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Emma Anne Jacobs

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**Living with Manic Experiences:
An Interpretative Phenomenological Analysis**

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ABSTRACT

Although psychological research into manic experiences is increasing, it remains an under-researched phenomenon. In particular, there is a dearth of qualitative research exploring these experiences in a clinical sample of people diagnosed with Bipolar Disorder. This study examined six participants' experiences of mania using Interpretative Phenomenological Analysis. Through semi-structured interviews, the participants provided detailed accounts of how they made sense of and experienced their manic states. Three master themes were described: "A mixed relationship with mania," "A separate and controlled self", and "The struggle to be different."

The first master theme explored the participants' mixed and ambivalent relationship with their manic experiences. These were viewed as both alluring and dangerous, but overall the perceived costs had outweighed the benefits, for all but one of the participants. Most participants described losses in relation to giving up their manic experiences, as well as losses related to the destructive consequences of their episodes. The second master theme examined perceptions of mania as a separate, uncontrollable phenomenon, over which they had little influence. It was hypothesised that these explanations served to relieve these participants from underlying negative emotions, such as guilt, regret, shame and self-stigma. The third master theme described how manic experiences had represented struggles to be different. These included a struggle against society; a struggle to experience a preferred self; and a struggle to access very unique experiences or abilities.

A number of issues were discussed in relation to the above themes. These included positive and conflicting appraisals of high moods; loss; entrapment and helplessness; ambivalence; negative moral emotions and a preferred manic identity. A range of therapeutic approaches were suggested as potentially helpful for some of these issues. These included Motivational Interviewing, Narrative, Constructivist and Compassion therapies. Additionally, the findings of the study provided support for existing therapies for Bipolar Disorder; particularly Cognitive-Behavioural Therapy (CBT) and Interpersonal & Social Rhythm Therapy (IPSRT).

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1: INTRODUCTION

1.1. PREFACE

This study examined accounts of manic experiences in six individuals diagnosed with a Bipolar Disorder (BD) using Interpretative Phenomenological Analysis (IPA). The analysis involved an in depth exploration of the participants' manic experiences and their understandings about them.

1.2. BACKGROUND

BD is a severe mental health problem which involves marked changes in mood from periods of deep depression to periods of chaotic, overactive behaviour known as mania. These mood changes are known as episodes, although people with this diagnosis often experience distressing sub-clinical mood instability in between episodes (Miklowitz & Johnson, 2006).

During manic episodes, individuals might experience euphoria, dysphoria, increased hedonism, psychomotor pressure, psychosis and irritability (Bentall, 2004). Episodes are also associated with impulsivity, disinhibition and risk-taking (Leahy, 2005). There is debate concerning whether individuals experience dysphoria simultaneously with euphoria, whether dysphoria is experienced at a later stage of mania, or whether these are experienced as ultra-rapid transitions between mood states (Bentall, 2004).

Sometimes manic experiences are referred to as hypomania; this is when the experience is less severe, lasts for less than a week or does not result in hospitalisation. They can also be known as 'highs' although this is arguably misleading, as manic states are at times experienced as distressing and unpleasant (Goodwin & Jamison, 1990). For the purposes of this study, the terms mania, manic experiences and high moods will be used interchangeably. Hypomania will also be used when referring to a milder state of mania.

The World Health Organisation identified BD as one of the top causes of lost years of life and health in 15-44 year olds, ranking above war, violence and schizophrenia. Furthermore, BD is

associated with higher rates of suicide than any other psychiatric diagnosis (Miklowitz & Johnson, 2006), with estimates as high as 20% (<http://www.bipolar-foundation.org>). The prevalence for Bipolar Disorder is thought to be 1.5% of the population (Bebbington & Ramana, 1995), and approximately 6.5% when including Bipolar spectrum disorders.

1.3. REVIEW OF RELEVANT PSYCHOLOGICAL THEORIES

Psychological theories of mania can be found in the psychodynamic, systemic and cognitive-behavioural literature. It is presently an exciting time in the field, with increasing attempts to develop psychological conceptualisations, particularly from the cognitive-behavioural perspective. However, despite these encouraging developments, mania is reportedly the least researched of psychiatric problems (Bentall, 2004). Below, extant theories from varied theoretical perspectives are presented, although it was noted that there was crossover between these approaches.

1.3.1. Psychodynamically informed theories

In psychodynamic theory individuals are considered to be governed by unwanted feelings and impulses, and the wish to ward off the pain caused by these through the use of unconscious defences (Leiper, 2006). Applied to BD, theorists described a manic defence hypothesis (Abraham, 1911; Bentall, 2004; McWilliams, 1994; Neale, 1988). Mania is regarded as a defence mechanism to protect the individual from underlying intolerable depression and low self-esteem.

McWilliams (1994) described how the person in a manic state can feel invulnerable, immortal, and assured of success. She postulated that self-esteem is maintained in mania by the elation associated with captivating others. More recently, Neale (1998) and Bentall (2004) developed links between this hypothesis and cognitive-behavioural theory. Neale (1988) contended that when negative events trigger low self-esteem, the person responds with grandiose ideas, which inhibit distressing beliefs about the self. These grandiose ideas escalate causing elevated mood and eventually mania.

Bentall (2004) similarly described a Dysphoria model in which mania is viewed as a response to depression related dysphoria via the pathway of risk-taking, leading to excitement, sleep loss and then mania. Euphoria and energy leads the person to believe that they are capable of extraordinary feats, altering current (depressive) beliefs about the self. Therefore, mania involves a person attempting to regulate their emotions by avoiding exceptionally distressing thoughts, and replacing them with thoughts of great capability and self-belief. Bentall (2004) cited research which demonstrated the mixed, dysphoric nature of episodes (Goodwin & Jamison, 1990) as evidence in favour of the manic defence hypothesis. The defence of euphoria is thus punctuated with the true underlying feelings of depression.

1.3.2. Cognitive-behaviourally informed theories

A range of cognitive-behavioural models of BD exist, many of which focus on appraisals of mood states and associated behaviours, as well as vicious cycles leading to the escalation of symptoms. In traditional CBT, it was hypothesised that a cognitive style existed during mania which was opposite to the depressive cognitive style. During mania, individuals perceive themselves as talented, superior and creative as opposed to worthless, slow and unlovable, and the future is regarded as full of unlimited possibilities rather than hopeless and pessimistic (Beck, 1967; Leahy and Beck, 1988). It is proposed that these cognitive styles have subsequent effects on mood and behaviour that perpetuate manic symptoms.

A further CBT conceptualisation suggests that dysfunctional assumptions surrounding extreme goal attainment lead to highly driven behaviour in mania and, self-blame for failure to meet standards in depression (Lam et al., 1999). These dysfunctional assumptions are postulated to interact with the condition and to be associated with more severe symptoms (Lam et al. 2004). For example, the belief that ‘one should excel at everything if one puts in enough effort’ may lead to driven behaviour, poor routine and sleep disruption, thereby prompting a manic relapse.

More recently, Mansell et al. (2007) developed the Integrative Cognitive Model (ICM), as a proposed refinement of existing cognitive-behavioural models of BD. Additionally, they associated their model with metacognitive theory (Wells, 2002) and the transdiagnostic approach

(Harvey et al, 2004), which contended that a range of psychological problems can be conceptualised according to similar processes. These surround problematic, and often catastrophic appraisals of intrusions (e.g. affect, thoughts and images), which are influenced by beliefs which have been learnt according to life experiences. These appraisals then lead to potentially unhelpful strategies for self-regulation.

Mansell et al.'s (2007) model emphasised interpretations of intrusions and changes in internal states. People with BD are believed to experience multiple, conflicting extreme personal appraisals for their intrusions and internal states, which interfere with mood regulation. Only one appraisal is thought to occupy awareness at any one time, but they have the capacity to switch with one another as the symptoms develop. These appraisals surround beliefs about mood and mood regulation and beliefs about self and self in relation to others. Examples of potential appraisal categories include catastrophe ('I am about to lose control of my mind'), success ('I have the energy to do anything I want', 'I can overcome my depression') social approval ('I can make everyone admire me') and self-criticism ('I am making a fool of myself').

These conflicting meanings lead to efforts to exert control over internal states by *ascent* or *descent* behaviours (for example, to prevent the feared catastrophe or attain success), which paradoxically provoke further mood changes, leading to a vicious cycle maintaining symptoms. Ascent behaviours include increased activities, risk-taking, substance misuse and sleep deprivation. Descent behaviours are deactivating, for example social withdrawal, extended sleep, rumination and self-critical thinking. Both behaviour types have consequent impacts on mood.

The model proposed that appraisal of changes in internal state, and the associated ascent/descent behaviours, are influenced by personal beliefs regarding the self and others; beliefs about information processing such as rumination, and beliefs about affective and physiological states. These beliefs are in turn likely to be affected by past life experiences, and current events. The model explained how escalation of symptoms occurs via changes in internal state, extreme appraisals, and attempts to control or enhance internal state changes, leading eventually to the confirmation of dysfunctional beliefs. The model is illustrated graphically in Figure 1. below.

Overall, it is the underlying meta-cognitive beliefs and the conflict between them that is seen to provoke mood symptoms. Suggestions for effective treatment include the development of mindful awareness of state changes, the acknowledgement of normal mood fluctuations, challenging extreme appraisals, and experimenting with ‘balance’ behaviours. For depression this could involve avoidance of social withdrawal and less rumination and for high moods the client could practice inhibiting ascent behaviours.

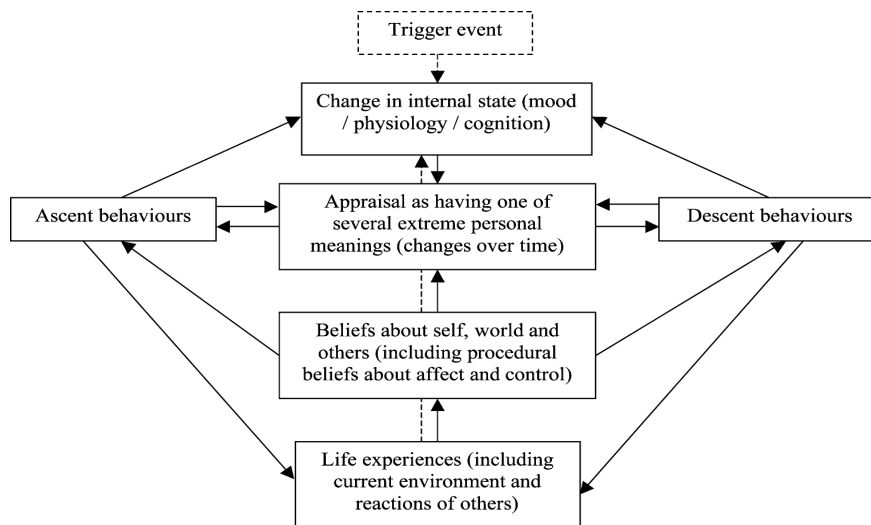


Figure 1.. Integrated Cognitive Model of Bipolar Disorder, reproduced form Mansell et al. (2007)

1.3.3. Contextually informed theories

Contextually informed theories of mania focus on interpersonal relationships. These draw from both systemic and Interpersonal Therapy perspectives. Systemic theory focuses on the systems of interaction between family members, with an emphasis on relationships as an important factor in psychological health (Carr, 2006). A number of studies have explored the role of families who display “High Expressed Emotion” (EE) towards the person with BD and have demonstrated its relationship with greater relapse rates (Miklowitz et al., 1988; Miklowitz et al., 2000; Miklowitz et al., 2005). High EE refers to intrusive, over-involved and hostile comments, and the effects of these are thought to be particularly marked when they have emanated from parents (Miklowitz et al., 2000).

Interpersonal Therapy (IPT; Robertson, 1999) and Interpersonal & Social Rhythm Therapy (IPSRT; Frank et al., 2000; Swartz et al. 2004) are therapies which have been applied to BD, and focus on social context. Both seek to address the interpersonal conflicts which people diagnosed with BD might face within their social networks. The theory is partly based on the notion that problems in relationships can cause recurrences of manic and depressive episodes, and therefore are important targets for intervention.

1.4. REVIEW OF RELEVANT QUALITATIVE STUDIES

Qualitative research enables rich descriptions of phenomena and can provide insight in to the meanings of experiences (Barker et al., 2005). Such approaches have seen increased prominence in research, as the qualitative paradigm has become more accepted as an important contribution to the evidence base (Brown & Lloyd, 2001). Smith (1996) contends that qualitative approaches are particularly useful when applied to mental health, to explore participants' own frames of reference, and their accounts of their conditions.

My review of the qualitative literature highlighted a wealth of qualitative research exploring a broad range of mental health experiences. Of most relevance to the present study, there is considerable literature on accounts of psychosis, some literature on Bipolar Disorder, and a very limited literature on mania specifically.

Although psychotic experiences can be a component of mania (Bentall, 2004), the term psychosis is increasingly used as a substitute for 'schizophrenia' (Boyle, 2002). However, the qualitative literature on psychosis seemed a relevant area to survey as the schizophrenia diagnosis is, like BD, considered a form of severe mental distress. Furthermore, some of these studies include participants with a BD diagnosis.

1.4.1. Qualitative studies about psychosis

Psychotic experiences include symptoms such as hearing voices or seeing things that others do not ('hallucinations'), and holding unusual beliefs that most others in the person's social

environment do not share ('delusions'). These experiences have traditionally been seen as signs of severe mental illness (British Psychological Society, 2000).

Below four qualitative studies which explored the experience of psychosis will be reviewed. These particular studies were selected as they were considered as the most relevant. This is because, like the present study, all of these studies had a phenomenological flavour, and examined mental distress from the service user's perspective. Knudson & Coyle (2002) and Rhodes & Jakes (2000) specifically used IPA methodology. Two studies included participants with the BD diagnosis (Rhodes & Jakes, 2000; Yung & McGorry, 1996). Jones, Guy & Ormrod (2003) did not report the diagnoses of their participants, except to say that the participants heard voices. This study therefore might have included participants diagnosed with BD.

Knudson & Coyle (2002) analysed two case studies of people with a diagnosis of schizophrenia who heard voices, using IPA. The analysis focussed on the participants' meaning-making concerning their voices, specifically in relation to their nature and origin, and how these interpretations influenced their efforts at coping. One participant conceptualized his voices as dissociated aspects of himself. He consequently coped by accepting these aspects, and this strategy had reduced his distress. The second participant described several interpretations about the meaning of her voices, and this was reflected in related coping strategies relevant to these interpretations. Thus, in both cases, the participants described a relationship between the meanings they attributed to their voices and the coping strategies which they used.

The authors suggested that there might therefore be a relationship between voice-hearers' meaning-making and the coping strategies which they employ. Professionals should therefore promote meaning-making, alongside the development of related individualised coping responses. This, they contended, would stand in contrast to other approaches which have promoted more generalised coping strategies. Furthermore, such an approach, they suggested, differs from conceptualisations of voice-hearing which disregard the person's reality, and view such phenomena as symptoms of psychopathology. This study might have been improved with some more participants, to see if the convergences noted for these participants were relevant to other voice-hearers.

In a similar study, Jones, Guy & Ormrod (2003) examined how voice-hearers construed their experiences, using Q-sort methodology. They drew from a diverse sample of constructions related to voice-hearing, covering, biomedical, psychological and spiritual categories. The beliefs of eleven voice hearers who used mental-health services were compared with nine non-service users.

The diagnoses of the service-users were not stated. The non-service user participants included both religious and non-religious individuals. They found that whilst service users experienced their voices as largely negative (e.g. frightening, distressing), most non-service users experienced them as largely positive. It was suggested that non-users might be more able to frame their experiences positively because of their belief that their voices were less problematic. The authors linked this with research by Romme & Escher (1993) which suggested that the amount of distress experienced by voice-hearers related to the degree to which the experiences were seen as normal.

A possible limitation of this study was that non-users appeared to be treated as one group, compared to service users. However, there was a range of non-religious, spiritualist and non-conformist Christians amongst these participants. The study might have been improved by more comparisons between these non-user groups, as it could be helpful to note different interpretative frameworks based on different background. This, in particular, might be useful when working with service users who do happen to be religious. Furthermore, the religious backgrounds of the service-users were not reported; as such readers were unable to assess if some of the participants had both negative voices and religious beliefs.

The authors suggested that the Q-sort which they designed, which covered 45 statements about conceptualisations of voices, could be a useful therapeutic tool. This, they proposed, could aid the therapeutic relationship, in terms of the therapist demonstrating openness to the possible theories about voice-hearing.

Rhodes & Jakes (2000) examined delusions drawing from a range of qualitative methodologies, including IPA. They followed Oltmanns's (1988) definition that delusions are beliefs which are

incredible to most other people in the person's culture; are not questioned by the person, and are distressing and preoccupying. Participants had a range of diagnoses including schizophrenia and BD. The authors outlined four case studies, from their sample of fourteen participants, in order to illustrate their hypothesis. This focussed on the correspondences between delusional themes and the person's life experiences and personal goals.

In one example, the participant held the belief that he was being tested by demons, and if he got things wrong he would go to hell. Conversely, if he got things right he would go to heaven. This appeared to correspond to his concern about whether he was competent to face the tests of life, due to underlying feelings of past failure. In particular, his parents and sister had died, and he had been left to care for his younger siblings, which he perceived had not worked out well.

Based on their investigation, the authors contended that delusions correspond to important concerns in the person's life. They concluded that delusional talk is expressive of the person's phenomenological world, rather than merely a symptom of illness. Better appreciation of delusional talk, and how this relates to the person's goals was proposed as an aid to the therapeutic alliance. However, the authors recommended replication of their study to aid confirmation of their findings.

Yung & McGorry (1996) examined the psychosis 'prodrome' (the initial period of disturbance preceding a psychotic episode), using retrospective reports of twenty-one young adults who had experienced first episode psychosis. Participants with both schizophrenia and BD diagnoses were included. Participants were interviewed in the recovery phase after an acute episode, about the period leading up to their psychosis, and the data was analysed using thematic analysis.

The results suggested a variety of prodromal phenomena including brief psychotic symptoms; mood, anxiety and sleep problems; and behavioural changes. Symptoms were often distressing and included suicidal thoughts in about one quarter of those sampled. The authors concluded that the prodromal phase is associated with a high level of disability and increased suicide risk. In terms of the participants diagnosed with affective psychosis, mania specific prodromes were noted, including increased energy and activity, elevated mood, and disinhibition. These were

linked to the clinical impression that psychotic mania is preceded by hypomania. However, the authors did not provide a detailed exploration of the experience of the participants' manic prodromes using a rigorous qualitative method.

1.4.1.1. *Overview*

Both Knudson & Coyle (2002) and Jones, Guy & Ormrod (2003) explored accounts of voice-hearing. These studies highlighted the individualised meanings and theories about voices which the participants had. Rhodes & Jakes (2000) elucidated how delusional talk can correspond with the person's life experiences and goals. Similarly to the above two studies, this demonstrated that severe mental distress can have very personal meanings, rather than just be signs of illness. Yung & McGorry's (1996) study explored retrospective reports of the psychosis prodrome, including mania-specific symptoms. As with the above studies, participants provided accounts of their mental distress. Whilst some of these studies reported that their samples included people diagnosed with BD, exploration of the specific experience of mania was very limited.

1.4.2. Qualitative studies about Bipolar Disorder

There are a number of qualitative studies which have investigated experiences of BD, exploring topics such as self-management, employment, medication, identity and quality of life. Below a number of studies considered to be of the highest quality are reviewed. In the case of qualitative studies which duplicated the same topic (e.g. medication or employment), the study selected for review was considered to be of a higher quality. This might be because the explanation of the methodology was clearer, or the study was thought to be more adherent with professional guidelines for the publication of qualitative research (Elliot, 1999).

Russell & Browne (2005) investigated how people diagnosed with BD avoided episodes and managed to 'stay well'. One hundred people who had stayed well for at least two years were interviewed and data was analysed using thematic content analysis. Participants described individualised plans for staying well, and a broad range of strategies were employed. Overall, participants remained mindful of their disorder, and used some specific strategies, such as

identification of warning signs, managing sleep and stress, medication, and accessing support. For some, 'staying well' meant being symptom free whilst for others it meant being able to take control of their distress.

This study was novel in demonstrating that people with BD can manage their distress, which was encouraging as often research is focused on deficits. However, the majority of participants were over thirty, which meant that younger adults were not well represented. It could be the case that people over thirty had better learnt how to manage their problems due to having more experience of episodes.

Michalak et al. (2006) examined how a diagnosis of BD impacted upon quality of life (QOL) using interviews and thematic content analysis, with thirty-five individuals. The sample included individuals who had been well for several years through to individuals recovering from an acute episode. Whilst quantitative research has highlighted the negative impact of the diagnosis on QOL, there is little qualitative research on the experience of QOL for these individuals. Overall, the majority of the participants sampled described how BD had had a profoundly negative effect upon their QOL, often having severe, enduring effects on their educational, vocational, financial, and interpersonal functioning. It was therefore suggested that functional and not just symptomatic recovery should be a priority in therapy.

One limitation of this study was that it did not adequately capture those who had had a more positive experience of quality of life, in spite of their BD. A study exploring their experiences could aid understanding of what the protective factors are which might help sufferers to have improved life satisfaction. Russell & Browne's (2005) study, as described above, is an example of this type of study, as this focused on the factors involved in 'staying well' with BD.

In a related study, Michalak et al. (2007) examined the specific relationship between BD and work functioning, using the same data set and method as described in the study above (Michalak et al., 2006). It was reported that quantitative research had demonstrated that BD can have a severe, and sometimes enduring, negative impact upon occupational functioning. However, there was a paucity of qualitative research exploring how sufferers experienced their work, and how

their mood symptoms impacted upon their functioning. The five main themes outlined were a lack of continuity and consistency in work history, loss, illness management strategies in the workplace, stigma and disclosure in the workplace, and interpersonal problems at work. The authors reported that these themes illustrated the complex effects of an intermittent, episodic condition upon work functioning.

The authors described a selection bias in their sample, as participants who responded were likely to be those who were most interested in and able to talk about the subject. Those with poorer self-management strategies in the workplace may have been under-represented. Furthermore, they suggested that longitudinal studies on vocational rehabilitation for people with BD would be helpful. These could identify effective solutions to some of the themes identified.

Clatworthy et al. (2007) explored the relationship between beliefs about BD and concordance with medication. Sixteen participants were interviewed about their perceptions of the diagnosis, its treatment and their concordance with medication. The interviews were analysed thematically, although the specific qualitative method was not reported. The results indicated that the majority of participants reported some degree of medication non-concordance. Non-concordance was associated with concerns about side effects, concerns about the effects of long term use, and doubts about the need for medication. These doubts were related to not accepting the diagnosis, not believing it is a chronic condition, and believing that the condition is not controllable. The authors concluded that professionals should try to elicit the client's beliefs about their medication, in order to improve concordance.

There were a number of limitations to this design. Firstly, all participants were aged over thirty-eight years, which meant that the views of younger adults were not investigated. Secondly, this study explored difficulties in concordance for those who were on prophylactic medication, and therefore, the views of individuals who did not take any medication were not captured.

Lim et al. (2004) conducted focus groups and individual interviews with eighteen people diagnosed with BD, to explore the psychosocial issues which they had faced. The data were thematically analysed using a phenomenological qualitative approach. The findings of the study

suggested that these participants experienced their lives as characterised by loss and damage, such as damage to relationships and friendships, employment and financial status. They additionally viewed themselves as unstable, defective, and helpless. Furthermore, the authors argued that these participants did not believe that they had the ability to successfully manage their condition. This study predominantly demonstrated a problem focus, which may have primed the participants to mainly describe the difficulties which they had faced, rather than exceptions to these, or how they were managing to cope. Furthermore, the sample was aged above twenty-eight, and therefore did not capture the experiences of younger adults.

Inder et al. (2008) explored the psychosocial impact of having a diagnosis of BD on the development of a sense of identity. They sampled fifteen young adults diagnosed with BD, who were in the fifteen to thirty-five age range. Data from eighteen months worth of IPSRT sessions was explored for content related to identity. This was then analysed using thematic analysis. The findings identified that for these participants, having a diagnosis of BD had a significant impact on identity development. BD created experiences of confusion and contradiction partly due to the differences in identity in varied mood states. They struggled to know whether their 'ill' or their well self was the real person, and had a negative self-concept based on others' judgements of them as an illness, rather than a person. The authors concluded that it was critical to be aware of the impact of BD on the development of self, as well as to facilitate greater self-acceptance during interventions. The sample was 80% female, and thus a more balanced gender spread could have improved this study.

1.4.2.1. *Overview*

This review has outlined some of the developing literature on experiences of BD which has emerged in recent years. The six studies outlined explored particular themes such as staying well, quality of life, employment, medication, psychosocial issues and identity. It was noted that three of these studies neglected to cover the views of younger adults in their late-teens and early-mid twenties, which is commonly found to be the age of onset (Miklowitz & Johnson, 2006). However, Inder et al.'s (2008) study provided a helpful analysis of the potential impact of the diagnosis on identity for this age range. The specific subtypes of BD, as well as the number of

previous episodes were generally not reported, although it is recognised that participants may not have been informed of a subtype for their diagnosis. Whilst the studies described exemplify the emerging literature exploring the lived experience of BD in general, there is a surprising dearth of literature focussed specifically on accounts of manic experiences.

1.4.3. Qualitative studies about manic experiences

As described above, there are a large number of qualitative studies examining psychotic experiences, as well as an emerging literature on BD. However, the specific exploration of manic experiences is largely absent amongst these studies. Below the limited qualitative research specific to manic experiences is reviewed.

Seal et al. (2008) interviewed twelve individuals aged over thirty years using IPA. These individuals self-reported to having had a history of hypomanic experiences. However, they did not meet the diagnostic criteria for BD. The aim of the study was to determine the protective strategies used by participants which meant that they did not experience significant functional disability related to their hypomania. The authors were particularly interested in how these individuals were able to “step outside” the vicious cycle of escalating symptoms proposed in the recent Integrated Cognitive Model (ICM; Mansell et al., 2007) of BD, so that their experience did not go out of control.

Three themes emerged in the interviews: ‘positive qualities’, ‘social meaning’, and ‘having hypomanic experiences is not a problem’. The ‘positive qualities’ theme included enhanced self-esteem and self-confidence, and a sense of freedom from a previous less lively self. Hypomania was also constructed as a coping strategy, in relation to life events, stress or workplace efficiency, which they could selectively display in different situations, depending on appropriateness.

The ‘social meaning’ theme included the responses of others, and how this shaped the individual’s perceptions of his/her experience. For example, positive reactions from significant others were linked with positive interpretations of their experiences, for some participants. When hypomanic, they became better partners, more fun and lively when with friends, and better

employees. At work, their associated productivity meant that they could satisfy their role more effectively, which was encouraged by managers.

The third theme, 'having hypomanic experiences is not a problem' explored how few of the participants described their hypomanic tendencies as being an abnormal state. Several participants described how these experiences did not mean that they were not 'normal,' and participants also described having control over their behaviour. This control was linked to self-awareness of their thoughts and behaviour, which enabled them to maintain an external impression which was socially acceptable. Some participants also reported that loved ones were helpful at noticing their excessive behaviour and reflecting this back to them.

The authors concluded that the participants' self-awareness and feedback from loved ones was consistent with Cognitive Behavioural Therapy (CBT) which draws from self-monitoring of moods and triggers, and feedback from trusted others. The theme of hypomania not being a problem meant that these participants were not likely to attribute extreme negative appraisals to their experiences, as postulated in the ICM (Mansell et al., 2007). The other difference noted was that individuals with a diagnosis of BD might be less willing to take the advice of others when in an activated mood state. Overall, the authors concluded that the study provided useful clues as to protective factors to circumvent the vicious cycle of the ICM.

However, the interviews focussed on how individuals coped with their hypomania, which may have created a bias against finding more problematic appraisals and coping styles. A further limitation was arguably that the theme 'having hypomania is not a problem' was not particularly novel, since the selection criteria for this study involved finding people for whom high moods were not problematic.

Mansell & Lam (2003) explored what they described as the ascent in to mania in a single case study design. This described the collaborative development of an idiosyncratic formulation based on a cognitive model of mania, in a participant diagnosed with BD undergoing CBT. The authors described how the client held the belief that he could overcome his depression and low self-esteem through the pursuit of highly demanding achievement related goals and rewarding activity.

Whilst still dysphoric, small increases in positive mood and energy triggered an overly positive sense of self (e.g. ‘I am back to my attractive, intelligent and outgoing self again’). He consequently engaged in a range of ‘ascent behaviours’ that fitted with his view of himself. These behaviours included stopping antidepressants, sleep deprivation, substance misuse, looking for social opportunities, adopting highly challenging goals and ignoring his problems. These behaviours in turn effected other people (not well known to the client), who encouraged him and were drawn to his optimism. This reinforced his behaviours and led to further mood escalation and energy, which itself triggered more hyper-positive thoughts about himself. The authors concluded that this case illuminated the process of how mania develops.

1.4.3.1. *Overview*

The qualitative literature on manic experiences is most limited. Seal et al.’s (2008) study offered an interesting insight in to these experiences in a non-clinical sample, whilst Mansell & Lam (2003) provided a useful single case study, which they related to emerging CBT conceptualisations of mania.

1.5. AIM AND RESEARCH QUESTION

The aim of this study was to gain an in-depth understanding of how a small group of individuals diagnosed with a BD made sense of their experiences of mania. Through semi-structured interviews, I aimed to capture the experience of living with mania and manic states, using Interpretative Phenomenological Analysis (Smith & Osborn, 2003). The key research question is:

What is it like for these participants to experience and live with manic states?

The interviews will endeavour to answer this question for these participants by focussing on how the person understands their manic experiences.

1.6. RATIONALE

Bentall (2004) reported that there had been less psychological research into mania than into any other psychiatric problem. Psychological understandings and therapies specific to BD are limited in comparison to “psychosis” and other areas such as depression and anxiety. However, encouragingly, the experience and symptomatology surrounding mania has seen some increased visibility in the literature in recent years, with attempts to develop psychological conceptualisations of mania and its maintenance. The subject of mania is therefore an important and developing field of research in clinical psychology.

Overall, the literature review has identified that no study exists which specifically explores accounts of manic experiences in a clinical sample, utilising a rigorous qualitative design. A qualitative approach is appropriate due to the exploratory nature of the research question, as it is hoped to capture in-depth information about understandings of mania. Therefore, this study could contribute to the limited research evidence base in this area.

1.7. CLINICAL RELEVANCE

This study could contribute to the literature by providing an in-depth insight in to the lived experience of mania. The research could highlight the feelings and perceptions of individuals with experiences of mania which could be useful and insightful information for any professional working with this population. It is hoped that this study will therefore enrich professional understanding of the experience of mania and in turn aid professionals in supporting these individuals.

Additionally, the study aims are congruent with the National Institute for Health and Clinical Excellence BD guideline (NICE; 2006), which state that professionals should respect the service user’s knowledge and experience of their condition. Furthermore, the interviews will partly focus on how people cope and self-manage with their experiences, as well as their attitudes and appraisals about their experiences. This will hopefully provide a useful complement to developing theoretical conceptualisations of manic experiences (e.g. Mansell et al., 2007).

2: METHODOLOGY

2.1. INTRODUCTION

2.1.1. A qualitative research paradigm

The aim of this research was to understand experiences of mania. Qualitative methods have been used extensively to explore participants' accounts of their mental health conditions. They are hence a tried and tested way to obtain valuable information (Smith, 1996).

2.1.2. Interpretative Phenomenological Analysis (IPA)

IPA has its epistemological underpinnings in the traditions of phenomenology (Husserl, 1913/1982) and hermeneutics (Heidegger, 1927/1996). Phenomenology is concerned with how we experience our lives, rather than discovering one true reality (Smith & Eatough, 2006, p.324). Hermeneutics is concerned with how people interpret experiences, which is sometimes referred to as their "sense-making" (Smith & Eatough, 2006, p.324). Therefore, the central concern of IPA is how people experience and make sense of their lives (Langdrige, 2007; Smith & Eatough, 2006).

IPA encourages immersion in the participant's world. The aim is to try and step "into the participant's shoes" (Smith & Eatough, 2006, p.332), to enter their world and understand their reality. However, alongside this empathic approach, IPA recognises that access to another's world is complicated by the researcher's own perspective. The researcher should examine and share their preconceptions and motivations regarding the research, in order to help the reader situate their analysis (Finlay & Gough, 2003).

Thus, the interpretation of data inevitably incorporates both the participant's and the researcher's sense-making about the phenomenon (Smith & Osborn, 2008). Consequently, IPA has defined a "double hermeneutic" (Smith, 2004). Smith (2004, p.40) described this as "the participant is trying to make sense of their personal and social world; the researcher is trying to make sense of the participant trying to make sense of their personal and social world."

The goal of an IPA study is to develop a narrative account of a phenomenon for a small group of participants. The aim is therefore “to provide a convincing account of the nature and quality of the participant’s experience of the phenomenon under question” (Willig, 2001, p.60). This is generated from a rigorous, idiographic analysis of each case, followed by an examination of the convergences and divergences amongst the group (Smith, 2004). This account should navigate between descriptions of the participants’ experiences and sense-making, as well as levels of interpretative analysis.

These levels of interpretation involve a slightly higher level of abstraction and incorporate more psychological language. Sometimes, particularly interesting aspects of the text are noted. For example, the researcher might explore the potential meaning of a metaphor or word. Furthermore, interpretation might explore contradictions, tense changes, or whether the participant had spoken in the first person. These levels of interpretation therefore represent a more critical, interrogative approach to the data (Smith, 2004). However, it is important for these interpretations to be evidenced in the participant’s speech.

Finally, the meanings inherent in the participants’ experiences are linked to extant theory. IPA can thus contribute to knowledge through interrogating or illuminating existing literature (Smith, 2004). Smith (2004) argues that the idiographic analysis of a small group of cases might bring us closer to the ‘essence’ of a phenomenon, as he described “delving deeper into the particular also takes us closer to the universal” (Smith, 2004, p.42, cited from Warnock; 1987).

2.1.2.1. *Rationale for IPA*

IPA was judged to be the most relevant to the aim of this research. It was deemed a particularly useful approach as phenomenological research specifically aims to study how people make sense of their lived experience (Starks & Brown Trinidad, 2007). This fitted well with the goal of this study, which was to approach the exploration of mania from a Constructivist perspective (Fransella, 2003), in terms of what was ‘real’ for these participants. The interpretative aspect of IPA was particularly appealing, as this had an interrogative and analytical flavour (Smith, 2004)

which married well with my professional background as a psychologist. Finally, IPA methodology was selected as there was significant IPA expertise within my supervisory team, as well as an IPA peer support group amongst my training cohort.

Prior to deciding upon IPA as the chosen method, other qualitative methodologies were considered. Methodologies from a more relativist Social Constructionist perspective (Burr, 1995; McGhee, 2001) such as Discourse Analysis (Potter & Wetherell, 1995) and Narrative Analysis (Reisman, 1993) could have been useful if I had wanted to focus more on the way the participants storied their experiences. These stories, in particular, might have been considered in the light of the dominant social narratives and linguistics of 'Bipolar Disorder' and 'mental illness.'

Grounded theory (Glaser & Strauss, 1967) seeks to develop an explanatory framework of a phenomenon, which can then be used to design interventions (Starks & Brown Trinidad, 2007). This has been described as a more realist qualitative method which has greater allegiance with positivist experimental research, but contends that experiments are not the sole means of drawing inferences from data (McGhee, 2001). This was not selected as the goal of this research was not to generate a theory about manic experiences based on the data collected. Furthermore, as described in Section 2.6.2., I personally felt more aligned with Constructivist and Social Constructionist philosophies (2.6.2.), as opposed to methodologies associated with the positivist paradigm.

2.2. DESIGN

2.2.1. Recruitment strategy

Participation in the research was promoted through a national BD website (www.mdf.org.uk). The website was approached for permission to advertise the research, and information was subsequently posted on a research forum. The information provided included the information sheet (Appendix 2). Potential participants were able to ask questions, and replies to these questions were posted on the forum. They could then choose to contact the researcher if they wanted to participate. Recruitment for the research was also promoted to local service user

groups in Hertfordshire. This was via email contact including supplying the information sheet (Appendix 2) as an attachment. To further broaden the recruitment process, an email was sent to all staff and students with a university email address, using the same procedure as was used with the local service user groups. This latter strategy was agreed as part of the School of Psychology ethics committee modification approval (Appendix 4), due to a poor initial response. However, students or staff known to the researcher could not take part for ethical reasons. Once the required number of participants was recruited, other people who expressed an interest were directed to the research forum described above (www.mdf.org.uk) so that they had the opportunity to take part in other research projects.

All potential participants were sent an information sheet (Appendix 2) and were given the opportunity to ask any questions. Six individuals were recruited, using a purposive sampling approach. Smith and Osborn (2008) recommended five to six participants as an appropriate sample size for studies such as this. This, they contended, allowed for a genuine engagement with each case, alongside a detailed analysis of convergences and divergences.

2.2.2. Inclusion criteria

Smith & Osborn (2008) recommended the recruitment of a homogenous sample, in order to find a similar group for whom the research question will be significant. To this end, the following inclusion criteria were utilised:

- i. Participants self-reported to having a diagnosis of “Bipolar Disorder” (Appendix 1).
- ii. Participants self-reported to having experienced mania and/or hypomania.
- iii. The participants were over eighteen years.

2.2.3. Participants

Background information about the six participants is provided in Table 1 below. All participants were given a pseudonym to protect their identity, and these will be used throughout this thesis. Four men and two women, aged forty-two to sixty-two years volunteered to participate.

Table 1. *Background information about participants*

Participant pseudonym	Sex	Age	Ethnic Origin	Occupation	Use of mental health services
James	Male	42	White British	IT Consultant	None
Peter	Male	59	White British	Business Support Assistant	Outpatient psychiatry
Luke	Male	46	White British	Software Developer	Outpatient psychiatry
Richard	Male	44	White British	Service user expert	Outpatient psychiatry
Vivian	Female	62	White British	Service user expert	Outpatient psychiatry
Helen	Female	49	White British	Writer	Monthly GP visits

2.3. ETHICAL ISSUES

This project was reviewed by the University of Hertfordshire School Of Psychology research ethics committee in February 2009 (Appendix 3). Modifications to the project to broaden the recruitment strategy were reviewed in March 2009 (Appendix 4). The ethical considerations for this study were informed by the Code of Ethics and Conduct (British Psychological Society, 2006).

2.3.1. Informed consent

An information sheet (Appendix 2) and consent form (Appendix 5) were utilised. The information sheet was sent to the potential participant prior to the interview. The participant was given the opportunity to ask questions both prior to and on the day of the interview. The right to withdraw at any time (pre, during or post interview), without explanation, was explained in the information sheet, and verbally prior to and post interview.

2.3.2. Confidentiality

Confidentiality was clearly explained prior to interview, in both the information sheet and verbally. This included the limits of confidentiality in the event of serious distress or disclosure of serious risk of harm to self or others. Interview recordings and transcripts were stored securely in a locked cabinet. Any information that could lead to the participants' identification was omitted or changed in the transcripts and the write-up.

2.3.3. Potential distress

Talking about experiences of mania and psychiatric treatment had the potential to cause distress. Participants could have experienced a range of emotions such as low mood, distressing recollections, regret or suicidal feelings. Safeguards were put in place to manage the potential for distress. The researcher planned to draw from her clinical skills to be empathic and to contain the participants' distress. Participants were informed that they could stop the interview at any time and/or take a break. Furthermore, they were informed that they did not have to answer questions which they did not wish to answer. Participants were offered a debriefing period following the interview and were given the opportunity to ask any questions. They were also provided with a debriefing sheet (Appendix 6), containing information about sources of support in the event that they experienced distress after the interview.

2.3.4. Risk management

In the event of someone presenting with either a very worrying mental state or imminent risk, the researcher planned to follow professional guidelines (Division of Clinical Psychology, 1995). This would have involved seeking immediate advice from a supervisor and possibly contacting an emergency service. These actions would also have been discussed with the client if clinical judgement deemed it safe to do so. The limits of confidentiality were explained in the information sheet (Appendix 2) and verbally prior to interview. The potential risk to the researcher was additionally addressed. The course administrator was contacted before and after the interview and the researcher sat nearest to the door and carried a personal alarm.

2.4. DATA COLLECTION

2.4.1. Semi-structured interviews

Interviews took place at the university and lasted for approximately one hour. They were audiotaped and transcribed verbatim. The interviews were semi-structured, which has been described as the exemplary method for IPA (Smith & Osborn, 2008). This afforded a flexible approach, whereby novel areas which arose could be incorporated. During each interview the participant was treated as the “experiential expert” on the subject and therefore the aim was to facilitate the sharing of their story (Smith & Osborn, 2008).

2.4.2. Interview schedule

A semi-structured interview schedule (Appendix 7) was devised to utilise flexibly and to prompt areas for exploration about manic experiences. This covered a broad range of areas considered relevant to the research question. The topic areas on the interview schedule included:

- How participants defined their mental health, diagnosis and manic experiences
- Their personal experience of mania
- How they understood becoming manic
- The perceived positives and negatives about manic experiences
- The impact of their manic experiences
- The causes of their manic experiences
- What treatments they had found helpful or unhelpful
- How they understood the concepts of self-management and recovery

Commencing with the participants’ own definitions seemed a non-threatening place to begin; it was also hoped that this would demonstrate openness to their language of mania, which might build rapport. Topics which might be more sensitive, such as treatments (e.g. sectioning, forced medication) were planned for later in the interview, as the participant might feel safer by this point (Smith & Osborn, 2008). The schedule was reviewed by the supervisory team prior to

interviewing, including my field supervisor, who is an expert on BD. This was to gain feedback on the relevance to the research question.

The first interview was treated as an opportunity to 'pilot' the schedule. This enabled me to discover which questions worked well and to amend the schedule accordingly. In particular, experiential questions such as "what was that like for you?", "If I were with you that day, what would you be doing?" and "take me through what happened," worked particularly well, and were thus used in later interviews. However, the data from the first 'pilot' interview was treated as primary data because of time and recruitment constraints.

2.5. DATA ANALYSIS

Analysis of the data adhered to the established procedure of IPA, as described by Smith & Osborn (2008). This involved a case by case analysis, followed by a cross-case analysis of shared themes. These themes were then developed into a narrative account.

2.5.1. Case by case analysis

It is recommended to immerse oneself in each transcript during the process of analysis via reading, re-reading and coding. The coding involved left and right side margin commentary. In addition, text was highlighted or underlined. Some parts of the interview were considered richer than others, warranting more commentary. The same description was sometimes repeated for similar themes which emerged as the data was coded. An example of a coded transcript is presented in Appendix 8. Appendices 9-11 further demonstrated the analytic process for this participant.

The left side coding was descriptive and involved briefly summarising what the participant had said. Following this, the right side coding involved a more interpretative approach to the data. Ideas and thoughts, based on the researcher's own sense-making of how the participant had made sense of their experience were thus noted (Smith, 2004). This stage therefore represented a more

critical engagement with the data, employing varied “levels of interpretation” (Smith, 2004, p.44), as was outlined in Section 2.1.2.

Following this, the themes from the right sided coding were listed chronologically into an Initial list of themes (Appendix 9). These themes were then clustered into broad categories with subcategories on a second piece of paper entitled Clustering of themes (Appendix 10). The aim here was to make connections between themes, considering which themes may have been inter-related. Titles were created to capture the meaning of each cluster. Finally, these clustered themes were reduced in to a Table of themes (Appendix 11). At this stage, some of the theme clusters were omitted or grouped together with a new title. The final themes were decided upon based on factors such as the frequency of the theme in the transcript, the richness of the descriptions provided, and the relevance to the research question (Smith & Osborn, 2008). The Table of themes (Appendix 11) also incorporated a narrative description of each cluster, which aided the researcher to crystallize her thinking and was useful for cross-group comparisons.

2.5.2. Cross-case analysis

Once each transcript had been analysed via the above procedure, all superordinate themes for the group were placed into a list (Appendix 12) and then clustered into master theme categories (Appendix 13). As with the single case analysis, particular theme clusters were omitted or grouped together with new titles, based on the factors described above. This stage required re-review of the transcripts in the light of emerging themes. The aim was to distinguish repeating patterns across the interviews, whilst also noting divergences in the data. A cross-group reference table (Appendix 14) was then devised to identify the best examples for each participant. Once sufficient evidence was found to support the proposed themes, a final table of master themes (Appendix 15) for the group was produced.

2.5.3. Narrative account

Following the cross-case analysis, the identified themes were translated into a narrative account (Chapter 3). Here the themes were outlined in the form of an argument, and this was evidenced

with verbatim extracts. This therefore highlighted the participants' sense-making of their experiences in their own words, as well as the sense-making and interpretations of these by the researcher. The extracts presented included researcher comments, a style which has been used in published IPA studies (Smith, 2009).

2.6. QUALITY

In order to ensure the quality of the research, methods were employed as recommended by guidelines (Brown & Lloyd, 2001; Elliot et al., 1999). These encompassed a number of credibility checks and reflexivity. Elliot et al. (1999) outlined further strategies to enhance quality. These included grounding one's understandings in the data, providing a coherent analysis, whilst preserving nuances in the data. Furthermore, the study needed to resonate with readers, so that they felt that it had enhanced their understanding. It is hoped that these latter strategies will be apparent in the following chapters.

2.6.1. Credibility checking

The goal of a qualitative study is to produce a credible and trustworthy account (Thornhill et al. 2004), and a number of strategies can be employed to check whether one's account is credible. The strategies used in the present study are described below.

2.6.1.1. Analytic auditing

Analytic auditing involved inviting two of the research supervisors to check the procedures utilised. One supervisor was sent a transcript, alongside the related initial list of themes, clustering of themes and a table of themes. This enabled the supervisor to complete an audit trail of the analytic procedure and the credibility of the themes generated. Feedback provided was that the IPA procedure was followed adequately, and that the themes made sense and were well rooted in the data. Subsequently, a second supervisor, with expertise in IPA, audited the Results chapter, with similarly positive feedback.

2.6.1.2. Triangulation

Smith and Osborn (2008) recommended the use of triangulation; the convergence of data from multiple perspectives, to provide confirmation of the validity of research findings. A successful IPA study involves the findings making sense in terms of personal and professional experience and the existing literature. Triangulation for this project involved informal feedback from my field supervisor, who is an expert within the field of BD (Sorensen et al. 2005). He commented upon the coherence of the overall analysis and the extent to which links could be made between the findings, his own personal and professional experience and the claims in the existing literature (Sorensen, 2009).

2.6.1.3. Peer review

Peer review was utilised via an IPA study group for all trainees in the cohort who conducted IPA studies. This was a further forum in which to check adherence to IPA and the credibility of the findings.

2.6.1.4. Participant validation

It was hoped that the participants would comment on the analysis, which is recommended as a further form of credibility checking by a number of authors (e.g. Elliot et al., 1999; Smith, 1996). However, there are mixed views within the IPA community regarding this strategy (Larkin, 2009). I favoured this strategy because it fitted with my commitment to reducing power differentials between professionals and service users. Participants were offered the opportunity to be further involved in the research. This was mentioned in the information sheet (Appendix 2) and explained in more detail following the interview. However, none of the participants chose to participate in validation.

2.6.2. Reflexivity

Reflexivity involves the researcher examining their preconceptions about the research (Finlay & Gough, 2003). “Owning one’s perspective” (Elliot et al. 1999) helps the reader evaluate the

researcher's perspective and interpretation of the data. In order to elucidate my perspective, I have made a statement of my own beliefs and assumptions in relation to the study below.

I am a 32 year old White British Jewish woman from England. I am a final year Trainee Clinical Psychologist, with a professional interest in severe mental distress. My final year placements have involved working in Forensic, Acute Inpatient and Early Intervention in Psychosis placements.

I have a longstanding interest in critical psychiatry. Prior to my clinical training, I studied at the University of East London, where I was exposed to social constructionism and critiques of diagnosis. I attended the London Critical Mental Health Forum meetings where I met Rufus May. I found him to be an inspirational figure, as someone who had recovered a meaningful life outside of the 'system', despite having been diagnosed with 'schizophrenia.' I became interested in his ideas about 'recovery', and my dissertation involved interviewing a group of service users about their understandings of their 'recovery.'

From these varied experiences, I developed the belief that psychiatric diagnoses might be socially constructed, and I felt motivated to make changes to services. I was drawn to clinical psychology, partly because it seemed that psychologists were powerful, influential professionals who were at the cutting edge of bringing in more psychological thinking to a medically-dominated specialty.

However, over the course of training, I feel that I have gradually become more uncertain in my views. I have come to realise that diagnoses and medication can be valued by some service users, and that deconstruction might sometimes go too far, as at the end of the day, there are people out there who are presenting with distress about their experiences, whatever we might call them. I think the uncertainty in my views is a broader theme which has come about from my training. I have been exposed to so many theoretical perspectives, and I feel that many of my views have been challenged to the extent that I now hold multiple positions about things. I suppose I am now a social constructionist, believing there is no one truth.

At first, this was uncomfortable, as sometimes it felt like I really did not know what I thought about anything anymore. However, I have gradually become more comfortable with the ambiguity. Pica (1998) described that wrestling with ambiguity is a common experience for clinicians in training.

I try to adopt a hopeful, recovery focus when working alongside people with severe mental distress, and have an interest in solution-focussed therapy (O'Connell, B., 2005) and narrative therapy (White and Epston, 1990) as these promote re-authoring one's life and finding a preferred future. This optimistic and idealistic approach towards distress might partly draw from stories of resilience and survival within my own family background, as my grandmother escaped from Nazi Germany in the 1930s, arriving as a refugee to the UK.

In approaching this thesis, I was enthusiastic about exploring a neglected area, but I came to it from a position of uncertainty. Two years ago I would not have believed in constructs of mania and bipolar disorder, whereas now I feel that these might be helpful descriptions for some people. For example, they may help people to access support when required. I therefore approach this study with openness to multiple constructions, although it may be the case that my critical psychiatry interests will influence how I approach these accounts.

3: RESULTS

3.1. INTRODUCTION

In this chapter, the results of an Interpretative Phenomenological Analysis (IPA) of six peoples' accounts of their manic experiences will be presented. The purpose of this analysis is to put forward one understanding of how these participants made sense of and lived with their experiences. Three master themes emerged from the analysis of the data:

- **“A blessing and a curse”: a mixed relationship with mania**
- **“You have no control over it”: a separate and controlled self**
- **“I was beautiful”: the struggle to be different**

These master themes and their superordinate themes are summarised in Table 2 below:

Table 2. Master themes and superordinate themes for the group

MASTER THEMES	“A blessing and a curse”: a mixed relationship with mania	“You have no control over it”: a separate and controlled self	“I was beautiful”: the struggle to be different
Superordinate Themes	<p>The allure and the danger of mania</p> <p>The desire to stay manic</p> <p>Loss and survival</p>	<p>The separation: is it me or is it mania?</p> <p>Losing control to mania</p> <p>The function of separation</p>	<p>The struggle against being ‘normal’</p> <p>The struggle to experience a preferred self</p> <p>The struggle to be special</p>

The remainder of this chapter will present a narrative account of the above themes. Both the convergences and divergences amongst the participants' accounts will be considered. The analysis is interspersed with verbatim extracts, although minor changes have been made to the text. Minor hesitations of less than two seconds and repeated utterances such as "eh" or "erm" have been deleted from the text for readability. Dotted lines at the beginning or end of excerpts indicate that the person was talking prior to or after the excerpt. All identifying names and information have been changed for reasons of confidentiality.

3.2. "A BLESSING AND A CURSE": A MIXED RELATIONSHIP WITH MANIA

3.2.1. Overview

This theme captured the perceived relationships that the participants had with their manic experiences. The participants had mixed views about their mania, and went through a process of weighing up the positive aspects against the risks and consequences that their experiences had for themselves and others. For some, this struggle between the positive and negative aspects led them to a desire to experience their mania at a milder level, before it became more severe. Most participants saw medication as a solution, as they had reached a point whereby the costs of their mania outweighed the benefits. Most participants no longer experienced mania, which they largely attributed to their use of medication. For some, no longer experiencing mania caused a sense of loss whereas for others there was a sense of survival. However, one participant had decided to come off his medication in an attempt to experience manic states.

3.2.2. The allure and the danger of mania

This theme reflected the opposing views the participants had about their mania, which led them to a process of weighing up the perceived benefits and risks of their experience. This mixed relationship placed the participants in a dilemma of whether or not they wanted to have their mania or not. The accounts indicated a considerable ambivalence about their experience.

Vivian, for example, shared some rich descriptions in her account, to exemplify how positive and alluring the experience of mania could be:

*Vivian:I just kept dancing there for hours and then it would start raining...
I wanted to stay like that all my life.....I didn't want to come out of my psychotic
episode.....I just felt fantastic.....I've never taken drugs ever but they say it is very
similar to LSD....and I can imagine people being uh addicted to LSD....but I had
some scary bits in it.*

Vivian's comparison with drug use emphasised the allure that the participants experienced concerning their mania. Such analogies between mania and the potential pleasure associated with drug use featured in most of the accounts. Whilst demonstrating how positively mania could be experienced, the above extract also typified the contrasting views which the participants had about their experiences. Vivian noted that her experience was both "fantastic" and "scary." Elsewhere in Vivian's account her mania is depicted as enjoyable and fun, but simultaneously she described herself as "very vulnerable" and indicated that she felt in need of protection:

*Vivian: ...my husband came back again and still found me in the house.....something
had to be done to get me to hospital.*

A similar pattern of contrasting views was noted in Luke's account. Luke described experiencing spiritual exaltation during one of his episodes, and he used phrases such as "magical" and "privileged." On the other hand he described his high mood as "dangerous", and stated "I was so extremely vulnerable." Luke believed that his mania had led to the breakdown of his first marriage, and consequently to lost time with his children. His mania was both a pleasurable and desired experience but, at the same time, also a dangerous and costly form of "illness."

For Richard, mania was "a blessing and a curse"; his ambivalence largely focussed on the feared consequence of depression. In the following extract, Richard stated that he would take a "cure" without hesitation, but subsequently stated that ideally he would prefer to have mania without

depression. This extract demonstrates the dilemma he faced between the allure and the perceived consequence of mania:

Richard:the mania is good fun ...ideally I think I'd wanna take away the depression and keep the mania...because I mean why do people take drugs?.....why do people go out and drink?.....they do that to achieve the same effect that people with manic depression get for free.....no the mania's the fun part of the equation.

Like Richard, the fear of depression following mania featured in Helen's account. She described how the positives were coloured by past experiences of being sectioned and being "thrown into depression" when her mania abated:

Helen:there is this sense of everything being wonderfully purposeful.....the feelings of being high are good in many ways but then there's reality..... and knowing what's gonna happen after that so.... it's kind of lovely while it's happening you're full of life and energy.....it's wonderful but then you kind of know that the pendulum is gonna swing back again.

The following extract from Peter's account further exemplified the participants' ambivalence:

Emma: If I could wave a magic wand and you never had mania again do you think that would be a good thing or a bad thing?

Peter: [laughs] I want a little bit

Emma: [laughs]

Peter: if you could take it all away but a little bit that would be great.....I would rather not have it yeah I would rather not have it.

James outlined a difference between hypomania and mania. For him, hypomania was a positive experience where you are calm, "think you could do anything", are getting more "emotional energy" but are "staying in control." Mania however was "not controllable", "turbulent", and was described in ways which suggested confusion and disorientation. James's account was somewhat

divergent, however, as he did not appear to be as ambivalent about his manic experiences as others. Whilst he outlined some negatives about mania, he did not seem to be weighing up the pleasure with the costs. He therefore had a different relationship with his mania, which will be described further below.

3.2.3. The desire to stay manic

The positive aspects of their mania meant that all the participants shared a desire, at some level, to experience mania. Many outlined differences between milder mania (hypomania) and mania, and several expressed that they were tempted to control their hypomania, so that it did not develop into a more severe state.

However, for James, rather than merely being tempted by his manic experiences, a strong feature of his account described his actual attempts to remain hypomanic via deliberately stopping his medication. In the following extract, James used the metaphor of a plane to illustrate his perspective:

James:if they rush through a hypomania into mania they're gonna crash down so they do it fast and it's like suddenly being in a plane that's had wheel locks on you know you been on the runway maybe you can move it around and it drags this bit of concrete behind and suddenly the wheel locks come off and you can take off and the first thing they do is right I'm gonna shoot straight up I'm gonna go up and up and up and I'm gonna fly and fly until I run out of fuel and then you crash land whereas the first thing I do once I become airborne I think right I'm gonna learn to land it and I'm gonna learn to hover over the motorway at just the same speed just off the ground.

James later used the image of a waterfall to illustrate the struggle he had in remaining hypomanic and keeping control of the experience. Here he described an episode precipitated by contact with his daughter, whom he had not seen for many years:

James:I was on the shore then my daughter came on the scene and it was like I went out into the sea into the emotions.....and I thought I'm not gonna let go and it drew me faster and faster through waters that were more and more rapid and then just at the last minute I went over the edge of the cliff but before I did I saw this guy to one side right near the edge of the waterfall really calm just sitting there and I thought I wanna go back cause there is a calmness just before the edge of the cliff..... there are positives before you get over the edge of the cliff.

For other participants, such as Luke, the desire to remain hypomanic was more of a temptation:

Luke:if I didn't have responsibilities I could imagine experimenting with my medication.....and then when it gets too much before mania stop it with chlorpromazine.....it would sometimes be tempting to try those sorts of things but I know certainly now that that there's far too much to lose and that it can't be easy otherwise lots of people would do that.... I suppose I would never sort of voluntarily allow mania to occur again and probably I'd carry on taking high doses of Lithium and Lamotrigine to stop it happening.

For Luke, there was a sense of sadness when losing the high and realising that he had to get back to "normal." However, he was ambivalent as losing the high was also a relief:

Luke:there's a bit of sadness of losing that high mood but realising that I have to get back to normal.....in some ways it's a relief and.....I can certainly see the relief in the people around me.

Peter described a similar yearning to experience hypomania. However, this was something he did not see as possible:

Peter:I think that slightly high is kind of there are pleasant things....and one does perhaps create a little bit more but.....that is such an unstable equilibrium.....if you could hold it there if you can have a tablet to hold it there.....you know I would

pay a million pounds for that tablet but the point is you know two days later and you're hanging off the ceiling....

Vivian indicated that during her mania, she had not wanted her pleasurable experience to end. During one episode she had gone to a different town, and struggled with the prospect of returning home, and losing the “fun” of her experience:

Vivian: ...but anyway they couldn't find me.....they were so worried.....I wouldn't tell the policeman who I was.....because I thought somebody's gonna come and get me and the fun will be over.....

As described earlier, the fear of depression as a consequence of mania featured in Richard and Helens' accounts. Richard's extract (in 3.2.2.) demonstrated that ideally he would like to keep mania, but not have depression, although he did not see this as possible. Helen's perception of her manic episodes was perhaps the most negative compared to others. Fear of her mania and its consequences was a strong theme:

Helen:it's horrible because.....I know that once the medication kicks in the likelihood is I'm gonna be thrown into depression...and there's also the fear of being sectioned....and there's all these other horrendous things that have happened in the past to come back to haunt you that you think this could all happen again.

Consequently, Helen did not express a desire to be manic, even though it had had some enjoyable aspects at times.

3.2.4. Loss and survival

Five of the participants had not experienced mania for between two and twenty-seven years, and attributed this to their use of medication. For some there was a sense of loss at not experiencing mania. However, for others, their accounts suggested a sense of survival rather than loss, as if the mania was a trauma that they had lived through.

Peter emphatically expressed that mania was not something he would want to re-experience. For him mania had been a destructive experience:

Peter: the downsides for me are the destruction it does to my job.....I've been lucky to maintain the job for thirty years and certainly came very close to losing my wife and my family and.....my income and my house.....it's not something I feel I want to happen.

Peter described a desire to be hypomanic (as described above), even though he saw that in reality this was impossible for him without this developing to mania. However, overall his account suggested a sense of survival from the destruction of his manic experiences:

Peter:I feel bloody lucky to have got my life back together to have got back into my job to have held the family together.....

His sense of survival in overcoming his difficulties had led him to become a role model to others in a support group:

Peter:a lot of people who come.....have seen me as a role model.....as somebody who has had very severe episodes but managed to keep their life together....

Helen and Vivian shared Peter's construction that overall mania had been a destructive experience. For Vivian, there was a sense that she had actively chosen to give up her mania, due to the threat of the consequences of losing her family. At one point whilst in hospital due to a manic episode, she was faced with an ultimatum by her husband that she should take Lithium or else lose her children. There was an element of loss in deciding to choose her family over her mania, but largely, this choice was a clear one for Vivian:

Vivian: yeah and so my moods are flat I don't like that I'm not creative anymore...so you feel there's some kind of loss.....because a lot of artists who happen to be bipolar they won't go on lithium because of it, it's a well known fact

Emma: so it sounds like you're weighing up things

Vivian: the children came first. I didn't worry about artists or anything, I just wanted those children to stay with me.

Vivian's relationship with her mania moved from her mania being a desired, yet vulnerable state, to being a state that she feared. At the time of the interview, Vivian had been taking Lithium for twenty-seven years and had had no recurrences. There was a sense that she had built a new life without her mania. When looking back on her experiences she described that she and her husband had "gone through hell together," which suggested that her current stability was constructed alongside a sense of her mania being a trauma that they had both survived.

Towards the end of the interview she described a process of adjustment. After so many years without mania, she expressed that she no longer feared recurrence:

Vivian: I don't feel like a person who is bipolar.....it's the same as my eye defect.....the stigmas I got and I was born with that.....over the years I have learned to live with it and it doesn't bother me anymore.....I don't even notice anymore.....now with my mental illness it's come to the same.

Helen had not had an episode of mania for two years, and her account indicated a sense of fear about her mania recurring. She described "horrendous" experiences of being sectioned and forcibly medicated, as well as regret and depression following her episodes. She compared this fear of recurrence to the fear that people with remitted cancer experience:

Helen:its living with the fear of the illness.....it's like my brother-in-law's had cancer and I guess it's like him....living with the reoccurrence of that and.....I guess it's no different for any other long term illness like that.... I just have to live with the fear that.....it can hit me at any time.

Helen hoped to put this fear behind her by taking control of her life through self-management skills. However, there was a sense that she had not quite mastered her fear, as she spoke about “putting the fear behind you” in the present tense as something she needed and was trying to do as part of her attempts to “live with the illness”, rather than as something she had now achieved.

For both Luke and Richard, the importance of medication concordance as a protective mechanism was emphasised. Luke perceived himself as having a “chronic mental illness” and stated that he should never come off medication as he will be “ill for the rest of my life.” For Luke, like other participants, in spite of the positive aspects of mania, ultimately the costs had outweighed the benefits:

Luke:the cost that comes with mania is just too much....you know ending a marriage.....me not being able to be a really good dad.....and finally being able to be a good father with them but they've missed out on so much and.....so although there are the slightly elated mood of hypomania is great having manic depression in general is disastrous.....

Richard's emphasis was on following the advice of expert professionals, as well as his “regime of medication.” I thought the use of the word “regime” indicated the importance of predictability and routine for Richard in controlling his mania. He described how in the past he was not “properly medicated”, and repeated this expression twice in quick succession, to emphasise the importance of this solution for him. Medication made things “controllable” and like most other participants, he described how his prophylactic use of Lithium was particularly important for him.

James's account differed from the other participants as mania was not something he had ‘let go’ of, nor was it something that he desired to overcome. In fact, he was actively hoping to manage his manic experiences due to the positives he saw in them. He recalled how a doctor encouraged him to take medication:

James: the whole thing was.....you stay on the medication then he said you gotta accept now you'll just be a steady Eddie.....and I think that frustrates people who are depressed...they wanna get back up there cause there are positives before you get over the edge of the cliff.

Elsewhere in the interview, James states how medication will “pull the plug” on his mania, and then he would feel as if “the wings were clipped.”

3.3. “YOU HAVE NO CONTROL OVER IT”: A SEPARATE AND CONTROLLED SELF

3.3.1. Overview

Participants described mania in ways which suggested it was an experience or object separate from the person, often as if it had a life of its own. However, sometimes the opposite was true within the same account, as mania was described as if it was in fact a part of the person. This arguably indicated that the participants were uncertain concerning whether or not, or to what extent, mania was something they perceived as separate to them. Related to the notion of mania as something separate, many of the participants described their experiences in ways which suggested that, during an episode, they lost control to their mania. In what follows, the possible function of describing mania as a separate, uncontrollable experience is explored in more detail.

3.3.2. The separation: is it me or is it mania?

This emphasis on mania as an “it” featured in most of the accounts, although occasionally examples of descriptions of the experience in the first person (e.g. ‘I was manic’) were found. These descriptions of mania therefore appeared to emphasise that mania was experienced by the participants as something which was separate to the person, or sometimes that the person was unclear about whether or not mania was something separate. In these descriptions, mania was arguably presented as an object (for example a ‘mind’ or ‘brain’) with a life of its own.

In Luke's account, mania was described as an 'it', for example he states "it became manic because..." and "it got out of control". It was noted that Luke did not say "I became manic", or "I got out of control." This pattern was observed in most of the other accounts.

Peter used a range of descriptions which suggested his mania was something separate which happened to him, and developed almost by itself:

Peter:it kind of ramps up very quickly.....you know starts the sleeplessness and free flowing thoughts and that perhaps starts over a fortnight and then.....the broader range of episode kick in of symptoms sorry kick in later.

Here Peter expressed, "it kind of ramps up" and the symptoms "kick in", the latter possibly being a metaphor of a drug kicking in to the system. This therefore indicated a process entirely separate to Peter, which he was subject to without choice. Helen used the same expression when describing one of her episodes:

Helen: I suppose that's the psychosis.....kicking in.

In the extract below, Peter described further how he made sense of how his mania developed:

Peter:the symptoms get worse and feed off each other.....I think that particularly in the social sense where.....people often encourage me.....if I'm being a bit cheeky and saying.....naughty things about life....and they're being kind of you know Peter's a good laugh and you know it kind of feeds it.

His description of the symptoms feeding off each other suggested that these symptoms had a life of their own and perhaps could be understood as a spreading disease process, out of Peter's control. Whilst he described how other peoples' reactions "encourage me", suggesting his own engagement with the development of mania, this is shortly followed by an expression that this encouragement feeds "it". Alternatively, he could have said "other people encourage me" and this leads me to, or this feeds my mania. Arguably, this indicated a switching between himself

(“people often encourage me”) and something separate to him. Elsewhere in his account, we see a similar change between mania being as an ‘it’ and an ‘I’ within the same sentence:

Peter: it comes on fairly quickly and once treatment kicks in I come down fairly quickly.

This possibly indicated some uncertainty over his role or agency in his manic experience. This uncertainty, or change between referring to mania in the first person or as something separate featured in Richard’s account:

Richard:well I it becomes a sort of self perpetuating circle that because you’re happy it becomes easier to sustain that happiness.

It is noticeable in the above extract how Richard changed from stating “I” to “it” immediately within the same sentence, identifying a “self-perpetuating circle” in the development of his mania. This possibly served to separate Richard from this circle. I noticed a similar change mid-sentence in the following extract from Richard’s account, as he immediately changed from ‘that you’ to ‘that things:’

Richard:when it’s so obvious that you that things have gone wrong that you don’t need to be a doctor.....

In both the above extracts, particularly because of the change being immediate, it appeared that Richard was correcting himself, from the position of the mania being I or you, to being something separate. This process of correction could indicate that he wanted to emphasise the separation. This separateness is emphasised again elsewhere. Richard referred to his experience as “the high” and “the mood.” Both these descriptions of his mania suggested his experience was something separate to him, which almost had a life of its own:

Richard:the high just kept going higher and higher....I suppose medically anything to an extreme is not gonna be healthy...and to just to have the mood just keep escalating out of control.....was obviously not a good thing.

Elsewhere, Richard spoke about his mania in the first person:

Richard: I was completely sort of manic and.....difficult to control.

Thus, in contrast the extracts described above, this clearly indicated that his mania was a part of him rather than something separate. Arguably, this alongside the aforementioned examples may indicate that Richard was unsure whether or not his mania was part of him or something separate to him.

Vivian's descriptions were aligned with the above examples. She described how her mania was "left to go on:"

Vivian: because it the other ones weren't left to go on for six weeks.

This indicated to me that for Vivian, mania had a life of its own. Later, she described her fear that mania could happen at any time, suggesting that "it" was something separate to her and unpredictable:

Vivian: and you know any day it could happen and I would lose my children still...and so after three years it hadn't happened and we could start relaxing.

James's account diverged somewhat from the others, as he tended to describe his mania in the first person: for example, "I know I can go high" and "the times when I go high quickest." James's account may have had a different quality to the other participants because he was actively trying to control his high mood. Therefore he possibly experienced a greater agency over his mental state, which was reflected in less use of language suggestive of separation.

However, in some respects James's descriptions of mania (rather than hypomania) suggested convergence with the other participants, as he appeared to have experienced considerable distress and dyscontrol, as described below.

3.3.3. Losing control to mania

Alongside the theme of mania being almost an object separate to the person was the sense that during an episode they lost control to this (separate) mania, or that mania was or became uncontrollable and therefore developed a life of its own.

This sense of losing control to mania was particularly strong in Helen's account. She used the metaphor of being in a speeding car to emphasise her lack of control:

Helen: yeah I think it just kicks in it's just as though you're sort of [sighs] you're in a car and it's an automatic car and suddenly somebody presses the accelerator you have no control over it and your brain just pops and it's just gone and you can't you've got no way of putting the break on you would love to but you can't.

Her descriptions suggested that her mania had a life of its own, and she perceived her mind in ways which indicated that she became controlled by it:

Helen:...my mind just has this capacity to race out of...to just go off on a tack that I can't control.....it's something that now happens that I just can't stop.

In the following extract, it is almost as if Helen became like a robot controlled by her independent, separate mind, which made rest a "physical impossibility:"

Helen:all I can say is I'm on the go all the time I mean you wouldn't be able sit and have this conversation with me because I wouldn't have sat still this long....

Emma: What would happen if you did sit still in that time?

Helen: well I can't I mean it's a sort of physical impossibility for me.

Overall, it appeared that Helen was keen to reiterate throughout her interview her lack of control and agency. Mania was “history repeating itself” and could strike at any time, very quickly and outside of her control.

Similarly, Luke described how he saw mania as not having control:

Luke:the edge between hypomania and manic was hard to define.....it was from the time of really enjoying the experience and feeling great to really not being able to have any control.....

Like Luke, Richard stated that feeling slightly manic was not an issue, but more severe mania involved a loss of control, and the use of the word “spirals” emphasised the strength of this process:

Richard:if you're feeling slightly manic you're not aware of any sort of issue it's.....when the mania spirals out of control....

For Peter, mania was a “chemical” process whereby “something seems to switch,” indicating a sudden change which stopped his sleep and triggered his overactivity:

Peter:to a large extent I do see it as being more chemical than psychological behaviour.....you know something seems to switch and to stop my sleeping and to trigger this degree of activity.

Vivian described how as her episode developed, rather than being a pleasurable experience, she experienced her mania as increasingly frightening and unpleasant:

Vivian:when my husband came back again....I was far worse than when he left me I was in the living room and.....I thought that Mohammed Ali the boxer was in the

living room as well and.....he started thumping me over the head and it was so frightening and it was so painful I could feel it.

James described the difference between hypomania and mania, stating that mania was “not really controllable.” Whilst his account was littered with examples of how positive mania could be for him, he also provided a description of a more negative experience during mania:

James:I was like crying on the bed and I was just so confused I couldn't handle the simplest of situations.....what I wanted to do is just sit somewhere quiet and let my mind calm down.

Similarly James's extract previously presented suggested a loss of control to mania, as he provided the metaphor of falling over the edge of a waterfall to represent his loss of control and being unable to maintain the “calmness” he experienced when hypomanic.

3.3.4. The function of separation

As described above the experience of mania tended to involve an emphasis on mania as separate to the person, something which had a life of its own and something to which the person lost control over. These descriptions married well with the participants' broader explanations for their mania. In particular, many of the participants saw their mania as part of a biochemical illness. Such explanations appeared to help the participants to overcome negative feelings which they had about themselves related to their mania, such as guilt, regret and self-stigma.

Peter's main framework of understanding was a “chemical” one. He stated that taking Lithium was the predominant reason why he had not experienced mania for seventeen years. However, elsewhere in his account he emphasised his own role in staying well. However, as the following extract demonstrates, Peter perceived his role as minor in comparison to Lithium:

Emma:it sounds like a lot of what you've talked about today is how things are different now and you're doing things that are really not allowing you to

Peter: yes but it's a combination of both I mean I suppose I have.....no doubt in my mind the lithium has caused or has brought about 90% of the benefit and I think the other ten percent is me not sleeping not being silly with alcohol you know and not having too many espressos late at night.

It seemed very important for Peter to emphasise Lithium over and above other aspects as the key factor. This was aligned with his very strong belief that his mania is predominantly a biochemical problem, something which was also emphasised elsewhere in his account.

This biochemical explanation was a common feature in most of the accounts. Four other participants also described their use of Lithium as a very positive and protective factor in their wellness. The emphasis on mania as a disease process marries well with descriptions of mania as something separate to the person, and a process to which the person is subject.

Peter's use of "90%", when referring to the benefit of Lithium, might have served to minimise the importance of his own behavioural self-management skills, skills which involved Peter's own agency in his mania. Perhaps giving more credence to his own potential impact on mania would conflict with his strongly held view of his mania as being a separate and uncontrollable disease process. In addition, it may have been threatening for Peter and other participants to acknowledge the impact which they potentially could have on their mania, as this could have understandably compounded their sense of guilt or regret about their episodes, and made them question whether they could have done more to prevent or control their mania.

Like Peter, Helen saw her mania as an inherent and uncontrollable illness. She described some potential environmental triggers for her manias, such as stress, birth trauma, and bereavements. However, in the following extract, she expressed that in some ways, she did not need to make sense of triggers:

Emma:you've used the word stress quite a lot is that something that helps you to make sense of what leads up to your episodes?

Helen:I don't think I make any sense of what leads up to my episodes.....I suppose I'm fortunate in that I can see that there's triggers but I see it was an illness and you know if I was a diabetic I wouldn't necessarily know what triggered it if I was an epileptic I wouldn't know what triggered it so in a sense I don't try and look back and wonder what triggered it. I mean I can clearly see.....that at the times when it has happened for me.....there have been triggers.... but.....I just think well it's an illness and it's no good trying to rationalise it I spent my life trying to work out what the hell's going on, but if I do that I'm just taking myself back cause all the time I'm constantly going over what might have triggered it what might what could I have done differently.

Her use of the word “fortunate” made me consider how it would be unfortunate for Helen to not see her mania as comparable to physical illness. It appeared that having an illness explanation meant she did not need to “rationalise” her mania, or be “constantly going over” what she could have done differently. This arguably would have been unfortunate for her, in terms of compounding her guilt and regret. Therefore, comparisons with physical illnesses were possibly comforting for Helen.

Elsewhere, Helen described how two of her episodes were precipitated by the death of a close relative. She described guilt at being in hospital due to mania and not being with her family. In the following extract, Helen described “learning to live with yourself”, and not just with the “illness” as important in her self-management:

Helen: I think the main thing is learning to live with yourself and the illness.

This provided a further indication that there was an element of guilt and regret for Helen concerning her experiences of mania. The theme of guilt featured in two further extracts in Helen’s account:

Helen:there was this sense of guilt.....a huge sense of guilt and a sense of feeling that here I am manic and frantic and I can't channel that energy into doing anything useful for anybody that I really wanted to do.

Helen:once I was sectioned I then felt even more guilty..... I felt again I was leaving my family at a time when it was difficult for everybody.

In the following extract, Vivian described how a biochemical explanation had helped her to overcome the self-stigma she experienced:

Vivian:the worst is stigma and in particular my own stigma... it has been my own stigma of being mentally ill I couldn't really take that....and when I was telling you when I had the serine experiment.....I reacted to that again and that gave me the secure the sureness that it was something with biochemical....it wasn't more how the person who wanted this to happen it was something in my body was happening so I could I'd go high

Emma: so that sounds like that was kind of an explanation for you of why

Vivian: yeah and that helped I didn't see myself so much anymore as mentally ill. I saw myself as somebody who could have diabetes and there is something biochemical wrong with them, and.....I hoped it would still be in my life it was gonna not be seen as a mental illness it's gonna be seen as a biochemical defect.

Elsewhere in her account Vivian outlined varied explanations as to why she may have experienced mania including childhood trauma, rejection sensitivity and grief. However, the following quote from the above extract was particularly notable:

Vivian: it wasn't more how the person who wanted this to happen it was something in my body was happening.

Vivian distinguished between herself as, “the person who wanted this to happen” and “something in my body was happening.” Therefore we can see how it helped Vivian to think of her mania as

something separate to the person, the body. Her use of the term “body” resonated with expressions used by other participants, as described earlier, such as “mind” and “brain”, which separate mania out, almost as an independent object.

Themes of guilt, shame, regret and stigma featured in most of the participants’ accounts. For example, Richard described how during his recovery from an episode his “conscience” returned to him, and he became aware of things which he had done:

Richard: I woke up and it was suddenly as though I was thinking straight and suddenly it was almost as though my conscience and sort of memory were both working as well because I suddenly became aware of some of things that I’d done on the ward.

It appeared that an important feature of recovery for these participants was making sense of their experiences and overcoming these negative feelings about their mania and themselves. Luke described how therapy had helped him to overcome his guilt:

Luke: and that helped my view of why that’s important is not necessarily to deal with the illness itself as to deal with the consequences of the illness to deal with uh the guilt the lack of self esteem that can follow on because of the things that have happened as a result of the illness.

Arguably, the participants’ constructions that their mania was a separate, uncontrollable disease process served to relieve them of underlying negative feelings they may have had about their manic episodes and themselves. Whilst the participants mentioned ways in which they had tried to manage their experience, there was an emphasis on a lack of agency in the experience despite these efforts. However, James diverged from the rest of the group, as he tended to speak about his mania in the first person. Although he described his mania in ways suggestive of distress and dyscontrol, his account largely focussed on his own agency in his experience, and how he was trying to control things, rather than how his mania was controlling or had controlled him.

3.4. “I WAS BEAUTIFUL”: THE STRUGGLE TO BE DIFFERENT

3.4.1. Overview

In this theme the participants’ understandings of how mania enabled them to be different in some way will be explored. For some, mania allowed them to be different to the ‘normal’, i.e. what they perceived as normal people and normal social rules. For others, mania was a way for a preferred self to be expressed, and for some mania helped them to experience themselves as special in some way. All these struggles to be different involved an element of freedom, for example from boundaries, social norms or their ‘normal’ or depressed selves. This freedom contributed to the allure of mania for these participants.

3.4.2. The struggle against being ‘normal’

There was an element of frustration at what was seen as normal in three of the accounts, and for these participants mania was arguably a forum for rebellion against society. In particular, participants described a process of breaking free from societal norms and expectations as a liberating aspect of their mania.

Luke described “playing the game” which for him meant doing “normal” things such as providing for the family and being successful financially:

Luke: well this sort of way that life is and has been for a while in the West and is increasingly across the world of this game where the most important thing seems to be accumulating goods and maybe getting married or settling down with somebody is all is just sometimes seems as if it’s taken as just another achievement, it’s one of things that one of the steps people have to go through towards success and could be sadly possibly even true with children and it’s like you know we have to get educated, do as well as we can through our education then get a job and work as hard as we can and then stop our job and dwindle away and die.

Elsewhere, he reiterated his view that for him, being normal involved behaving according to society's expectations:

Emma: what does normal mean to you?

Luke: behaving as one is expected to behave, you know being like a father is expected to be and a husband is expected to be and a wage earner is expected to be.....you know the sticking to the rules at work really and... not trying to be too original.

Luke expressed that being normal is “not trying to be too original.” Based on this and other aspects of his account, it seemed that Luke perceived his mania as a form of being original, not sticking to the rules and breaking out from the normal:

Luke: but would we lose something then if we all play the game and we all take the same part and nobody does anything different.

Furthermore, Luke indicated that he perceived his manic experiences as an alternative form of success to that of being successful in “the game:”

Luke: I've experienced things that people who are very successful in other ways haven't experienced.

In the following extract, Luke described further how his manic experiences were spiritual and this for him was a more valuable form of success than material success:

Luke:there have been these experiences of elation and spirituality that most people don't have I feel are very rich experiences I'd certainly prefer those experiences to say having a private jet.

Like Luke, James perceived people who experienced mania as different to “normal people”. For him normal people lived according to social rules and expectations of how they should behave in situations:

James:I think normal people are locked in one particular way of doing things.....they live according to the expectation of how they should behave in a certain situation in your pub you're allowed to do certain things if you're in an office you're allowed to do certain things if you're sitting alone in a restaurant you're expected to be a little bit you know I'm keeping to myself.....there's all these situations where.....there's an expectation of you behave this way and people all do that that that's what I feel normal people do.

James later described how rather than be “normal” mania freed him to do whatever he wanted:

James:we're all acting like we're normal....you're walled in then.....the wall suddenly drops and.....I can do anything now I can shop crazily I don't care about the bill that's not here in the moment the moment is I like this thing I want it I want that I want that or I like this person I want that I want that.

Elsewhere, he provided an example of how he perceived he had felt free to break normal social rules:

James: I was a little bit high then and....there was a woman.....and she was sitting over there reading the paper and I just went over and I asked if I could read the TV guide.....she actually hadn't opened it.....so I just asked her and then she just got it out and gave it to me and I went back and I read it and I gave it back....that moment felt you know I felt like you know first of all she was afraid of me and then it popped and then she just gave it to me.

Vivian saw her regular life as uninteresting and after one episode she commented that she was “back to all this boring grind again.” There was a strong theme of rebellion in Vivian’s account.

It seemed that her mania allowed her to break free from the “boring grind” and the boundaries of her normal life:

Vivian: ...all my boundaries were gone.....I just did what I liked.....I slept when I wanted I ate when I wanted I let people in I let all the gypsies in our house.

During a hospitalisation, Vivian described her rebellious behaviour:

Vivian: I was extremely high.... I always thought it was such fun and I always rebelled and I was always getting the patients going in the ward.....because we have lunch once and I would tell them all was all metal cutlery and I said now all bend your spoons.....and I did mine and everybody did bent their spoon and then when we had a meal next we all had plastic cutlery.

She later provided a further example of rebellion during her mania:

Vivian: I used to cycle on the middle of the busy roads....hold all the cars up on purpose to get them all hooting and everything I was a bit of a rebel.

In summary, for these three participants, mania was a way for them to struggle against what they perceived to be their normal life and normal social rules and expectations. During mania, they had liberated themselves from these rules and this provided them with a sense of freedom, which they did not experience at other times.

3.4.3. The struggle to experience a preferred self

A further aspect in the participants’ efforts to be different through their mania was their struggle to release a preferred self. This theme emerged in four of the participants’ accounts. For James, it seemed that mania afforded him the opportunity to be more fully in touch with his emotions. For Luke and Richard, mania enabled sides of themselves to surface, which were opposites to their depressed selves. For Vivian, mania allowed her to be more fun and rebellious compared to

other times. In Richard and Vivian's account, it appeared that there was an element of identity confusion concerning whether their manic or their non-manic self was the real person.

James's account suggested that mania was a way for him to fully experience emotions, something he was unable to appreciate in the same way when he was not manic. For example, James described how he had suppressed his feelings about his daughter whom he had never met, as his present wife did not approve of him having contact with her. However, when James did make contact twelve years later, he was able to release his suppressed emotions, such as excitement about their contact. He compared the depth of feeling he experienced during his manic episode to other highly emotive events:

James:....it was like falling in love or like having a new baby.

James commented that all of his manias had been triggered by "emotional events" and during mania he became "emotionally higher." In an episode precipitated by contact with his daughter, he described how he "went out into the sea into the emotions." He later described how his mania enabled him to be more expressive, for example through poetry. He suggested that the advantage of mania was that it helped him to be more like a baby. By this he meant natural and true to how you really felt, and able to connect freely with people:

James:... the advantage that it pushes you out of where you were....babies are born natural the human adult world isn't.....so people are outside the moment.....so kind of children grow.....to become young adults and grow up that way and in that process they lose that naturalness....I mean like a baby doesn't just connect with people emotionally if it's angry it doesn't inhibit oh I'm just a little bit angry so I'll keep it to myself.....everyone knows and the baby's happy everyone wants to pick it up and hold it so it's kind of that thing they're uninhibited they can connect freely with people they're fluid they live in the moment they know not to spend all their time thinking about the future or worried about the past they're just stuck there in the moment.

Luke described mania in ways which suggested that it was the opposite or a release from his depressed self:

Luke:finding things easy as well for a change cause when depressedeverything seems to be really hard work but when I'm a bit elated you know everything to do with work and home all seems to be you know easily within my stride and everything seems to go well and it's as if everybody likes me.

Similarly, Richard described how mania meant you had “cut through” depression, and had more self-belief:

Richard:another aspect of it is that.....because you think you're writing good stuff.....you're not embarrassed for other people to see it.....but possibly in a low mood I could write the same thing but not want anybody to see it and throw it in the bin.....

Elsewhere Richard described being shy when not manic, but mania enabled:

Richard: “a more sociable side of me an airing.”

His use of the expression “an airing” suggested that this sociable side of him is somehow released when manic, or not possible at other times. For Richard, being manic therefore enabled him to bring forward a completely different side of his personality, which made him unsure which side of him was the real person:

Richard:effectively you're having two different lifestyles really.....it's difficult to decide which is the real person.....

Vivian appeared to have a similar struggle in knowing whether her manic self was the real her or not. In the following extract, she described how she disguised her mania when the doctors came to assess her, and afterwards felt relieved that she could get back to being herself again:

Vivian:it was dangerous because I was able to keep all the doctors away when I was so ill be able to for half an hour be normal and then when they were gone oh thank goodness now I can just be me again I can just do what I like.

However, later in the interview, Vivian appeared to suggest that after an episode she felt like she was herself again:

Vivian: and I was so embarrassed because I suddenly was myself Vivian again....and Vivian didn't do things like that when she was normal, it was like her rebellious side her fun side her was coming out.

Elsewhere Vivian was an 'I', and her manic self a 'she'; a different person to whom she looked upon with disapproval:

Vivian: and I would be ashamed because I felt I was an intelligent woman and she shouldn't do these things.

The above three extracts demonstrated that at different points in the interview, Vivian expressed that both her manic and her non-manic selves were the real her. This arguably indicated Vivian's struggle to know who was or should be the real her. As illustrated above, at times her manic, fun, rebellious self is described as her real self, whilst elsewhere she commented that after an episode she was back to being Vivian again, and felt regretful and embarrassed about events.

She linked her manic self to her experiences of childhood abuse, which included being physically assaulted if she was rebellious or did not agree with her father. This was replayed in her adulthood through her mania, which gave her the opportunity to resist restrictions on her behaviour and act in a rebellious manner towards authority figures, which included her husband:

Vivian:I loved spreading toothpaste all over the mirrors and get my husband all annoyed

Emma: oh right [laughs]

Vivian: [laughs]

Emma: it sounds again like that sort of rebellious side of you comes out

Vivian: well that is from my childhood with my father that's why.

She later elaborated on the link between her rebellious side and her relationship with her father:

Vivian:I felt rejected and he did hit me as well not all the time but I mean if I was rebellious and I wouldn't agree with him then he would hit me.

In summary, for these four participants, being manic enabled them to release preferred parts of themselves which they struggled to express or experience when they were not manic, or when they were depressed. Mania therefore was a liberating experience for them, although in some cases the difference between their manic and non-manic selves may have caused some identity confusion.

3.4.4. The struggle to be special

For many of these participants, mania had helped them to experience themselves as being unique in some way. Five of the participants described some form of special ability which they had accessed when manic, for example creativity or intelligence, or a unique experience which they had had. These unique experiences perhaps served to communicate that they had felt or had been very privileged or special. However, some participants saw themselves as both special and ill, which appeared to be somewhat contradictory explanations.

James detailed a number of abilities which he possessed when manic. He described being “really in tune with art”, a feeling of “extreme beauty”, and “seeing glowingness” when manic, which he compared to the experience of taking LSD. Elsewhere, he recalled having had a “Nobel prize winning idea” during an episode of mania. In the extract below, James provided a rich description of how special he had felt during mania:

James: I would sometimes open the front door and the sun will come out at that moment so it felt like nature [laughs] was following me I'd be really intensely aware of birdsong, so I thought the birds were really aware not that I was anything unusual but not the fact that I was different to other people.

Luke described some of his manic experiences as exalted and spiritual. In particular, he recalled special abilities which he had learnt when he met God:

Luke: I felt like I'd completely left my body and I met this guide or angel.....and the guide took me around showing me a.....different dimension and at one point took me to show me what God was and God was.....this wonderful sort of energy really.....there was this feeling of perfect joy and love.....so when the guide brought me back it was quite sad to come back to earth again and go back to a normal life and the guide told me not to worry that you know eventually I'd be able to go there as much as I wanted and in fact I could choose to go there now I could leave I could well die I could commit suicide and then go straight there and there were lots of tasks to do involving helping people who had died, who were very confused about being dead and it was quite sad [laughs] a difficult choice for a little while.

For Peter, mania was like going “into that other realm.” He described experiencing insight, “wonderful intelligence” and “knowings about things.” When manic, he had believed that he had great capabilities:

Peter:feeling that you'd tapped into a source of energy that wasn't there before and that you had knowings about things that you didn't before in that state I would believe that I could write a leading scientific paper about anything you know you name it I could do it whether it's architecture geology psychiatry.....

Vivian described how during an episode “I was beautiful.” The following extracts exemplify how special she had felt during her mania:

Vivian: it was [sighs] in places fantastic it was like dreams have come true and life was fantastic and I was having lots of hallucinations and I would go in the garden in the evening and I would hear waterfalls and I would hear streaming of water and there was no water in our garden at all.

She later continued:

Vivian: and so beautiful things happened but you know I was cycling on the motorway and I thought that I was gonna cycle to heaven and because all the cars with their lights it was in the dark and the lights shone up into the sky when they went uphill so I thought that's where the cars all went to heaven so I was gonna do the same.

Participants differed in how they made sense of these special experiences or abilities. James suggested that the origin of his need to feel or be special went back to his family where he had been “the special child:”

James:the situation I was in with the jealous older siblings and the special child who gets all the attention from the mother....

For Peter and Vivian, although very special at the time, these experiences were looked back upon with disbelief, and as symptoms of illness. This disbelief is demonstrated in Vivian’s comment:

Vivian: and you can't imagine how you can think these things up, it is unbelievable.

Luke described how he had suppressed his special experiences due to fears about how others would perceive him:

Luke: well it's when you've had a fantastic experience in your life you want to tell people.....when you tell people....I met god and just described it.....obviously people would think that I wasn't in my right mind or on drugs or something.....

A strong theme in his account was whether or not his experiences were real and what reality actually meant:

Luke:for some years after it I still believed that it had been real or real for me.....it had been real but now.....I've been doubting the reality of that experience and that it was because I was very ill.....

Elsewhere, he continued on this theme:

Luke:the thing I'd like to understand is....what reality is for different people having these experiences whether they think they're having a spiritual experience or whether they think they're superman or whether they think they're the.....best footballer in the world.....what's going on that makes them feel that way, and....is there any validity in any of it...

He therefore had quite mixed understandings of his special experiences, on the one hand he was someone who had had privileged spiritual experiences, and on the other hand he had “chronic mental illness” and must “never ever come off medication.”

Arguably, Luke's feeling of being special and successful due to his manic experiences protected him from bad feelings about struggling to meet societal standards of material success, as previously described. Believing in his specialness and the reality of his experience also helped him to avoid his difficult feelings that rather than being exalted, his experiences were unreal, therefore meaning instead that he was ill.

For several participants, the uniqueness or abilities experienced during their manic states made them feel different compared to other “normal people” who had not experienced mania or “mental illness,” as typified in an extract from Richard's account:

Richard: ...people who experience mental illness are more sensitive.....or intuitive than inverted commas normal people....the idea that that group is nicer people than the other group.

Luke commented that during hypomania:

Luke: I feel better than a normal person could ever feel in their whole life.

He later also commented that he found normal people to be “shallow:”

Luke: I'm starting to prefer to spend time with other people like that...normal people in some ways seem very shallow because their moods don't vary to the extent that people with bipolar disorder do so they can't relate to lots of the experiences.

A similar in-group mentality was observed in Peter's account of his milder manic experiences when growing up:

Peter: ...there was a group of us at school who were very bright and quite creative and quite kind of scientifically engaged and we sometimes used to get kind of like quite bursts of creativity and be perhaps a little bit eccentric compared with how the common you know run of people would think.

In summary, most participants had experienced themselves as being very special, due to their unique experiences during mania and/or the special abilities they had accessed whilst manic. Participants had different ways of making sense of these experiences; some saw them retrospectively as signs of illness, whereas one participant struggled between whether his experiences had been real or symptoms of illness. Several participants saw their mania as a special and unique experience or ability which differentiated them from other people, and thus created an in-group mentality.

4: DISCUSSION

4.1. INTRODUCTION

The aim of this study was to gain an in-depth understanding of how six individuals diagnosed with BD experienced and lived with manic states. Semi-structured interviews were conducted to explore topics such as the experience of manic states, the positives and negatives about these, and how the participants understood the causes. The data were then subjected to an IPA, a rigorous qualitative method. Three master themes emerged from the analysis:

- **“A blessing and a curse”:** a mixed relationship with mania
- **“You have no control over it”:** a separate and controlled self
- **“I was beautiful”:** the struggle to be different

In this chapter I will focus on how these themes relate to existing theory. The clinical implications, strengths and limitations and ideas for future research will also be discussed. The participants’ pseudonyms from previous chapters will continue to be used.

4.2. “A BLESSING AND A CURSE”: A MIXED RELATIONSHIP WITH MANIA

The first master theme explored was the participants’ mixed relationship with their manic experiences. This master theme indicated that these participants had experienced considerable ambivalence in relation to their mania. However, most participants reached a point where the perceived costs of their mania outweighed the perceived benefits.

4.2.1. The allure, the danger, and the desire to stay manic

The first superordinate theme described how most participants had mixed views about their manic experiences, which led them to a process of weighing up the perceived benefits and the risks. Manic experiences were compared to illicit drug use in the majority of the accounts, due to their

alluring and pleasurable nature. However, at the same time, these experiences led to feelings of vulnerability and fear.

The second superordinate theme described the participants' dilemma as to whether or not they wanted to have their mania. As all participants noted positive aspects, most of the group consequently shared a desire to experience mania again. Participants noted differences between hypomania and mania, and several expressed that they were tempted to keep control of their hypomania before it developed in to a more severe state. However, one participant, James, was actively trying to experience hypomania due to the positives he associated with his experience.

The participants experienced conflict about their manic experiences, and had very mixed and sometimes opposing ideas about them. At times, mania was described in terms of conflicting emotions and descriptions (e.g. dangerous/magical/scary/fantastic). This marries well with a range of extant psychological theories, which focus on inner conflict and conflicting emotions and beliefs (e.g. Abraham, 1911; Bentall, 2004; Mansell et al., 2007) in BD.

This internal conflict provides support for the Integrated Cognitive Model (ICM; Mansell et al., 2007), described in Section 1.3.2. Participants described their mood states in terms of extreme appraisals. For example, they felt that they were losing control, that their experience was fantastic or dangerous, that they had greater self-belief, were much more sociable, could achieve more goals, and that they had made a fool of themselves. As postulated in the ICM (Mansell et al., 2007), the participants' appraisals of their moods were extreme and conflicting, and may have led them to engage in ascent or descent behaviours, in order to escalate or deactivate their manic experiences.

Additionally, these conflicts arguably link to the psychoanalytical manic defence hypothesis (Abraham, 1911). This hypothesis highlighted the underlying dysphoria during manic states. Furthermore, this focus on inner conflict links with the increased recognition of the complexity of BD symptomatology. For example, Bentall (2004) cited Goodwin & Jamison's (1990) collation of mania symptomatology data of 700 service users. They found that whilst euphoria was reported by 71% of service users, 72% also reported to be depressed, and 80% to be irritable. In

the light of this data, Bentall (2004) reported that mania is likely to involve both dysphoria and euphoria. Based on his review of the literature, Bentall (2004) thus concluded that the five components of mania are dysphoria, increased hedonism, psychomotor pressure, psychosis and irritability.

The desire to stay or return to manic states due to positive attributions about the experiences has been linked to a poor outcome in psychological therapy (Lam et al., 2005a). One participant, James, was seeking to experience his manic states, whilst others described missing their highs.. Lam et al. (2005a) found that clients who did not do well in CBT overvalued the personal attributes associated with high moods such as being more creative, entertaining, outgoing, dynamic, productive and persuasive. These attributions are in turn thought to lead to unhelpful behaviours such as highly driven behaviour and poor sleep and routine, which could provoke relapse. These positive descriptions of high moods link well with the descriptions provided by the participants in this study.

4.2.2. Loss and survival

The third superordinate theme explored the stage the participants had reached in relation to their manic experiences. Five participants had not experienced manic states for between two and twenty-seven years, whilst one participant, James, reported a current experience of hypomania. No longer experiencing mania was attributed to the use of medication. However, as described above, alongside their concordance, they experienced an element of loss in no longer being able to be hypomanic. However, for most participants this sense of loss was overshadowed by the costs of their experience, which for some participants led to a sense of survival, as if the mania was a trauma that they had lived through.

Coming to terms with their experiences was an important element for most of the participants. They expressed how destructive their experiences had been in their lives, threatening their marriages, family life, employment and income. This had led participants to 'give up' their mania due to the perceived losses and consequences. Some had reached a point whereby they perceived

they had overcome their mania and no longer feared the mania, and one participant, Peter, described himself as a role model who had survived severe episodes.

Morrison et al. (2003) reviewed studies exploring the relationships between Post-Traumatic Stress Disorder (PTSD) and psychosis. They found a number of studies had found such relationships. Some described how psychosis could shatter the person's experience of themselves, the world, and others in a similar way to other traumata (Janoff-Bulman, 1979). Symptoms outlined included terror, helplessness, re-experiencing of the episode, and avoidance of reminders. Morrison et al. (2003) similarly found that studies have linked the experience of hospitalisation with PTSD. This relates to experiences such as witnessing or experiencing abuse or harassment, restraint and being forcibly medicated.

A number of qualitative studies have described a process of mourning or depression in people diagnosed with schizophrenia (Birchwood et al., 2005; Hochman et al., 2005; Mauritz & Meijel, 2009; Rooke & Birchwood, 1998; Wittmann & Keshavan, 2007). These studies identified a grieving process which the participants went through which helped them to come to terms with their experiences. Psychosis was sometimes seen as an immense life altering event and losses described related to identity, potential, relationships, and functioning.

Such losses are thought to lead to post-psychosis depression (Birchwood et al., 2005; Rooke & Birchwood (1998). Rooke & Birchwood (1998) undertook a correlational design with 49 participants, using self-report measures, to explore this construct. Measures included the Hopelessness Scale (Beck & Weissman, 1974) and the Personal Beliefs About Illness Questionnaire (PBIQ; Birchwood et al., 1993). The PBIQ explored areas such as entrapment and loss of autonomy. Findings suggested that post-psychosis depression may be related to feared relapse, compulsory detention, residual symptoms and loss of employment. Appraisals of psychosis included loss, humiliation and entrapment, which the authors contended may impact on levels of hopelessness. They also described how these losses may subsequently lead to an engulfment by and internalisation of an illness identity (Birchwood et al., 1993).

Rooke & Birchwood (1998) argued that schizophrenia was unique in its capacity to trigger depression. However, although the above studies focused on the schizophrenia diagnosis, evidence from the present study, previous research (Lim et al., 2004; Michalak et al., 2006) suggest that themes of loss and post-episode depression are not unique to schizophrenia, and are also relevant in BD.

For example, Lim et al. (2004) obtained similar findings to the present study. They conducted focus groups with eighteen people diagnosed with BD to explore the psychosocial issues that they faced. One of their master themes indicated that participants experienced their lives as characterised by loss and damage, such as damage to relationships and friendships, employment and financial status. They concluded that people with BD are constantly coming to terms with their experiences and the losses that they have faced (Lim et al., 2004).

Inder et al. (2008)'s qualitative study, as described in Section 1.4.2., found that a diagnosis of BD had a significant impact on identity in young adults, creating experiences of confusion, contradiction, and self-doubt. Their lives were characterized by disruption and discontinuity and on definitions of self based on their diagnosis.

4.3. “YOU HAVE NO CONTROL OVER IT”: A SEPARATE AND CONTROLLED SELF

In this section, the second master theme will be explored, through discussion of the superordinate themes of separateness, loss of control and negative emotions.

4.3.1. Separation and loss of control

The first superordinate theme was the participants' descriptions of mania in ways which suggested it was an experience separate from the person, often as if it had a life of its own. However, sometimes within the same account, mania was described as if it was a part of the person. This arguably indicated that the participants were uncertain and conflicted concerning whether or not, or to what extent, mania was something separate to them. Related to the theme of

separation, a second superordinate theme related to participants' descriptions of their experiences in ways which suggested that, during an episode, they lost control to their mania.

Themes of separateness and loss of control have also been found in qualitative studies by Foster (2003) and Lim et al. (2004). Foster (2003) conducted narrative-style interviews with service users with varied diagnoses. Her findings suggested that loss of control and separateness may be common experiences in a range of mental health problems. She described how participants sometimes regarded their mental health problems as controlling, and as located externally, as a separate entity. Consequently, the problems became objectified as an entity which exercised control over the client from an external location. The person thus perceived that they were helpless or trapped, at the mercy of this entity.

Within the current study, most participants experienced their mania in a similar fashion; as a separate entity to which they lost control. At times this was described as something internal but separate to the self, such as the body, mind or brain; whilst sometimes external metaphors were used. Examples of these were Helen's image of being in an out of control car with no brakes or James's image of falling over the cliff of a waterfall.

Lim et al.'s (2004) study, (as described in 4.2.), featured a master theme concerning the participants' experience as being out of their control. The authors concluded that people with BD perceived themselves as being helpless and unable to change or influence their condition, as they believed that they have little or no control over their episodes. Related to this, the participants believed that the only way to control their symptoms is through medication. Furthermore, participants expressed their inability to prevent episodes, for example via the recognition of early signs.

In the current study, most participants similarly attributed their stability to the use of medication. Medication was seen as the crucial protective factor, as something which had saved them from the distress and negative consequences of their episodes. This emphasis on medication concordance, over and above self-management strategies, could possibly be associated with the construct of an external locus of control (Rotter, 1966).

The construct of locus of control (Rotter, 1966) refers to whether an individual sees a situation as under his or her internal control, via one's own actions, or under the external control of other factors. It seemed that the participants' experiences of losing control to mania, and then regaining control via medication, may have understandably left them with an external locus of control, as they did not experience personal control during their experiences. This may therefore have impacted on their quality of life, as their experience of losing control during mania and their related fear of recurrence impacted negatively on their lives. For example, Helen equated the fear which she experienced to that which patients with remitted cancer experience. Several participants expressed that they should never come off their medication due to similar fears. Having a sense of internal control has been associated with improved quality of life and functioning in people with severe mental health problems (Eklund & Bäckström, 2006), arguably because individuals feel less threatened by their problems.

A related construct is low self-efficacy. Lim et al. (2004) postulated that people with BD lack belief in their ability to predict or control their episodes, which the authors link to self-efficacy theory. Bandura's (1995) self-efficacy theory proposes that people are motivated to act when they believe they can obtain desired results by their actions. Therefore, the person's belief in their own ability to achieve an outcome is critical in their success. Self-efficacy beliefs are therefore thought to be strongly associated with actions chosen, the amount of effort and persistence, and consequently the results attained.

Lim et al. (2004) apply this theory to BD, contending that individuals may lack confidence in their ability to influence the onset or course of their episodes, and consequently they may be unlikely to look out for early signs and develop self-management plans. This lack of belief in their ability may paradoxically contribute to multiple recurrences, therefore compounding their sense of low self-efficacy.

In the present study, participants emphasised loss of control to mania and when describing how episodes developed, they talked in ways which suggested that mania, a separate object, had a life of its own. This study therefore concurred with Lim et al.'s (2004) findings that individuals may

not believe in their own potential agency in their experience, and consequently may experience low self-efficacy. Having a low sense of self-efficacy is unsurprising, considering that the participants may also have an external locus of control, viewing medication as the predominant solution.

BD is known to be highly recurrent (Lam & Wong, 2005) and this factor may help to explain the participants' sense of being unable to act in the face of their mania. This resonates with learned helplessness and hopelessness theories of depression, which hypothesise that past failure to manage depression leads to expectations that it is impossible to change one's situation (Abramson et al., 1989; Seligman, 1974).

4.3.2. Self-stigma and the moral emotions

A third superordinate theme explored the possible function of perceiving mania as a separate and uncontrollable experience. Specifically these constructions married well with the participants' explanations of their mania as a biochemical illness. Whilst participants described ways in which they had tried to manage their experiences, there was an emphasis on a lack of agency despite these efforts. Explaining mania in terms of separation and dyscontrol arguably relieved these participants from negative emotions which they had about themselves, such as guilt, regret, shame and self-stigma.

Stigmatisation refers to the majority tendency to distance from and limit the rights of disparaged groups. People with mental health problems are one of the most stigmatized groups in society; such stigma can have a huge impact on disability in terms of social exclusion, over and above the disability individuals face related to their distress (Hinshaw & Stier, 2008; Smith, 2002).

The extreme stigma attributed to people with mental health problems can lead to the internalisation of this degraded status, which is known as self-stigma (Major & O'Brien, 2005). Hinshaw & Stier (2008) contend that self-stigma is more likely in this group, because many types of mental distress involve despair, pessimism and low self-worth. Negative emotions about oneself may be particularly acute following manic episodes due to the socially deviant behaviours

associated with these states, such as hypersexuality, impulsivity and flamboyant behaviour (Leahy, 2005). These post-episode negative emotions might include self-stigma, regret, embarrassment, guilt and shame.

These negative emotions have been described as the moral emotions (Kroll & Egan, 2004; Tangney et al., 2007). The moral emotions are thought to be evoked by self-evaluation, and they can lead to a sense of worthlessness. Kroll & Egan (2004) reported that negative moral emotions are directly associated with some psychiatric problems. For example, excessive guilt with depression, guilt and shame with PTSD, and guilt with obsessive-compulsive disorder (OCD). The authors argued that moral worry, which relates to one's tendency to fret over the moral choices and actions one has made, is a common process in humans, and they concluded that such moral emotions, conflicts and worries should be explored with clients. Kroll & Egan (2004) did not specifically mention post manic episode moral worries, yet this seemed to emerge as an important theme in the participants' accounts in the current study. This could therefore be a useful area to explore in treatment.

4.4. "I WAS BEAUTIFUL": THE STRUGGLE TO BE DIFFERENT

In this section, the third master theme will be explored, through discussion of the superordinate themes related to the varied struggles to be different which emerged in the accounts. In all three superordinate themes, mania was in some ways a liberating experience, which added to its allure.

4.4.1. The struggle against being 'normal'

The first superordinate theme explored how, for some participants, mania was seen as an opportunity to struggle against what they perceived as normal people and normal social rules. Manic experiences were arguably a forum for rebellion against society, and their process of breaking free from norms and expectations was a liberating experience for these participants.

The theme of mental distress being a form of rebellion against life circumstances, society and social norms resonates with a number of extant theories (Laing, 1960, 1967; Levine, 2001; Scheff,

1966; Szasz, 1984, 2007, 2008; Smail, 2005). These authors have all been associated with the critical psychiatry tradition (Double, 2006) and were also influenced by postmodernist philosophy, in particular the work of Michel Foucault (1961/2009), who described the historical and social construction of 'madness.'

Scheff (1966) viewed people with mental distress as socially deviant, precisely because they have labels of illness, and are therefore expected to behave in a certain way. These stigmatising labels are applied to those who fail to conform to dominant social norms of behaviour, and serve to help the majority come to terms with and understand deviant behaviours. However, these expectations then lead individuals to believe that they are supposed to act in a certain way and, over time, they come to do so. Effectively, expectations of deviant behaviour become a self-fulfilling prophecy. This theory may be relevant as mania, in particular, as it is associated with behaviours which deviate from common social norms, such as hypersexuality, impulsivity and flamboyancy (Leahy, 2005).

Szasz (1984, 2007, 2008) viewed mental illness as a myth which legitimised the use of social control towards those with disapproved thoughts, emotions and behaviours. He maintained that psychiatrists should actually be "soul doctors" who deal with spiritual "problems in living," rather than treating an illness. Similarly, Laing (1960, 1967) viewed psychosis as way for people to communicate concerns about their lives. These communications were a valid expression of their lived experience rather than merely symptoms. He argued that individuals can develop mental distress because of impossible situations, where they are unable to conform to the expectations around them. For him, psychosis was therefore an expression of distress and alienation, yet should be valued as a transformative experience, as it is a means to work through this distress.

Modern proponents of critical psychiatry, such as Levine (2001) and Smail (2005) have emphasised mental distress as a reaction to wider society and social problems. Levine (2001) argues that the focus on disease has distracted society from the underlying causes of mental distress. For him, mental distress is rebellion, all be it at times self-destructive, against an increasingly impersonal society obsessed with expectations and wealth. Those who are mentally distressed are pressured to return to 'normal,' but normality can be a dehumanising reality for

many. Aspects of modern society such as technology, productivity and urban anonymity have created a sense of alienation, leading to so much disconnection and discontent that many people are suffering mental distress as a result.

Smail (2005) has similarly argued that mental distress can be understood as a response of the individual to his situation in society. For Smail (2005), the assumption that mental distress is caused by something within the person which needs to be fixed is unfounded. Society can be regarded in some respects as being responsible for such distress. Both these authors propose radical changes to the way mental distress is addressed.

Smail's (1998) concept sees therapy as a change to encourage individuals to change their social worlds, for example by taking part in communal endeavours which can make people forget themselves and thereby find happiness. Levine (2001) believes that society needs to be rehumanised and therapy should focus on peoples' underlying, legitimate anger, and help them to find a more constructive way to rebel. He believes that people should be helped to transform their lives, for example through engagement with others, local activism and caring about global issues. These approaches can lead people to have a more human, satisfying life.

However, some authors challenge such theories. For example, Smith et al. (1980) outline the positive effects of labels. For example, once labelled, the person may be more able to access effective treatments. Ghaemi (2009) critiques those who deconstruct mania, such as Healy (2008). He noted the evidence for the major prophylactic and antisuicide benefits of lithium, and contended that diagnosis is very important, as many adults have died from untreated BD.

In the present study, three participants described their mania in terms of rebellion. Two, however, simultaneously saw their mania as a biochemical illness. This is in contrast to the aforementioned authors who viewed mental distress and mania as an anti-social form of protest, and sometimes not as a real illness. The third participant for whom this theme was relevant, James, did not express strong views about diagnosis and illness, yet he had very rich meanings about his mania being a way to not be normal.

In summary, the struggle against being normal was a feature in some participants' accounts. This was a way for them to break free from the frustrations of their normal lives, or normal social rules. These themes were explored in relation to critical psychiatry theories, although for these participants, the anti-diagnosis, and anti-labelling aspects which accompany these theories did not seem as relevant. Although there was disparity between participants' views and those of critical psychiatry, such theories did indicate some relevant meanings. These included distress being a protest against modern society, social circumstances, and normal social rules; themes which did resonate for these participants.

4.4.2. The struggle to experience a preferred self

The second superordinate theme explored how for most participants, mania was an opportunity to experience preferred selves. These included a more emotional self, a non-depressed self, a more sociable self, and a more fun and rebellious self. Mania therefore was a liberating experience for them, although in some cases, participants may have experienced identity confusion concerning whether their manic or their non-manic self was the real person.

The notion of having different selves within our personality has a long tradition in psychological literature (Rowan, 1989). Social constructionists describe distributed selves (Wetherell & Maybin, 1996) highlighting the complex and multiple nature of identity. The self is not fixed but is continually constructed through our involvements in cultural and social contexts. Whilst multiple selves could be considered a normal part of existence (Goffman, 1959; Rowan, 1989; Wetherell & Maybin, 1996), for these participants it appeared to be a struggle, as their manic self allowed them access to a different, preferred identity, which they struggled to access when not manic.

Seal et al.'s (2008) study (as described in Section 1.4.3.), explored a non-clinical sample of people who experienced hypomania. These participants described positive qualities about their hypomania, including enhanced self-esteem and self-confidence, and a sense of freedom from a previous less lively self. When hypomanic, they reportedly became better partners, more fun and lively, and better employees. This finding resonated with the present study, as participants

described preferred selves during manic states, such as non-depressed, more emotional and more fun selves.

For some participants, the marked difference between their manic and non-manic selves created some confusion over who was the real person, or which person they really should be. Radden (2009) has described how individuals with BD can experience radically different states associated with their manic and depressed phases. These changes can be as disruptive to identity as those seen in people diagnosed with Dissociative Identity Disorder (DID; DSM-IV-TR; 1994). In DID, people exhibit 'alters', entirely alternate personalities within themselves (Mollon, 1996). However, Radden (2009) noted that in BD, these changes are the effects of symptoms, rather than central, defining symptoms. However, the person can be seen to have very different attitudes and dispositions when manic or depressed. Individuals can experience these changes for weeks or months depending on the length of an episode.

Similarly, Inder et al.'s (2008) study (as described in Section 1.4.2.) concluded that a diagnosis of BD impacted on the development of identity in young adults. These participants expressed experiences of confusion, disruption and contradiction, which made it difficult for them to establish continuity in their identity. Radden (2009) and Inder et al.'s (2008) conclusions resonated with some of the participants' accounts in the current study, as they appeared to experience similar struggles with their identity.

4.4.3. The struggle to be special

The third superordinate theme explored how for many of these participants, mania had helped them to experience themselves as being very special. Five of the participants described some form of special ability which they had accessed, for example creativity or intelligence, or a very unique experience. These unique experiences perhaps served to communicate that they had felt or had been very privileged or special. Participants had different ways of making sense of these experiences; some saw them retrospectively as signs of illness, whereas one participant struggled to decide whether his experiences had been real or symptoms of illness. Several participants

perceived that their manic experiences differentiated them from other people, and thus they expressed an in-group mentality (Tajfel, 1982).

The theme of mania leading to feelings of being very special could be linked to the concept of the manic defence (Abraham, 1911; Bentall, 2004; Lyon et al., 1999; McWilliams, 1994; Neale, 1988). As described in section 1.3.1, these authors viewed the elation of mania as a defence mechanism to protect the individual from underlying depression and low self-esteem. The participants in this study described experiences such as feeling different to others, feeling special, privileged, incredibly intelligent, exalted and beautiful. These indeed appear to fit with this hypothesis, as they are the extreme opposites of depression.

Bentall's dysphoria model seems relevant in the sense that many of the participants described thoughts of great capability and self-belief during their manic states. Underlying depressive self beliefs may have been present, particularly for Luke and Richard, who talked about their manic selves as the opposite to their depressed selves, as described in 4.4.2.

Other authors have adopted a more credulous approach (Kelly, 1955/1991) towards manic experiences, rather than explaining these as an unconscious defence. Notably, Jamison (1996) examined the lives of historical figures associated with creativity, genius and exalted highs, such as Lord Byron, Vincent Van Gogh and Virginia Woolf. She postulated that the special abilities which they possessed were related to their BD. She therefore contended that BD could in some ways be seen as a gift.

Others have noted the similarities between accounts of mania and psychosis with those of mystical experiences (Greenberg et al., 1992; Laing, 1960/1967; Whitney, 1998). Laing (1960, 1967) postulated that psychosis was very meaningful and could be a transcendental experience with spiritual and healing aspects.

Thornhill et al. (2004) conducted a narrative analysis of 15 accounts of recovery from psychosis. Participants included people with a diagnosis of BD. One of the key narratives found was narratives of "enlightenment", which involved participants finding new perspectives,

understanding and personal growth. This arguably supports Laing's (1960/1967) writing on the potentially healing nature of psychosis.

Greenberg et al. (1992) found that hallucinations and grandiose or paranoid beliefs are features of normative Jewish mysticism. They postulate that what distinguishes psychosis in orthodox Jews is the duration of the state, the ability to control entry to the state, and significant deterioration in functioning. Interestingly, in the present study, Luke described a mystical experience of meeting God and having a special role in helping the dead. However, he decided not to continue with his endeavours, which suggests that like mystics, he had the ability to control entry into or exit from the state.

Whitney (1998), in an account of mania, described his experience as a "spiritual emergency" which captured both his quest for meaning and his exploration of spiritual and existential themes during his experience. He argued that "religious or spiritual problem" could be a differential diagnosis for a manic episode.

Charles et al. (2007), in a study of people's explanations for their mental illness, found that clients simultaneously held contradictory beliefs, such as believing that they had a mental illness as well as a problem with their soul. In the present study, Luke similarly appeared to hold contradictory meanings, on the one hand being chronically mentally ill, and on the other being very special due to his unique experiences. A qualitative study was also found to relate to Luke's account (Judge et al., 2008). The authors found that individuals experienced 'coming to terms with psychosis', for example realising that past experiences that they believed to be authentic were actually symptoms, and questioning what was real and what was their illness.

4.5. CLINICAL IMPLICATIONS

The findings of this study provide support for CBT for BD. This targets appraisals of mood states, and how these may influence behaviours which maintain instability. For example, positive appraisals about mood states and oneself when high might lead to ascent behaviours such as deliberate sleep deprivation, and highly driven behaviour. Participants in this study described

positive appraisals of their experiences, although for most, over time, the costs had outweighed the benefits. CBT has demonstrated effectiveness as a “standalone” psychological treatment for BD (Lam et al., 2005b; Scott et al., 2006). However, more research is needed, as Lam et al. (2005a) demonstrated that having positive appraisals of mild manic states might be associated with poor outcome in CBT.

Whilst the experiences of these participants linked well with cognitive models of manic experiences, a plethora of other therapeutic approaches might be potentially useful, in light of some of the broad themes which emerged for these participants.

Some of the positive attributions described by participants may have led them to have an addictive relationship with their manic states, and many of them used analogies of drug addiction. Therefore, Motivational Interviewing (MI) could be a very apt approach, as this is a well evidenced intervention in the field of addictive behaviours (Arkowitz, 2008; Luty; 2003; Treasure, 2004). Arkowitz (2008) described that MI targets ambivalence about change and aims to increase motivation to change based on the person’s own values rather than from external persuasion or coercion. Such external pressure to change, it is argued, can create a paradoxical decrease in the desire to change. MI adopts a client-centred style to encourage the client to give their own reasons for attempting to change. Arkowitz (2008) promoted MI either as a stand-alone treatment or as an integration with existing therapies. They outline the use of MI for various psychological problems, although curiously there is no application of MI described specifically for BD. Swartz et al. (2007) have described a one session MI intervention for depression designed to improve the client’s participation in subsequent treatment. The application of MI in BD seems highly relevant.

In recent years, there has been a ‘narrative turn’ in the social sciences, with an emphasis on how people live in a story-shaped world (Roberts, 2000; Smith & Sparkes, 2008). Alongside this new paradigm, postmodern approaches to therapy have emerged which focus on helping people to make sense of their identities and selves, as well as create new narratives about their lives. For example, Narrative Therapy (White, 1988; White, 1995; White & Epston, 1990) encourages the re-authoring of oneself, in order to move away from a problem-saturated narrative. Similarly in

Constructivist Therapy, the co-construction and experimentation with new possible selves is encouraged (Buirns & Martin, 1997; Neimeyer, 2002). Such approaches could be highly appropriate when the person struggles with their identity or their preferred manic self. In the present study, Vivian described how in therapy, she was encouraged to develop the aspects of her manic self; being fun, lively and rebellious, in a more socially appropriate way in her non-manic experience. This is arguably an example of how these approaches could be applied.

Interpersonal Therapy (IPT; Frank et al., 2000; Robertson, 1999) seems particularly relevant in the light of the theme of 'giving up' mania, and related themes such as the impact upon relationships, loss, trauma and survival. Robertson (1999) describes Interpersonal Therapy (IPT) for BD. This helps to address the interpersonal conflicts which may emerge in families following an episode, where aggression, and financial or sexual excesses may have damaged relationships. The therapist aims to assist the person to clarify their 'former role' and mourn aspects of it that are lost, such as pleasurable highs, as well as identifying a 'new role.' The grieving of lost potential or a lost period of life is an additional aspect of this approach.

Frank et al.'s (2000) Interpersonal and Social Rhythm Therapy (IPSRT) focusses on the interpersonal upheavals and transitions people with BD experience, alongside practical behavioural intervention. Like Robertson (1999), one transition described is the loss of the pleasurable aspect of hypomania, which can tempt people to seek mood elevation through medication non-concordance or deliberate insomnia. The therapy aims to help people to relinquish their mania, by reminding them of the negative consequences of their highs, and encouraging rewarding life goals associated with stability.

Gilbert's (2005) compassion therapy could be a useful approach to specifically address the client's self-critical emotions (e.g. shame), due to their manic episodes. The goal of such an approach is to help the client foster a more compassionate approach towards oneself, for example by developing compassionate imagery or a compassionate inner voice.

Like CBT, many of the outlined therapies have been shown to be effective as stand alone treatments for varied psychological problems (Burke et al. 2003; Winter et al., 2008). IPSRT, in

particular, is an integrative approach with specific evidence of effectiveness for BD (Miklowitz et al. 2008).

Therefore, a broad clinical implication of this study is arguably that existing CBT approaches could be improved through the integration of varied therapeutic models. Such an integrative approach has been applied to psychosis (Rhodes & Jakes, 2009), as these authors combine Narrative and Solution-Focussed therapies in their CBT practice. Varied approaches, as described, could be integrated in to therapy, if the themes identified for these participants were subsequently found to be relevant in further studies. Furthermore, in practice, many clinical psychologists draw from multiple therapeutic modalities, and this is arguably a particular strength of the profession. However, the current political climate appears to promote CBT as a superior therapy (Nel, 2008).

Manic experiences could be very profound and unique experiences for these participants, and may have helped them to access abilities, such as creativity or spirituality, which they struggled to access when not manic. Clinicians could adopt a credulous approach (Kelly, 1955/1991) to clients' special experiences, and provide space for them to express their meanings. Clinicians should remain open to the fact that mania can be an extremely positive and transformative event in some cases, providing the person with a sense of spirituality and exaltation. Furthermore, mania has been associated with creativity and brilliance in historical figures (Jamison, 1996), and the experience may indeed enable individuals to access their potential. In treatment, clinicians should gently explore the realistic and intense sense of loss that individuals may face in having to 'give up' the positive aspects of their highs. As mentioned before, processing loss of the positives is an important aspect of IPT and IPSRT, and as such these may be particularly useful in this regard.

Overall, this study demonstrated that people who have lived with manic experiences can provide rich accounts of their experiences and their meaning-making. This highlights the importance of entering the client's world during therapy, in order to better appreciate how they live with and survive mental distress.

The emerging narrative approach towards severe mental health problems (Roberts, 2000) may also enhance service provision, encouraging professionals to better appreciate the individuality and content of each client's experience. Furthermore, the incorporation of client narratives in to professional training could further encourage students to develop empathy, and avoid the objectification of people in to dehumanised disorders (Patterson & VanMeir, 1996)

This is therefore an exciting time in the field of mania, as this phenomenon is less researched compared to other experiences associated with severe mental health problems, such as voice-hearing and unusual beliefs (Bentall, 2004). Such an approach stands in contrast to the biochemical approach, which views mania as a disease process devoid of meaning.

4.6. STRENGTHS AND LIMITATIONS OF THE STUDY

4.6.1. Strengths

Mania remains one of the least researched of all psychiatric phenomena (Bentall, 2004). Bentall (2004) suggested that this may be because individuals are unable to remember their manic experiences. However, the present study was original in evidencing that sufferers can provide detailed accounts of their experiences.

The literature review demonstrated that there is a dearth of literature focussed specifically on accounts and views of manic experiences. Whilst one study was found exploring hypomania in a non-clinical sample (Seal et al., 2008), the present study was novel in its in-depth exploration of manic experiences in a clinical sample. The dissemination of this study could potentially improve existing knowledge about manic experiences, and therefore might provide a valuable contribution to both psychological theory and clinical practice.

Finally, deploying an IPA research strategy was an ideal methodology for answering the research question. IPA facilitated the collection of in-depth accounts of lived experiences. IPA guidelines were carefully followed during both data collection and analysis. Starting with a case by case analysis, this method encouraged the researcher to do justice to each account. This subsequently

made possible a genuine and detailed consideration of the convergences and divergences across the group. The interpretative aspect of the method fostered an interrogative approach to the data, whilst the phenomenological approach encouraged a simultaneous immersion in to the participants' worlds. Finally, the study benefited from a supervisory team with considerable experience of IPA, as well as a peer IPA supervision group. Both of these ensured adherence to and understanding of this approach.

4.6.2. Limitations

Due to time constraints for this project, the first six people willing to participate were recruited, and these participants were all aged over 40 (aged 42-62). The participants were recruited from local service user organisations and a national BD website, and these were arguably forums which attract an older age group, as well as individuals with a particular perspective. For example, they might have represented individuals with a strong service user and BD identity, and a firmer belief in medical constructions of their diagnosis. Furthermore, due to the older age range, this study had a flavour of life review, in terms of looking back over many episodes, and how these participants had adjusted over time.

Therefore, the perspective of younger adults, who may have had fewer episodes, and consequently less time to adjust, was neglected. This was a shame as a dearth of studies with younger participants was identified in the literature review, with only one study specific to this population (Inder et al., 2008). The recruitment strategy could also have targeted websites specific to younger adults diagnosed with BD (e.g. www.steady.org.uk), as well as other student populations. However, younger adults might be less inclined to participate in research because they do not identify with the diagnosis as much as those in the older age range, particularly people who are involved in service user organisations and web forums.

The fact that many of these participants had 'let go' of their manic experiences meant that they may have come from a particular perspective, which is possibly different to other individuals. For example, medication non-concordance is less common than concordance, and thus other people

may be battling with their manic experiences more than those sampled. Such individuals were therefore not well captured in the present study.

In the current study, most participants had not experienced manic episodes for some time, ranging from two to twenty seven years, although one participant described a current experience of hypomania. Sampling participants who were closer in time to the experience might have assisted the researcher to get even closer to the phenomenology of manic states. A clinical sample of participants who are currently hypomanic, but not distressed might be possible, and may shed further light on the positive aspects of the experience.

IPA was a useful approach for exploring the experience of mania from a Constructivist perspective, in terms of what was 'real' for these participants. However, given the significant debates about the validity of psychiatric diagnosis, and the literature on their social construction (e.g. Bentall, 2004; Boyle, 2002), other qualitative methods might have been more useful. For example methodologies which adopt a Social Constructionist perspective (e.g. Discourse Analysis or Narrative Analysis) might have highlighted how the participants storied their experience according to dominant social narratives of 'Bipolar Disorder' and 'mental illness.' Although this study reflected how most of the participants talked about their experience as a biochemical disease, other methodologies might have afforded a greater depth of exploration of these constructs.

4.7. FUTURE RESEARCH

There are a numerous future research avenues which could be explored. The present study focussed on participants aged between forty-two and sixty-two. All participants had experienced multiple episodes of mania, and most had reached a point whereby they had decided to adhere to medication in an attempt to avoid their manic experiences.

It could be interesting to explore the experiences of younger adults who have had fewer episodes, and who may therefore have a different perspective. For example, younger adults with a recent first episode of mania could be sampled. One qualitative study by Inder et al. (2008) explored

identity development in young adults with BD. However, there is no study looking specifically at experiences of mania in this age group.

One participant had largely positive attributions, did not adhere to medication, and was deliberately seeking manic experiences. It would be most interesting to conduct a study specifically targeting people with such marked positive attributions, who deliberately seek to experience manic states, and therefore struggle with their medication concordance. This could be useful as such individuals have been shown to do less well in therapy (Lam et al., 2005a).

Although most participants were concordant, it seemed that some had struggled with regards to letting go of their mania, had experienced it as addictive and therefore expressed considerable ambivalence. Studies exploring the effectiveness or experience of Motivational Interviewing (MI) would be helpful, as this specifically addresses ambivalence. Whilst MI has been applied to varied psychological problems (Arkowitz & Miller, 2008), there is no study of MI applied specifically to BD.

Finally, the present study could be repeated with other homogenous samples, such as those with other types of BD. All the participants in this study met the criteria for Bipolar I, as they had been hospitalised due to mania. A study with people diagnosed with Bipolar II may shed light on their unique experiences. Furthermore, there is very little research into the phenomenology of mixed episodes. Furthermore, research has indicated that both Bipolar II and mixed episodes are the most dangerous presentations, with a greater risk for suicide (Akiskal, 2007). Therefore, further investigation of these areas should be a priority.

Finally, future research could target a sample of individuals with a more recent manic episode, for example, within the last year. They might provide even richer accounts, as recall of the experience may be much improved.

4.8. CONCLUSION

This study presented an Interpretative Phenomenological Analysis (IPA) of six peoples' accounts of their manic experiences. Through semi-structured interviews, the participants were provided with the space to describe what it was like to experience and live with manic states, and how they made sense of these experiences. Three master themes were described.

The first master theme, '*A mixed relationship with mania*,' explored the participants ambivalence related to the risks and benefits of their experiences. Manic experiences were viewed as both alluring and dangerous, and most participants eventually reached a point whereby they took their medication in order to not experience mania. For them, the perceived costs outweighed the benefits. Participants described losses, such as the loss of their 'highs,' as well as losses related to the destructive consequences of their episodes. For some, there was a sense of survival from their experiences. However, one participant had a different relationship, in that he did not adhere to medication, and was actively trying to experience his high moods.

The second master theme, '*A separate and controlled self*,' explored the participants' descriptions of mania as an experience or object separate from the person, often as if it had a life of its own. Many of these participants described how during an episode they lost control to their mania. The possible function of perceiving mania in this manner was examined. These descriptions married well with their explanations of mania as a biochemical illness. Whilst participants' described ways in which they had managed their experiences, there was an emphasis on a lack of agency despite these efforts. Explaining mania in terms of separation and dyscontrol arguably relieved these participants from negative emotions which they had about themselves, such as guilt, regret, shame and self-stigma.

The third master theme, '*The struggle to be different*,' explored how manic experiences enabled the participants to be different in some way. Firstly, for some, manic experiences were a form of rebellion against society and social rules. Secondly, for most participants, mania was an opportunity to experience a preferred self; a self which they struggled to experience when not manic. Examples described were a more emotional, a non-depressed, a more sociable, and a more

fun and rebellious self. Finally, most participants described how mania enabled them to access special abilities, or very unique experiences. In all these struggles to be different, mania was a liberating experience, which added to its allure.

These themes were related to extant psychological theory and their clinical implications were explored. Issues discussed in relation to manic experiences included positive appraisals of high moods; ambivalence; loss and trauma; low self-efficacy, entrapment and helplessness; medication; self-stigma and negative moral emotions; social context; preferred selves; and special and unique abilities and experiences during manic states.

The findings of the study were relevant to developing cognitive-behavioural conceptualisations of manic experiences, as outlined in the Integrated Cognitive Model (ICM; Mansell et al., 2007). In particular, the participants' conflicts between positive and negative appraisals of their experiences, might link to the extreme and conflicting appraisals noted in this model, as well as the postulated relationship between positive appraisals and the maintenance of instability.

However, a plethora of other therapeutic approaches, such as MI and postmodern therapies, were suggested to be potentially helpful in addressing particular issues. These included grief, loss, ambivalence, shame and a preferred manic identity. The integrative approach of IPSRT was noted as particularly relevant in relation to the present findings. This therapy specifically targets feelings of loss and grief which individuals may experience in relation to their mania. It was suggested that a range of approaches could be integrated to address the varied issues described.

The study did not represent the views of younger adults, who may be less adjusted and have had fewer recurrences. Individuals who are non-concordant and may be having current struggles with their manic experiences were also not well represented, as most of these participants had 'let go' of their experiences. Furthermore, a sample of individuals with a more recent episode could have improved this study.

Despite these limitations, the study provided an original contribution to an under-researched phenomenon, and was a novel area of investigation, as no existing qualitative research was found

exploring manic experiences in a clinical sample. The dissemination of the findings could contribute to psychological knowledge and emerging conceptualisations of manic experiences. In addition, the study demonstrated that people who have lived with manic experiences can provide rich accounts of their experiences. Ideas for future related research studies were suggested.

4.9. FINAL REFLECTIONS

I enjoyed the interviewing process. I felt IPA enabled me to immerse myself and ‘get close’ to these participants’ experiences. Overall, I felt excited to be exploring a novel area of research, and it felt like these interviews gave a voice to experiences; a voice that may not have been adequately heard before.

In addition, I feel I have learnt a lot from this process. In my clinical work I have drawn from my experience of interviewing, to become a better explorer with my clients. I feel freer to immerse myself in my clients’ stories and meanings, and I sense that this style has benefited both my clinical skills and my therapeutic relationships.

I valued the idiographic approach to analysis; combining a descriptive and interpretative method. This enabled me to have a detailed engagement with each account. This interpretative element of the analysis was both challenging and fascinating. I enjoyed thinking about how I understood the participants’ underlying meanings and struggles.

The findings surprised me in the extent to which most participants held strongly medical explanations. This has encouraged me to adopt a more credulous (Kelly, 1955/1991) and “not-knowing” (Anderson & Goolishian, 1992) approach in my work, which views clients as experts on themselves and on the difficulties they have faced and which values clients’ own descriptions of their problems, which may include diagnostic categories.

I imagined manic experiences would be described in more positive ways than they were, perhaps because I associated mania with euphoria, and this is how mania is often presented in popular culture. This has taught me just how distressing and unpleasant an experience mania can be. This is something I will try to be more aware of in my professional practice.

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6: APPENDICES

Appendix 1. DSM-IV-TR (1994) diagnostic criteria (Table 3 - 5)

Appendix 2. Information sheet

Appendix 3. School of Psychology ethics committee approval

Appendix 4. School of Psychology ethics committee modification approval

Appendix 5. Consent form

Appendix 6. Debriefing sheet

Appendix 7. Interview schedule

Appendix 8. Transcript – Luke

Appendix 9. Initial list of themes - Luke

Appendix 10. Clustering of themes - Luke

Appendix 11. Table of themes – Luke (Table 6)

Appendix 12. List of superordinate themes for the group

Appendix 13. Clustered superordinate themes for the group

Appendix 14. Cross-group reference table (Table 7)

Appendix 15. Table of master themes for the group (Table 8)

Appendix 1. DSM-IV diagnostic criteria

Below the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; 1994) descriptions for episodes associated with BD are described. However, there are debates as to the validity of 'Bipolar Disorder' as a diagnosis (Bentall, 2004; Boyle, 2002). The DSM-IV-TR (1994) descriptions of BD presently includes Bipolar I Disorder, Bipolar II Disorder, Cyclothymia, and Bipolar Disorder, Not Otherwise Specified (NOS). These diagnosis subtypes are thought to vary depending on the different patterns of mood:

- Bipolar I Disorder refers to when a person has experienced at least one manic episode and one depressive episode.
- Bipolar II Disorder refers to at least one depressive episode, but no manic episodes. Instead of a manic episode, at least one hypomanic episode must have been experienced.
- Cyclothymic Disorder refers to repeated mood swings, which have not met the criteria for manic or depressive episodes.
- Bipolar Disorder (NOS) is diagnosed when a person has symptoms that do not fit into the above categories.

The DSM-IV-TR (1994) criteria for BD related mood episodes are presented below. A mixed episode is included because manic episodes can often involve a mixture of euphoria and dysphoria (Bentall, 2004). As the criteria for a Major Depressive Episode can be met during a 'mixed' manic episode, these are also presented.

Table 3. Criteria for a manic episode

A) A distinct period of abnormally and persistently elevated, expansive or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary)
B) During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree: 1) inflated self-esteem or grandiosity 2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep) 3) more talkative than usual or pressure to keep talking 4) flight of ideas or subjective experience that thoughts are racing 5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) 6) increase in goal-directed activity (at work, at school, or sexually) or psychomotor agitation 7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
C) The symptoms do not meet criteria for a Mixed Episode.
D) The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
E) The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment) or a general medical condition (e.g., hyperthyroidism).

Table 4. Criteria for a mixed episode

A) The criteria are met both for a Manic Episode and for a Major Depressive Episode (except for duration) nearly every day during at least a 1-week period.
B) The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
C) The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment), or a general medical condition (e.g., hyperthyroidism)

Appendix 1. continued - DSM-IV diagnostic criteria

Table 5. Criteria for a major depressive episode

<p>A) Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure</p> <p>Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations</p> <p>1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.</p> <p>2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)</p> <p>3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.</p> <p>4) insomnia or hypersomnia nearly every day</p> <p>5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)</p> <p>6) fatigue or loss of energy nearly every day</p> <p>7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)</p> <p>8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)</p> <p>9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide</p>
<p>B) The symptoms do not meet criteria for a Mixed Episode</p>
<p>C) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.</p>
<p>D) The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)</p>
<p>E) The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation</p>

Appendix 2. Information sheet



University of Hertfordshire

Doctorate in Clinical Psychology

INFORMATION SHEET

Who I am

Hello, my name is Emma Jacobs. I am a Clinical Psychologist in my final year of training at the University of Hertfordshire. I am employed by Cambridgeshire and Peterborough NHS Trust to work as a clinician and carry out research as part of my Doctorate in Clinical Psychology. I would like to invite you to take part in my research study to investigate experiences of hypomania/mania. I am interested in your experiences of hypomania/mania including your views about your manic episode(s) and how you make sense of your experiences. Before you decide whether you would like to give consent to take part, please take the time to read the following information which I have written to help you understand why the research is being carried out and what it will involve.

Why am I doing this study?

I am very interested in subjective experiences of and views about hypomania/mania. I feel it is an exciting time in the research field with increasing attention being focussed on how best to understand and work psychologically with people with these experiences. However, there is a lack of qualitative research looking at how people make sense of and live with their 'high' moods.

The researchers

The study is being carried out by myself, Emma Jacobs, and is supervised by three experienced Clinical Psychologists, Mr. Steve Davies, Dr. Pieter Nel and Dr. John Sorensen. Dr. John Sorensen is the field supervisor for the project. He is a specialist in the field and has published a relapse prevention treatment manual for people with the diagnosis of bipolar disorder.

What is the purpose of the study?

The aim of the current study is to gain an in-depth understanding of how individuals diagnosed with a bipolar disorder experience and make sense of their manic experiences. Through semi-structured interviews, I will aim to capture the personal experience of living with hypomania, mania and manic states, using a qualitative research approach called interpretative phenomenological analysis (Smith and Osborn, 2003). This method aims to explore subjective experience in depth from the participant's perspective.

What do I gain from taking part?

There is no immediate benefit for taking part in this research. However, you will have an opportunity to speak openly and honestly about your experience. This could help clinical psychologists and other professionals to better understand the lived experience of hypomania/mania, which could ultimately contribute to improving psychological understandings and treatment.

What is involved?

If you decide that you would like to take part you will be asked to sign a consent form and complete a brief background information sheet (e.g. age, gender etc.). You will then be invited to participate in an hour long in depth conversation in the form of a semi-structured interview [the interview will be guided by a number of topics but will also be flexible]. This will be carried out at the University of Hertfordshire in Hatfield, UK. During this time we will discuss your thoughts and feelings about your experience of hypomania/mania. All interviews will be tape recorded and later transcribed verbatim.

Who is taking part?

Males and females aged over 18 years are invited to take part. A maximum of 6 people are required. All participants must have a diagnosis of Bipolar Disorder and have experienced hypomania and/or mania.

Do I have to take part?

No. If you do not want to take part, or if you change your mind at any time during your participation in this study, you do not need to give a reason. Participation is entirely voluntary and you can withdraw at any time.

Will taking part be upsetting for me?

I am aware that talking about mental health experiences can be very emotive and it could potentially cause some discomfort and distress. If this does occur you can take a break and you can stop the interview at any time. Despite these potential difficulties, some researchers suggest that people taking part in research interviews can find the process of talking through their experiences therapeutic and beneficial. You will be given details of helpful sources of support following the interview, should you feel that you require support.

Is the interview confidential?

The interview will be confidential and I will also change your name and any identifying information in the interview transcript to protect your anonymity. I will then write a thesis about my interviews and all identifying information will be removed. Similarly, confidentiality will be preserved if I later publish my research. The only limits to this confidentiality would be if you became very distressed during the interview, in which case we may need to contact your GP. In this rare event I would be bound by my professional ethics to breach confidentiality, which I would discuss with you first.

What will happen to the interview transcript?

The interview transcript will be transcribed and analysed for themes. There may also be an opportunity for you to be involved further should you be interested in discussing how I have analysed the interviews and whether you think the themes make sense to you.

How can I find out about the results of the study?

An individual summary of the project can be sent to you on request.

What if I have questions or concerns?

If you have any further questions about the research, please feel free to contact me via email, telephone or post, details of which are below.

Who has reviewed this study?

This study has been reviewed and approved by the University of Hertfordshire Psychology Ethics Committee. Every effort has been made to ensure that this research conforms to the ethical standards and guidelines of the British Psychological Society. The ethics registration protocol number is PSY/02/09/EJ.

What do I do next?

If you would like to take part then please email me at the following address:

maniaresearch@hotmail.com

I would greatly appreciate your support in this study. Thank you for taking the time to read this information sheet.

Emma Jacobs

Trainee Clinical Psychologist

Telephone number: 01707 286 322
Postal address: Doctor of Clinical Psychology Training Course
University of Hertfordshire
Hatfield, Herts., AL10 9AB

Principal supervisor: Mr. Steve Davies, Deputy Course Director, Doctor of Clinical Psychology Training Course, above address.

Appendix 3. School of Psychology ethics committee approval

Revised (September 2006)

SCHOOL OF PSYCHOLOGY ETHICS COMMITTEE APPROVAL

Student Investigator: Emma Jacobs

Title of project: Living with manic experiences: An interpretative phenomenological analysis

Supervisor: Steve Davies

Registration Protocol Number: PSY/02/09/EJ

The approval for the above research project was granted on 23 February 2009 by the Psychology Ethics Committee under delegated authority from the Ethics Committee of the University of Hertfordshire.

Signed:



Date: 123 February 2009

Dr. Nick Troop

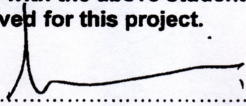
Chair

Psychology Ethics Committee

STATEMENT OF THE SUPERVISOR:

From my discussions with the above student, as far as I can ascertain, s/he has followed the ethics protocol approved for this project.

Signed (supervisor):



Date:

28.7.09

Appendix 4. School of Psychology ethics committee modification approval

APPROVAL OF PROTOCOL APPLICATION FOR MODIFICATION

We support the approval of modification of the above protocol	✓
We do not support the modification of the above protocol for the following reasons:	

Signature:



Nicholas Troop

Date: 28th March 2009

(Acting) Chair of Ethics Committee

Ethics LK/CH/2006

Created: 19/09/06

Appendix 5. Consent form



University of Hertfordshire

Doctorate in Clinical Psychology

CONSENT FORM

Title of Project: Living with manic experiences: An interpretative phenomenological analysis

Researcher: Emma Jacobs, Trainee Clinical Psychologist

Please tick:

1) I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information and if needed ask questions that were satisfactorily answered.

2) I understand that participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3) I understand that my information will be filed in a locked cabinet and the information I provide will be anonymised for the use of the study.

Name of Participant:

Date:

Signature:

Appendix 6. Debriefing sheet

DEBRIEFING SHEET

Thank you very much for taking part and making this study possible.

The aim of the study is to explore how people make sense of and live with their 'high' moods. It is hoped that this interview captures your in depth personal experience, and can be used alongside other interviews to contribute to better professional understanding of the lived experience of hypomania and mania.

I am aware that talking about mental health experiences can be very emotive and it could potentially cause some discomfort and distress. This could happen during, immediately after or in the days following the interview.

Below you will find details of various organisations who may be able to provide you with additional advice and information.

Regards,

Emma Jacobs
Trainee Clinical Psychologist

Contact Information:

Doctor of Clinical Psychology Training Course
University of Hertfordshire
Hatfield
Hertfordshire
AL10 9AB

Email address: maniaresearch@hotmail.com

Programme Director: Professor David Winter
Course Administrator: Mrs. Jean Thomas
Telephone number: 01707 286 322

SUPPORT and RESOURCES INFORMATION

<p>British Association for Behavioural and Cognitive Psychotherapies (BABCP) Tel. 0161 797 4484 Email: babcp@babcp.com Web: www.babcp.com</p>	<p>Mind 15-19 Broadway, London E15 4BQ Email: info@mind.org.uk Info Line: 0845 766 0163 Web: www.mind.org.uk</p>
<p>UK Council for Psychotherapy 2nd Floor Edward House 2 Wakley Street London EC1V 7LT Tel: 020 7014 9955 E-mail: info@psychotherapy.org.uk Web: http://www.ukcp.org.uk/</p>	<p>Sane 1st Floor Cityside House, 40 Adler Street London E1 1EE Email: info@sane.org.uk Tel: 020 7375 1002 Saneline helpline: 0845 767 8000 Web: www.sane.org.uk</p>
<p>MDF The BiPolar Organisation Castle Works 21 St. George's Road London SE1 6ES, UK Tel: 08456 340 540 Web: http://www.mdf.org.uk</p>	<p>The Samaritans Tel: 08457 90 90 90 Email: jo@samaritans.org http://www.samaritans.org/</p>
<p>Rethink 89 Albert Embankment London SE1 7TP Tel: 0207 840 3188 Email: advice@rethink.org Web: http://www.rethink.org</p>	<p>Mental Health Foundation, 9th Floor, Sea Containers House, 20 Upper Ground, London, SE1 9QB, United Kingdom. Tel: 020 7803 1101 Email: mhf@mhf.org.uk Web: www.mentalhealth.org.uk</p>
<p>DrugScope Prince Consort House Suite 204 (2nd Floor) 109/111 Farringdon Road London EC1R 3BW Tel. 020 7940 7500 Web: www.drugscope.org.uk</p>	<p>Alcohol Concern 64 Lemn Street London E1 8EU Tel: 020 7264 0510 E-mail: contact@alcoholconcern.org.uk Web: www.alcoholconcern.org.uk</p>

Appendix 7. Interview schedule

Pre-interview:

Consent form / Explain tape recording / Explain confidentiality and limits
Background information sheet
Purpose of interview/ basic rapport building

Personal language of mania:

How would you define your mental health experiences?
How would you define / describe your mania? What do you call it?
How do you feel about the diagnosis?

The experience of mania:

Sometimes mania happens in episodes – does that make sense for you or is it different? How?
Can you tell me about the most recent experience of mania? What happened?
What was it like for you to experience mania?
Can you describe a day in your life when you were manic?
Have you ever experience unusual beliefs that others did not share during your mania? Can you tell me about these?
Have you ever seen or heard things others did not? Can you tell me about these?
How do you think others experienced you?
Can you tell me about other times when you experienced mania?
How different or similar are your experiences of mania at different times?

Becoming manic (most recent episode):

I wonder how the mania started for you? (Gradual / sudden)
I wonder if you notice a similar pattern each time or if it varies?
Could you tell me about what happened when you were becoming manic?
How do you think your becoming manic then developed in to more extreme mania?

**Positives and Negatives*

Can you tell me about if there were positives / good sides about the experience?
What do you see as the benefits of the experience? (Then / Now)
Can you tell me about if there were negatives / down sides about the experience?
How are your experiences of depression and mania related?
Would you see mania overall as a positive or negative experience for you?
If I waved a magic wand and you never had mania again, do you think that would be a good or bad thing?
Why? How would your life be different?

Impacts

Has mania impacted on your life (e.g. work and relationships). In what ways?
Can you describe the feelings you have when looking back at your manic episode(s)? (e.g. happy, regret, embarrassed, amused etc..)
What role has mania played in your life?.

Causes

What do you see may have been causes or triggers of your changing mood state in to mania?
Why do you think it happens / happened?
Why do you think you have the experience of mania?

Treatments and medication

What have been your experiences of treatment for mania?

Did you feel you needed treatment? Why?

What have you found helpful?

What have you found unhelpful?

What is it like when the mania is going away / reducing?

Self-management

In what ways have you coped and self-managed your experience of mania?

What does 'recovery' mean for you?

(Debriefing and sources of further support).

Appendix 8. Transcript – Luke

The sample transcript has been removed in the final thesis in order to preserve confidentiality.

Appendix 9. Initial list of themes (Luke)

Own versus known language/understanding of mania 6
Medication controls/protective and prevents (lithium) 9/34
Medication lithium not worth the risk of coming off 43
Carer burden – marriage ended because of illness 47
Self as a risk (to new spouse) 52
Trigger – life cycle event (new marriage), relief at less stress post-wedding 58
Trigger – long haul flight 63
Searching for explanations 68
Altered reality – appreciate beauty, nature 74
Altered reality – spiritual, privileged 80
Carer burden – being a worry to spouse 84
Risk-taking and fearlessness 95
Mania as spiritual (needing to be healed) 105
Hypomania and mania = enjoyment versus dyscontrol 113-5
Mania as becoming a foreigner 119
Mania as a medical emergency 122
Special ability – best feeling ever (not accessible to ‘normal’ people) 130
Altered reality – spiritual, exalted, another dimension 134
Hypomania and mania – H can function, feet on the ground 136
Externalising mania – it became manic 139
Explanations: lack of sleep 140
Special ability: adjusted to environment (don’t need suncream) 151
Not wanting to be limited by space (roof over head) 149
Special ability: not needing shoes 153
Normal versus Irrational 161
Special ability: connected to nature, noticing details 166
Going beyond limitations (talks about physical limits – ‘a tiny house’) 171
Altered reality – left my body – met a guide, spiritual experience, ‘different dimension’ 189
Left body (going beyond limitations) 186
Spiritual exaltation – discovering G-d 190
Self as special 190
Special ability – role in helping the dead 204
Self-concept – ‘very sensitive’ 222
Running away – (town) risk taking 226
Self as extremely vulnerable 232
Having no limits, being beyond ‘normal’ limitations (‘could have done anything’) 234
Illness/brain versus Soul/healing 238
Self as stupid/impulsive 250
Mania as horrible 263
Medication as protective 261
Special ability – ‘exalted’ by nature (whereas others less appreciation) 286
Hypomania – can cope, better self-efficacy (than depression) 290
Special ability – using techniques to connect with G-d, access to something when manic 309
Suppression of experience, not sharing (due to disbelief) 329

Self-doubt/Uncertainty about beliefs, questioning of reality 348
Ill versus exalted/spiritual 351
Questioning reality versus privileged special ability 368
Fearlessness (re death) 374
Playing the game – pretending you don't believe / pretend to be normal 383
Miserable routine vs spiritually exalted 395
Hypomania vs Losses/costs of mania (end marriage, father role, work) 423/438
Being special and different to normal (shallow) people 450
Successful at the game (material wealth) versus mania as form of success 461
Stress as an explanation 472
Flirting with danger – wanting to be high at the right level 480
Addiction analogy – high as a temptation, having to stay sober 488
Regret and loss, lost time 508
Searching for explanations, uncertainty re this (chemistry versus spiritual) 509/514
Struggling to be the provider for the family (playing the game) 533
Trigger – working 24 hour callout 542
Sadness at losing the high, sense of loss, and having to be 'normal', ambivalence (as also a relief when over) 559
Social expectations, meeting social roles, sticking to rules 570
Mania is being original (not boring/normal) 582
High as dangerous/risk-taking, sense of fearlessness 596
Spouse as almost a parental figure/monitor 650
Self as chronically ill and medicated 667
Normal = shallow 679
Unreal versus valid (spiritual) experiences 702
Threatened by non-medical explanations ('just a psychological thing') 741

Appendix 10. Clustering of themes - Luke

Medical understanding

Medication controls/protective and prevents (lithium) 9/34
Medication lithium not worth the risk of coming off 43
Mania as a medical emergency 122
Medication as protective 261
Threatened by non-medical explanations ('just a psychological thing') 741
Self as chronically ill and medicated 667

Searching for explanations

Trigger – life cycle event (new marriage), relief at less stress post-wedding 58
Trigger – long haul flight 63
Searching for explanations 68
Explanations: lack of sleep 140
Stress as an explanation 472
Trigger – working 24 hour callout 542

Reality vs Crazy

Own versus known language/understanding of mania 6
Unreal versus valid (spiritual) experiences 702
Questioning reality versus privileged special ability 368
Ill versus exalted/spiritual 351
Suppression of experience, not sharing (due to disbelief) 329
Self-doubt/Uncertainty about beliefs, questioning of reality 348
Playing the game – pretending you don't believe / pretend to be normal 383
Searching for explanations, uncertainty re this (chemistry versus spiritual) 509/514

Mania as spiritual

Mania as spiritual (needing to be healed) 105
Altered reality – appreciate beauty, nature 74
Altered reality – spiritual, privileged 80
Altered reality – spiritual, exalted, another dimension 134
Altered reality – left my body – met a guide, spiritual experience, 'different dimension' 189
Left body (going beyond limitations) 186
Spiritual exaltation – discovering G-d 190
Self as special 190
Special ability – role in helping the dead 204
Illness/brain versus Soul/healing 238
Special ability – 'exalted' by nature (whereas others less appreciation) 286
Special ability – using techniques to connect with G-d, access to something when manic 309
Miserable routine vs spiritually exalted 395

Being special and different

Special ability – best feeling ever (not accessible to 'normal' people) 130
Special ability: adjusted to environment (don't need sunscreen) 151

Special ability: not needing shoes 153
Special ability: connected to nature, noticing details 166
Normal = shallow 679
Being special and different to normal (shallow) people 450
Successful at the game (material wealth) versus successful in terms of mania (mania as form of success) 461
Struggling to be the provider for the family (playing the game) 533
Social expectations, meeting social roles, sticking to rules 570
Mania is being original (nor boring/normal) 582

Hypomania vs mania

Hypomania and mania = enjoyment versus dyscontrol 113-5
Hypomania and mania – H can function, feet on the ground 136
Hypomania vs Losses/costs of mania (end marriage, father role, work) 423/438
Mania as horrible 263
Flirting with danger – wanting to be high at the right level 480
Addiction analogy – high as a temptation, having to stay sober 488
Hypomania – can cope, better self-efficacy (than depression) 290
Sadness at losing the high, sense of loss, and having to be ‘normal’, ambivalence (as also a relief when over) 559
Regret and loss, lost time 508
Self as extremely vulnerable 232

Mania as external

Externalising mania – it became manic 139

Relationships

Carer burden – marriage ended because of illness 47
Self as a risk (to new spouse) 52
Carer burden – being a worry to spouse 84
Spouse as almost a parental figure/monitor 650

Other

Not wanting to be limited by space (roof over head) 149
Normal versus Irrational 161
Risk-taking and fearlessness 95
Mania as becoming a foreigner 119
Going beyond limitations (talks about physical limits – ‘a tiny house’) 171
Self-concept – ‘very sensitive’ 222
Running away – (town) risk taking 226
Self as extremely vulnerable 232
Having no limits, being beyond ‘normal’ limitations (‘could have done anything’) 234
Self as stupid/impulsive 250
Fearlessness (re death) 374
High as dangerous/risk-taking, sense of fearlessness 596

Appendix 11. Table of themes – Luke (Table 6)

<p><u>1. Grieving for a privileged state</u></p> <p>1.1. The battle between pleasure and costs 1.2. Hypomania as temptation 1.3. The sadness of letting go</p>	<p>1.1. Luke had mixed views on his mania, and struggled between the pleasure of his experience and the costs. He described experiencing spiritual exaltation which was very positive for him and he used words like magical, privileged, exalted, and a 'better feeling than a normal person could have in their whole life.' He described times when he 'completely left my body' and met a guide/angel who took him around a different dimension, showed him what G-d was, he felt close to a feeling of perfect joy and love. On the other hand he could see negatives and costs of having mania, for example he described his high mood as 'dangerous', "I was extremely vulnerable", and had led to the breakdown of his first marriage, lost time with his children and regrets. He saw a difference between hypomania and manic, one was enjoyable and 'feeling great', the other was dyscontrol. He felt he should never come off medication as he has a "chronic mental illness" and will be "ill for the rest of my life." He therefore had competing ideas of his mania, on the one hand his mania was a pleasurable and desired spiritual experience and on the other hand it was a dangerous and costly form of illness.</p> <p>1.2. Luke talked about how if he didn't have responsibilities he could imagine experimenting with his medication to induce hypomania. This was 'tempting' for him but he also felt there was too much to lose. He said that once you go high you 'don't want to be stopped'. However, he stated he would never voluntarily allow mania to happen again, and wants to keep taking medication, despite the allure of his experience.</p> <p>1.3. Luke stated that there is sadness when losing the high and realising you have to get back to 'normal' and 'normality.' However he is ambivalent as in some ways this is a relief though, for him and others around him.</p>
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<p><u>2. The struggle to be special</u></p> <p>2.1. The struggle between being special or normal</p> <p>2.2. The struggle between being special or ill</p>	<p>2.1. Luke talked about ‘playing the game’ which meant doing the ‘normal’ things like material success/providing for family. Luke saw the game and the ‘normal’ people who play it as ordinary and not special or 'original', unlike him. He thought normal was shallow because normal life/people lacked depth (unlike people who had experienced mania). Normal for him = behaviour as one is expected to as a father, husband and wage earner. I got the sense that he felt inadequate or resentful about the game and not having achieved enough, in the material sense. He stated that he preferred to be rich from his spiritual experiences rather than have a 'private jet.' He felt his manic experiences were spiritual/exalted and therefore made him special.</p> <p>2.2. Luke struggled to make sense of his identity, on the one hand he saw himself as special due to his manic experiences being exalted and spiritual. He described special abilities that he possessed which he learnt when he met G-d, and the ability to help the dead. He stated that he suppressed his beliefs due to fears of being disbelieved, however at other points he questions if his experiences were real, and what is reality and whether they are spiritual experiences and if there is any validity to them. He therefore has mixed understandings of his mania and self, on the one hand he is special/spiritual and exalted, and on the other hand he is ‘ill’ and should never come off lithium. these are completely opposing views, and this uncertainty must be a dilemma for Luke,</p> <p><u>Summary:</u> Luke’s need to be special (due to his mania) protects him from bad feelings about not meeting societal standards of material success and also feelings that rather than being exalted, his experiences were unreal, therefore meaning instead that he is mad/ill.</p>
<p><u>3. Mania as external</u></p> <p>3.1. Mania as ‘it’ and not I</p>	<p>3.1. Luke talks in ways which suggest his mania is not him but ‘it’, for example he states ‘<u>it</u> became manic because’ and ‘<u>it</u> got out of control’. These suggest some kind of external control, something uncontrollable which happens to him, rather than saying I became manic, I got out of control.</p>

Appendix 12. List of superordinate themes for the group

The struggle for control: 'the calmness before the edge of the cliff' (James)
Mania as intense emotion (James)
Mania as special and different (James)
Mania as external (Peter)
A mixed relationship with mania (Peter)
A sense of survival: the roles of lithium and 'taking responsibility' (Peter)
Mania as being special and different (Peter)
Grieving for a privileged state (Luke)
The struggle to be special (Luke)
Mania as external (Luke)
Mania as external and uncontrollable? (Richard)
The safety of an expert medical model (Richard)
A mixed relationship with mania (Richard)
A mixed relationship with mania (Vivian)
Integrating the manic and normal selves (Vivian)
Discovering living without mania (Vivian)
Externalised explanations of mania (Helen)
'Living with the fear of the illness' (Helen)

Appendix 13. Clustered superordinate themes for the group

1. Mixed relationship

A mixed relationship with mania (Peter)
A mixed relationship with mania (Richard)
A mixed relationship with mania (Vivian)
The struggle for control: 'the calmness before the edge of the cliff' (James)
Grieving for a privileged state (Luke)
A sense of survival: the roles of lithium and 'taking responsibility' (Peter)
Discovering living without mania (Vivian)
'Living with the fear of the illness'
(Helen)

2. Mania as external / separate / controlling

Mania as external (Peter)
Mania as external (Luke)
Mania as external and uncontrollable? (Richard)
Externalised explanations of mania (Helen)
Integrating the manic and normal selves (Vivian)
The safety of an expert medical model (Richard)

3. Wanting to be different / mania as different

Mania as special and different (James)
Mania as being special and different (Peter)
The struggle to be special (Luke)
Mania as emotional release (James)
Integrating the manic and normal selves (Vivian)
A mixed relationship with mania (Vivian) – (fun, freedom and rebellion)

Appendix 14. Cross-group reference table (Table 7)

	JAMES	PETER	LUKE	RICHARD	VIVIAN	HELEN
A mixed relationship with mania						
1.1. The allure and the danger of mania						
1.2. The desire to stay manic						
1.2. Loss and survival						
2. A separate and controlled self						
2.1. The separation: is it me or is it mania?						
2.2. Losing control to mania						
2.3. The function of separation						
3. The struggle to be different						
3.1. The struggle against being 'normal'						
3.2. The struggle to experience a preferred self						
3.3. The struggle to be special						

Appendix 15. Table of master themes for the group (Table 8)

MASTER THEMES	“A blessing and a curse”: a mixed relationship with mania	“You have no control over it”: a separate and controlled self	“I was beautiful”: the struggle to be different
Superordinate Themes	<p>The allure and the danger of mania</p> <p>The desire to stay manic</p> <p>Loss and survival</p>	<p>The separation: is it me or is it mania?</p> <p>Losing control to mania</p> <p>The function of separation</p>	<p>The struggle against being ‘normal’</p> <p>The struggle to experience a preferred self</p> <p>The struggle to be special</p>