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BIPOLAR DISORDERS IN YOUNG ADULTS

Maria Nascimento Cunha

Instituto Superior de Educação e Ciências (ISEC Lisboa). Membro do conselho científico do CIAC – Centro de Investigação de Artes e Comunicação

ABSTRACT

Approaching human development is exploring a vast terrain, whose central nature is that of discovery, change, advances, new acquisitions and growth.

Psychology brings us to human self-contemplation with a scientific character, a science that seeks to understand the processes that justify and drive human behavior, through the observation and study of behavior, and psychological phenomena, in all their complexity and multifactorial, namely, stimuli, genetic predisposition, physiological system, cognitive system, social and cultural environment, previous life experiences and personal characteristics.

Keywords: human development; bipolar disorder; adults

Cognitive development

Cognition is the process of learning and elaborating knowledge. The human being develops his capacities, intellectual and emotional, from this process. It is closely linked to behavior, learning, reception and elaboration of the various stimuli arising from the interaction of the Self with society. It is the way of processing, structuring, memorizing and interpreting received information. In this process, what is fundamental is the individual's interpretation of the stimulus received, as well as the motivation and interest in doing so. Cognitive functions directly influence the capacity for emotional regulation, decision-making and impulse control, fundamental characteristics for maintaining interpersonal relationships, for quality of life and consequently for mental health.

According to models that assume a knowledge development perspective, thinking evolves sequentially

from less structured levels to more structured and elaborate levels. Cognitive development is seen as a sequence of irreversible stages, involving changes in the process by which individuals perceive and reason about their world.

Piaget – formal thinking

Cognitive development in adulthood was not addressed by Jean Piaget, who divided cognitive development into four stages, as follows: Sensory-Motor Stage (18-24 months); Preoperative Stage (2 to 7 years); Operative-Concrete Stage (7 to 11 years old); the fourth and last Formal-Operative Stage (11 years and beyond). The operational-formal stage, last addressed by Piaget, refers to the individual's ability to use abstract and symbolic reasoning. Individuals at this stage are already able to see other people's perspectives. Developing hypothetical-deductive thinking. We can say that there is a beginning of flexibility. In short, these are Piaget's significant contributions to this study.

John Dewey - reflective thinking

The American philosopher John Dewey, among other accomplishments, stood out for emphasizing that the educational experience must be reflective, resulting in new knowledge. The author proposes reflective thinking through exchanges of experiences, thinking about the world in contact with the world.

Dewey (1979) described reflective thinking as a self-analysis that the individual makes when faced with real problems, continually reassessing their values, beliefs, assumptions, principles and hypotheses, in the face of contrasting information and the various forms of interpretation relevant to these conflicts. This author distinguishes two important moments for the development of reflective thinking.

The first moment, when faced with real, conflicting situations, the subject is invaded by a state of doubt, hesitation, mental perplexity, that is, a cognitive dissonance, consequently originating the act of thinking. In a second moment, this individual seeks reliable, scientific knowledge, to form his critical sense on solid bases. It is the beginning of a flexibility of thinking. We can say that it makes the bridge between the formal thought described by Piaget and the post-formal thought - more elaborate.

It is concluded that reflective thinking resorts to personal experiences, the exchange of experiences and the willingness to investigate scientific knowledge as a basis for the critical formation of an individual. This style of thinking appears between the ages of 20 and 25, it is also linked to psychobiological development, since the more myelinated the brain becomes, the number of synapses and dendritic connections increases until the cortical connections become thicker and denser.

The individual, faced with a real and conflicting situation, is able to preliminarily examine the circumstantial context, identify the etiology of the problem, create hypotheses that will be tested in the future in an attempt to solve the issue, elaborate these hypotheses and finally test them.

Jan Sinnott - post-formal thinking

In the 70s, a significant group of authors questioned the existence of a continuation of cognitive development beyond that described by Piaget, which would be the emergence of the 5th stage. Under the argument that there is a continuity of development in adult life, a more complex form and less dependent on logic and the duality of truth vs. lies, this new area of development was named by Jan Sinnott (1993) as post-formal.

Post-formal thinking emerges in early adulthood, with the emergence of reflective thinking, and develops primarily through university study. The ability to deal with inconsistency, contradiction, imperfection, ambiguity, uncertainty and tolerance comes about through the sum of resources, namely personal experiences, intuition, logic and emotion. Greater complexity of cognitive operations, as it combines the subjective, emotional and symbolic with the logical, analytical and objective components of the previous stage. Allowing a relativism of knowledge, acceptance of contradiction and synthesis between discordant elements. It is the most advanced level of cognitive development.

K. Warner Schaie

K. Warner Schaie's model of development integrates cognitive development into the social context. For this author, there are three motivating goals that must be applied in each of the seven stages. The motivating goals start with the acquisition of knowledge and skill, that is, what the individual needs to know. The second refers to practical integration, that is, using the acquired knowledge and skills. And the third goal, called “search for meaning” by Schaie, refers to the need for knowledge or skill that the individual should have, but which for some reason still does not have, in order to solve a practical question, therefore it would be what should know.

The seven stages are: Acquisitive, Fulfilling, Responsible, Executive, Reorganizing, Reintegrating, and Inheritance Creation. We will only address stages one, two and three (acquisitive, achieving and responsible), as they are the most relevant for this study.

The acquisitive stage occurs in childhood and adolescence. It is about acquiring information and skills for one's own worth or as preparation for participation in society.

The achieving stage is between late teens and early thirties. The knowledge and skills acquired in the previous stage are used to achieve goals, usually related to entering adult life, unlike the previous stage, this acquired knowledge is focused on the outside, for professional progress and for a new family composition. Once again, we see how much cognition interferes with psychosocial development and how much these skills are interconnected.

The responsible stage begins at approximately age 30 and lasts until age 60. At this stage, the individual uses his knowledge and skills not only to solve practical problems in his own life, but as he does for those who somehow live in a relationship of dependency with him, such as children or employees.

Psychosociological development

Erik Erikson

Erikson's theory of psychosocial development is innovative in considering identity formation as a lifelong construction process. Development takes place in the interaction between individual, environment and historical moment. Each individual is shaped, in part, by environmental and historical circumstances shaping the environment and influencing the course of history. In this way, and despite being based on the Freudian theory that considered that the personality is formed in the first six years of life, giving primacy to the unconscious processes in the relationship with the parents, Erikson does not believe in this irreversibility of the personality, defending its construction throughout the existence of the subject.

Thus, personality development is not limited to childhood, despite considering it an important period. (Erikson, 1976).

The period most relevant to the author is adolescence, where the task of constructing identity is a primary task, which is why it is a phase of reconstruction of previous stages and preparation for adult life. In adult life, he considers investment in the next generations and reflection/balance on life to be tasks.

The stages of human development in young adults

Erikson (1968, 1976, 1980) describes psychosocial development in 8 stages. At each stage, the subject is faced with carrying out developmental tasks requiring, for their resolution, to carry out a new synthesis or dynamic balance of the self-depending on the period of physical/cognitive growth in which he is situated and the demands of society. That is, throughout development, society places new demands on the ego, implying that the individual develops skills to deal with these demands. Each stage involves specific developmental tasks (of a psychosocial nature), referred to in two opposite terms - that is why they are called bipolar crises, resolution can take place in two ways: either it occurs in a balanced and dynamic way between two poles or which contributes to the harmonious development of the personality; or, it occurs predominantly in the negative or positive pole, entailing implications for the individual's psychosocial adjustment and the quality of resolution in later stages. At each stage, the word crisis means a turning point with implications for the individual's development.

Each age or period of development is characterized by specific tasks (which must be accomplished to progress to the next stage) and by the experience of a particular conflict or crisis. It is through the resolution of the conflict of each stage that the individual acquires new capacities, that he develops.
The resolution of a given stadium is independent of the resolution of the previous one, but the resolution quality of a current stadium depends on the previous ones. However, these positive (adjustment) or negative (disadjustment) resolutions are not definitive.

Description of the stages of psychosocial development from stage six, the phase covered in this study.

Stage 6 - Intimacy vs. Isolation

Defined by the author as the Young Adult phase, it covers individuals aged between 20 and 35 years. With an identity already constructed, the young adult's task is to develop intimate relationships, whether romantic or friendly. Intimacy encompasses feelings of attachment, proximity and bonding, unlike the relationship models of the previous phase. If you cannot establish these social ties, you may isolate yourself by distancing yourself from others. In fact, he is afraid to establish relationships and therefore avoids commitments. The basic question of this stadium is "Will I share my life with someone else or will I live alone?".

The balanced resolution of the crisis produces the virtue of love, conceived as the ability to be with others (not only in the context of loving relationships, but also in the context of friendly relationships) feeling comfortable with oneself. In fact, the development of a sense of true intimacy is only possible after acquiring the identity

In this way, intimacy is the ability to unite one's identity with that of another person without fear of losing something of oneself. This union, which goes beyond sexual fulfillment, implies the ability to establish relationships of sharing and mutuality, which can exist even in the physical absence of the partner. Intimacy implies communication, identity sharing and can exist both in friendship relationships and in love and sexual union with the same sex or with the opposite. According to Erikson (1976, 1980) the danger of this stage is the deep feeling of isolation, that is, the avoidance of contacts that imply intimacy and the search for stereotyped interpersonal relationships. This distancing contributes to polarized relationships. The individual becomes self-centered, the "other" becomes an object of exploitation. Difficulties in establishing intimate relationships with another person often give rise to pathological situations at this stage, because they reveal a latent fragility of identity (Erikson, 1976, 1980). Young people are often afraid to become intimately involved with others for fear of losing their own identity.

The family and psychosocial development

For Erikson (1968) a secure sense of identity is an important developmental item with which the young person is confronted, marking the end of adolescence, being a condition for later true individual maturation. In this process we cannot forget the importance of family characteristics. Conger & Peterson (1984) refer that the approach of developmental tasks, their success or lack thereof, in resolving these crises are significantly affected by the quality of the parent-child relationship. Bhushan & Shirali (1992) found that subjects with greater identity belong to balanced families, who experience more openness and fewer problems, placing the family at the center of psychosocial development. Kamptner (1988) obtained results that indicate that security in family relationships promotes the development of identity directly and also indirectly by increasing the adolescent's social confidence. Other studies (Adams & Jones, 1983; Grotevant & Cooper, 1983) have observed that family environments that are cohesive and warm, expressive, and that promote open discussion, facilitate identity development.

The results of the aforementioned studies reveal a conceptual link between the family context and youth development. For all these reasons, we can say that the family, in which an individual is born and raised,

has an important effect on shaping psychological development and the quality of subsequent interpersonal relationships.

In fact, it is in the family of origin that the child acquires security and, consequently, the basic trust that makes it possible to explore the world and establish future meaningful relationships with others. In this process, we cannot neglect the perceptions that each member of the family has about the atmosphere and satisfaction experienced in the family. For this very reason, we consider important the subjective evaluation that the individual makes of the family context and we tried to evaluate it in this study.

Normality and pathology in human development

The term "normal" when dealing with human evolution should not be understood as a value judgment, but as a scientific parameter to evaluate certain paths, forms and expressions of development. According to Foucault (1989) and Koller (2011) the idea of normality has been used as an instrument of social control, defining behaviors, thoughts and feelings as "appropriate" for a given population. On the other hand, Helen Bee (2000) states that there is a fine line between what happens in an atypical or typical way, since some problems considered deviant may, at certain stages, be part of normative development.

The truth is that the idea of pathology is almost always associated with something negative, such as illness. A vision based on biomedical parameters, which do not always consider the individual in a holistic and integrated perspective.

The concept of mental health is broad, and its definition or identification of what determines it is not always easy. However, just as health is not just the absence of disease, so mental health is more than just the absence of mental disturbance. In this sense, it has been increasingly understood as the product of multiple and complex interactions, which include biological, psychological and social factors (Alves and Rodrigues, 2010; Gama et al. 2014).

The Psychiatric Classification Manuals DSM-5 / CID-11

There are two fundamental manuals for diagnosis: the Diagnostic and Statistical Manual of Mental Disorders, 5th edition, or DSM-5, developed by the American Psychiatric Association (APA) and the International Classification of Diseases (ICD), or ICD-11, which in January 2022 became available completely digitally, recently approved by the WHO Assembly - World Health Organization.

Both are very important work tools as they bring a certain uniformity to medical practices, diagnostic and intervention measures, that is, they allow for the creation of understandable standards and categorizations in different geographic and scientific areas. The DSM-5 values cultural issues more than the ICD-11, which allows it to be more cross-cultural and applicable in different parts of the world, not taking this component into account. Deep down they complement each other and have the same common goal.

However, there are important criticisms of these tools, the most common being the understanding that too much primacy is being given to symptomatology, placing non-biological issues, such as the history of life

experiences, in the background. Russo & Venâncio (2006) point out that the most recent versions of these manuals abolished the so-called dimensional diagnosis, which involved a kind of continuity between the different frames, with no sharply demarcated and rigid borders, being replaced by a classification where the borders were well delimited and objective. They draw attention to the strictly biological view articulated to the hegemony of pharmacological treatment. These researchers question whether the growth the disproportionate number of diagnostic categories is not closely related to the production of new drugs, that is, an economic interest.

David Kupfer, who chaired the task force of the American Psychiatric Association for the 5th edition of the DSM, was scientifically based on works in neurobiology and the importance of the etiology of psychiatric disorders (Surís et al., 2016), as well as on the consensus of experts (Stein & Reed, 2019). The research focused on long-term treatment strategies for recurrent mood disorder, the pathogenesis of depression, and the relationship between biomarkers and depression. Of paramount importance for the study of bipolar disorders, he was the founding president of the International Society of Bipolar Disorders - International Society of Bipolar Disorders (ISBD), which has the Australian Gin Malhi as its current president.

In the same way that, for a better theoretical support in the diagnosis and in the textual description of the disturbances, dimensional, transversal, historical and environmental aspects of the disturbances were proposed.

With regard to the ICD-11, there has been a change in reasoning based on the study of the causes and mechanism of development of a pathology. (Gaebel et al., 2020). In order to remedy previously criticized issues at the level of neuroscience and global mental health, they protect the idea that the diagnosis should be dimensional and not categorical, by crossing an entire spectrum, allowing health agents to intervene in a more specific way (Reed et al., 2019; Santos et al., 2020).

This allows a staggered presentation of disorders and their symptoms, by making them qualitative, despite generating greater complexity in diagnoses, compromising clinical practice (Gaebel et al., 2020).

Bipolar disorders

Bipolar Disorder, which was originally called "manic-depressive insanity", appears between the ages of 15 and 25, is manifested mainly by severe fluctuations in mood, characterized by episodes of mania and depression, interspersed with periods of apparent normality. It manifests itself with cognitive, physical and behavioral symptoms. It is a chronic condition, which accompanies the entire life cycle of the individual and this translates into a serious maladjustment in occupational and social interactions. Present in about 0.5 to 1 percent of the population, it is more frequently diagnosed in women, at a ratio of 3 to 2 (Andreasen and Black, 1991).

According to the DMS-5, Bipolar Disorder can be divided into two classes: Type I, characterized by at

least one manic episode, which may or may not be accompanied by depressive episodes; and Type II, characterized by hypomanic episodes, accompanied by at least one major depressive episode.

“The distinction between bipolar I and bipolar II is based on the presence or absence of hospitalization for mania.” (M.C.Hardy-Bayle , 2001, p.14

The use of the specifier “with mixed features” applies to states in which there is concomitant occurrence of manic and depressive symptoms, although these are seen as opposite poles of mood. Cyclothymic Disorder is characterized by alternation between hypomanic and depressive periods over at least two years in adults (or one year in children) without, however, meeting the criteria for an episode of mania, hypomania or major depression (APA, 2014).

The diagnosis is made by clearly identifying symptoms of mania, hypomania and major depression (Appendix A), taking into account the frequency and time these symptoms have been present, and by checking the clinical and personal history of the patients, followed by of a longitudinal follow-up of the evolution of the disease. It almost always arises following the individual's own complaints or expressions of concern from family members or friends. The causes that seem to be at the origin of this disorder are biological and environmental, so family history and current work or social contexts must be considered during the treatment/intervention.

Elevated or irritable mood can be classified as mania or hypomania, depending on its severity and the presence of psychotic symptoms. Mania is a severe state of high mood or irritability, associated or not with psychotic symptoms, which cause changes in the individual's behavior and functionality. The duration of the manic state must be at least one week, with elevated mood or irritability present most of the day, nearly every day. The minimum duration criterion is unnecessary if hospitalization is necessary. In hypomania, mood elevations and behavioral/functional disturbances are less severe and with a shorter duration than the manic state (four consecutive days), which usually does not bring the person to medical attention. However, hypomania can progress to mania (AKISKA, 2002).

It should be noted that the presence of psychotic symptoms is always indicative of a serious condition and, even if the other activation symptoms are not so prominent, it automatically rules out the possibility of a hypomanic episode. This is a mistake frequently made in the psychiatric clinic, especially among less experienced professionals.

Due to the marked impairment and clinical severity of full-blown mania, the DSM 5 recommends adopting the diagnosis of manic episode with mixed features for individuals who present with symptoms that simultaneously meet the criteria for mania and depression.

DSM 5 also includes the category “other specified bipolar disorder and related disorder” to classify atypical conditions, marked by the occurrence of symptoms that do not meet the minimum duration and

frequency criteria to characterize even an episode of hypomania (APA, 2014).

Symptomatology

In this fluctuation of states, the following symptoms may be self-reported or observable:

Symptoms of Mania: Increased energy levels, restlessness; Increased activity (social, sexual and motor); Elevated, exaggerated mood; Strong Irritability; Talking too much or too fast; Distractibility, lack of concentration; High self-esteem or grandiosity; Unrealistic thoughts, flight of ideas; Bad assessment of situations which leads to taking unnecessary risks and prone to accidents.

Symptoms of depression: Depressed mood, constant sadness, anxiety, feeling empty; Pessimism; Feeling of worthlessness, complete hopelessness; Loss of interest and pleasure in any activity; Lack of energy, constant fatigue; Lack of concentration, memory; Inability to make decisions; Sleep disturbances, sleeping a lot or not being able to sleep at all; Recurrent suicidal ideation, being able to elaborate a plan or carry out a suicide attempt.

Common diagnostic mistakes

Not being easy to diagnose, common mistakes often occur, which have serious consequences. A diagnostic error leads to errors in prognosis, errors in intervention, such as wrong medication or therapies, with results for the patient that can be decisive for their quality of life or even put their lives at risk.

Here are the three most common misdiagnosis errors:

1. confuse recurrent episodes of major depression with normal reactions to life's difficulties;
2. fail to detect manic or hypomanic episodes;
3. Judging the patient to have schizophrenia rather than bipolar disorder with psychotic features during manic, mixed, or major depressive episodes (Basco & Rush, 2009, p. 27)

Risk factors

First degree relatives; Unemployment, since employment is proven to be a protective factor in mental health issues; Low socioeconomic status - the context influences our possibilities, our experiences and, consequently, our successes and frustrations. Even more, in access to primary diagnostic care, either for financial reasons or for “sensitivity” to recognize that there is a problem; SNS injuries; Negative experiences (such as bereavement); Single Marital Status – lack of social relationships, isolation from oneself and in relation to others. We are social beings; Low self-concept; Use of drugs

Treatment/Intervention

Medication, with mood stabilizers, anticonvulsants and antipsychotics. According to published clinical trials, for episodes of Mania, lithium, divalproex and antipsychotics such as olanzapine, among others, are administered. For depressive episodes, they also include lithium, lamotrigine and quetiapine, or the combination of selective serotonin reuptake inhibitors (SSRI).

- Psychotherapy (for the individual, extended to the family). It will help especially in understanding and accepting the condition, which is chronic, learning to deal with negative emotions and thoughts.- Electroconvulsive Therapy (ECT) – Electric shocks to the brain

The combination of medications, patient-to-patient adjustment, as well as simultaneous psychotherapy, have improved the prognosis for these patients.

Interference of Bipolar Disorders in cognitive and psychosocial development

It is noticed that bipolar disorders, having a psychotic nature, are related to violent, antisocial behavior, violence both towards the close family and towards the community in general. Misfits in school or work performance, unhealthy relationships, and divorce. Associated mental disorders arise from Anorexia Nervosa, Bulimia Nervosa, ADHD, Panic Disorder, Social Phobia and Substance Abuse Related Disorders. Bipolar II Disorder is more common in women than men who may have an increased risk of developing postpartum episodes.

For all this, we can see that bipolar disorders affect individuals physically, psychologically and socially, their families and their friendships and relationships, and can be more or less disabling depending on the predominance of symptoms.

CONCLUSION

It will be necessary to continue to act as early as possible, investing in diagnosis, intervention for their own sake and the inherent social impact (both at a human level, as well as a source of expense).
We would like to leave some important questions for reflection:
- Do you consider that there is an underestimation of this disturbance? Could the number of cases be higher and not be diagnosed?
- Once the problem has been identified, will the intervention be working?
- What measures can be taken to make the patient accept their condition and, more importantly, adhere to an adequate follow-up/treatment?
- Will the families be supported and prepared to deal with these patients? What can be done?

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