would have to make sure that the irritability isn't caused by something else</p> <p>P13: So you must be aware that when a child has ADHD they will often become irritable, or if they have another disorder like oppositional defiant disorder which is there as well or conduct or something</p> <p>So if the irritability is still there you know you should start looking more at personality traits and possibly a personality disorder at a later stage.</p>



<p><i>Multi-disciplinary approach</i></p>	<p>L130</p>	<p>patient</p> <p>And talk to colleagues. Talk to other psychologists who see teenagers with bipolar and find out how they are managing them. If you can, join or start some sort of journal club where these issues can be discussed.</p>
<p><i>Individual approach</i></p>	<p>L327</p>	<p>Also speak to other professionals from other disciplines, you know, and just get to know how they are managing the patients and how this can impact on how you manage the patient</p>
<p><i>Parental involvement</i></p>	<p>L227</p>	<p>I take each case as it stands</p>
<p><b>Interventions</b></p>	<p>L329</p>	<p>You need the families to provide you with feedback about the ...um... the mood. Is it ongoing and what triggers it, if anything? How long does the mood last? And how do they display the mood?</p>
<p><i>Family interventions</i></p>	<p>L336</p>	<p>So there you need the help of the parents together with your own assessment of the um... the client over that period.</p>
<p><i>Expressive therapies</i></p>	<p>L52</p>	<p>P25: I prefer to. I take kind- of a family oriented approach. So... that's what I find effective. . I can't imagine working alone with the adolescent without looking at what's happening with the family and without getting help from the family.</p>
<p><i>Expressive therapies</i></p>	<p>L142</p>	<p>What I do is I get to know what type of music they like and that becomes an entry point into building a therapeutic relationship because generally teenagers like music. And I ask about other interests and I get them to let me into their world</p> <p>Where the adolescent has difficulty speaking. Sometimes, the males struggle to discuss their emotions openly like the females, although this isn't</p>

<i>Psycho-education</i>	L299	<p>strictly the case. So in that regard, I will do art therapy and they depict their ideas on paper and then we discuss.</p> <p>P35: So if you give them the information you also remove the blame and make the bipolar an illness that isn't part of the individual, you take it outside of the individual</p>
<i>Therapeutic Relationship</i>	L319	<p>P37: Yes, mainly that and to help them find a way to remove the guilt and shame that comes with the diagnosis sometimes and also to lessen the burden of the illness on the person and the family as a whole. I mean, it can really be debilitating when someone believes they have an illness that they can do nothing about.</p>
	L177	<p>But if you approach it in a way that isn't threatening and you really create, or develop a good relationship with them then it works. You need their buy-in I would say</p>
	L276	<p>So an open and safe therapeutic space where the difficulties can be shared by each of the family members is useful</p>
	L303	<p>I think the most important thing I would say is if you're nurturing the therapeutic relationship so, being sensitive to the needs and feedback of your client, then you will most certainly make progress in therapy</p>

**Table 6: Participant 4**

THEME AND SUB-THEMES	LINE NUMBER	QUOTE
<p><b>1. Diagnostic challenges</b></p> <p><i>Differential diagnosis</i></p>	L103	<p>P19: And one of the other challenges is that unfortunately a lot of the time, they will first be diagnosed as depressed before the bipolar is identified</p>
	L107	<p>P20: I think a lot of the time, the more manic behaviour will be seen by families as the child just being wild.</p>
	L191	<p>It becomes difficult to make a diagnosis of bipolar sometimes. Especially since as I mentioned, adolescents experience so many other challenges</p>
	L163	<p>If, in sort-of middle to late adolescence, the mood is still predominantly irritable then I would consider something else like a neurological problem or some other psychiatric disorder rather than a bipolar</p>
	L170	<p>P32: I'd say a borderline personality structure would probably look like bipolar, you know, that emotional instability and those unpredictable, unstable relationships and that fluctuation between crisis and normality.</p>
	L265	<p>there could also be borderline together with bipolar</p>

<i>Developmental Considerations</i>	L276	Not forgetting that substance use is something we see so commonly so the bipolar may be as a result of a substance, in which case the symptoms usually resolve after the effects of the um, the substance have resolved but in some instances it's just bipolar with comorbid substance use
	L283	P55: Ya. And it could also be ADHD or something that emanates from childhood, commonly a conduct disorder or something.
	L286	P56: And it could also be trauma-related. So as a result of some or other trauma that the teenager experienced as a child or more recently
	L68	well, pause, the thing is that kids are complicated on the whole. Because children can be emotional for all sorts of reasons and more specifically ... teens can also be quite an emotional bunch
	L253	just see if there are attachment issues or something like that
<i>Diagnostic Prevalence</i>	L291	Unfortunately I see it so often where there are attachment difficulties that play out in adolescence and the teenager struggles with their moods
	L21	R5: I must say I do see it in my practice and relatively prevalently so I would say if I see 10 teens, 3 or 4 would have bipolar.
	L27	So I would say it's relatively prevalent in the sense that there are more teens being diagnosed with bipolar of late

	L62	Ya, as I was saying for me I see those teens who have bipolar and we're actually seeing younger and younger patients, sadly.
	L23	So I don't know if it's the area I'm working in or whether it's because I am surrounded by psychiatrists
<b>3.Presentation and symptoms</b>	L74	But I suppose the frequency of the mood swings and the intensity as well as, I would say, how it impacts on their daily functioning is what gives an indication of whether you're dealing with bipolar or at least a mood disorder
	L82	the more prominent, frequent and impactful the mood swings are the greater the distinction
	L90	P17: So, similar to ADHD and some other mental illnesses that can affect youngsters, their behaviour becomes quite prominent across various contexts.
	L92	So their parents and family will report that they are a behavioural problem at home and the same will be said at school.
	L94	They're also more likely to befriend people who are also just as eccentric in their behaviour and their relationships will be unstable during that time around their episodes  and it's when the depressive symptoms begin that the

	<p>L112</p> <p>L120</p> <p>L151</p>	<p>family will realise that the child is isolating themselves from others or they lose interest in their sporting or school activities or something like that</p> <p>And some will become more irritable than anything</p> <p>P29: I'd say it's prominent in the pre-teen phase to...sort-of early adolescence, so from around age 11-12 to around 15, 16 in some. But in many instances it starts from a young age.</p>
<p><b>4.Management and intervention</b></p> <p><i>Management approach</i></p> <p><i>Multi-disciplinary approach</i></p> <p><i>Referral for further management</i></p> <p><i>Narrative therapy</i></p>	<p>L109</p> <p>L299</p> <p>L219</p>	<p>P42: I generally work with my colleagues here. I make sure that I am aware of how the medication is working because it makes sense that I would want them to be stable as soon as possible so that my work can be productive</p> <p>to refer them to someone who can do family therapy or something if it would be more useful for them to be seen together</p> <p>... I don't sort-of want to make the bipolar the centre of attention in therapy because I always try and remember that this is a whole human being with other difficulties, aspirations, goals etc. so what's happening not just as a by-product of the bipolar but in addition to it?</p> <p>and you're able to see how they speak about themselves and their problems so you're also able to build a different narrative together</p>

<p><i>Psycho-education</i></p> <p><i>Therapeutic Relationship</i></p>	<p>L205</p> <p>L231</p> <p>L303</p>	<p>another important thing for me is that they learn about bipolar, but there I really involve the parents</p> <p>P62: So I just involve the parents from an educational point of view.</p> <p>P48: and the thing is that they become so much more open to discussing things because you're not putting blame on them</p>
<p><b>6.External influences</b></p>		
<p><i>Family influences</i></p> <p><i>Psychosocial influences</i></p>	<p>L139</p> <p>L179</p> <p>L187</p> <p>L228</p>	<p>So sort-of family problems or other difficulties with poor support from their families or significant others to be able to kind-of withstand the difficulty of bipolar.</p> <p>P35: Other times you find that the home environment is a difficult one where the teenager is struggling to deal with things at home</p> <p>P37: they're being rejected by their peers or just being rejected on the whole where they end up having these mood swings</p> <p>Ya, because that's the thing is the burden of it. On them, on their academic lives, on their families their relationships with others.</p>

To whom it may concern:

This letter serves to confirm that I have read the dissertation written by Karabo Makhafula and applied the necessary corrections for language and style.

I have achieved B.A. (Communications) degree with English as a major and have since done proofreading work in a full-time and freelance capacity for various companies, including Media24 publications and the University of Johannesburg. I was also the editor of several magazines.

If you have any further queries, please feel free to contact me at the details provided below.

Yours sincerely

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