



STRESS, EMOTIONS, AND COPING: THE LIVED EXPERIENCES OF PRIMARY CAREGIVERS WHO RAISE ADOLESCENTS WITH BIPOLAR DISORDER

KIMBERLY MORTON CUTHRELL ^{a*}

^a Capella University, Minnesota, USA.

AUTHOR'S CONTRIBUTION

The sole author designed, analyzed, interpreted and prepared the manuscript.

Received: 23 May 2022

Accepted: 28 July 2022

Published: 03 August 2022

Original Research Article

ABSTRACT

The purpose of this phenomenological study was to examine the relationship between primary caregivers and their adolescents who have bipolar disorder and the caregivers' coping and adapting skills in handling their adolescents' behaviors. The caregivers' perceptions of their coping and adapting skills were interpreted and analyzed through transcribing, coding, and mapping processes by using Creswell's six-coding step strategy [1]. The data were analyzed using Blumer's [2] symbolic interaction, and constructs from R. Lazarus's [3] stress and emotion theory, Selye's [4] stress theory, and R. Lazarus and Folkman's [5] transactional model of stress and coping provided the foundation of this phenomenological study to explore the stress and emotions of the primary caregivers of adolescents with bipolar disorder. Sixteen caregivers from North Carolina were selected by purposive sampling (snowball sampling) to share their stories during semi-structured interviews. The results of this qualitative analysis were examined using a phenomenological approach that took advantage of narrative inquiry and symbolic interaction that looked for emergent themes. Primary thematic results indicated that the primary caregivers of adolescents with bipolar disorder encountered stress, physical alignments, and emotional problems that often led to damaged marriages; strained or broken family relations; employment problems; and negative associations with neighbors, law enforcement, social services, and the school system. An unexpected finding was that the men in the study who were caring for adolescents with bipolar disorder were more likely than women in similar circumstances to prefer physical methods such as jogging and walking as ways to reduce their stress. No other studies found this specific finding. Results will be used to enhance the current literature by providing empirical insights that support the need for further research into bipolar disorder among adolescents.

Keywords: Bipolar disorder; adolescents; caregivers; stress; coping; emotions.

1. INTRODUCTION

Wade [6] had asserted that in the past 10 years, there has been a rise in the number of children and adolescents diagnosed with bipolar disorder. The purpose of this phenomenological study was to increase current understanding of the stress and emotions of the primary caregivers rearing

adolescents with bipolar disorder. Rearing an adolescent who has bipolar disorder may be causally related to stress and tension in the family. Although families were once viewed as havens for individuals experiencing stress from external pressures, they are increasingly challenged to meet the emotional needs of parents, children, and grandparents [7]. For example, the caregivers of adolescents with

*Corresponding author: Email: researcher@kimberlymortoncuthrell.com;

disabilities have even more vulnerabilities to stress than the caregivers of adolescents without disabilities [8].

Families experience a wide variety of positive and negative stresses. Caring for individuals with bipolar disorder increases stress levels when relatives serve as the primary caregivers for family members who are ill, disabled, or frail [9,10]. An adolescent with bipolar disorder can wreak havoc on a family routine, exhaust family resources, and cause immense stress for the child's caregivers, in addition to producing severe discomfort for the adolescent [11]. Subsequently, caregivers often suffer physical, emotional, and financial distress. Siblings of the ill adolescent also are affected, and caregivers struggle to balance the needs of all family members, including their own [12]. The negative impacts resulted in the caregivers feeling isolated from others, feeling like a bad parent, and feeling misunderstood. The experiences of these caregivers showed the need for additional training for systems (mental health, legal, family, school, hospital, and social services); support group for caregivers experiencing the same phenomenon; and enhanced treatment availability for adolescents with bipolar disorder (Kim et al, 2006). An adolescent with bipolar disorder can be difficult to discipline; frequently becomes irritable, manic, or depressed; and may attack siblings, parents, and others (Lederman & Fink, 2003). Such chaos within the family leaves an overload of stress and a cyclone of emotions that impede the caregivers' ability to cope with the stressors of managing the adolescent with bipolar disorder. Given the challenges of living with adolescents who have bipolar disorder, a deeper understanding of the stressors and coping strategies of these caretakers was needed.

There are strong opinions that ranged from a very conservative viewpoint of keeping things as they are or a liberal outlook that advocates diagnosing at a young age [13,12, 14,15]. Each opinion was justified and logical, but there has been no consensus or strong evidence to support caution on diagnosing children and adolescents with bipolar disorder [15]. Biederman et al. [16] asserted that despite the ongoing controversy, the view that the number of children and adolescents diagnosed with bipolar disorder is rare or nonexistent has been increasingly challenged not only by case reports but also by research. Furthermore, studies have presented the conclusion that some children and adolescents who were not diagnosed at an early age became adults with bipolar disorder. Several researchers have supported the diagnosis of bipolar disorder for children and adolescents who exhibit signs and symptoms of the psychiatric disorder to eliminate a prolonged lack of treatment

and the exacerbation of behaviors; facilitate interventions in familial and social disruptions; and identify earlier prevention of systemized settings (psychiatric hospitalizations, detention/jails, residential care, etc.) [17-20]. Not surprisingly, research conducted on juveniles found that 2% of incarcerated juveniles had Bipolar I disorder, whereas 4% had Bipolar II disorder [21].

The words parent, family, and family member are used interchangeably to refer to the parents and primary caregivers of children and adolescents with serious emotional disorders [22]. According to Stephens, Townsend, Martire, and Druley [23], a primary caregiver refers to the family member who spends the most time caring for the disabled person. To qualify as a primary caregiver, one has to assist the family member with at least one personal or instrumental activity of daily living (IADL; e.g, bathing, meal preparation, feeding) or to provide supervision per day up to 12 hours at times [10, 23]. A nonprimary caregiver may provide respite care when the primary caregiver is unavailable [23].

According to Faedda and Austin [24], bipolar disorder can severely interfere with adolescents' development and education as well as disrupt family life. The stress on all family members can be substantial and may lead to serious consequences, including illness of parents and siblings, parental discord, and divorce. One parent usually has to give up a job or other activities to care for an adolescent with bipolar disorder, but this decision does not necessarily ensure long-term stress relief for the designated parent. Instead, this action can have a negative impact on the family emotionally and financially. Taking care of adolescents with bipolar disorder often is a thankless and demanding job. Moreover, for children, adolescents, and adults with bipolar disorder, researchers have identified traits of moodiness, nightmares, sleep problems, sensory to light, integration difficulties, extreme temper tantrums, depression, food sensitivities, anxiety, hyperactivity, impulsivity, distractibility, oppositional traits, and so on [12, 25].

Bipolar disorder is frequently diagnosed with other psychiatric disorders such as attention deficit hyperactivity disorder, separation anxiety, obsessive-compulsive disorder, autistic spectrum disorders, oppositional defiant disorder, and conduct disorder [26-28]. The comorbidity of psychiatric disorders can create confusion for parents [29] (Greenberg, 2007). The symptoms of each diagnosis must be treated separately [28], but many parents are unable to distinguish which symptoms are associated with their adolescents' various psychiatric disorders.

Adolescents with bipolar disorder often display random irritable mood swings, a situation that often makes caregivers feel as if they are “walking on eggshells” to avoid a sudden outburst [30 p. 86]. Subsequently, caregivers question their ability to cope with the stress of dealing with their adolescents’ disorder. The prevalence of this disorder in children and adolescents underscores the need for programs to educate and provide support for caregivers [31]. According to reported statistics, in the 10-year span from 1993 to 2003, there was a 40-fold increase in the rate at which adolescents were being diagnosed with bipolar disorder [15]. Thus, the parent-adolescent relationship bears the most stress when adolescents have bipolar disorder [32-33,6] (Usita et al, 2006).

Everyone has advice for parents who have adolescents with bipolar disorder, but they do not know what it is like to raise adolescents with bipolar disorder (Austin & Faedda, 2006) [34]. Even when people do not offer advice, parents often feel withdrawn, embarrassed, and confused [12, 27, 35]. Undoubtedly, bipolar disorder is a serious mental health disorder [36, 12]. Son and Kirschner (2000) asserted that 5% to 8% of adolescents are affected by bipolar disorder. Adolescents with a family history of bipolar disorder are twice as likely as others to develop the illness (England et al, 2003). A family history of bipolar disorder may contribute to the adolescents’ unpredictable aggressive, suicidal, and hypersexual behaviors. The caregivers feel ashamed having adolescents with bipolar disorder [33]. One of the difficult struggles for a caregiver may be fully accepting their adolescents as they are while trying to maintain their parent-adolescent relationship [27, 33] (Siklos & Kerns, 2006) and preserve their relationships with other family members in the home (Fristad et al, 2007) [33].

1.1 Research Objectives

The literature addressed the controversial views surrounding children and adolescents diagnosed with bipolar disorder. Many mental health professionals have opposing viewpoints regarding whether children and adolescents should be diagnosed with other mental health illnesses instead of bipolar disorder. The literature revealed that even though children and adolescents may have other mental health illnesses [37], attention has been focused on children and adolescents who display symptoms similar to adults who have bipolar disorder and who have unexplained episodes of intense irritability, rapid mood swings, depression, and severe manic and aggressive behaviors [38, 12].

2. METHODOLOGY

2.1 Sampling Techniques

Sixteen caregivers were selected. The researcher believed that this number of caregivers was sufficient to address the research questions because it was not necessary to obtain data from a large sample to acquire valid results. In qualitative research, Yin [39] asserted that only a sample of a target population is needed for a study. The actual number of participants for a study depends upon the nature of the phenomenon being studied and the circumstances. No absolute number has been agreed upon for any particular technique, so the number often is left to the judgment of the researcher and those referring to the study [1, 40, 41] (Hycner, 1985). One reasonable method of determining the appropriate number of participants for a study is to review the literature and find similar studies with a similar number of participants. Caregivers were chosen through purposive sampling. All of the participants were raising adolescents between the ages of 13 and 17 who had been diagnosed with bipolar disorder. All of the participants signed an informed consent form to be interviewed. The researcher factored in several key components while recruiting the participants. First, the researcher was cautious about the process of recruitment because of confidentiality in the mental health field. Therefore, the researcher considered whether some questions might be uncomfortable for some caregivers to discuss. According to Fowler [42], some participants may not be as effective if personal or sensitive questions are asked. Second, the participants were informed that the interviews would be stopped if the caregivers became too emotional to proceed. The researcher had conversations in person prior to interviewing the caregivers to explain the interview process and to answer any questions that the caregivers had about the study. The researcher also advised the participants that the interviews would be audio recorded, provided information on how the researcher would safeguard the audiotapes, and explained the measures that would be implemented to protect their privacy as well as the destruction of the audio recording after completion of the research. Participants were interviewed in their homes, which increased their level of comfort to engage in an interview [43]. The locations were mutually determined by the researcher and the caregivers with the hope that the caregivers would feel more comfortable in familiar places. Two participants were from High Point, North Carolina, and 14 were from Greensboro, North Carolina. The participants’ homes were unremarkable and common to those of middle-class, suburban neighborhoods in the United States.

2.2 Research Design

This qualitative research was driven by the theoretical frameworks of R. Lazarus's [3] stress and emotion theory, Selye's [4] stress theory, and R. Lazarus and Folkman's [5] transactional model of stress and coping model. These frameworks were used to develop the research questions. The semi-structured interview questions were augmented by probing questions that encouraged more detailed responses from the participants. Probing questions can be used as guidance to gather more information in a phenomenological study. The conceptual framework provided a foundation for the research questions. The researcher asked each participant the same research questions. The researcher also asked the research questions in the same chronological order to ensure reliability and validity [1, 41] (Sprenkle & Piercy, 2005). The research questions and conceptual framework were appropriate methods for understanding the lived experiences of primary caregivers raising adolescents with bipolar disorder.

The theoretical frameworks also dictated the thematic data analytic scheme being used. Interviewees are the primary unit of analysis [44] with their informed consent (Bailey, 1996) [45]. This study involved 16 North Carolina caregivers who were raising adolescents with bipolar disorder. The researcher expected that the interviews would produce exceptional and complex data that were analyzed from the perspectives of narrative inquiry and symbolic interaction. The presentation and analysis of the findings provided many viewpoints of the caregivers' lives as they made sense of the behaviors of their adolescents with bipolar disorder [46,47] (Marmorstein, Malone, & Iacono, 2004). The interview process considered the (a) duration of the interview sessions; (b) interview procedures; (c) researcher's responsiveness to caregivers' questions; and (d) coverage of key questions and information, including the advantages, if any, of the stress and emotion of coping with children with bipolar disorder (Kahn et al, 2004; Mezulis et al, 2004) [49].

Procedures to interpret and organize the data included the development of research questions, the research design, instrumentation design, and so on. This work was completed in consultation with mental health professionals, caregivers' support groups, research on caregivers, and collaborative input and feedback from the researcher's dissertation committee. However, early on in the study, the procedures and instruments were evaluated for validity and reliability based upon the theories of R. Lazarus and Selye, the researcher's knowledge in the field, and the caregivers' lived experiences. According to Maiers, McKenzie, Evans,

and McKenzie (2009), four aspects of data collection are assessed: (a) caregiver demographics and interview questionnaires;

(b) follow-up with caregivers, if needed; (c) integration of the data relevant to mental health treatment; and d) commitment of resources to the study. The outcome measures consisted of data collection and missing data rates, burden on caregivers and their support systems, and efficiency of data entry that might be helpful for caregivers in receiving mental health treatment

3. FIELD TESTING

Before engaging in this study, the researcher interviewed three professionals in the mental health field to determine the effectiveness of the research questions. The field test [50] helped the researcher to analyze the reliability and validity of the research questions. The length of the interviews, which were expected to be 2 hours long, depended on the information that the professionals provided. The interviews were conducted in person unless it was more convenient to conduct the interviews over the telephone. The field test interviews with the professionals were conducted in the same format that would be used with the caregivers. The researcher used the same interview format so that a timed run through of the interview questions could be completed to test the timing. Although the interviews were not research based in scope, the field testing were helpful in understanding human behavior and the nuances of gathering information in a constructive and orderly manner.

The researcher believed the field test interviews, whether for counseling or research purposes, could be unusually exciting and unexpectedly difficult (i.e., as an anxiety-provoking experience). However, several key points were noted for a field test [50]. For example, the researcher could become overwhelmed by the content and effect. The researcher could try to convey a sense of what felt overwhelming during the interviews to make sense of this process. Based upon the field test experience, the professionals may point out that the researcher will have to accept the fact that the caregivers may jump from one idea to the next or start one thought or start several thoughts at once while trying to express all of these ideas. The researcher also may have to understand that caregivers' thinking can be unusually complex, which manifests in a pattern of modifying, correcting, and explaining each phrase while talking, making it difficult to follow their train of thoughts. In addition, the caregivers may wish to express rich ideas, yet they may have difficulty slowing down their thinking

process enough to present the ideas in an organized fashion. The professionals also may identify questions that need to be modified, deleted, or rephrased.

3.1 Data Analysis

To move beyond simplistic descriptions of people’s lives and lived experiences, the researcher must think differently about the questions asked and the topics discussed in the interview process itself [51]. Once the data were collected and the tapes transcribed, the researcher began the process of presentation and interpretation. After transcribing the tapes, the researcher started the coding process by reading individual interview question responses, identifying similar responses on a separate sheet of paper, and then integrating the overall codes into themes that supported the research questions. At the same time, themes emerged relating to stress and emotions as catalysts for coping and adapting and integrating the caregivers’ systems for support. Some of the themes that emerged related to systems (e.g, family, school, community, spiritual belief, friends, mental health, hospitals, legal areas), which required critical listening and thinking in order to determine whether a pattern was established [52]. It was expected that a large volume of data associated with stress and coping in caregiving would be collected. Analyzing the large volume of diverse data produced in this qualitative research was handled by coding the information.

Coding gave the researcher a visual perspective of the data [1]. Mapping also provided the researcher with a conceptual framework to interpret the research findings. Mapping is the process of making a visual picture of the data. It was helpful in organizing the data in a more manageable format and to help the researcher to understand the data. The analysis was applied to the narratives of the caregivers. Coding is

used as a way to understand the narrative data in a phenomenological fashion [1]. It also provides clues regarding the symbolic interaction occurring in the individuals between their emotions and situations or outcomes.

4. CODING AND MAPPING FRAMEWORK

The qualitative research process is an inductive approach that moves from narrative to understanding [53]. With these philosophical premises in mind, the researcher coded and mapped the information into four overarching categories. These categories addressed the caregivers’ explanatory frameworks about factors that helped or hindered them before their adolescents were diagnosed with bipolar disorder; their initial reactions to realizing that their adolescents had a mental illness; how they made meaning of the diagnosis; and how they implemented coping and adaptive skills to handle new experiences. The researcher believed that this organization of the findings would emerge inductively to provide a chronological presentation. The researcher was immersed in the interview data by finding similar themes addressed by the multiple caregivers.

Creswell [1] used a 6-step process (see Fig. 1) to explore the interview responses. The first part of this process is to prepare and organize the qualitative data. Because transcribed interview data were used for all of the participants, this step was relatively easy and merely consisted of collecting the interview Journal and transcription [1]. The second step involves reading the journal entries and transcriptions to determine which of the themes the answers could be applied to [1]. The third step involves an actual coding scheme being developed for the responses. During the fourth step, the coding system is used to describe themes that could be examined further.

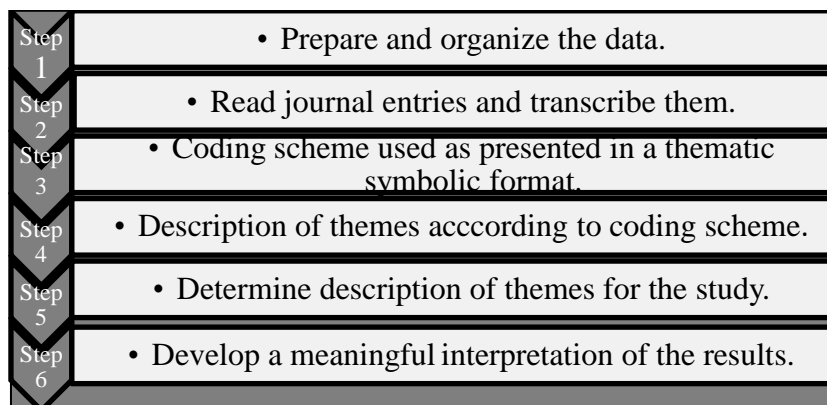


Fig. 1. Creswell’s coding steps

The themes found represented the major findings of the study. The fifth step is to determine how the themes would be described in the dissertation. This was done partially by providing narrative passages of the interviews. The final stage of qualitative data analysis is to attempt an understanding of the data according to the themes. This will often provide an interpretation that is meaningful [1].

5. ANALYTICAL PROCEDURES

Data analyses and data collection are intrinsically related [54]. Each informs the other in a dynamic, reciprocal, nonlinear process of questioning, reflecting, and interpreting (Sprenkle & Piercy, 2005). Narrative and other qualitative researchers generally do not employ such terms as validity and reliability to evaluate the analysis because those terms are grounded in the paradigm of quantitative methodologies [55]. However, Hess and Handel [56] described analytical procedures as a back-and-forth movement from one kind of data to another, from one participant's story to another, and from one participant's theme to another while the researcher searches for meanings and connectedness. According to Sprenkle and Piercy (2005), the only rule of analysis procedures is to remain vitally connected and find meanings of individuals' conversations and stories.

6. RESULTS AND DISCUSSION

This section introduces the caregivers to provide insight into their lived experiences of raising adolescents with bipolar disorder. At the time of the study, all of the caregivers, mothers and fathers, were residing with adolescents who had bipolar disorder. Bipolar disorder can manifest some of the following behaviors: moodiness, nightmares, sleep problems, sensitivity to light, integration difficulties, extreme temper tantrums, depression, food sensitivities, anxiety, hyperactivity, impulsivity, distractibility, oppositional traits, and so on [12, 25]. The researcher presented each caregiver with the same request: Describe what it is like to raise an adolescent with bipolar disorder. All names were changed to protect the participants' identities. The caregivers' gender, age, marital status, personal mental health or substance abuse disorder, and race/ethnicity are outlined in Table 1. The caregivers ranged in age from 32 to 50, with the majority of them being in their 40s. Four (25%) participants were married, six (38%) were divorced, one (6.3%) was separated, and five (31.3%) were single at the time of the study. Ten (63%) participants reported various mental health disorders. Three (19%) participants reported current or past substance use.

Table 1. Emotional descriptions of raising adolescents with bipolar disorder

Theme	Frequency (N = 16) and percentage
Hard	16 (100)
Embarrassing	13(81)
Frustrating	11(69)
Stressful	10 (63)
Difficult/challenging	10 (63)
Frightening/terrifying/scary	6 (38)
Confusing	6 (38)
Nervous	3 (19)
Exhausting	2 (13)
Blame/guilt	2 (13)
Isolated	2 (13)

The symbolic descriptions that were provided by the caregivers are in Table 2. The most common theme or analogy was to say that having an adolescent with bipolar disorder is like a living nightmare or bad dream ($n = 13$), followed by living in a war zone or battlefield ($n = 7$). Other symbolic descriptions mentioned by one caregiver that were not represented in the table included, "in survival mode," "on an island by myself," "like a referee," and "living with a demon."

Table 2. Symbolic descriptions of life with adolescents with bipolar disorder

Theme	Frequency (N = 16) and percentage
Nightmare/bad dream	13(81)
Living in a war zone or battle field	7 (54)
Disaster (e.g. bad storm)	5(31)
Being in prison	4(25)
Being on a roller coaster	4 (25)
Hell	3 (19)
Zombie	3 (19)
Monster	2 (13)
Wild animal	2 (13)

The second interview question that pertained to Research Question 1 asked the caregivers whether they had noticed any link between their adolescents' behaviors and their own physical well-being or health. The themes that emerged from the caregivers' responses are found in Table 3. The results identified numerous ailments that were common to all participants. Several additional ailments not listed in the table were mentioned by only one caregiver. These ailments included a kidney transplant, an eye injury, diabetes, crying, difficulty thinking and forgetfulness, and the shakes.

Table 3. Caregivers' physical or health issues

Theme	Frequency (<i>N</i> = 16) and percentage
Stress	16 (100)
Hypertension	9 (56)
Panic attack	7 (44)
Headaches/migraines	7 (44)
Nerves/nervous breakdown	7 (44)
Sleep problems	6 (38)
Hair loss	5 (31)
Obesity	5 (31)
Ulcers	4 (25)
Stomach pain	4 (25)
Poor appetite	3 (19)
Burnout	3 (19)
Worrying	3 (19)
No sex drive	2 (13)
Miscarriage	2 (13)
Fatigue/weakness	2 (13)
Restless	2 (13)
Chest pains/pounding heart	2 (13)

The caregivers' responses were broken down into positive and negative experiences. The positive experiences are discussed first, followed by the negative experiences. The thematic results (see Table 4) indicate that 15 of the 16 caregivers (93.4%) had positive experiences with people from mental health services. In addition, 13 of the 16 caregivers (81.3%) stated that they had had positive experiences with one or more hospitals. Other agencies or positive support systems included the school, the legal system, the family, and social services. However, the caregivers also pointed out that except for mental health services and hospitals, these resources were not very helpful in any kind of substantial way.

Table 4. Caregivers' positive experiences with support systems

Theme	Frequency (<i>N</i> = 16) and percentage
Mental health services	15 (94)
Hospital	13 (81)
School	8 (50)
Legal	8 (50)
Family	7 (44)
Social services	3 (19)

The negative experiences are outlined in Table 5. The caregivers were the most likely to have negative experiences with social services ($n = 13$), followed by family ($n = 9$), the school system ($n = 8$), and the legal system ($n = 8$). With regard to family, abandonment was often cited as an issue.

Table 5. Caregivers' negative experiences with support systems

Theme	Frequency (<i>N</i> = 16) and percentage
Social services	13 (81)
Family	9 (56)
School	8 (50)
Legal	8 (50)
Hospital	2 (13)
Mental health services	1 (6)

The third interview question pertaining to Research Question 1 asked the caregivers to explain their coping strategies when their adolescents acted up. The identified themes listed in Table 6 indicated that 15 of the 16 caregivers (93.8%) prayed or went to church. Other common themes ($n = 8$) included listening to music or singing, reading books, and/or engaging in some form of exercise. Other coping strategies mentioned by only one caregiver that were not included in the table included meditating, going to work, going on the Internet, doing worksheets, writing in a journal, going fishing, playing games, sitting on the porch, going to the movies, going to parks, coaching oneself, talking, and going to a resource program.

Table 6. Caregivers' coping techniques

Theme	Frequency (<i>N</i> = 16) and percentage
Pray/church	15 (94)
Listen to music/sing	8 (50)
Read	8 (50)
Exercise (walk, jog, etc.)	8 (50)
Draw/color	3 (19)
Take medicine	3 (19)
Interact/play with dogs	3 (19)
Sew/Embroidery	2 (13)
Go to therapy	2 (13)
Isolate self	2 (13)
Ride in car	2 (13)

Overall, the results suggested that caregivers who have adolescents with bipolar disorder feel as if they are in a "Living Hell," given the abhorrent behavior of their adolescents. These caregivers mentioned repeatedly that they struggled with behaviors of their adolescents that were sexually inappropriate; violent; dangerous (setting fires, physically attacking someone or themselves); very embarrassing, or illegal. Because of their adolescents' inappropriate behaviors, these caregivers suffered physical and emotional health problems [57]. The caregivers lived in constant fear of their adolescents, and they routinely worried about their adolescents' behavior and well-being, as well as

the well-being of the family in general. Because of their adolescents' behaviors, they were stressed and emotionally exhausted, and they suffered from ailments such as depression, panic attacks, hypertension, obesity, ulcers, and headaches. Some of the caregivers actually blamed themselves or felt guilty about their adolescents' diagnosis, and these feelings contributed to their emotional and physical distress. All of these physical and emotional problems, in combination with the adolescents' behavior, likely resulted in damaged marriages; strained or broken family relations; employment problems; and negative associations with neighbors, law enforcement, social services, and the school system. The caregivers tried to cope with all of these negative feelings and experiences mostly by praying, but they also were likely to listen to music; read a book; or exercise (i.e., go to the gym, jog, walk). In some cases, the caregivers were able to find assistance through external sources [57] such as mental health services that would provide therapy and medication, or help the caregivers to find group homes in which to place their adolescents. In fact, 12 of the 16 caregivers (75%) specifically mentioned either having placed their adolescents in group homes or having plans to place their adolescents in group homes. All of the caregivers reported high levels of stress experienced on a daily basis from parenting an adolescent with bipolar disorder. Twelve of the caregivers reported that their adolescents were diagnosed with other mental health illnesses prior to receiving a diagnosis of bipolar, which contributed to unpleasant parenting experiences; delay of appropriate treatment; and daily struggles of stress, frustration, and exhaustion. The caregivers feel ashamed having adolescents with bipolar disorder [33]. Although some caregivers did not want their adolescents to have a diagnosis of bipolar disorder, they were relieved to finally know why their adolescents were behaving as they were. One of the difficult struggles was fully accepting their adolescents as they were while trying to maintain their parent-adolescent relationship [27, 33], (Siklos & Kerns, 2006) and preserve their relationships with other family members in the home (Fristad et al, 2007) [33].

The unexpected finding from this study was that the men who were caring for adolescents with bipolar disorder were more likely than the women to prefer physical methods of reducing their stress, such as jogging and walking. No other studies found this specific finding. An expected finding was that many of the caregivers who were raising adolescents with bipolar disorder encountered stress, physical ailments, and emotional problems, all of which

resulted in damaged marriages; strained or broken family relations; employment problems; and negative associations with neighbors, law enforcement, social services, and the school system.

Bipolar disorder is a serious mental health disorder [36, 12]. Son and Kirschner (2000) asserted that 5% to 8% of adolescents are affected by bipolar disorder. Adolescents with a family history of bipolar disorder are twice as likely as others to develop the illness (England et al, 2003). A family history of bipolar disorder may contribute to the adolescents' unpredictable aggressive, suicidal, and hypersexual behaviors.

Ten of the caregivers reported having a mental health diagnosis of bipolar disorder, depression, post-traumatic stress disorder, or obsessive compulsive disorder. Caregivers' ability to sustain appropriate health was difficult. As mentioned previously, all 16 of the caregivers reported facing diverse health and emotional issues. The stress and emotion of raising adolescents with bipolar disorder led 12 of the 16 caregivers to place their adolescents in group homes or consider placing their adolescents in group homes.

The caregivers coped with the lived experiences of raising adolescents with bipolar disorder by praying, listening to music, reading, exercising, drawing, sewing, going to therapy, isolating self, and riding in a car. Raising adolescents with bipolar disorder can wreak havoc on a family routine, exhaust family resources, and cause immense stress for the caregivers [11]. Subsequently, caregivers often suffer physical, mental, emotional, and financial distress. Siblings also are affected, and caregivers struggle to balance the needs, including their own, of all family members [12]. The negative impacts resulted in the caregivers feeling isolated from others, feeling like a bad parent, and feeling misunderstood.

7. LIMITATION

Limitation of this study was related to the sample size. Sixteen caregivers were selected by purposive sampling (snowball sampling) from communities in North Carolina, which may limit the transferability of the findings. What these caregivers report may be idiosyncratic and may not represent what other caregivers in a larger sampling would report. Caregivers of adolescents were selected to participate in this study, so the findings were not as applicable to younger children with bipolar disorder. Though the study presented a limitation, the research is significant to contribute to the body of literature.

8. RECOMMENDATION FOR FUTURE RESEARCH

Though this study may add to the knowledge about the lived experiences of primary caregivers raising adolescents with bipolar disorder, there are numerous other areas where the research can be expanded. For example, further research could explore the experiences of foster parents and adoptive parents and also could enhance the knowledge base of the lived experiences of caregivers who are single and raising adolescents with bipolar disorder. Future research should compare the experiences of caregivers whose adolescents are not prescribed psychotropic medication to those who are prescribed medication. Future research should explore the lived experiences of caregivers whose adolescents with bipolar disorder have more depressive than manic symptoms. Research focusing on understanding the experiences of professionals within systems (i.e., mental health, school, social services, family, legal, and hospital) who are involved with adolescents who have bipolar disorder may enhance competency levels, interventions, and resources in many settings. Thus, concerning the family system, opportunities for research should be focused on how adolescents with bipolar disorder affect siblings. Since family systems may offer a wealth of knowledge, future research should explore advanced treatment and interventions in many settings. Even more interesting, after the completion of this phenomenological study, several other caregivers expressed their willingness to share their experiences of raising adolescents with bipolar disorder. The numbers were sufficiently high to conduct another study that could generate improved treatment methodologies, integrated approaches, and practical guidelines.

9. CONCLUSION

The purpose of this phenomenological narrative study was to explore the stress and emotions of caregivers who are raising adolescents with bipolar disorder. The findings of this study were consistent with the literature that caregivers who raise adolescents with bipolar disorder experience a great amount of stress and emotion and have difficulty implementing effective coping skills. The depth of that stress and the manner in which it can immobilize a well-intentioned and caring parent was an important finding in this research. Research participants consistently related how difficult it was to parent adolescents with bipolar disorder. All of the caregivers reported high levels of stress experienced on a daily basis from parenting an adolescent with bipolar disorder. Twelve of the caregivers reported that their adolescents were

diagnosed with other mental health illnesses prior to receiving a diagnosis of bipolar, which contributed to unpleasant parenting experiences; delay of appropriate treatment; and daily struggles of stress, frustrate, and exhaustion. Although some caregivers did not want their adolescents to have a diagnosis of bipolar disorder, they were relieved to finally know why their adolescents were behaving as they were.

The unexpected finding from this study was that the men who were caring for adolescents with bipolar disorder were more likely than the women to prefer physical methods of reducing their stress, such as jogging and walking. No other studies found this specific finding. Interesting findings were that many of the caregivers who were raising adolescents with bipolar disorder encountered stress, physical alignments, and emotional problems, all of which resulted in damaged marriages; strained or broken family relations; employment problems; and negative associations with neighbors, law enforcement, social services, and the school system. The stress and emotion of raising adolescents with bipolar disorder led 12 of the 16 caregivers to place their adolescents in group homes or consider placing their adolescents in group homes. The caregivers coped with the lived experiences of raising adolescents with bipolar disorder by praying, listening to music, reading, exercising, drawing, sewing, going to therapy, isolating self, and riding in a car. These caregivers' experiences may encourage policymakers to recognize the constant stress and emotion of caregivers who are raising adolescents with bipolar disorder and implement appropriate interventions and resources. The results of this research could augment current understanding of the daily stress facing caregivers raising adolescents who have bipolar disorder.

Through the caregivers' descriptive narratives, the researcher became aware of the incredible struggles that they encountered raising adolescents with bipolar disorder. A wealth of knowledge was gained about the daily challenges and the difficulties they experienced with systems which adds to the literature on caregivers' lived experiences raising adolescents with bipolar disorder. Undoubtedly, the day-to-day struggles that the caregivers faced placed many strains on the family unit, the caregivers' emotional and physical well-being, employment conditions, and interactions with systems.

CONSENT

All of the participants signed an informed consent form to be interviewed.

ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Author has declared that no competing interests exist.

REFERENCES

1. Creswell JW. Research design: Qualitative, quantitative and mixed methods approaches (3rd ed.). Los Angeles, CA: Sage; 2009.
2. Blumer H. Symbolic interactionism: Perspective and method. Englewood Cliffs, NJ: Prentice-Hall; 1969.
3. Lazarus R. Psychological stress and the coping process. New York, NY: McGraw Hill; 1966.
4. Selye H. The stress of life. New York, NY: McGraw-Hill; 1956.
5. Lazarus R, Folkman S. (2nd ed.). Stress, appraisal, and coping (2nd ed.). New York, NY: Springer; 1984.
6. Wade J. Crying alone with my child: Parenting a school age child diagnosed with bipolar disorder. *Issues in Mental Health Nursing*. 2006;27:885-903.
7. McKenry P, Price S. Families coping with change: A conceptual overview of families and changes and coping with stressful events and transitions (3rd ed.). New York, NY: Sage; 2005.
8. Brehaut J, Kohen D, Raina P, Walter S, Russell D, Swinton M, O'Donnell M. The health of primary caregivers of children with cerebral palsy: How does it compare with that of other Canadian caregivers? *Pediatrics*. 2004;114: 182-191.
9. Lazarus R. Stress and emotion: A new synthesis. New York, NY: Springer; 1999.
10. Meadows S, McLanahan S, Brooks-Gunn J. Parental depression and anxiety and early childhood behavior problems across family types. *Journal of Marriage and Family*. 2007; 69(5):1162-1178.
11. Hellander M, Sisson D, Fristad M. Internet support for parents of children with early-onset bipolar disorder. In B. Geller & M. DelBello (Eds.), *Bipolar disorder in childhood and early adolescence*. New York, NY: Guilford Press. 2003;314-329.
12. Papolos D, Papolos J. The bipolar child: The definition and reassuring guide to childhood's most misunderstood disorder (3rd ed.). New York, NY: Broadway; 2006.
13. Geller B, Luby J. Child and adolescent bipolar disorder: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*. 1997;36:68-76.
14. Rea M, Tompson M, Miklowitz D, Goldsteing M, Hwang S, Mintz J. Family-focused treatment vs. individual treatment for bipolar disorder: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*. 2003;71:482-492.
15. Youngstrom E, Youngstrom J. Evidence-based assessment of pediatric bipolar disorder, Part II: Incorporating information from behavior checklists. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2005; 44(8):823-828.
16. Biederman J, Mick E, Faraone S, Spencer T, Wilens T, Wozniak J. Current concepts in the validity, diagnosis and treatment of pediatric bipolar disorder. *International Journal of Neuropsychopharmacology*. 2003;6(3):293-300.
17. Barton L. Attention deficit hyperactivity disorder and bipolar disorder in children and their coexisting comorbidity: A challenge for family counselors. *Family Journal*. 2001;9(4):424-430.
18. Gary S, Sachs M, Baldassano M, Truman C, Guille C. Comorbidity of attention deficit hyperactivity disorder with early and late onset bipolar disorder. *American Journal of Psychiatry*. 2000;157:466-478.
19. Kowatch R, Fristad M, Birmaher B, Wagner K, Findling R, Hellander M. Treatment guidelines for children and adolescents with bipolar disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2005;44(3): 213-235.
20. Wozniak J. Pediatric bipolar disorder: The new perspective on severe mood dysfunction in children. *Journal of Child and Adolescent Psychopharmacology*. 2003;13(4): 449-451.
21. Chang K, Steiner H, Ketter T. Studies of offspring of parents with bipolar disorder. *American Journal of Medical Genetics Part C: Seminars in Medical Genetics*. 2003;123, 26-35.
22. Robinson A, Friesen B, Jivanjee P, Pullmann M. Preserving family bonds: Examining parent perspectives in the light of practice standards for out-of-home treatment. *American Journal of Orthopsychiatry*. 2005;75(4):632-643.
23. Stephens M, Townsend A, Martire L, Druley J. Balancing parent care with other roles: Interrole conflict of adult daughter caregivers.

- Journal of Gerontology: Psychological Sciences. 2001;56B(1):24-34.
24. Faedda G, Austin N. Parenting a bipolar child: What to do and why. Oakland, CA: New Harbinger; 2006.
 25. Zylstra R, DeFrance G, McKay J, Solomon C. Childhood bipolar disorder: A clinical vignette. *Journal of Clinical Psychiatry*. 2005;7(5):231-236.
 26. Crome I, Chambers P, Frisher M, Bloor R. The relationship between dual diagnosis: Substance misuse and dealing with mental health. London, England: Goldings House Cummings, C, & Fristad, M. 2008, Pediatric bipolar disorder: Recognition in primary care. *Current Opinions in Pediatrics*. 2009;20, 560-565.
 27. Pavuluri M, Graczyk P, Henry D, Carbray J, Heidenreich J, Miklowitz D. Child and family-focused cognitive-behavioral therapy for pediatric bipolar disorder: Development and preliminary results. *Journal of American Academy of Child Adolescent Psychiatry*. 2004;43(5):528-537.
 28. Piterman L, Jones K, Castle D. Bipolar disorder in general practice: Challenges and opportunities. *Medical Journal of Australia*. 2010;19(3):14-17.
 29. Gentil V. Bipolar disorder and concurrent psychiatric and medical conditions. *Journal of Clinical Psychiatry*. 2009;70(8):29-36.
 30. Apps J, Winkler J, Jandrisevits M. Bipolar disorders: Symptoms and treatment in children and adolescents. *Pediatric Nursing*. 2008;34(1):84-88.
 31. Davidson J. A phenomenology of fear: Merleau-Ponty and agoraphobic life-worlds. *Sociology of Health & Illness*. 2000;22:640-681.
 32. Forgone SV, Glatt SJ, Tsuang MT. The genetics of pediatric-onset bipolar disorder. *Biological Psychiatry*. 2003;53, 970-977.
 33. Rose L, Mallinson R, Gerson, L. Mastery, burden, and areas of concern among family caregivers of mentally ill persons. *Archives of Psychiatric Nursing*. 2006;20(1): 41-51.
 34. Bynum M, Brody G. Coping behaviors, parenting, and perceptions of children's internalizing and externalizing problems in rural African American mothers. *Family Relations*. 2005;54(1):58-71.
 35. Sullivan, A, & Miklowitz, D. Families functioning among adolescents with bipolar disorder. *Journal of Family Psychology*. 2010;24, 60-67.
 36. Coe N, Van Houtven C. Caring for mom and neglecting yourself? The health effects of caring for an elderly parent (Occasional paper) Tilburg, The Netherlands: University of Tilburg; 2009.
 37. Davanzo P, Yue K, Thomas A, Thomas, B, Mintz, J, Venkatraman, T, McCracken J. Proton magnetic resonance spectroscopy of bipolar disorder versus intermittent explosive disorder in children and adolescents. *American Journal of Psychiatry*. 2003;160:1442-1452.
 38. Johnson J, Cohen P, Brooks J. Associations between bipolar disorder and other psychiatric disorders during adolescence and early adulthood: A community-based longitudinal investigation. *American Journal of Psychiatry*. 2000;57(10):1679-1681.
 39. Yin R. Case study research: Design and methods (4th ed.), Los Angeles, CA: Sage; 2009.
 40. Gay LR, Airasian P. Educational research: Competencies for analysis and applications. Upper Saddle River, NJ: Merrill Prentice Hall; 2003.
 41. Greenstein T. Methods of family research. (2nd ed.). Thousand Oaks, CA: Sage; 2003.
 42. Fowler F. Survey research methods. (3rd ed.) Thousand Oaks, CA: Sage; 2002.
 43. Josselson R. The cal attitude in narrative research: Principles and practicalities. In J. Clandinnin (Ed.): *The handbook of narrative inquiry*. Thousand Oaks, CA: Sage. 2007;537-567.
 44. Bless, C, & Higson-Smith, C. Fundamentals of social research methods, an African perspective (3rd ed.; Lansdowne, SA: Juta; 2000.
 45. Arksey H, Knight, P. Interviewing for social scientists: An introductory resource with examples. London: Sage; 1999.
 46. Dieker L, Merikangas K, Szatmari P. Psychopathology among offspring of parents with substance abuse and/or anxiety: A high-risk study. *Journal of Child Psychology and Psychiatry and Allied Disciplines*. 1999; 39:711-720.
 47. Rapley T. The art (fulness) of open-ended interviewing. *Qualitative Research*. 2001; 1(3):303-323.
 48. Mezulis A, Hyde J, Clark R. Father involvement moderates the effect of maternal depression in infancy on child behavior problems. *Journal of Family Psychology*. 2004;18:575-588.
 49. Wakschlag L, Pickett K, Kasza K, Loeber R. Is prenatal smoking associated with a developmental pattern of conduct problems in young boys? *Journal of American Academy of Child & Adolescent*. 2006;45(4):461-468.

50. Janesick V. The choreography of qualitative research design: Minuets, improvisations, and crystallization. In N. Denzin & Y. Lincoln (Eds.): *Handbook of qualitative research* (2nd ed.) Thousand Oaks, CA: Sage. 2000; 379-399.
51. Cushman P. Ideology obscured: Political uses of the self in Daniel Stern's infant. *American Psychologist*. 1991;46(3):206-219.
52. Levine R, Fitzgerald H. *Analysis of dynamic psychological systems*. New York, NY: Plenum Press; 1992.
53. Psathas G. *Conversation analysis: The study of talk-in-interaction* (Qualitative research methods; Thousand Oaks, CA: Sage; 1994.
54. Patton M. *Qualitative research and evaluation method* (3rd ed.) Thousand Oaks, CA: Sage; 2002.
55. Schwandt T. *Dictionary of qualitative inquiry* (2nd ed.) Thousand Oaks, CA: Sage; 2001.
56. Hess R, Handel G. *Family worlds: A psychosocial approach to family life*. Chicago, IL: University of Chicago Press; 1959.
57. Chappell N, Reid R. Burden and well-being among caregivers: Examining the distinction. *Gerontologist*. 2002;42(6):772-780.
58. Axelson D, Birmaher B, Strober M, Gill M, Valeri S, Chiappetta L, Keller M. Phenomenology of children and adolescents with bipolar spectrum disorders. *Archives of General Psychiatry*. 2006;63(10):1139-1148.
59. Baker B, Heller T, Henker B. Expressed emotion, parenting stress, and adjustment in mothers of young children with behavior problems. *Journal of Child Psychology and Psychiatry*. 2000;41(7):907-915.
60. Bandura, A. Self-efficacy. In V. Ramachandran (Ed.): *Encyclopedia of human behavior* (pp. 71-81; New York, NY: Academic Press. (1994).
61. Barker R. *The social work dictionary*. Silver Spring, MD: National Association of Social Workers; 1991.
62. Braverman H. *Labor and monopoly capital: The degradation of work in the twentieth century*. New York, NY: Monthly Review Press; 1974.
63. Brody E, Brody S. The informal system of health care. In C. Eisdorfer, D. Kessler, & A. Spector (Eds.): *Caring for the elderly: Reshaping health policy*. Baltimore, MD: Johns Hopkins Press. 1989;34-60.
64. Brooks J, Richter L, Robenstone E. Consequences of adolescent drug use on psychiatric disorders in early adulthood. *Annals of Medicines*. 2000;32(6):401-407.
65. Bryman, A. Integrating quantitative and qualitative research: How is it done? *Qualitative Research*. 2006;6, 97-113.
66. Cadman D, Boyle M, Szatmari P, Offord D. Chronic illness, disability, and mental and social well-being: Findings of the Ontario Child Health Study. *Pediatrics*. 1987;79(5): 805-813.
67. Capella University. *Informed consent*; 2010. Available: <https://campus.capella.edu/web/iguide/search?q=IRB+Consent>
68. Carbray J, McGuinness T. Pediatric bipolar disorder. *Journal of Psychosocial Nursing and Mental Health Services*. 2009;47(2):22-26.
69. Cohen M. Families coping with childhood chronic illness: A research review. *Families, Systems, & Health*. 1999;17(2):149-164.
70. Creswell J. *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd ed.; Thousand Oaks, CA: Sage; 2003.
71. Easton K, McComish J, Greenberg R. Avoid common pitfalls in qualitative data collection and transcription. *Qualitative Health Research*. 2000;10:703-708.
72. Eatough V, Smith JA. I was like a wild wild person: Understanding feelings of anger using interpretative phenomenological analysis. *British Journal of Psychology*. 2006;97:483-498.
73. Faedda G. Childhood onset bipolar disorder: Pharmacological treatment overview. *Journal of Development and Learning Disorders*. 2004;8:37-64.
74. Faedda G, Baldessarini R, Glovinsky I, Austin N. Treatment emergencymania in pediatric bipolar disorder: A retrospective case review. *Journal of Affective Disorders*. 2004;82:149-158.
75. Folkman S, Lazarus R. The relationship between coping and emotion: Implications for theory and research. *Social Science & Medicine*. 1988;26(3):309-317.
76. Foltz R. *Medicating our youth: Who determines rules of evidence? Reclaiming Children & Youth*. 2010;19(2):10-15.
77. Gergen K. *Realities and relationships: Soundings in social constructionism*. Cambridge, MA: Harvard University Press; 1994.
78. Grim B, Harmon A, Gromis J. Focused group interviews as an innovative quanti-qualitative methodology (QQM): Integrating quantitative elements into a qualitative methodology. *Qualitative Report*. 2006;11(3):516-537.
79. Gross J. Antecedent and response focused emotion regulation: Divergent consequences for experience, expression, and physiology. *Journal of Personality and Psychology*. 1998; 74:224-237.

80. Haley W, Gitlin N, Wisniewski S, Feeney-Mahoney S, Coon D, Winter L, Ory M. Well-being, appraisal, and coping in African-American and Caucasian dementia caregivers: Findings from the REACH study. *Aging & Mental Health*. 2004;8(4):316-329.
81. Hammersley M. *Taking sides in social research*. London, England: Routledge; 2000.
82. Harden J. Uncharted waters: The experience of parents of young people with mental health problems. *Qualitative Health Research*. 2005; 15(2):207-223.
83. Heller T, Roccoforte J, & Cook, J. Predictors of support group participation among families of persons with mental illness. *Family Relations*. 1997;46(4):437-442.
84. Henry C, Donatienne V, Frank B. Anxiety disorders in 318 bipolar patients: Prevalence and impact on illness severity and response to mood stabilizer. *Journal of Clinical Psychiatry*. 2003;64:331-335.
85. Heru A, Ryan C. Burden, reward and family functioning of caregivers for relatives with mood disorders: 1-year follow-up. *Journal of Affective Disorders*. 2004;83(2):221-225.
86. Hodges K, Wotring, J, & Pennel, J. Using a data support system to build an empirically-based culture for change. Presentation at the 19th annual conference: A system of care for children's mental health: Expanding the research base, February 2005, Tampa, FL; 2006.
87. Karger H, Stoesz D. *American social welfare policy: A pluralist approach*. Boston, MA: Allyn & Bacon; 2022.
88. Karlin N, Bell P, Noah J. Long-term consequences of the Alzheimer's caregiver role: A qualitative analysis. *American Journal of Alzheimer's Disease and Other Dementias*. 2001;16(3):177-182.
89. Kawanishi, Y. *Families coping with mental illnesses: Stories from the US and Japan*. New York, NY: Taylor & Francis Group; 2006.
90. Lazarus J. *Stress relief & relaxation techniques*. Los Angeles, CA: Keats; 2000.
91. Lazarus R. *Stress, appraisal, and coping*. New York, NY: Springer; 1974.
92. Lazarus R. Emotion and adaptation. In E. Jenkins, J. Oatley, & J. Stein (Eds.): *Human emotions: A reader*. Boulder, CO: Blackwell. 1991;38-43.
93. Lazarus, R. Coping theory and research: Past, present, and future. *Psychosomatic Medicine*. 1993;55:234-247.
94. Lazarus RS, Cohen JB. Environmental stress. In I. Altman & J. F. Wohlwill (Eds.): *Human behavior and the environment: Current theory and research*. New York, NY: Plenum. 1977;23-36.
95. Levine H. Reconstructing ethnicity. *Journal of the Royal Anthropological Institute*. 1999; 5(2):165-180.
96. Lombardo G. *Understanding the mind of your bipolar child: The complete guide to the development, treatment, and parenting of children with bipolar disorder*. New York, NY: St. Martin's Press; 2006.
97. Marshall C, Rossman G. *Designing qualitative research* (3rd ed.) Thousand Oaks, CA: Sage; 1999.
98. Marshall P. Human subjects protections, institutional review boards, and cultural anthropological research. *Anthropology*. 2003;76(2):269-285.
99. Michalak E, Yatham L, Kolesar S, Lam R. Bipolar disorder and quality of life: A patient-centered perspective. *Quality of Life Research*. 2006;15(1):25-37.
100. Moustakas C. *Phenomenological research methods*. Thousand Oaks, CA: Sage; 1994.
101. Olfson M, Blanco C, Liu L, Moreno C, Laje G. National trends in the outpatient treatment of children and adolescents with anti-psychotic drugs. *Archives of General Psychiatry*. 2006;63:679-685.
102. Oliwenstein L. *Psychology today: Taming bipolar disorder*. New York, NY: Penguin; 2004.
103. Olson P, Pacheco M. Bipolar disorder in school-aged children. *Journal of School Nursing*. 2005;21(3):152-157.
104. Ong S, Caron A. Family-based psychoeducation for children and adolescents with mood disorders. *Journal of Child & Family Studies*. 2008;17(6):809-822.
105. Parekh B. *Rethinking multiculturalism: Cultural diversity and political theory*. London, England: Macmillan; 2000.
106. Patton M. *Qualitative evaluation and research methods* (2nd ed.) Newbury Park, CA: Sage; 1990.
107. Perlick D, Rosenheck R, Clarkin J, Maciejewski P, Sirey J, Struening E, Link B. Impact of family burden and affective response on clinical outcome among patients with bipolar disorder. *Psychiatric Services*. 2004; 55(9):1029-1035.
108. Peterson G, Hennon C. Conceptualizing parental stress with family stress theory. In P. McKenry & S. Price (Eds.): *Families and change: Coping with stressful events and transitions* (3rd ed.) Thousand Oaks, CA: Sage. 2005;25-48.

109. Richards H, Schwartz L. Ethics of qualitative research: Are there special issues in health services research, *Family Practice*. 2002; 19:135-139.
110. Richards L. Closeness to data: The changing goals of qualitative data handling. *Qualitative Health Research*. 1998;8:319-328.
111. Richards L. Data alive! The thinking behind NVivo. *Qualitative Health Research*. 1999;9, 412-428.
112. Richards L. Handling qualitative data: A practical guide. London, England: Sage; 2005.
113. Richardson, J. The concepts and methods of phenomenographic research. *Review of Educational Research*. 1999;69(1):53-82.
114. Sadala M, Adorno R. Phenomenology as a method to investigate the experiences lived: A perspective from Husserl and Merleau-Ponty's thought. *Journal of Advanced Nursing*. 2001; 37(3):282-293.
115. Sandelowski M. Telling stories: Narrative approaches in qualitative research. *Journal of Nursing Scholarship*. 1991;23(3):161-6.
116. Schwandt T. Three epistemological stances for qualitative inquiry. In N. Denzin & Y. Lincoln (Eds.): *Handbook of qualitative research* (2nd ed) Thousand Oaks, CA: Sage. 2000;189-213.
117. Selye H. *Stress without distress*. Philadelphia, PA: Lippincott; 1974.
118. Selye H. *The stress of life* (2nd ed.). New York, NY: McGraw Hill; 1978.
119. Selye H. *History and present status of the stress concept*. New York, NY: McGraw Hill; 1985.
120. Shaver P, Schwartz J, Kirson D, O'Connor C. Emotion knowledge: Further exploration of a prototype approach. *Journal of Personality and Social Psychology*. 1987;52:1061-1086.
121. Simon L. *Bipolar: My bipolar road trip in 4-D*. New York, NY: Washington Square Press; 2002.
122. Singh T. Pediatric bipolar disorder: Diagnostic challenges in identifying symptoms and course of illness. *Journal of the American Academy of Child Adolescent Psychiatry*. 2008;44:213-222.
123. Stephens M, Franks M, Atienza A. Where two roles intersect: Spillover between parent care and employment. *Psychology and Aging*. 1997;12:30-37.
124. Viner R. Putting stress in life: Hans Selye and the making of the stress theory. *Social Studies of Science*. 1999;29(3):391-410.
125. Vitaliano P, Young H, Zhang J. Is caregiving a risk factor for illness? *Current Directions in Psychological Science*. 2004;13(1):13-16.