Pictures speak a thousand words: Using photo-elicitation and IPA to explore men's experience of mood management following a diagnosis of Bipolar disorder

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Declaration and signature of candidate

I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.

I confirm that the decision to submit this thesis is my own.

I confirm that except where explicitly stated, the work has not been submitted for another academic award.

I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.

Signed: CBurman

Date: 30th April 2020

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Thesis Abstract

This thesis aims to further develop our understanding of what it is like to live with, and manage, a diagnosis of Bipolar disorder.

Paper one presents a thematic synthesis of 13 qualitative research studies exploring people's experiences of living with the symptoms and diagnostic label, published between 2010 and 2019. Each of the 13 studies were critically appraised before results were synthesised. The findings are discussed with particular consideration of the implications for clinical practice. Recommendations for future research, including methods of improving the quality of research in this area, are presented.

Paper two presents an empirical study exploring men's experiences of managing mood symptoms. Photo-elicitation methods were used to guide semi-structured interviews, and Interpretative Phenomenological Analysis was used to analyse the resulting transcripts. Four super-ordinate themes were identified: (1) 'managing symptoms: living with the enemy' (2) 'we're managing more than mood episodes' (3) 'managing goes beyond a list of strategies' and (4) 'medication is a necessary evil'. Particular attention is again paid to the clinical implications of the findings.

Paper three is an executive summary of the empirical paper. It has been written to be accessible by practitioners and service users alike and is intended to support the dissemination of findings to study participants and supporting organisations.

Paper One: Literature Review

What is it like to live with the symptoms and diagnostic label of Bipolar disorder? A thematic synthesis of qualitative literature

Target Journal

Clinical Psychology & Psychotherapy (Author Guidelines, Appendix A).

Note: aspects of this paper's formatting do not conform to target journal guidelines in order to support its readability for the purpose of thesis submission (and to meet thesis specifications).

Word Count

7998.

Institutional Affiliation

This literature review was carried out as part of the requirements for the Professional Doctorate in Clinical Psychology (DClinPsy) at Staffordshire University, UK.

Conflicts of Interest

None to declare.

Abstract

This paper aims to provide a comprehensive review of recent qualitative literature on the experience of living with Bipolar disorder and consider the possible implications for clinical practice and future research. A systematic literature search was conducted using MEDLINE, CINAHL, PsychArticles, PsychINFO, Scopus, and ScienceDirect. 13 papers were included in the final analysis. These papers were critically appraised, and the findings were thematically synthesised. Three key analytic themes are presented (1) ‘Bipolar is omnipresent’ (2) ‘Bipolar is not all bad news (for everyone)’ and (3) ‘diagnosis may bring context and temporary relief (but not solutions)’. A fourth, “feeling well’ is a double-edged sword’, is presented as an underlying theme. During discussion of the findings, particular attention is given to the discrepancies between the pervasive experiential impact of Bipolar and the current focus of psychological interventions on relapse prevention and symptom reduction. The clinical implications are considered, particularly regarding the potential for recovery-focused approaches in Bipolar, and the role of clinical psychologists. Recommendations for areas of future research, as well as ways to improve the scope and quality of research in this area, are also presented.

Key Practitioner Message

- Living with Bipolar means living with a label that brings stigma, demands a new way of living, and may be repeatedly accepted, questioned, then rejected.
- It means living with a label and symptoms that disrupt one’s sense of self and force questions about the veracity of one’s experiences.
- Positive aspects of Bipolar are also reported, though these typically oppose the aims of intervention.
- Practitioners should be mindful that the impact of Bipolar is not confined to episodes of mood disturbance.
- Practitioners should also consider the impact of overlooking the wider aspects of living with Bipolar; whether their role should extend beyond

a focus on relapse prevention and symptom reduction, and whether these are indeed the meaningful goals of service users.

Keywords: Bipolar Disorder, Qualitative, Experience, Thematic Synthesis, Review

Introduction

Background

Bipolar disorder (Bipolar) is a chronic mental health condition; those diagnosed experience periods of depressed and elevated moods, accompanied by respective decreases and increases in energy levels. These episodes are typically followed by euthymia i.e. periods of neutral mood (Goodwin & Jamison, 2007). Bipolar Type 1 (Bipolar-I) may be diagnosed following at least one episode of mania; an elevated mood state which can include psychotic features such as hearing voices. Bipolar Type 2 (Bipolar-II) is diagnosed based on the experience of at least one episode of depression, and one episode of hypomania; a less severe form of elevated mood state (American Psychiatric Association [APA], 2013).

In 2011, the direct cost of Bipolar to the UK's National Health Service (NHS) was estimated to be £342million (Young, Rigney, Shaw, Emmas, & Thompson, 2011) though previous estimates of the wider socio-economic costs were around £2billion (Das Gupta & Guest, 2002). Whilst there is no single trajectory for living with Bipolar, a prospective study found that, on average, people with Bipolar-I experience at least sub-syndromal mood symptoms 47% of the time (Judd et al., 2002). In a later study, those with Bipolar-II reported experiencing such symptoms 54% of the time (Judd et al., 2003). It has also been estimated that approximately 25% of people diagnosed with Bipolar attempt suicide, and that they account for up to 14% of all suicide deaths globally (Schaffer et al., 2015).

National Institute for Health and Care Excellence (NICE) guidelines recommend a range of pharmacological treatments for managing acute periods of mania, hypomania, and depression, as well as for long-term management. It is recommended that 1:1 psychological interventions are also offered for managing periods of depression, as well as 1:1, group, or family interventions for relapse prevention (NICE, 2014). However, medication non-adherence is common (Jawad, Watson, Haddad, Talbot, & McAllister-Williams, 2018). Furthermore, strong evidential support is lacking for psychological interventions, with recent reviews indicating the quality of research is often poor, the reported effectiveness of interventions is highly varied, and any treatment effects are specific to discrete outcomes (Chatterton et al., 2017; Miziou et al., 2015; Oud et al., 2016). For example, Miziou et al. (2015) reported very limited support for the efficacy of psychological interventions in Bipolar beyond psychoeducation in relapse prevention; though even these treatment effects were limited to a subsection of participants for manic episodes specifically. Oud et al. (2016) suggested more optimistic findings including moderate-quality evidence for reductions of both manic and depressive relapses following 1:1 intervention. However, conclusions regarding other forms of intervention were limited by low evidence quality.

Proudfoot et al. (2009) highlight the need to explore the lived experiences of those diagnosed with Bipolar, to more fully understand the difficulties they face; difficulties which may complicate adherence to treatment and efforts to manage symptoms. Indeed, qualitative research has highlighted the ways in which life with a diagnosis of Bipolar can be extremely disruptive, not only to one’s own life (e.g. Inder et al., 2008) but to the lives of those around them (e.g. Granek, Danan, Bersudksy, & Osher, 2016). A recent review of the literature exploring distress in Bipolar highlighted a number of sources of distress including uncertainty, loss, and the diagnosis itself (Warwick, Mansell, Porter, & Tai, 2019).

It is acknowledged that there have been numerous criticisms regarding the reliability and validity of psychiatric diagnoses including Bipolar (Bentall, 2003; Kinderman, 2014; Moncrieff, 2008; Timimi, 2014). However, this review is interested in the personal accounts of those who experience symptoms associated with Bipolar and have received a diagnosis, irrespective of whether Bipolar ‘exists’ per se. The use of psychiatric terms such as ‘symptoms’ and ‘mood states’ is therefore for pragmatic purposes, reflecting the language used in the studies of interest.

Rationale for Review

A previous meta-study reviewed qualitative literature exploring people’s experiences of Bipolar symptoms and living with the label (Russell

& Moss, 2013a). The authors reviewed nine research papers published from 1991 – 2009; commenting on the dearth of research in this area and recommending further studies be undertaken. A cursory literature search identified numerous subsequent studies have been published.

Aim

This literature review aims to provide a synthesis of people's experiences of living with Bipolar as reported in theses and journal articles published since 2010. It aims to answer the research question: *'What is it like to live with the symptoms and diagnostic label of Bipolar?'*

It is hoped that updating the Russell and Moss (2013a) review will offer new insights into the experience of living with Bipolar, and that such insights may be relevant and meaningful to practitioners supporting those with a Bipolar diagnosis. For example, considering the currently limited evidence for the efficacy of psychological interventions, a greater understanding of what it means to live with the symptoms and label of Bipolar may indicate ways to adapt interventions.

This review will also consider the extent to which recent studies have complemented the literature base and highlight key considerations for future study.

Method

Scoping Searches

A preliminary search of the Cochrane Library was undertaken to identify whether any existing systematic reviews had been published since 2013, and to therefore ensure that this literature review would be complementing the literature base. Review articles were also included in the primary search strategy to further ensure that comparable reviews had not been undertaken in this timeframe. No such reviews were identified. Through a process of hand searching, one meta-synthesis was identified as similar at face value (Walsh, Corcoran, Crooks, Cooke, & Cummings, 2016). However, Walsh et al. (2016) did not update the review by Russell & Moss (2013a). Rather, their scope was to review published and unpublished studies conducted in the USA exclusively; searching databases for papers available before October 2014. In light of these criteria, only six papers included in their review were published after 2009. The focus of Walsh et al.'s (2016) review was also broader; including studies which explored management of bipolar symptoms.

It was therefore concluded that the proposed review, updating the work of Russell & Moss (2013a), would indeed complement the literature base. Of note, due to the differences in scope and search criteria, only one paper included in the review by Walsh et al. (2016) was also included here (Freedberg, 2011).

Search Strategy

This literature review followed a systematic search strategy, guided by the SPIDER framework tool (Cooke et al., 2012) as well as the strategies reported in published reviews (Russell & Moss, 2013a; Warwick, Mansell, Porter, & Tai, 2019). Search terms were divided into two categories: 'Bipolar' and 'Qualitative'. To delineate between them, the Boolean operator 'AND' was employed. The Boolean operator 'OR' was also used within each category to capture all variations. The final search terms were agreed through consultation with a systematic review advisor at Staffordshire University:

("Bipolar Disorder" OR "Bipolar Affective Disorder" OR "Bipolar Spectrum Disorder" OR "Manic Depress*") AND ("Liv* Experience*" OR "Liv* With" OR Qualitative)

An electronic literature search was conducted using MEDLINE, CINAHL, PsychArticles, PsychINFO, Scopus, and ScienceDirect. Searches of the first four databases were facilitated via EBSCOhost. Terms were searched in the titles, abstracts, and keywords of articles to ensure that all relevant papers were collated. Truncation was used where multiple variations of phrases was anticipated e.g. "manic depress*" was used to capture variations including 'manic depression' and 'manic depressive'. Qualitative search terms relating to specific approaches such as "grounded theory" were explored during subsequent scoping exercises though revealed no new studies. Adhering to the search criteria, limiters were set, where applicable, to include studies published from 2010-2019; academic journal articles and dissertations; and studies with adult populations published in English.

Search Criteria

The search criteria, discussed and agreed during research supervision, were adapted from those outlined by Russell & Moss (2013a):

Inclusion criteria

- The paper uses a qualitative research design.
- The study's primary aim, or focus of the results, is on the experience of living with Bipolar by individuals who have received a diagnosis.
- The paper contains first-person accounts from such individuals i.e. there are quotations discussing the experience of living with the Bipolar label and/or symptoms.
- The paper is published in English (due to limited resources associated with undertaking a doctoral student project).
- The study is based on an adult population.

Exclusion criteria

- Data from participants with Bipolar is not analysed separately from those without a Bipolar diagnosis, including spouses, clinicians, family members, or those with other primary mental health diagnoses e.g. Borderline personality disorder (BPD), Schizophrenia, or Schizoaffective disorder.
- Experiences of living with Bipolar are confined to a specific area of life or functioning e.g. parenting, employment, or self-management.
- The study focuses specifically on participants diagnosed less than six months previously.
- The study is based on observational data only e.g. autobiographies or blogs.

- The paper focuses on participants who identify themselves as having recovered from Bipolar and are therefore providing retrospective accounts.

Study Selection

Initially, MEDLINE, CINAHL, PsychArticles, SCOPUS, and ScienceDirect databases were searched in April 2019, returning 1526 papers. All search results were exported to a reference management tool (RefWorks) where 328 duplicates were automatically removed. The remaining 1198 studies were screened using a two-step process of selection (Aveyard, Payne, & Preston, 2016). In step one, a total of 1159 studies were removed when screened at the title and abstract level. The most common reason for exclusion was ‘irrelevant topic’ (n=988), such as prevalence rates of Bipolar in older adults (Porciúncula et al., 2017). Many studies were excluded due to their focus on a specific domain of life or functioning (n=55), including experiences of the menopause (Perich, Ussher, & Parton, 2017). Another main reason for exclusion was first-person accounts not coming from those with the Bipolar diagnosis (n=23), such as parents of children diagnosed with Bipolar (Crowe et al., 2011).

In step two, the remaining 39 studies were screened at full-text level, and a further 25 studies were removed. The most common reason for exclusion was Bipolar participant’s data not being analysed separately from others (n=9), including those with a BPD diagnosis (Bonnington & Rose, 2014).

A selection of the full-text papers was reviewed by the author’s research supervisor as a method of checking reliability, and any discrepancies were resolved through discussion. However, no statistics were used in order to calculate inter-rater reliability.

A supplementary search of PsychINFO, undertaken in June 2019, returned no new eligible studies. An overview of the screening process is shown in Figure 1.

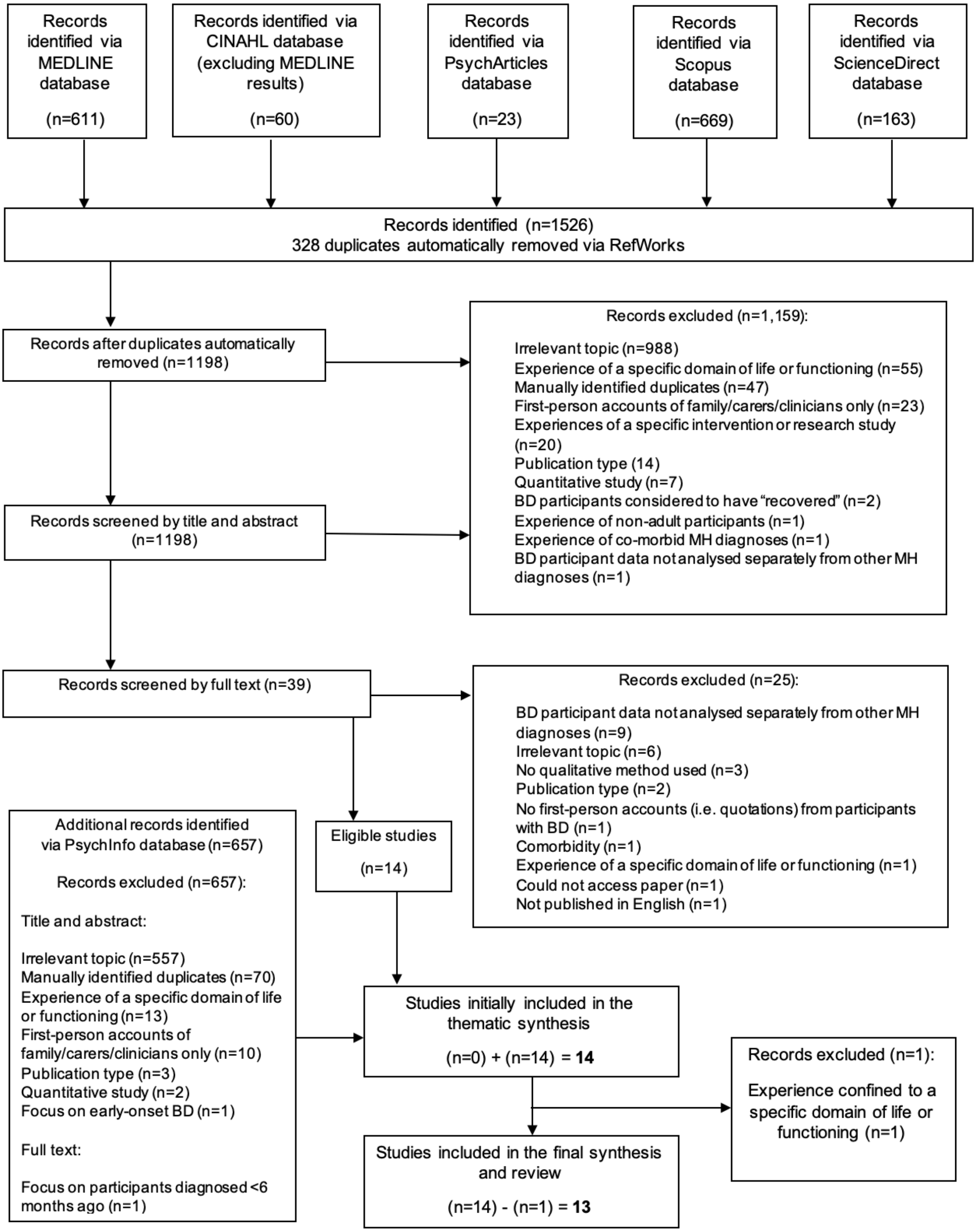

Figure 1. Flowchart of study identification process

Results

Search Results

14 studies were initially shortlisted for inclusion in the review. However, one was later removed during the thematic synthesis process, prompted by its extremely limited impact on the synthesis (Rusner, Carlsson, Brunt, & Nyström, 2010). It was subsequently re-reviewed and deemed too specific to an area of life or functioning.

Of the studies included in the final analysis, four primarily explored ‘symptoms’ (Fletcher, Parker, & Manicavasager, 2013; Mortensen, Vinberg, Mortensen, Jorgensen, Eberhard, 2015; Russell & Moss, 2013b; Samalin et al., 2014), three primarily explored ‘living with the label’ (Delmas, Proudfoot, Parker, & Manicavasagar, 2011; Goldberg, 2012; Michalak et al., 2011) and six explored both (Crowe et al., 2012; Fernandez, Breen, & Simpson, 2014; Freedberg, 2011; Goldberg, 2019; Inder et al., 2010; Lobban, Taylor, Murrary, & Jones, 2012).

Studies primarily exploring ‘symptoms’ focused on experiences of hypomania in Bipolar-II (Fletcher et al., 2013), quality of life (QoL) during mixed states (Mortensen et al., 2015), positive states in Bipolar (Russell & Moss, 2013b) and residual symptoms (Samalin et al., 2014). Studies focusing on ‘living with the label’ explored how patients and families adjust to the diagnosis (Delmas et al., 2011), patients’ initial reactions to the diagnosis (Goldberg, 2012) and internalized stigma (Michalak et al., 2011). Of the remaining studies, three broadly explored the impact of Bipolar on the lives of those diagnosed (Crowe et al., 2012; Freedberg, 2011; Inder et al., 2010), one explored the positives of Bipolar (Lobban et al., 2012), one explored women’s experiences of loss and recovery (Fernandez et al., 2014) and one focused on the definitional boundaries between ‘normal’ and ‘abnormal’ experiences (Goldberg, 2019). A summary of the 13 studies, and their findings, is provided (Appendix B).

Study Characteristics

Qualitative approach

A range of qualitative approaches were used including Thematic Analysis (TA) (n=4), Interpretative Phenomenological Analysis (IPA) (n=3), the Constant Comparison Method (CCM) (n=1), and a Discourse Theoretical Approach (n=1). The remaining studies (n=4) utilised various phenomenological and hermeneutic approaches.

Country of study

The studies were conducted across numerous countries: Australia (n=3), the USA (n=3), New Zealand (n=2), the UK (n=2), Canada (n=1) Denmark (n=1), and France (n=1).

Details of participant demographics

Participants' age at interview was reported clearly in all but one study (Inder et al., 2010). However, only seven studies reported the length of time since participants were diagnosed (Delmas et al., 2011; Fernandez et al., 2014; Fletcher et al., 2013; Freedberg, 2011; Goldberg, 2012, 2019; Mortensen et al., 2015). As mentioned, the review excluded studies where participants were exclusively diagnosed less than six months previously. There was no evidence that the remaining studies focused exclusively on those diagnosed less than six months previously; they were thus included to avoid undue exclusion of (likely) relevant papers.

Participants' gender was clearly reported in 12 studies, however for Inder et al.'s (2010) study, this information was identified elsewhere (Warwick et al., 2019). In total, there were 120 female participants compared to 51 males. It was less common for studies to report other demographic details such as relationship status or educational histories. For example, only five studies provided clear, explicit details of participants' ethnicities (Freedberg, 2011; Goldberg, 2012, 2019; Michalak et al., 2011; Russell & Moss, 2013b). The information available from these studies indicates that just 9/50 participants were from black & minority ethnic (BME) backgrounds.

Critical Appraisal of Study Quality

Criteria from the Critical Appraisal Skills Program (CASP, 2018) ‘Qualitative Checklist’ were used to structure the evaluation of study quality (Appendix C). However, papers were not excluded on the basis of their quality ratings. The CASP was selected to facilitate a structured approach to the evaluation of papers as in previous qualitative syntheses (e.g. Piccenna, Lannin, Gruen, Pattuwage, & Bragge, 2016; Satink et al., 2013; Warwick et al., 2019).

Summary of study quality

A summary of the CASP ratings for each study is provided (Appendix D). The following text provides a more detailed and transparent overview of the quality appraisal process and context for the ratings. All studies were deemed to appropriately use a qualitative approach in the context of a clear statement of aims, satisfying the CASP’s screening criteria.

Appropriateness of specific qualitative methodology. Though none of the papers described the use of an inappropriate methodology, just five provided a clear justification for their chosen approach (Freedberg, 2011; Goldberg, 2012, 2019; Lobban et al., 2012; Michalak et al., 2011).

Recruitment strategy. The recruitment strategy in four studies was deemed likely to have led to bias. This was due to participants being recruited from just one arm of a Randomised-Controlled Trial (RCT) (Crowe et al., 2012), as well as reliance on participants being known to either the researcher’s doctoral classmates (Goldberg, 2012, 2019), or the researchers themselves (Samalin et al., 2014). It was not possible to tell whether the recruitment strategy in one study was appropriate due to a lack of explanation for why two participants without an existing Bipolar diagnosis were included (Lobban et al., 2012).

Only two studies had exclusion criteria relating to other primary mental health diagnoses (Fletcher et al., 2013; Inder et al., 2010). Participants’ mood state at interview was considered in just six studies, with highly variable levels of detail provided (Fernandez et al., 2014; Fletcher et al., 2013; Freedberg, 2011; Michalak et al., 2011; Morternsen et al., 2015; Samalin et al., 2014). For example, only two studies used formal measures to assess for depressive and manic symptoms for the purpose of screening appropriate participants (Fernandez et al., 2014; Freedberg, 2011). Fletcher et al. (2013) and Michalak et al. (2011) also formally assessed participants' mood state, however this was not for inclusion purposes. Fletcher et al. (2013) reported study participants were euthymic, hypomanic, depressed, or experiencing mixed states. It is not possible to determine the extent to which these varying mood states may have impacted upon participant responses.

Only five studies clearly report specific Bipolar diagnoses (Fernandez et al., 2014; Fletcher et al., 2013; Lobban et al., 2012; Michalak et al., 2011; Samalin et al., 2014) though Fernandez et al. (2014) and Samalin et al. (2014) do not detail whether these diagnoses were confirmed or self-reported. Of the remaining studies, four indicated an existing (unspecified) Bipolar diagnosis was confirmed (Crowe et al., 2012; Delmas et al., 2011; Mortensen et al., 2015; Russell & Moss, 2013b).

Data collection. 10 studies used interviews to collect data, however example interview questions were often omitted (Delmas et al., 2011; Fernandez et al., 2014; Inder et al., 2010; Russell & Moss, 2013b). One study used transcribed therapy session notes (Inder et al., 2010), one used interviews and focus groups (Michalak et al., 2011) and one used focus groups exclusively (Samalin et al., 2014).

Of the four TA studies, only one reported data was collected until saturation was reached (Samalin et al., 2014). However, Michalak et al. (2011) reported using purposive sampling to capture the experiences of more male participants and those with a Bipolar-II diagnosis. The one CCM study reported collecting data until theoretical saturation was reached (Fernandez et al., 2014).

Explicitly detailed information about the development of questionnaires and topic guides was present in only five studies (Fernandez et al., 2014; Fletcher et al., 2013; Freedberg, 2011; Mortensen et al., 2015; Samalin et al., 2014). Delmas et al. (2011) explained that an initial pilot of the interview was undertaken with four people with a Bipolar diagnosis and that adjustments were made according to their feedback. However, details about the feedback that was received, and subsequent changes that were made, was omitted. Similarly, Russell & Moss (2013b) state that consultations with a self-help group convenor aided the development of their interview schedule. Absence of these details limits the trustworthiness of the remaining studies (Yardley, 2000).

Six studies provided some details of the data collection setting, all of which were deemed appropriate (Fernandez et al., 2014; Fletcher et al., 2013; Freedberg, 2011; Lobban et al., 2012; Michalak et al., 2011; Russell & Moss, 2013b). Nine studies provided details about the length of interviews and/or focus groups, indicating that they were appropriate. However, three studies provided no such information (Crowe et al., 2012; Inder et al., 2010; Mortensen et al., 2015). Whilst Delmas et al. (2011) state that interviews lasted between 19-98 minutes, the authors do not clarify the average duration, so it is unclear how many interviews were as short as 19 minutes.

Researcher's role. Only two studies provided detailed critical examination of the researcher's role (Freedberg, 2011; Russell & Moss, 2013b), with the best example offered by Freedberg (2011). The author outlines how her professional nursing background influenced the specific research question; describes previous clinical experiences which may have influenced the process of data collection and analysis; and detailed how a reflexive journal was used to maintain efforts to bracket presuppositions and beliefs.

Lobban et al. (2012) were the only other authors to outline existing beliefs or expectations. However, they also state that the interviewer informed participants of their own Bipolar diagnosis, though further reflections about this are not offered, which limits the quality rating.

Whilst nine studies reported the use of more than one researcher in data analysis, descriptions of reflexivity processes were varied (Crowe et al., 2012; Delmas et al., 2012; Fernandez et al., 2014; Inder et al., 2010; Lobban et al., 2012; Michalak et al., 2011; Mortensen et al., 2015; Russell & Moss, 2013b; Samalin et al., 2014;). For example, Inder et al. (2010) simply stated that two researchers undertook the analysis, with no reference to divergences or how they may have been resolved. Mortensen et al. (2015), however, state that the authors discussed all methodological steps (including interactions between interviewers and interviewees) and also reference the resolution tool that was used during the analytic process.

It is unclear whether Goldberg's (2012, 2019) data was analysed by multiple researchers. The author does acknowledge the hermeneutic position that one cannot remove themselves from the analysis and states a social constructionist epistemological approach. However, no critical examination of this position is provided, and no reference is made to other efforts to maintain reflexivity.

Though not the only study to omit such critical examination, it is a key limitation of Inder et al.'s (2010) study as this was the only study to collect data from recorded therapy sessions which is considered a uniquely different context.

Ethical considerations. Nine studies confirmed that ethical approval was sought. Three simply did not state whether ethical approval was sought (Fletcher et al., 2013; Inder et al., 2010; Russell & Moss, 2013b) and one reported ethical approval was not required due to legislation in Denmark at the time (Mortensen et al., 2015).

Nine studies reported obtaining informed consent. Three reported obtaining 'consent' or 'written consent' (Michalak et al., 2011; Mortensen et al., 2015; Russell & Moss, 2013b) and one failed to detail whether consent was obtained (Fletcher et al., 2013). 12 studies detailed attempts to ensure participants' anonymity by using methods such as pseudonyms or identification numbers. Only one study (Fletcher et al., 2013) made no reference to anonymity. Three studies also made reference to, or provided details of, how data was stored securely throughout the study (Crowe et al., 2012; Freedberg, 2011; Mortensen et al., 2015).

Consideration for participants' emotional wellbeing was discussed in only two studies beyond screening for major mood symptoms (Fernandez et al., 2014; Freedberg, 2011). Lobban et al. (2012) failed to discuss the possible implications of two participants without a Bipolar diagnosis being told they meet the diagnostic criteria (for the purpose of the study), which limits the quality rating.

Data analysis. The most in-depth description of the analysis process was provided by Freedberg (2011), including a thorough step-by-step account supported by a summary figure, as well as samples of transcript data used to illustrate how meaning units were condensed into themes.

The robustness of four studies was limited by their failure to provide enough detail about the analytic process itself e.g. a step-by-step account (Delmas et al., 2011; Goldberg, 2012, 2019; Lobban et al., 2012), relying instead on referencing the original paper detailing the approach, or describing the philosophical underpinnings of it. Whilst similarly lacking step-by-step accounts, two studies did provide summary tables illustrating how clusters or super-ordinate themes were derived from lower ordinate themes, as well as providing relevant transcript excerpts (Fletcher et al., 2013; Russell & Moss, 2013b).

11 studies provided transparent evidence for the interpretation and analysis of data by providing verbatim accounts of sufficient length to support the themes identified by the authors. However, three of them failed to provide any information detailing which quotes related to which participants (Fernandez et al., 2013; Inder et al., 2010; Samalin et al., 2014). This makes it difficult to appreciate how representative the supporting evidence is of the sample. One study provided very limited support for their findings, with two of the three main themes not supported by verbatim accounts (Delmas et al., 2011). The remaining study provided four lengthy quotes in the appendix section; however, the identified themes lacked much evidence beyond quotations of particular words or phrases used by participants (Mortensen et al., 2015).

Of the studies using IPA (n=3) only one reported findings indicative of the individual meaning-making of participants (Russell & Moss, 2013b). Such personal sense-making was similarly reported in the hermeneutic approach adopted by Goldberg (2012, 2019).

Clear statement of findings. 11 studies provided a clear and explicit discussion of their findings; linking them back to the original research question(s) as well as placing them in the context of the study's limitations (Crowe et al., 2012; Delmas et al., 2011; Fernandez et al., 2014; Fletcher et al., 2013; Freedberg, 2011; Goldberg, 2012, 2019; Lobban et al., 2012; Michalak et al., 2011; Mortensen et al., 2015; Russell & Moss, 2013b).

Samalin et al. (2014) related their findings to the original research question, however consideration of the study's limitations was extremely brief. This therefore limits the quality rating in light of the potentially biased sample. Similarly, Inder et al. (2010) clearly stated their findings in relation to the research question, but with little consideration of the study's limitations.

Is the research valuable? 10 studies indicated the value of their findings by presenting and discussing them in the context of existing research related to Bipolar, other mental health diagnoses, and/or chronic health conditions. The remaining studies instead discussed their findings primarily in the context of psychological theory and social commentary (Goldberg 2012, 2019; Russell & Moss, 2013b).

Nine studies considered the clinical implications of their findings (Delmas et al., 2011; Fernandez et al., 2014; Fletcher et al., 2013; Freedberg, 2011; Inder et al., 2010; Lobban et al., 2012; Michalak et al., 2011; Russell & Moss, 2013b; Samalin et al., 2014), however only one referenced specific policy and guidelines (Samalin et al., 2014). Future research suggestions were made by just five studies (Fernandez et al., 2014; Fletcher et al., 2013; Freedberg, 2011; Lobban et al., 2012; Russell & Moss, 2013b).

Though Delmas et al. (2011) did consider their findings in the context of research literature and psychological theory, as well as detailing clinical implications of their findings, it is noted that the depth of these considerations was limited. The value of the research is also limited by the lack of rigour in the data analysis itself. Similarly, the value of other papers was limited by the potentially biased sampling methods used (Crowe et al., 2012; Goldberg, 2012, 2019; Samalin et al., 2014) and uncertainty about the appropriateness of the data collection method (Inder et al., 2010).

Data Synthesis

Thematic synthesis, outlined by Thomas & Harden (2008), was considered the most appropriate method for the purpose of this review. The process involved the following steps:

- Data from the 'results' and/or 'findings' sections of all articles were read and re-read to maximise familiarity with findings. Where applicable, data was also read and re-read from appendices providing supplementary quotes.
- Papers were entered into qualitative data analysis software (NVivo) to support the generation of line-by-line codes. Participant quotes and author interpretations were coded as 'first order' and 'second order', respectively.
- Codes were compared across papers to check for consistency. They were then grouped by shared meaning to develop initial descriptive themes.
- Initial descriptive themes were then further refined into analytic themes with the aim of answering the specific research question.

As mentioned, many of the studies failed to provide a clear and critical examination of the relationship between researchers and participants, and a clear statement of reflexivity. Following the guidance of Thomas & Harden (2008) allowed for mitigation against the limitations of this. Author interpretations were coded separately from those based on first-person accounts; it could therefore be confirmed that no themes were exclusively derived from the interpretations of study authors.

Themes

Three key analytical themes are presented, with a fourth theme underlying them. The first key analytical theme, 'Bipolar is omnipresent', encompasses four sub-themes. This is outlined diagrammatically in Figure 2.

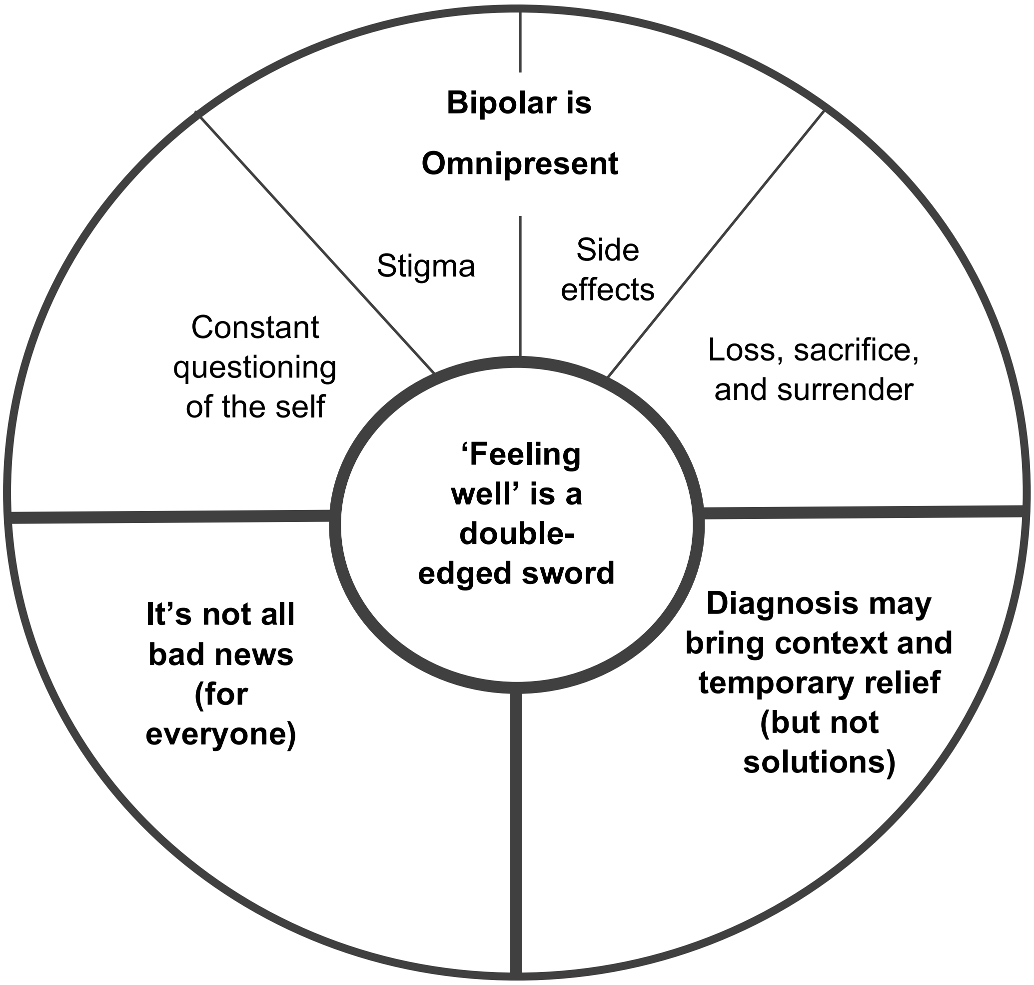

Figure 2. Model of themes – 'Living with Bipolar'

Theme 1. Bipolar is omnipresent. The main theme highlights the pervasive impact of Bipolar, and that it is not restricted to periods of elevated or depressed mood. Only Samalin et al. (2014) asked participants explicitly about symptoms persisting beyond major mood episodes which impact functioning. However, all studies discussed impacts of living with Bipolar that extend beyond episodes, including stigma, continual self-questioning, loss, and side effects of medication. General disruptions to personal relationships and occupational functioning were also commonly reported.

Taken together, this paints a picture of Bipolar as omnipresent in the minds and lives of many participants. Though described below as discrete sub-themes, these areas are likely to overlap considerably in the daily lives of participants.

Subtheme 1.1. Constant questioning of the self. Continual questioning and re-evaluating of past and present experiences was reflected in most of the studies as a result of receiving the diagnosis. For many, a difficulty trusting oneself, and the authenticity of their experiences, seems to be central to life with Bipolar. The ongoing questioning of present experiences is summarised well by this author: "…*participants began to struggle with determining if their positive experiences consisted of 'true' positive feelings or the feared pathological symptoms… participants started questioning all their emotional experiences*" (Goldberg, 2019, p. 10). Even when not questioning themselves, some experience inquisition from friends and family.

For some, ongoing questions are directed at the diagnosis itself; whether it was correct in the first place, or still relevant years later. For others, the diagnosis becomes fused with their sense of self, at times as a result of others' responses: "*In contrast to somatic illnesses that you may have, several participants felt that mental disorders are often seen by others as something you are. You are a 'manic depressive'…*" (Mortensen et al., 2015, p. 196).

Subtheme 1.2. Loss, sacrifice, and surrender. Though explored most directly by Fernandez et al. (2014), most studies described experiences of loss. The impacts were wide-ranging, including feeling a loss of control and autonomy over one's life; of occupation and educational opportunities; of relationships; of predictability in their lives and of trust in themselves.

Though the word loss was often used by study authors and participants alike, this does not seem to fully capture the experiences described. 'Sacrifice' and 'surrender' seem appropriate adjuncts to reflect the way in which not all losses are passive, but are the consequences of difficult choices participants felt forced to make, and can sometimes feel like 'giving in'. Active attempts to control mood symptoms, or to provide some stability, often come at a cost. Descriptions of such costs included a restricted sense of freedom and autonomy; restricted social circles and engagement;

avoidance of intimate relationships; and disconnection from enjoyable activities.

Subtheme 1.3. Stigma. Stigma, including self-stigmatization, was commonly identified in the studies. At times self-stigma reflected participants' internalized views about the diagnostic label as meaning inadequacy, dangerousness, and 'being crazy'. However, it also appeared to be related to feelings of guilt and shame when participants reflected on their actions during mood episodes (particularly mania). Some participants spoke of 'judicious disclosure' whereby they would strategically limit those they told about their diagnosis. However, the nature of the mood symptoms can mean this decision is taken away from some people.

Subtheme 1.4. Side effects. Side effects of medication were also discussed in a few of the studies, capturing a range of physical symptoms including altered perceptions of taste, weight gain and increased hunger, hair loss, reduced libido, and cognitive impairments. The most consistently reported side effect was that of emotional blunting or disconnection. This is of particular interest given that accounts of the positives of Bipolar include a richer experience of life through the breadth of mood experiences.

Theme 2. Bipolar is not all bad news (for everyone). Despite the multitude of negative impacts, some participants experienced positives too. Lobban et al. (2012) studied this most directly, however most studies referenced positive aspects. The vast majority related to the 'highs' (i.e. hypomania and/or mania) and there was considerable descriptive overlap between these states. Indeed, at times it was unclear whether participants were reflecting on one state or the other. However, there were reports of both states initially bringing fun, joy, and a sense of feeling limitless. As such, they were described as having ego-syntonic qualities i.e. consistent with one's self-image and goals.

However, benefits extending beyond this were considered by participants in some studies. Such benefits related to the combination of experiencing the 'highs' and the 'lows', as well as benefits of depressed states specifically. Participants identifying such benefits expressed that the breadth of mood experiences in Bipolar led to experiencing life more richly and that this could facilitate connection and empathy with others, creative pursuits, and self-understanding.

Theme 3. Diagnosis may bring context and temporary relief (but not solutions). Authors of a few studies summarised that their participants' journey to receiving the diagnosis was often not straightforward; typified by multiple other diagnoses being applied and over-turned.

Most papers discussed initial reactions to receiving the diagnosis. Broadly speaking, initial reactions were either that the diagnosis was coherent with previous experience and viewed as helpful, or it was a threat signifying that everything would now be different. Participants and authors described how the diagnosis sometimes fit with participants' previous experiences and helped to make sense of them. The diagnosis for these participants confirmed a tacit recognition that 'something was going on', which could be validating. For others, the diagnosis was a shock and signified ceaseless change. Participants viewed themselves in that moment as 'being Bipolar' rather than hearing that they 'had Bipolar'. This was associated with a view of themselves as not being 'normal'.

In the longer-term, acceptance does not appear to be a passive or definitive process. Though it may allow some to contextualise difficult past experiences, the diagnosis also proposes a new framework for future life. Unfortunately, this framework appears to be poorly defined. For many, the experience of navigating life after diagnosis is typified by limited and conflicting information about Bipolar, as well as feeling misunderstood and unsupported by clinicians and loved ones alike. All the while, oscillations between acceptance and rejection of the diagnosis are influenced by changes in mood state.

Theme 4. 'Feeling well' is a double-edged sword. The paradoxical nature of 'feeling well' was found to underlie the other themes. Elevated moods were the most commonly identified positive in Bipolar, however they (and euthymia) may undermine trust and acceptance of the diagnosis, as well as fuelling self-questioning and doubt. Positive or non-aversive experiences can be difficult to reconcile with the concept of a ‘mental illness.’ During periods of euthymia, there is also space for feelings of guilt and shame to emerge which facilitate the process of self-stigmatisation.

Though benefits of Bipolar were not strictly limited to elevated moods, descriptions of depression were generally ego-dystonic; it was an abnormal and unwanted facet of the self. For most, depression brings with it isolation, pain, and feelings of worthlessness. Participants and study authors described how periods of ‘feeling well’ are, by contrast, desirable. These states may offer respite and a welcomed break from long periods of depression.

Descriptions of early help-seeking, and the process of receiving a diagnosis, suggest that hypomanic and manic experiences were not always recognized by participants and often went unreported. Even after receiving the diagnosis, what constitutes hypomania or mania is not always clearly understood. As such, periods of ‘feeling well’ can lead to a state of constant questioning.

‘Feeling well’ is also identified explicitly as a barrier to interventions. Whilst hypomania and mania may lead to feeling ‘too good’ to need help, periods of euthymia may signal that the diagnosis is just no longer relevant. The responses of others may play a role in reinforcing the idea that ‘everything is fine’ during these times. The social desirability of hypomania is described well by these authors: “*…participants believed friends and colleagues… viewed them as ‘being in a good mood’, ‘funny’, ‘energetic’ or ‘more productive than usual*’” (Fletcher et al., 2013, p. 462).

Discussion

In this review, 13 qualitative studies were critically appraised and thematically synthesised to answer the question: ‘*what is it like to live with the symptoms and diagnostic label of Bipolar?’*

The key themes illustrate how ‘living with Bipolar’ means living with a label that can bring external and internal stigma; that can be initially validating but offers little certainty for long-term solutions; that can be more easily reconciled with past experiences but creates uncertainty in the present and for the future; and can continually disrupt one's sense of self. It also means living with mood states which encourage oscillations between acceptance and rejection of the diagnosis and treatment. Mood states can also lead to significant loss, and maintaining stability often necessitates continued sacrifice. For some, Bipolar brings positives too. Primarily, this is the euphoria that can be experienced in elevated mood states, though for others the full breadth of the emotional spectrum can lead to life feeling richer and more meaningful.

Underlying all of this appears to be the nature of 'feeling well' as a double-edged sword. Whilst elevated moods constitute the majority of positively reported experiences, they are also identified as barriers to continued acceptance of the diagnosis (as well as help-seeking and treatment adherence) and lead to unintended consequences in the longer-term. Similar findings have been reported in mixed-methods research investigating nonadherence in Schizophrenia and Bipolar (Gibson, Brand, Burt, Boden, & Benson, 2013). Though not exclusively positive experiences, elevated moods are often described as being initially ego-syntonic. This appears to create a unique challenge to one's sense of self in Bipolar, as it is hard to view seemingly value-consistent behaviour as symptomatic. For some, this leads to rejection of the label, or at least the notion of needing support. The obstructive nature of ego-syntonicity has been acknowledged in other mental health presentations, perhaps most notably in Anorexia Nervosa (e.g. Gregertsen, Mandy, & Serpell, 2017). Periods of euthymia are similarly difficult to reconcile with the notion of a 'mental illness' and can undermine faith in the diagnosis. Euthymia can also lead to reflections on previous 'episodes' and induce shame and guilt; perpetuating the experience of stigmatisation.

The findings highlight that the impact of Bipolar is not experienced as cyclical, but rather its presence can be felt at all times. Michalak, Yatham, & Lam (2005) similarly concluded that QoL can be impaired in those with a Bipolar diagnosis even outside of major mood episodes. However, many QoL and health-related QoL measures focus primarily on psychosocial functioning, and the authors note that the absence of Bipolar-specific measures may limit their findings by failing to capture the uniqueness of the Bipolar experience. This review highlights key experiential aspects of living with Bipolar, such as stigma and continued self-questioning, which go beyond psychosocial functioning. Indeed, these findings (from a number of studies worldwide) support the inclusion of related items in a proposed Bipolar-specific measure which was developed, in part, by interviews with a limited sample of people with Bipolar in Canada and the USA (Michalak & Murray, 2010).

Consistent with Russell & Moss (2013a) many studies spoke of loss. Loss, such as that of autonomy and social connection, has also been discussed elsewhere as central to distress in Bipolar (Warwick et al., 2019). However, the thematic synthesis process in this review highlighted how many losses were secondary to difficult choices made by participants; indicating that conceptualising these experiences simply as loss may be reductive, and that acknowledging sacrifice and surrender may be more appropriate. Perhaps acceptance of such sacrifice is important in the longer-term; it has been suggested that a ‘good life’ with Bipolar requires accepting some dependence to promote empowerment (Rusner et al., 2010).

The findings also indicate that living with Bipolar can encompass a wider range of positive experiences than are reflected in the individual studies and go beyond those related to elevated moods as reported previously (Russell & Moss, 2013a). This supports more recent mixed-methods research suggesting that over 60% of participants with Bipolar, and over 20% with Major Depression, identified advantages including greater empathy and a deeper appreciation of living (Parker, Paterson, Fletcher, Blanch, & Graham, 2012).

The review findings indicate discrepancies between the aims of current psychological interventions and the experience of living with Bipolar. Outcome measures for Bipolar typically focus on relapse prevention and symptom reduction (e.g. Colom et al., 2009; Lam et al., 2000; Lam, Hayward, Watkins, Wright, & Sham, 2005; Lobban et al., 2010; Morriss et al., 2016). By definition, the aim is to therefore increase periods of euthymia. The underlying theme of this review indicates that euthymia can facilitate a questioning of the diagnosis and increase ambivalence towards future help-seeking. It can also provide space for reflections on previous mood episodes, inducing powerful feelings of shame and guilt, leading to self-stigmatisation.

It is important not to deny the benefits of reducing the incidence and magnitude of mood symptoms, but also to highlight how exclusive focus on these goals may be reductive. The implicit message of this focus is that 'everything is fine' when one is not experiencing a major mood episode. This is incongruent with the pervasive nature of the impact of Bipolar as described here, as well as how service users with Bipolar have described recovery to be about more than the absence of symptoms (Todd, Jones, & Lobban, 2012). For some, this may also be difficult to reconcile with their experience that unique benefits of Bipolar are fostered by the breadth of mood states. Similarly, the most commonly reported side effect of medication was emotional blunting and disconnection; a behavioural adverse event (BAE) often cited as a result of medications commonly prescribed for Bipolar (Szmulewicz et al., 2016). This also indicates discrepancies between what medications can currently offer and what may be of most importance or value to service users.

Implications for Clinical Practice

Practitioners working with people diagnosed with Bipolar may want to consider more recovery-focused approaches. These have been described as representing a move away from traditional care models (Davidson, 2005; Department of Health, 2001; Jacob, 2015). Unfortunately, obfuscation of the term recovery, in this context, is common due to connotations of remedy or cure (Davidson, O'Connell, Tondora, Styron, & Kangas, 2006; Roberts & Wolfson, 2004). Indeed, within the Bipolar literature, studies focusing on experiences of 'recovery' have defined the term by absence of relapse (e.g. Mansell, Powell, Pedley, Thomas, & Jones, 2010). However, a key guiding principle, relevant to the presented findings, is that hope of living a *meaningful life* is emphasised for those facing enduring symptoms (Jacob, 2015; Repper & Perkins, 2003).

A pilot RCT found a significant improvement in personal recovery, as well as reduced relapse rates, for people with Bipolar undergoing recovery-focused CBT (Jones et al., 2015). However, a recent meta-analysis of longitudinal recovery in serious mental illness (including Bipolar) reported recovery-focused interventions had only modest effects on outcomes such as hope and empowerment (Thomas, Despeaux, Drapalski, & Bennett, 2017). As such, though evidence for recovery approaches is emerging, its efficacy in Bipolar remains unclear. In the interim, this may therefore present an opportunity for practitioners to flexibly explore recovery approaches and begin developing practice-based evidence.

In light of the complex experiential factors associated with living with Bipolar, clinical psychologists' skills in developing formulations to support decision-making (Division of Clinical Psychology [DCP], 2010) may be particularly valuable to service users. They may also play an important role in supervision, for example, supporting colleagues to maintain a strong therapeutic alliance with service users. This can facilitate acceptance of the diagnosis and improve traditional clinical outcomes (Crowe, Wilson, & Inder, 2011). It is likely that acceptance of the diagnosis, or at least of the difficulties they have continued to experience and what this means for them as an individual, would be important if supporting service users in recovery-focused approaches too (Spandler & Stickley, 2011).

For practitioners, it is worth remembering how, for service users, problems do not necessarily cease upon remission of major mood symptoms. It is worth also considering how an exclusive focus upon relapse prevention and symptom reduction may be experienced by those who do not consider this their priority in living with Bipolar.

Limitations

Though dissertations and theses were included where available, no further systematic searches of 'grey literature' databases were undertaken. It is therefore not possible to examine the extent that these findings were influenced by publication bias. However, this decision was made to facilitate a deeper exploration of the included studies at the expense of possible breadth. It is also noted that an exhaustive inclusion of literature is not necessary for thematic synthesis (Thomas & Harden, 2008).

In addition, most of the short-listing process to find suitable studies, as well as the subsequent data extraction, coding, and thematic synthesis was undertaken by one author. This therefore increases the chances of the findings being unduly influenced by author subjectivity. It is hoped that the level of transparency provided about the review process helps to address this.

Future Research

To improve the quality of research in this area, future studies should report a greater range of sociodemographic details about participants, as well as clinical information such as specific Bipolar diagnosis and co-morbid mental health diagnoses. From the available information, it appears that participants from BME backgrounds are under-represented. Efforts should therefore be made to increase ethnic representation and give voice to a wider range of experiences. Similarly, male participants remain under-represented in this area. In total, 70% of participants were female. In nine studies, 25% or fewer participants were male, despite gender equal prevalence rates of Bipolar being widely reported (Diflorio & Jones, 2010).

Particularly for studies focusing on the impact of the Bipolar label, researchers should consider stricter exclusion criteria relating to co-morbid diagnoses such as Schizophrenia or BPD, as it remains unclear the extent to which living with other psychiatric labels may influence the data. Greater transparency and critical reflection of researchers' role is also paramount for future studies. This should include a clear statement of the researcher's interest in the area, relevant personal or clinical experiences (within the boundaries of anonymity and confidentiality) as well as expectations about study findings.

Beyond clinicians working towards practice-based evidence, it would be valuable for future research to continue evaluating the feasibility, acceptability, and efficacy of recovery interventions on a larger scale. This is particularly relevant given that recovery-oriented healthcare policy is already markedly ahead of the evidence (Slade et al., 2015) and recovery in Bipolar has been paid relatively little attention (Jones, Mulligan, Higginson, Dunn, & Morrison, 2013; Tse et al., 2014).

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.

Aveyard, H., Payne, S., & Preston, N. (2016). *A post-graduate's guide to doing a literature review in health and social care.* Maidenhead, UK: Open University Press.

Bentall, R. P. (2003). *Madness explained.* London, UK: Penguin.

Bonnington, O., & Rose, D. (2014). Exploring stigmatisation among people diagnosed with either bipolar disorder or borderline personality disorder: A critical realist analysis. *Social Science & Medicine, 123,* 7-17. https://doi.org/10.1016/j.socscimed.2014.10.048

Chatterton, M. L., Stockings, E., Berk, M., Barendregt, J. J., Carter, R., & Mihalopoulos, C. (2017). Psychosocial therapies for the adjunctive treatment of bipolar disorder in adults: Network meta-analysis. *British Journal of Psychiatry, 210*(5), 333-341. https://doi.org/10.1192/bjp.bp.116.195321

Colom, F., Vieta, E., Sanchez-Moreno, J., Palomino-Otiniano, R., Reinares, M., Goikolea, J. M., … Martinez-Aran, A. (2009). Group psychoeducation for stabilised bipolar disorders: 5-year outcome of a randomised clinical trial. *British Journal of Psychiatry, 194*(3), 260-265. https://doi.org/10.1192/bjp.bp.107.040485

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research, 22*(10), 1435-1443. https://doi.org/10.1177/1049732312452938

Critical Appraisal Skills Programme, 2018. CASP Qualitative Checklist. [online] Available at: https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

Crowe, M., Inder, M., Carlyle, D., Wilson, L., Whitehead, L., Panckhurst, A., …Joyce, P. (2012). Feeling out of control: a qualitative analysis of the impact of bipolar disorder. *Journal of Psychiatric and Mental Health Nursing, 19*(4), 294‐302. https://doi.org/10.1111/j.1365-2850.2011.01786.x

Crowe, M., Inder, M., Joyce, P., Luty, S., Moor, S., & Carter, J. (2011). Was it something I did wrong? A qualitative analysis of parental perspectives of their child's bipolar disorder. *Journal of Psychiatric and Mental Health Nursing, 18*(4), 342-348. https://doi.org/10.1111/j.1365-2850.2010.01673.x

Crowe, M., Wilson, L., & Inder, M. (2011). Patients' reports of the factors influencing medication adherence in bipolar disorder – an integrative review of the literature. *International Journal of Nursing Studies, 48*(7), 894-903. https://doi.org/10.1016/j.ijnurstu.2011.03.008

Das Gupta, R., & Guest, J. F. (2002). Annual cost of bipolar disorder to UK society. *British Journal of Psychiatry, 180*(3), 227-233. https://doi.org/10.1192/bjp.180.3.227

Davidson, L. (2005). Recovery, self-management and the expert patient: Changing the culture of mental health from a UK perspective. *Journal of Mental Health, 14*(1), 25-35. https://doi.org/10.1080/09638230500047968

Davidson, L., O'Connell, M., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services, 57*(5), 640-645. https://doi.org/10.1176/ps.2006.57.5.640

Delmas, K., Proudfoot, J., Parker, G., & Manicavasagar, V. (2011). Recoding past experiences: A qualitative study of how patients and family members adjust to the diagnosis of bipolar disorder. *The Journal of Nervous and Mental Disease, 199*(2), 136-139.

Department of Health. (2001). *The journey to recovery: The government's vision for mental health care*. London, UK: Department of Health.

Diflorio, A., & Jones, I. (2010). Is sex important? Gender differences in bipolar disorder. *International Review of Psychiatry, 22*(5), 437-452. https://doi.org/10.3109/09540261.2010.514601

Division of Clinical Psychology (2010). *The core purpose and philosophy of the profession*. Leicester, UK: British Psychological Society.

Fernandez, M. E., Breen, L. J., & Simpson, T. A. (2014). Renegotiating identities: experiences of loss and recovery for women with bipolar disorder. *Qualitative Health Research, 24*(7), 890‐900. https://doi.org/10.1177/1049732314538550

Fletcher, K., Parker, G., & Manicavasagar, V. (2013). A qualitative investigation of hypomania and depression in bipolar II disorder. *Psychiatric Quarterly, 84*(4), 455-474. https://doi.org/10.1007/s11126-013-9259-1

Freedberg, R. P. (2011). Living with bipolar disorder: A qualitative investigation (Doctoral dissertation, Western Michigan University, USA). Retrieved from: https://scholarworks.wmich.edu/dissertations/407

Gibson, S., Brand, S. L., Burt, S., Boden, Z. V. R., & Benson, O. (2013). Understanding treatment non-adherence in schizophrenia and bipolar disorder: A survey of what service users do and why. *BMC Psychiatry, 13*(1), *153.* https://dx.doi.org/10.1186%2F1471-244X-13-153

Goldberg, S. (2012). Becoming the denigrated other: Group relations perspectives on initial reactions to a bipolar disorder diagnosis. *Frontiers in Psychology, 3,* 347. https://doi.org/10.3389/fpsyg.2012.00347

Goldberg, S. (2019) Narratives of bipolar disorder: Tensions in definitional thresholds. *The Humanistic Psychologist*. Advance online publication. http://dx.doi.org/10.1037/hum0000131

Goodwin, F. K., & Jamison, K. R. (2007) *Manic-depressive illness: Bipolar disorders and recurrent depression* (2nd ed.). New York, NY: Oxford University Press.

Granek, L., Danan, D., Bersudsky, Y., & Osher, Y. (2016). Living with bipolar disorder: the impact on patients, spouses, and their marital relationship. *Bipolar Disorders, 18*(2), 192-199. https://doi.org/10.1111/bdi.12370

Gregertsen, E. C., Mandy, W., & Serpell, L. (2017). The egosyntonic nature of anorexia: An impediment to recovery in anorexia nervosa treatment. *Frontiers in Psychology, 8, 2273.* https://dx.doi.org/10.3389%2Ffpsyg.2017.02273

Inder, M. L., Crowe, M. T., Moor, S., Luty, S. E., Carter, J. D., & Joyce, P. R. (2008). “I actually don't know who I am”: The impact of bipolar disorder on the development of self. *Psychiatry: Interpersonal and Biological Processes*, *71*(2), 123-133. https://doi.org/10.1521/psyc.2008.71.2.123

Inder, M. L., Crowe, M. T., Joyce, P. R., Moor, S., Carter, J. D., & Luty, S. E. (2010). “I really don't know whether it is still there”: Ambivalent acceptance of a diagnosis of bipolar disorder. *Psychiatric Quarterly, 81*(2), 157‑165. https://doi.org/10.1007/s11126-010-9125-3

Jacob, K.S. (2015). Recovery model of mental illness: A complementary approach to psychiatric care. *Indian Journal of Psychological Medicine*, 37(2), 117–119. https://dx.doi.org/10.4103%2F0253-7176.155605

Jawad, I., Watson S., Haddad, P. M., Talbot, P. S., & McAllister-Williams, R. H. (2018). Medication nonadherence in bipolar disorder: a narrative review. *Therapeutic Advances in Psychopharmacology, 8* (12)*,* 349-363. https://dx.doi.org/10.1177%2F2045125318804364

Jones, S., Mulligan, L. D., Higginson, S., Dunn, G., & Morrison, A. P. (2013). The bipolar recovery questionnaire: Psychometric properties of a quantitative measure of recovery experiences in bipolar disorder.

Journal of Affective Disorders, 147(1-3), 34-43. https://doi.org/10.1016/j.jad.2012.10.003

Jones, S., Smith, G., Mulligan, L. D., Lobban, F., Law, H., Dunn, G., … Morrison, A. P. (2015). Recovery-focused cognitive-behavioural therapy for recent-onset bipolar disorder: Randomised controlled pilot trial. *British Journal of Psychiatry, 206*(1), 58-66. https://doi.org/10.1192/bjp.bp.113.141259

Judd, L. L., Aliskal, H. S., Schettler, P. J., Endicott, J., Maser, J., Solomon, D. A., … Keller, M. B. (2002). The long-term natural history of the weekly symptomatic status of bipolar I disorder. *Archives of General Psychiatry, 59*(6), 530- 537. https://doi.org/10.1001/archpsyc.59.6.530

Judd, L. L., Akiskal, H. S., Schettler, P. J., Coryell, W., Endicott, J., Maser, M. D., … Keller, M. B. (2003). A prospective investigation of the natural history of the long-term weekly symptomatic status of bipolar II disorder. *Archives of General Psychiatry, 60*(30), 261-269. https://doi.org/10.1001/archpsyc.60.3.261

Kinderman, P. (2014). *A prescription for psychiatry: Why we need a whole new approach to mental health and wellbeing.* Basingstoke, UK: Palgrave Macmillan.

Lam, D., Bright, J., Jones, S., Hayward, P., Schuck, N., Chisholm, D., & Sham, P. (2000). Cognitive therapy for bipolar illness – A pilot study of relapse prevention. *Cognitive Therapy and Research, 24*(5), 503-520. https://doi.org/10.1023/A:1005557911051

Lam, D., Hayward, P., Watkins, E. R., Wright, K., Sham, P. (2005). Relapse prevention in patients with bipolar disorder: Cognitive therapy outcomes after 2 years. *The American Journal of Psychiatry, 162*(2), 324-329. https://doi.org/10.1176/appi.ajp.162.2.324

Lobban, F., Taylor, K., Murray, C., & Jones, S. (2012). Bipolar disorder is a two-edged sword: A qualitative study to understand the positive edge. *Journal of Affective Disorders, 141*(2-3), 204-212. https://doi.org/10.1016/j.jad.2012.03.001

Lobban F., Taylor, L, Chandler, C., Tyler, E., Kinderman, P., Kolamunnage-Dona, R., … Morriss, R.K. (2010). Enhanced relapse prevention for bipolar disorder by community mental health teams: Cluster feasibility randomised trial. *The British Journal of Psychiatry, 196*(1), 59-63. https://doi.org/10.1192/bjp.bp.109.065524

Mansell, W., Powell, S., Pedley, R., Thomas, N., & Jones, S. A. (2010). The process of recovery from bipolar I disorder: A qualitative analysis of personal accounts in relation to an integrative cognitive model. *British Journal of Clinical Psychology, 49*(2), 193-215. https://doi.org/10.1348/014466509X451447

Michalak, E., Livingstone, J. D., Hole, R., Suto, M., Hale, S., & Haddock, C. (2011). ‘It’s something that I manage but it is not who I am’: Reflections on internalized stigma in individuals with bipolar disorder. *Chronic Illness, 7*(3), 209-224. https://doi.org/10.1177/1742395310395959

Michalak, E. E., & Murray, G. (2010). Development of the QoL.BD: A disorder-specific scale to assess quality of life in bipolar disorder. *Bipolar Disorders, 12*(7), 727-740. https://doi.org/10.1111/j.1399-5618.2010.00865.x

Michalak, E. E., Yatham, L. N., & Lam, R. W. (2005). Quality of life in bipolar disorder: A review of the literature. *Health and Quality of Life Outcomes, 3*(1), 72. https://doi.org/10.1186/1477-7525-3-72

Miziou, S., Tsitsipa, E., Moysidou, S., Karavelas, V., Dimelis, D., Polyzoidou, V., & Fountoulakis, K. N. (2015). Psychosocial treatment and interventions for bipolar disorder: A systematic review. *Annals of General Psychiatry, 14*(1), 19. https://doi.org/10.1186/s12991-015-0057-z

Moncrieff, J. (2008). *The myth of the chemical cure: A critique of psychiatric drug treatment*. Basingstoke, UK: Palgrave Macmillan.

Morriss, R., Lobban, F., Riste, L., Davies, L., Holland, F., Long, R…Jones, S. (2016). Clinical effectiveness and acceptability of structured group psychoeducation versus optimised unstructured peer supports for patients with remitted bipolar disorder (PARADES): A pragmatic, multicentre, observer-blind, randomised controlled superiority trial. *Lancet Psychiatry, 3*(11), 1029-1038. https://doi.org/10.1016/S2215-0366(16)30302-9

Mortensen, G. L., Vinberg, M., Mortensen, S. L., Jorgensen, B. M., & Eberhard, J. (2015). Bipolar patients’ quality of life in mixed states: A preliminary qualitative study. *Psychopathology, 48*(3), 192‑201. https://doi.org/10.1159/000381479

National Institute for Health and Care Excellence. (2014). *Bipolar disorder: Assessment and management.* (NICE Clinical Guideline No.185). Retrieved from: https://www.nice.org.uk/guidance/cg185/chapter/Key-priorities-for-implementation

Oud M., Mayo-Wilson, E., Braidwood, R., Schulte, P., Jones, S. H., Morriss, R., … Kendall, T. (2016) Psychological interventions for adults with bipolar disorder: Systematic review and meta-analysis. *British Journal of Psychiatry, 208*(3), 213-222. https://doi.org/10.1192/bjp.bp.114.157123

Parker, G., Paterson, A., Fletcher, K., Blanch, B., & Graham, R. (2012). The ‘magic button question’ for those with a mood disorder – would they wish to re-live their condition? *Journal of Affective Disorders, 136*(3), 419-424. https://doi.org/10.1016/j.jad.2011.11.008

Perich, T., Ussher, J., & Parton, C. (2017). “Is it menopause of bipolar?”: A qualitative study of the experience of menopause for women with bipolar disorder. *BMC Women’s Health, 17*(1), 110. https://doi.org/10.1186/s12905-017-0467-y

Piccenna, L., Lannin, N. A., Gruen, R. L., Pattuwage, L., & Bragge, P. (2016). The experience of discharge for patients with an acquired brain injury from the inpatient to the community setting: A qualitative review. *Brain Injury, 30*(3), 241-251. https://doi.org/10.3109/02699052.2015.1113569

Porciúncula, L. R., Mello, E. F., Nogueira, E. L., Gomes, I., Bisol, L. W., & Neto, A. C. (2017). Prevalence of bipolar disorder in a sample of older adults. *Scientia Medica, 27*(4), 11-21. https://doi.org/10.15448/1980-6108.2017.4.28026

Proudfoot, J. G., Parker, G. B., Benoit, M., Manicavasagar, V., Smith, M., & Gayed, A. (2009). What happens after diagnosis? Understanding the experiences of patients with newly-diagnosed bipolar disorder. *Health Expectations, 12*(2), 120-129. https://doi.org/10.1111/j.1369-7625.2009.00541.x

Repper, J., & Perkins, R. (2003). *Social inclusion and recovery: A model for mental health practice*. Edinburgh, UK: Bailliere Tindall.

Roberts, G., & Wolfson, P. (2004). The rediscovery of recovery: Open to all. *Advances in Psychiatric Treatment, 10*(1), 37-48. https://doi.org/10.1192/apt.10.1.37

Rusner, M. Carlsson, G., Brunt, D., & Nystrom., M. (2010). A dependence that empowers – the meaning of the conditions that enable a good life with bipolar disorder. *International Journal of Qualitative Studies on Health and Wellbeing, 5*(1), 4653. https://doi.org/10.3402/qhw.v5i1.4653

Russell, L., & Moss, D. (2013a). A meta-study of qualitative research into the experience of 'symptoms' and 'having a diagnosis' for people who have been given a diagnosis of bipolar disorder. *Europe's Journal of Psychology, 9*(2), 385-405. https://doi.org/10.5964/ejop.v9i2.560

Russell, L., & Moss, D. (2013b). High and happy? Exploring the experience of positive states of mind in people who have been given a diagnosis of bipolar disorder. *Psychology and Psychotherapy: Theory, Research and Practice, 86*(4), 431‐446. https://doi.org/10.1111/j.2044-8341.2012.02064.x

Samalin, L., Bellivier, F., Giordana, B., Yon, L., Milhiet, V., El-Hage, W., … Llorca, P. M. (2014). Patient's perspectives on residual symptoms in bipolar disorder: A focus group study. *The Journal of Nervous and*

Mental Disease, 202(7), 550-555. http://dx.doi.org/10.1097/NMD.0000000000000157

Satink, T., Cup, E. H., Ilott, I., Prins, J., de Swart, B. J., & Nijhuis-van der Sanden, M. W. (2013). Patients' view on the impact of stroke on their roles and self: A thematic synthesis of qualitative studies. *Archives of Physical Medicine and Rehabilitation, 94*(6), 1171-1183. https://doi.org/10.1016/j.apmr.2013.01.011

Schaffer, A., Isometsä, E. T., Tondo, L., Moreno, D. H., Turecki, G., Reis, C., … Yatham, L. N. (2015). International society for bipolar disorders task force on suicide: Meta-analyses and meta-regression of correlates of suicide attempts and suicide deaths in bipolar disorder. *Bipolar Disorders, 17*(1), 1-16. https://doi.org/10.1111/bdi.12271

Slade, M., Bird, V., Clarke, E., Le Boutillier, C., McCrone, P., Macpherson, R, … Leamy, M. (2015). Supporting recovery in patients with psychosis through care by community-based adult mental health teams (REFOCUS): A multisite, cluster, randomised, controlled trial. *The Lancet Psychiatry, 2*(6), 503-514. https://doi.org/10.1016/S2215-0366(15)00086-3

Spandler, H., & Stickley, T. (2011). No hope without compassion: The importance of compassion in recovery-focused mental health services. *Journal of Mental Health, 20*(6), 555-566. https://doi.org/10.3109/09638237.2011.583949

Szmulewicz, A., Samamé, C., Caravotta, P., Martino, D.J., Igoa, A., Hidalgo-Mazzei, D., … Strejilevich, S. A. (2016). Behavioural and emotional adverse events of drugs frequently used in the treatment of bipolar disorders: Clinical and theoretical implications. *International Journal of Bipolar Disorders, 4*(1), *6.* https://dx.doi.org/10.1186%2Fs40345-016-0047-3

Thomas, E. C., Despeaux, K. E., Drapalski, A. L., & Bennett, M. (2018). Person-oriented recovery of individuals with serious mental illnesses:

A review and meta-analysis of longitudinal findings. *Psychiatric Services, 69*(3), 259-267. https://doi.org/10.1176/appi.ps.201700058

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology, 8*(45), 1-10. https://dx.doi.org/10.1186%2F1471-2288-8-45

Timimi, S. (2014). No more psychiatric labels: Why formal psychiatric diagnostic systems should be abolished. *International Journal of Clinical and Health Psychology, 14*(3), 208-215. https://doi.org/10.1016/j.ijchp.2014.03.004

Todd, N. J., Jones, S. H., & Lobban, F. A. (2012). "Recovery" in bipolar disorder: How can service users be supported through a self-management intervention? A qualitative focus group study. *Journal of Mental Health, 21*(2), 114-126. https://doi.org/10.3109/09638237.2011.621471

Tse, S., Murray, G., Chung, K. F., Davidson, L., Ng, K. L., & Yu, C. H. (2014). Exploring the recovery concept in bipolar disorder: A decision tree analysis of psychosocial correlates of recovery stages. *Bipolar Disorders, 16*(4), 366-377. https://doi.org/10.1111/bdi.12153

Walsh, J., Corcoran, J., Crooks, P., Cooke, N., & Cummings, C. (2016). The lived experience of bipolar disorder: A systematic review and meta-synthesis. *Journal of Psychiatry and Mental Health. 1*(2). 1-7. http://dx.doi.org/10.16966/2474-7769.102

Warwick, H., Mansell, W., Porter, C., & Tai, S. (2019). 'What people diagnosed with bipolar disorder experience as distressing': A meta-synthesis of quality research. *Journal of Affective Disorders, 248,* 108-130. https://doi.org/10.1016/j.jad.2019.01.024

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15*(2), 215-228. https://doi.org/10.1080/08870440008400302

Young, A. H., Rigney, U., Shaw, S., Emmas, C., & Thompson, J. M. (2011). Annual cost of managing bipolar disorder to the UK healthcare system. *Journal of Affective Disorders, 133*(3), 450-456. http://dx.doi.org/10.1016/j.jad.2011.06.016

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Reference examples follow:

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Colour figures. Colour figures may be published online free of charge; however, the journal charges for publishing figures in colour in print. If the author supplies colour figures at Early View publication, they will be invited to complete a colour charge agreement in RightsLink for Author services. The author will have the option of paying immediately with a credit or debit card, or they can request an invoice. If the author chooses not to purchase color printing, the figures will be converted to black and white for the print issue of the journal.

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The journal offers rapid publication via Wiley's Early View service. **Early View** (Online Version of Record) articles are published on Wiley Online Library before inclusion in an issue. Note there may be a delay after corrections are received before the article appears online, as Editors also need to review proofs. Once the article is published on Early View, no further changes to the article are possible. The Early View article is fully citable and carries an online publication date and DOI for citations.

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When the article is published online:

- The author receives an email alert (if requested).
- The link to the published article can be shared for free with your contacts or through social media.
- The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).

- The corresponding author and co-authors can nominate up to ten colleagues to receive a publication alert and free online access to the article.

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8. EDITORIAL OFFICE CONTACT DETAILS

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Author Guidelines updated 18th April 2018

Appendix B: Summary Table of Study Characteristics

	Author(s) (Year) Country	Title	Study Sample		Data Collection Data Analysis	Key Themes	Key Strengths/Limitations
1	Inder, Crowe, Joyce, Moor, Carter, & Luty (2010) New Zealand	"I really don't know whether it is still there": Ambivalent acceptance of a diagnosis of bipolar disorder	Participants Age Range Gender Bipolar Type	(N=15) Not Reported Female (N=12) Male (N=3)* Not Reported *as reported in Warwick et al. (2019)	Recorded Therapy Sessions Thematic Analysis – Boyatzis (1998)	1. Experiencing the Symptoms 2. Making Sense of the Symptoms 3. Experiencing Treatment	Key Strength(s): Only study including exclusion criteria relating to other formal mental health diagnoses. Key Limitation(s): Unclear how collecting data through therapy sessions over 18-month period may have affected the results. No specific demographic details provided for those interviewed for their qualitative paper.

2	Delmas, Proudfoot, Parker, & Manicavasagar (2011) Australia	Recoding past experiences: A qualitative study of how patients and family members adjust to the diagnosis of bipolar disorder	Participants Age Range Gender Bipolar Type	With Bipolar (N=17) 26-62 Years Female (N=15) Male (N=2) Not Reported	Semi-Structured Interviews Phenomenology and Lived Experience Framework - Todres & Holloway (2004)	1. Misdiagnosis & Growing Awareness 2. Accepting the Diagnosis 3. Factors That May Have Facilitated an Earlier Acceptance	Key Limitation(s): Insufficient detail about the process of data analysis. Very limited support for findings (i.e. few verbatim accounts from participants)
3	Freedberg (2011) United States	Living with bipolar disorder: A qualitative investigation	Participants Age Range Gender Bipolar Type	(N=8) 19-43 Years Female (N=7) Male (N=1) Not Reported	Semi-Structured Interviews Phenomenological Approach – based on Lindseth & Norberg (2004)	1. Diagnosis Brings Understanding Accompanied by Irrevocable Change 2. Finding Effective Treatment is an Interminable Process 3. Bipolar Disorder is the Third Partner in Every Relationship 4. Caring for Oneself is as Important as Receiving Formal Treatment	Key Strength(s): Most detailed description of the data analysis process. Most detailed critical examination of the role of the researcher. Most thorough consideration of ethical issues including the wellbeing of participants.
4	Michalak,Livingston, Hole, Suto, Hale & Haddock (2011) Canada	‘It’s something I manage but it is not who I am’: Reflections on internalized stigma in individuals with bipolar disorder	Participants Age Range Gender	(N=32) Not Reported (Mean Age 41.1 Years) Female (N=20) Male (N=12)	Interviews and Focus Groups Descriptive Qualitative Methods - Sandelowski (2000; 2010) including Thematic Analysis (Braun &	1. Stigma *a. Expectations & Experiences* *b. Sense of Self/Identity* *c. Judicious Disclosure* d. *Moving Beyond Internalized Stigma*	Key Strength(s): Used purposive sampling methods during recruitment to increase representation of males and those with Bipolar-II.

			Bipolar Type	Bipolar-I (N=25) Bipolar-II (N=7)	Clark, 2006)		
5	Crowe, Inder, Carlyle, Wilson, Whitehead, Panckhurst, O'Brien, & Joyce (2012) New Zealand	Feeling out of control: A qualitative analysis of the impact of bipolar disorder	Participants Age Range Gender Bipolar Type	(N=21) 22 – 71 Years Female (N=16) Male (N=5) Not Reported	Interviews Thematic Analysis – Boyatzis (1998)	1. Feeling Out of Control *a. Feeling Overwhelmed* *b. Loss of Autonomy* c. *Feeling Flawed*	Key Limitation(s): All participants recruited from one arm of an RCT. Likely to lead to bias.
6	Goldberg (2012) United States	Becoming the denigrated other: Group relations perspectives on initial reactions to a bipolar disorder diagnosis	Participants Age Range Gender Bipolar Type	(N=6) 39 – 55 Years Female (N=5) Male (N=1) Not Reported	Interviews Hermeneutic Approach – Gadamer (1976; 1992) & Taylor (1989)	1. Being Labelled 2. Prior Negation of Bipolar Diagnosis	Key Strength(s): Provided a clear justification for specific methodology. Key Limitation(s): All recruited participants known to researcher's doctoral researcher's classmates. Likely to lead to bias. Insufficient detail about the process of data analysis.

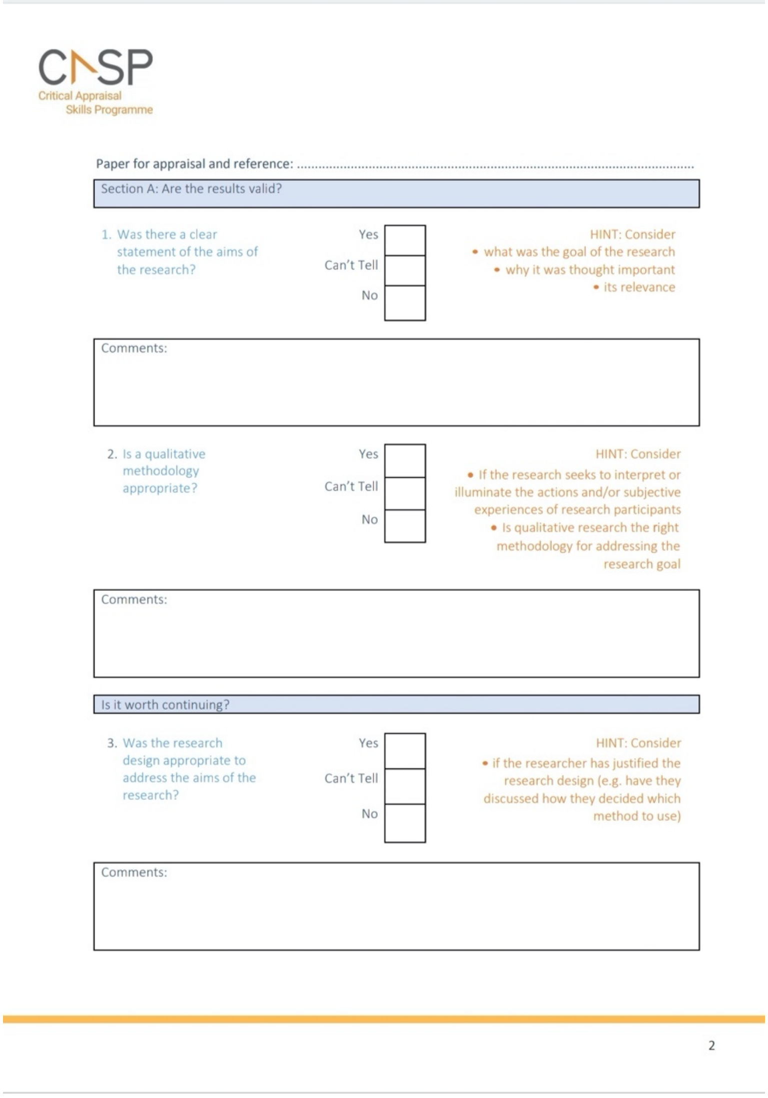
7	Lobban, Taylor, Murrary & Jones (2012) United Kingdom	Bipolar disorder is a two-edged sword: A qualitative study to understand the positive edge	Participants Age Range Gender Bipolar Type	(N=10) 24-57 Years Female (N=4) Male (N=6) Bipolar-I (N=6) Bipolar-II (N=4)	Semi-Structured Interviews Interpretative Phenomenological Analysis – Smith, Jarman, & Osbourne (1999)	1. Direct Positive Effects of Bipolar on Everyday Experiences 2. Lucky to Be Bipolar 3. Relationship Between Self and Bipolar Experiences	Key Strength(s): Provided a clear justification for specific methodology. Key Limitation(s): Insufficient detail about the process of data analysis. Acknowledges interviewer's own Bipolar diagnosis though offers no further reflections on this in the write-up.
8	Fletcher, Parker, & Manicavasagar (2013) Australia	A qualitative investigation of hypomania and depression in bipolar II disorder	Participants Age Range Gender Bipolar Type	(N=13) 22-63 Years Female (N=7) Male (N=6) Bipolar-I (N=0) Bipolar-II (N=13)	Semi-Structured Interviews Interpretative Phenomenological Analysis – Smith, Jarman, & Osbourn (1999); Smith & Osbourn (2003)	1. Hypomania Ascent Beliefs 2. Hypomania Descent Beliefs 3. Beliefs About Depression 4. The Impact of Chronicity	Key Strength(s): Provided multiple sociodemographic details relating to participants in the sample. Strict inclusion criteria to ensure sample included only participants with Bipolar-II.

9	Russell & Moss (2013) United Kingdom	High and happy? Exploring the experience of positive states of mind in people who have been given a diagnosis of bipolar disorder	Participants Age Range Gender Bipolar Type	(N=4) Late 30s – Early 60s Female (N=3) Male (N=1) Not Reported	Semi-Structured Interviews Interpretative Phenomenological Analysis – Smith, Flowers, & Larking (2009)	1. Conceptual Fuzziness: What is 'Happiness'? Is it being 'High? 2. Rejecting the Ferris Wheel idea of 'Happiness' and Welcoming the Enjoyment & Excitement of 'Being High' 3. The Self-Acceptance and Peacefulness of 'Happiness' in Contrast to the Disruption and Chaos of 'Being High' 4. The Importance of Community and Connection in 'Happiness' in Contrast to the Disruption of Social Relationships when 'Being High'	Key Strength(s): Only study to use 'respondent validation' methods. Critical examination of researcher's own role. Only IPA study to report findings indicative of individual sense-making of participants. Key Limitation(s): Very limited discussion of ethical considerations.

10	Fernandez, Breen, & Simpson (2014) Australia	Renegotiating identities: Experiences of loss and recovery for women with bipolar disorder	Participants Age Range Gender Bipolar Type	(N=10) 29 – 68 Female (N=10) Male (N=0) Bipolar-I (N=7) Bipolar-II (N=2) Cyclothymia (N=1)	Semi-Structured Interviews Constant Comparative Method – Glaser & Strauss (1967)	1. Identity Bound by the Diagnostic Label 2. Multidimensional Effects of the Bipolar Identity 3. Strategies for Renegotiating Identity	Key Strength(s): Provided multiple sociodemographic details relating to participants in the sample. One of only two studies to use formal mood measures for the purpose of screening participants based on current mood state. Key Limitation(s): Lack of details re: interview questions.
11	Samalin, Bellivier, Giordana, Yon, Milhiet, El-Hage, Courtet, Hacques, Bedira, Dillenschneider, & Llorca (2014) France	Patients' perspectives on residual symptoms in bipolar disorder: A focus group study	Participants Age Range Gender Bipolar Type	(N=23) Not Reported (Mean Age 47.8 Years) Female (N=13) Male (N=10) Bipolar-I (10) Bipolar-II (13)	Focus Groups Thematic Analysis – Braun & Clark (2005)	1. Persistent Manifestations Between Acute Episodes 2. Disruption of Socio-Professional Interactivity 3. Treatment & Management	Key Strength(s): Data was collected until thematic saturation was reached. Key Limitation(s): All participants recruited were known to the researchers. Likely to lead to bias.

12	Mortensen, Vinberg, Mortensen, Jorgensen, Eberhard (2015) Denmark	Bipolar patients' quality of life in mixed states: A preliminary qualitative study	Participants Age Range Gender Bipolar Type	(N=6) 31-49 Years Female (N=3) Male (N=3) Not Reported	Semi-Structured Interviews Discourse Theoretical Approach – Jorgensen & Phillips (1999)	1. Experiences of Being in Mixed States 2. Quality of Life and Functioning in Mixed States	Key Strength(s): Provided multiple sociodemographic details relating to participants in the sample. Clear description of efforts to increase reflexivity through multiple analysts. Key Limitation(s): Failed to provide information about where interviews took place or how long they lasted.
13	Goldberg (2019) United States	Narratives of bipolar disorder: Tensions in definitional thresholds	Participants Age Range Gender Bipolar Type	(N=6) 39 – 55 Years Female (N=5) Male (N=1) Not Reported	Interviews Hermeneutic Approach – Gadamer (1976; 1992) & Taylor (1989)	1. Experiences Pre-Bipolar Diagnosis 2. The Bipolar Diagnosis was Life-Changing 3. Hypervigilance Towards Emotional Experiences 4. Delegating the Threshold Determination 5. Lived Experience is also Suspect 6. Blurred Thresholds for Mania & Hypomania	Key Strength(s): Provided a clear justification for specific methodology. Key Limitation(s): All recruited participants known to researcher's doctoral researcher's classmates. Likely to lead to bias. Insufficient detail about the process of data analysis.

Appendix C: Critical Appraisal Skills Programme (CASP, 2018) Qualitative Checklist



Paper for appraisal and reference: ....

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

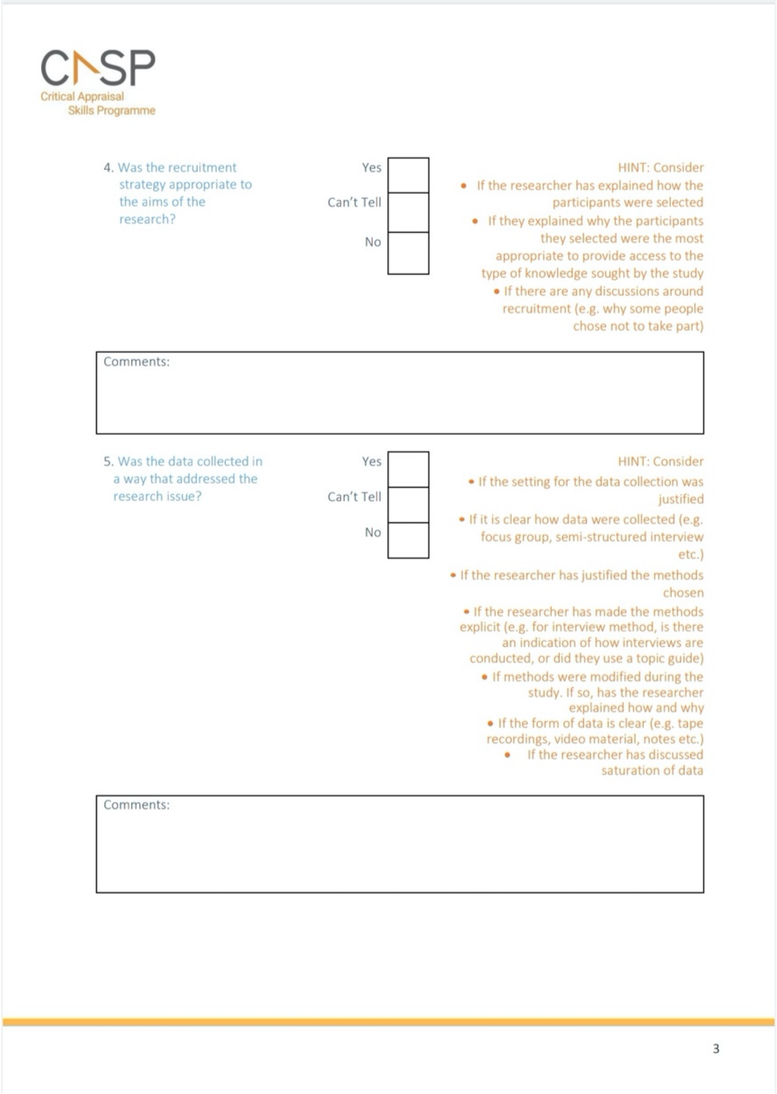
3. Was the research design appropriate to address the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

2



CASP
Critical Appraisal
Skills Programme

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

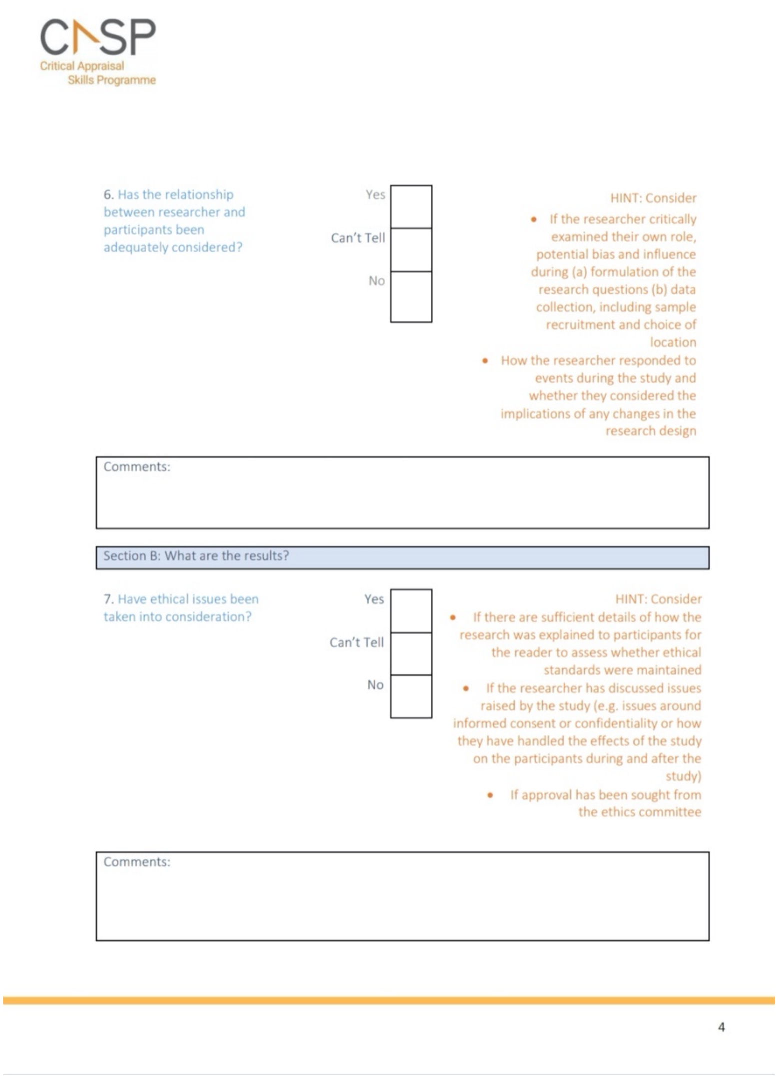
Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:



CASP Critical Appraisal Skills Programme

6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

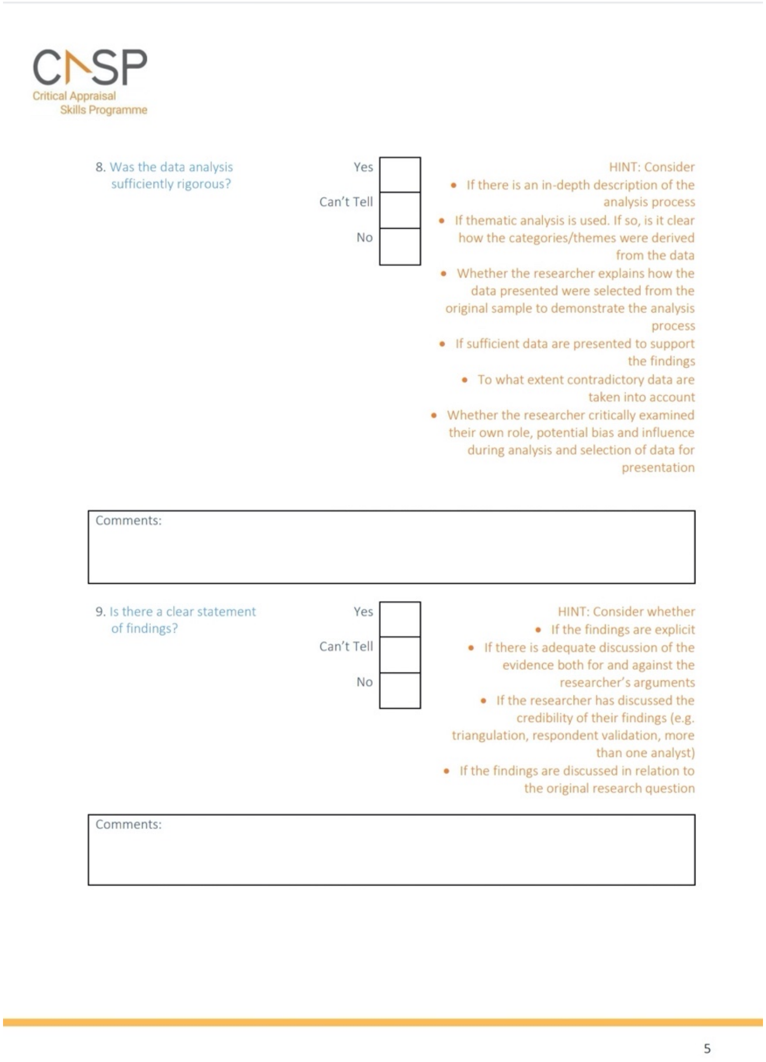
7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

4



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8. Was the data analysis sufficiently rigorous?

☐ Yes
☐ Can't Tell
☐ No

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

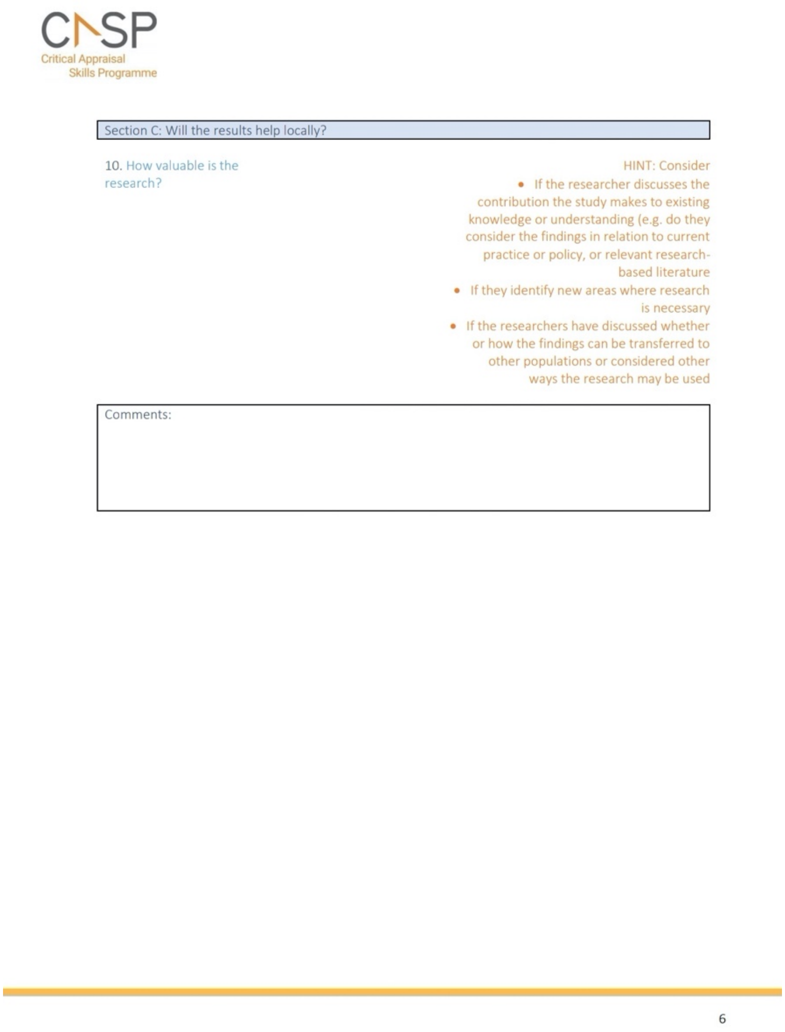
Comments:

9. Is there a clear statement of findings?

☐ Yes
☐ Can't Tell
☐ No

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:



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Section C: Will the results help locally?

10. How valuable is the research?	HINT: Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

Appendix D: Table of Summary CASP Quality Ratings

Study	CASP Quality Question									
	1	2	3	4	5	6	7	8	9	10
Inder et al. (2010)	Yes	Yes	Partially	Partially	Can’t Tell	Can’t Tell	Can’t Tell	Partially	Partially	Partially
Delmas et al. (2011)	Yes	Yes	Partially	Partially	Partially	Can’t Tell	Partially	Can’t Tell	Yes	Partially
Freedberg (2011)	Yes	Yes	Yes	Partially	Yes	Yes	Yes	Yes	Yes	Yes
Michalak et al. (2011)	Yes	Yes	Yes	Yes	Yes	Partially	Partially	Yes	Yes	Yes
Crowe et al. (2012)	Yes	Yes	Partially	No	Partially	Can’t Tell	Partially	Yes	Yes	Partially
Goldberg (2012)	Yes	Yes	Yes	No	Partially	Partially	Partially	Partially	Yes	Can’t Tell
Lobban et al. (2012)	Yes	Yes	Yes	Can’t Tell	Yes	Partially	Can’t Tell	Can’t Tell	Yes	Yes
Fletcher et al. (2013)	Yes	Yes	Partially	Yes	Yes	Can’t Tell	Can’t Tell	Partially	Yes	Yes
Russell & Moss (2013b)	Yes	Yes	Partially	Partially	Yes	Yes	Can’t Tell	Yes	Yes	Partially
Fernandez et al. (2014)	Yes	Yes	Partially	Partially	Yes	Partially	Yes	Partially	Yes	Yes
Samalin et al. (2014)	Yes	Yes	Partially	No	Yes	Partially	Partially	Partially	Partially	Partially

Mortensen et al. (2015)	Yes	Yes	Partially	Partially	Partially	Partially	Can’t Tell	Can’t Tell	Yes	Partially
Goldberg (2019)	Yes	Yes	Yes	No	Partially	Partially	Partially	Partially	Yes	Can’t Tell

1. *Were the research aims clearly stated?* ***2.*** *Is a qualitative methodology appropriate for these aims?* ***3.*** *Was the research design appropriate for these aims?* ***4.*** *Was the recruitment strategy appropriate?* ***5.*** *Were the methods of data collection appropriate?* ***6.*** *Was there appropriate consideration of the relationship between the researcher(s) and participants?* ***7.*** *Were ethical issues appropriately considered?* ***8.*** *Was the data analysis rigorous enough?* ***9.*** *Were the findings, and their significance, clearly stated?* ***10****. Is the research valuable?*

Pictures speak a thousand words: Using photo-elicitation and IPA to explore men's experience of mood management following a diagnosis of Bipolar disorder

Target Journal

Clinical Psychology & Psychotherapy (Author Guidelines, Appendix A).

Note: aspects of this paper's formatting do not conform to target journal guidelines in order to support its readability for the purpose of thesis submission (and meet thesis specifications).

Word Count

7981.

Institutional Affiliation

This empirical study was carried out as part of the requirements for the Professional Doctorate in Clinical Psychology (DClinPsy) at Staffordshire University, UK.

Conflicts of Interest

None to declare.

Data Sharing and Data Accessibility

Access to the full data set is not possible as consent to share full transcripts was not obtained from participants.

Abstract

Bipolar disorder is considered a lifelong mental health condition, characterised by periods of marked mood disturbance. Current interventions primarily aim to reduce symptom intensity and prevent relapse; however, outcomes are highly variable and evidence for their effectiveness is limited. To increase the representation of men's experiences in this area, the present study aimed to explore the ways in which men make sense of managing mood symptoms. After taking photographs which represented their experiences of managing mood symptoms, semi-structured interviews were conducted with six men diagnosed with Bipolar disorder. Transcripts were analysed using Interpretative Phenomenological Analysis. Four super-ordinate themes were identified: (1) 'managing symptoms: living with the enemy' (2) 'we're not just managing mood episodes' (3) 'managing goes beyond a list of strategies' and (4) 'medication is a necessary evil'. Making room for the disruption caused by triggers and symptoms was described as an important aspect of manging moods for some men, representing a novel finding. Descriptions of masculinity or 'male identity' were absent from the sense-making of participants. When discussing the findings, particular attention is paid to the clinical implications for practitioners. Key strengths and limitations of the study are presented, as well as recommendations for future research.

Key Practitioner Message

- Making room for the disruption caused by triggers and symptoms, rather than simply avoiding them, can be an important aspect of managing for some men.
- Practitioners should hold in mind that the impact of living with Bipolar may extend beyond the experience of major mood episodes, and so be willing to adopt more flexible and holistic approaches to intervention beyond symptom reduction and relapse prevention.
- Practitioners should avoid 'prescribing' strategies for managing moods; instead spending time exploring the personal significance and

meaning of these activities with service users, as well as the possible barriers to engaging with them.

- Clinical psychology may play an important role in using formulation to support service users' understanding of the psychosocial aspects of Bipolar and facilitate a more transparent and collaborative approach to treatment planning.

Keywords: Bipolar Disorder, Qualitative, Men's Mental Health, Photo-Elicitation, IPA

Introduction

Bipolar Disorder

Bipolar disorder (Bipolar) is considered a severe mental disorder (e.g. Barber & Thornicroft, 2018) typified by marked, and cyclical, periods of elevated and depressed mood. Periods of neutral mood, known as euthymia, typically intersperse these episodes of mood disturbance (Goodwin & Jamison, 2007). Diagnosis of Bipolar Type 1 (Bipolar-I) requires at least one episode of mania; a severe form of elevated mood which can include psychotic experiences. Bipolar Type 2 (Bipolar-II) is associated with at least one episode of hypomania, a less severe form of elevated mood, as well as episodes of depression (American Psychiatric Association [APA], 2013). Equivalent prevalence rates of Bipolar have been widely reported between men and women (Diflorio & Jones, 2010). Bipolar is considered a lifelong condition (Goodwin & Jamison, 2007), however outcomes in Bipolar are highly variable, with some experiencing extended periods of stability (e.g. Russell & Browne, 2005; Warwick, Tai, & Mansell, 2019). This suggests a need for an improved understanding of managing mood symptoms. Whilst there have been numerous challenges to understanding distress in ‘medicalised’ terms such as diagnosis, symptoms, and mood states (e.g. Timimi, 2014) the use of such terms here are for pragmatic purposes, reflecting the language used in the studies of interest.

Regarding treatment, NICE guidelines recommend a combination of medication and psychological therapy, with a focus on reducing symptoms during mood episodes and preventing relapse (National Institute for Health and Care Excellence [NICE], 2014). However, evidence supporting psychological interventions (primarily Cognitive Behavioural Therapy [CBT]) is limited by low quality studies, as well as narrow and highly variable treatment outcomes (e.g. Chatterton et al., 2017; Miziou et al., 2015; Oud et al., 2016). Furthermore, access to psychological interventions for Bipolar is limited (Lam et al., 2010; Jones et al., 2018). Nonadherence with medications is also common (Jawad, Watson, Haddad, Talbot, & McAllister-Williams, 2018) and evidence for their effectiveness is limited beyond the reduction of acute mania (Geddes & Mikowitz, 2013). Though definitions vary, self-management interventions involve service users taking an increased responsibility for their health, primarily through increased understanding about their condition(s) and the acquisition of skills to monitor and attenuate symptoms (Cook, 2004). Development of self-management interventions for Bipolar has been slow compared to other areas of both physical and mental health (Jones, Deville, Mayes, & Lobban, 2011) with limited evidence to support those available (Janney, Bauer, & Kilbourne, 2014). Current interventions for Bipolar are therefore limited by a number of factors, including availability and demonstrated efficacy. This further indicates the need for an improved understanding of symptom management.

Managing Mood Symptoms

Studies focusing on what people do to manage Bipolar symptoms commonly report strategies such as understanding triggers and early warning signs, self-monitoring, maintaining ‘healthy habits’, and maintaining social connection (e.g. Murray et al., 2011; Nicholas, Boydell, & Christensen, 2017; Russell & Browne, 2005). There is considerable overlap between such strategies and the protocols of psychological interventions for Bipolar, including monitoring mood, recognising and responding to early warning signs, as well as understanding and improving sleep (e.g. Jones et al., 2018). Other studies have focused on the experience of symptom management itself, i.e. what that is like, placing greater emphasis on the processes involved (e.g. Cappleman, Smith, & Lobban, 2015; Mansell, Powell, Pedley, Thomas, & Jones, 2010; Morton, Michalak, Hole, Buzwell, & Murray, 2018; Saunders et al., 2017).

However, studies are often limited to specific populations, such as those ‘living well’ with Bipolar or are considered to have ‘recovered’ from symptoms (e.g. Mansell et al., 2010; Murray et al. 2011; Russell & Browne, 2005), or those who have undergone a particular intervention (e.g. Morton et al., 2018). This of course limits the transferability of the findings (Willig, 2008), including to those who may be experiencing more recurrent or disruptive mood symptoms. It has also been highlighted that the existing literature focuses exclusively on self-management strategies people find effective (Michalak et al., 2016).

Gender Issues in Bipolar Research

Numerous qualitative studies have explored the experiences of women diagnosed with Bipolar. Some studies relate to female-specific topics such as pregnancy (e.g. Dolman, Jones, & Howard, 2016) and menopause (e.g. Perich, Ussher, & Parton, 2017), yet others explore seemingly gender-neutral topics such as loss and recovery (Fernandez, Breen, & Simpson, 2014), or parenting (Venkataraman & Ackerson, 2008). There do not appear to be any published qualitative studies specifically exploring the experiences of men diagnosed with Bipolar. The under-representation of male participants has been identified as a limitation to synthesising findings (Russell & Moss, 2013a; Walsh, Corcoran, Crooks, Cooke, & Cummings, 2016).

Sajatovic, Micula-Gondek, Tatsuoka, and Bialko (2011) found men diagnosed with Bipolar perceived themselves as less masculine than the general population. Those perceiving themselves as more masculine were also significantly less likely to adhere to treatment. No comparable differences were observed in the female participants. Men diagnosed with Bipolar have also reported higher levels of self-medication through alcohol than women (Kriegshauser et al., 2010). Furthermore, research also indicates gender differences in presentation; men have been found more likely to experience a predominance of elevated mood episodes (Nivoli et al., 2011), whereas women are more likely to experience rapid cycling of symptoms and mixed states (Arnold, 2003).

Rationale

Overall, there are numerous limitations to current interventions for Bipolar, an absence of published qualitative studies exploring men’s experiences, and some evidence to suggest experiential differences between men and women. Current approaches, including medication, psychological therapies, and self-management interventions, have a shared focus on symptom management and relapse prevention. There is therefore a vital gap in the literature exploring men's experiences of managing mood symptoms.

Primary Research Aims

This study aims to complement the existing literature by focusing exclusively on men's experiences of managing mood symptoms. Building on existing research of mixed gender samples, the primary research question is: '*How do men make sense of their experiences of managing mood symptoms, including what is helpful and unhelpful*?'

Method

Design

There is emerging evidence of the value that photo-elicitation methods offer in exploring men's experience (e.g. Oliffe & Bottorff, 2007; Oliffe et al., 2019). They have been used to allow participants to become active agents in controlling interview processes and reduce researcher bias (e.g. Burton, Hughes, & Dempsey, 2017; Sandhu et al., 2013). Similarly, one of the commitments of Interpretative Phenomenological Analysis (IPA) is to 'give voice' to participants through exploration of their personal meaning-making (Larkin, Watts, & Clifton, 2006), lending itself well to underrepresented groups. Burton et al. (2017) outline a case for this combination of approaches, describing how photo-elicitation facilitates the process of sense-making and personal reflection.

The present study therefore used a combination of photo-elicitation and IPA to explore men's experiences. Photographs were taken by participants; capturing salient aspects of their experiences and used to guide a semi-structured interview. Interview data was analysed using IPA, following the steps outlined by Smith, Flowers, and Larkin (2009).

Ethical Considerations

The study was reviewed by an Independent Peer Review (IPR) panel at Staffordshire University (Appendix B). Ethical approval was granted by an NHS Research Ethics Committee ([REC] Appendix C) and the Health

Research Authority ([HRA] Appendix D). All participants provided written informed consent to participate. Their anonymity has been preserved by pseudonyms, which they had the option to choose themselves. Data was stored securely in line with Staffordshire University policy. Participants were screened for mood symptoms, ensuring only those who were euthymic took part. This was primarily to maximise sample homogeneity, addressing limitations of previous research (e.g. Fletcher, Parker, & Manicavasagar, 2013). However, it was also a measure to protect participants from harm, as in previous research (e.g. Fernandez, Breen, & Simpson, 2014). Of note, no participants were ultimately excluded on this basis.

Participant Criteria

Inclusion criteria

- Men aged over 18, living in the UK.
- Self-reported diagnosis of Bipolar, supported by The Mood Disorders Questionnaire (MDQ) (Hirschfeld et al. 2000) following Twiss, Jones, and Anderson's (2008) scoring system. See Appendix E for permissions.
- Diagnosis made in the last 5 years*
- Fluent English.
- Able to take and send photographs to the author (consistent with previous research e.g. Burton, Hughes, & Dempsey, 2017).
- Euthymic in mood, confirmed by an Altman Self-Rating Mania Scale (ASRM) score of ≤ five (Altman, Hedeker, Peterson, & Davis, 1997) and a Centre for Epidemiologic Studies Depression Scale (CES-D) score of ≤15 (Radloff, 1977).

*Criterion removed in January 2020 to aid recruitment (see Appendix F for ethical approval).

Exclusion criterion

- Self-reported diagnosis of Schizophrenia, Schizoaffective disorder, or Borderline personality disorder. This was due to overlap in symptoms (Bambole et al., 2013; Tamminga et al., 2013; Coulston, Tanious, Mulder, Porter, & Malhi, 2012) and potential difficulty differentiating experiences related to living with Bipolar, specifically.

Recruitment

Electronic copies of the study advert (Appendix G) were posted online. With permission, hard copies were placed on noticeboards where relevant support groups or drop-in clinics were held. The author delivered brief presentations to participating NHS teams, and to service users attending 'Bipolar education' groups. Participants expressing an interest contacted the author to answer screening questions (Appendix H) before being provided the Participant Information Sheet ([PIS] Appendix I). Those still interested were provided the consent form to be signed and returned to the author (Appendix J). Finally, the MDQ, ASRM, and CES-D were completed to confirm self-reported Bipolar diagnoses, and screen for current mood symptoms (Appendix K; L; M). Of note, the only men who were not eligible to take part were those reporting no clinical diagnosis of Bipolar or reporting a co-morbid diagnosis of Schizoaffective disorder.

Participants

Purposive sampling methods were used to obtain a sample of six participants, consistent with sample size recommendations for IPA as part of doctoral research (Smith et al., 2009). Two participants were recruited through 'Bipolar education' groups hosted by the participating NHS site; the remaining four responded to study adverts on social media. Participants' mean age was 47 years (range 28 – 71 years), and mean time since diagnosis was 6 years (range <1 – 36 years). See Table 1 for further information.

Procedure

A mutually agreed date for the interview was arranged approximately one week after screening questionnaires were completed. Participants were advised to begin taking photographs leading up to this date, considering the guidance provided (Appendix N).

Table 1

Participant Clinical & Demographic Information

Pseudonym	Age	Bipolar Sub-Type	Years Since Diagnosis	Episodes of Depression (Approximate)	Episodes of Hypo(Mania) (Approximate)	Relationship Status	Highest Level of Education	Employment Status	Support for Mood
Nelson	42	Bipolar-II	5	2	2	Married	National Vocational Qualification	Full-Time	Counselling Wife Friends
Ted	28	Unknown to Participant	<1	10	20	In a Relationship	Certificate of Higher Education	Full-Time	Psychiatrist Counselling
Jamie	45	Unknown to Participant	3	50	70	Married	Higher National Certificate	Full-Time	Psychiatrist GP CBT Therapist

									Support Group
Steve	37	Bipolar-I	3	10	4	In a Relationship	Bachelor's Degree	Unemployed	Psychiatrist GP Family
Fred	71	Unknown to Participant	10	400	100	Married	City & Guilds	Retired	Psychiatrist Support Group Wife
Sam	60	Unknown to Participant	36	10	4	Married	Bachelor's Degree	Retired	Psychiatrist

Participants were asked to choose six photos for the interview and consider the following questions when taking them:

- What has it been like managing symptoms since I was diagnosed?
- What has been helpful?
- What has been unhelpful?

Participants sent their six photographs to the author via email prior to the interview. Two interviews were conducted face-to-face in private rooms hosted by the supporting NHS site, the remaining four interviews were conducted via telephone. All interviews were audio recorded and, consistent with previous research (Burton et al., 2017), were guided by generic questions about the photographs themselves (Appendix O). Data relating to participants' sociodemographic information, as well as clinical history, were also recorded at this stage (Appendix P).

Participants were verbally debriefed at the end of the interview; providing the opportunity to ask questions and raise concerns. A courtesy telephone call was also arranged for one week after the interview.

Data Analysis

The interview's lasted an average of 81 minutes (range: 71 – 104 minutes). All interviews were transcribed verbatim by the first author to facilitate initial familiarisation with the data. Analysis of the transcription data followed the IPA guidance outlined by Smith et al. (2009).

Transcripts were read numerous times to facilitate further immersion in the data. Preliminary responses to the participants and the transcripts were noted down to slow the process of data summation. Next, in a process of line-by-line commenting, annotations were made around the transcript identifying descriptive, linguistic and conceptual features. Emergent themes were subsequently developed through analysis of these annotations; concise statements capturing both descriptive and interpretative information first noted in the left-hand margin of the transcript (Appendix Q) before being written down separately in chronological order (Appendix R). These themes were then clustered together within each case (Appendix S) before connections were made across the dataset, delineating super-ordinate and sub-ordinate themes (Appendix T).

Epistemological Position & Reflexivity

The principles of IPA are consistent with the author's epistemological position, critical realism. Within critical realism, a 'real' social world is not denied, however attempts to access it are contextualised by the assumption that direct access may not be provided by the data (Willig, 2008). Critical realism supports competing explanations of phenomena; accepting they may bring us closer or further from 'reality', and that all are fallible (Fletcher, 2017).

IPA involves a double hermeneutic process whereby researchers attempt to make sense of the participant making sense of their experience; transparency about researchers' own assumptions and ways of thinking is therefore paramount (Smith et al., 2009). To maintain reflexivity, a research diary was maintained by the author throughout data collection and analysis; regular analytic discussions were also held during supervision.

The author has a close relationship with someone who has received a Bipolar diagnosis, prompting an initial interest in people's experiences of living with the symptoms and diagnostic label. Being male, the author was particularly interested in the experiences of men.

During the process of bracketing, preconceptions included an assumption that self-criticism linked to traditional notions of masculinity may be a barrier to managing mood symptoms. A further assumption was that men may feel isolated due to symptoms and stigma associated with a diagnosis of Bipolar which may not be readily understood or shared by peers.

Results

The results revealed four super-ordinate themes, including a total of eleven sub-ordinate themes (Table 2). A supplementary table containing additional data extracts across the sample is provided (Appendix U) as well as additional photographs discussed at interview (Appendix V).

Table 2

Super-ordinate and Sub-ordinate Themes

Super-ordinate Theme	Sub-ordinate Theme	Contributing Participants
1. Managing Symptoms: Living with the Enemy	a. Diagnosis: taking the symptoms seriously	Nelson, Ted, Jamie, Steve
	b. Awareness of triggers: avoiding the Symptoms	All
	c. Making room: allowing disruption	Nelson, Ted, Sam
2. We're Not Just Managing Mood Episodes	a. Living with stigma	All
	b. Threat	Nelson, Ted, Jamie, Steve, Sam
	c. Ripple effects	Ted, Jamie, Steve
3. Managing Goes Beyond a List of Strategies	a. The importance of feeling supported	All
	b. Part of something bigger	Nelson, Ted, Jamie, Fred, Sam
	c. Right tools for the job	Nelson, Ted, Jamie, Fred, Sam
4. Medication is a Necessary Evil	a. Side effects are a misnomer	Nelson, Ted, Jamie, Steve
	b. Medication isn't just taking pills	Ted, Jamie, Steve

1. Managing Symptoms: Living with the Enemy

Descriptions of mood symptoms were almost universally negative. Only one participant, Ted, described Bipolar to have a "*positive aspect*" as elevated moods have, at times, facilitated heightened productivity. Many photographs represented practical strategies used for managing moods. Strategies varied between participants, for example exercise, mindfulness, walking, and learning about Bipolar. However, their sense-making revealed considerable overlap in their functions. For most participants this involved avoiding triggers (and therefore symptoms). For some, strategies could also function to make room for them. The use of strategies was underpinned by the diagnosis itself, providing a way to begin understanding past and present experiences.

1a. Diagnosis: Taking the symptoms seriously. Most participants discussed the significance of the diagnosis, and how it facilitated taking the symptoms seriously. In turn, this supported them to make changes in their lives. Though none described management of Bipolar to be straightforward, some spoke about the diagnosis as being a turning point following a "*very long road*" (Jamie) or "*lengthy battle*" (Ted). For them, the road to diagnosis was paved with short-term medication or counselling for the presenting problem i.e. depression. Anti-depressant medication alone was viewed as ineffective or actively harmful.

A common feature of the turning point was the reappraisal of elevated mood states as a symptom or problem, enabling them to develop ways of managing these too. Jamie described the point of diagnosis as instrumental in abstaining from alcohol (Figure 1) by facilitating an understanding that "*binge drinking*" was often a response to elevated moods:

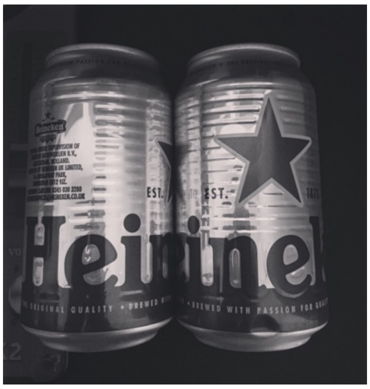

Figure 1. Jamie's photograph (taking the symptoms seriously)

> “…*it was like ‘I’m feeling really good I want to go out’ and it’s almost like wanting to keep that feeling going… it did end up causing issues but like it caused issues for years… the day before I was diagnosed umm I was admitted to a psychiatric hospital and I’d been drinking heavily… I’ve not drank since… that’s two and a half years ago…[the photo] represents a couple of things for me it represents kinda pre-diagnosis and post-diagnosis*” *(Jamie)*

1b. Awareness of triggers: Avoiding the symptoms. For all participants, an awareness of stimuli which can trigger or exacerbate their mood symptoms is an important aspect of managing. Such awareness facilitates the development of strategies to avoid triggers (and therefore symptoms). The need to rest and preserve energy levels was common, with other triggers including rumination and a perceived lack of control.

Fred described rumination to be a trigger for mood episodes. Most of the photos taken by Fred represented things which had a beneficial or detrimental effect on his mood over the preceding week. The photo of the wheelie bin (Figure 2) promoted discussion of how a simple mistake, erroneously putting wood into the recycling bin, led him to spend most of the night ruminating. These ruminations appeared to elicit some core beliefs from his early life experiences, and ultimately impacted on his mood:

Figure 2. Fred’s photograph (awareness of triggers)

"…it bothered me in the night 'cause I was thinking about it…I couldn't sleep… anyway my mood dropped a bit because of it… it really bothered me…[I was thinking] I've got it wrong 'cause when I was a kid umm 'you've got it wrong' it was always 'it's wrong' y'know 'you've got it wrong'" (Fred)

He explained how attending a Bipolar education group enabled him to build on such awareness by developing a strategy for managing rumination by imagining his brain as having 'faulty wiring':

"*…so when that comes into my mind I think 'oh right, yeah, but that's in the past, that means the frontal lobe and the amygdala aren't working together at this second in time… it just seems to help….*" *(Fred)*

1c. Making room: Expecting disruption. As well as avoiding triggers and symptoms, some participants made sense of strategies by describing how they make room for them too. For example, Ted spoke about painting as a way to channel his heightened energy during manic episodes, satisfying the need to be "*constantly moving constantly doing something constantly thinking*". Sam made sense of managing Bipolar through a metaphor:

"…*one model is thinking of it in terms of a bank account… at times when you're depressed the amount of money coming in each day has been reduced quite a lot so you're wise to only spend what's there*…" (Sam)

Consistent with this, Sam spoke about the importance of activities which "*put cash in the bank*" to mitigate against inevitable withdrawals made by episodes of depression. Similarly, he spoke about the importance of maintaining regular activities like exercise (Figure 3):

Figure 3. Sam's photograph (expecting disruption)

> "…*since then, depressions I have always managed with um trying to keep stuff going, then there's a less sharp hill to climb once you're better… again it's this business of not dropping too many things so you don't have to go through the business of picking them all up again*…" *(Sam)*

Though such activities were described as conducive to maintaining stable mood, the key difference is the mitigation, rather than avoidance, of unwanted symptoms. Sam's account indicates an inevitability of experiencing mood episodes, whilst not feeling resigned to this. Keeping routines going does not mean that depressive episodes will be stopped, but that they will be less impactful. Similarly, Nelson reports preparing all his clothes and meals for the week ahead; whilst this is a method of avoiding a build-up of stress, which reduces the likelihood of mood symptoms, the aim is not to avoid triggers entirely. Rather, he is making room for fluctuations in mood associated with triggers which are, inevitably, outside of his control.

2. We're Not Just Managing Mood Episodes

Though asked to take photographs representing what is helpful and unhelpful in managing mood symptoms, living with Bipolar was about more than discrete mood episodes for participants.

2a. Living with stigma. Though the word stigma was rarely used, its presence was reflected on by all of the participants. For some, stigma actively impacts the way that they manage life with Bipolar, including a perceived need for 'social performance'. For Fred, internalised stigma made it difficult to disclose his diagnosis to others and seek support:

> *"…if I actually wanted to be umm come out if you like, come out, I'm thinking [shudders]… there were two things: the fear that I've got [pause] this thing, Bipolar, and then… the challenge… to actually accept it and…get some somebody that could help me" (Fred)*

His repeated use of the metaphor 'coming out' draws a parallel with the considerable shame and stigma associated with the self-disclosure of one's sexual identity (Corrigan & Matthews, 2003). His involuntary shudder, in the place of a verbal narrative, reflects an ineffable quality to the experience. This, combined with his initial use of the term “*thing*”, highlights an internalisation of stigma; that there was something unspeakable about the diagnosis, invoking feelings of disgust and fear.

Nelson described being ‘treated differently’ by colleagues in a former job, but also felt strongly that being open about his diagnosis is important. As part of his ongoing management, he described ways that he attempts to subtly challenge others’ perceptions of him, holding in mind the potential for stigmatising beliefs or attitudes. One of the functions of organising his clothes for the week ahead (Figure 4) is to portray an identity beyond Bipolar:

Figure 4. Nelson’s photograph (living with stigma)

> *“…people’s experiences of people with Bipolar can vary and some of them think that they’re unpredictable and I like to portray a picture of predictability y’know?... because I come in in the same stuff all the time… they know they can rely on me… I’m there at the same time every day, I leave at the same time every day, I go for lunch at the same time every day, and they soon forget about the Bipolar, it becomes secondary*” *(Nelson)*

2b. Threat. Over half of the participants described ways in which Bipolar is, and has been, a source of threat. Bipolar was seen as a threat to various aspects of their own lives and the lives of others, including to freedom, control, certainty, and a sense of safety. For some, their own thoughts were described as a source of threat from which they sought refuge.

When recounting a recent social event, the author asked Sam what that experience was like. In response, Sam spoke about the strength of mood symptoms, reflecting on the fragility of social plans and how Bipolar poses a threat to upholding them:

> "*Obviously that was going to be quite dependent on where I was emotionally at the time, fortunately I was fairly well… had I not been in that same place I would not have been able to go so y'know the impact on life and what I feel I'm able to do is part of the cost of the mental health issue*" *(Sam)*

Ted reflected particularly on the ways Bipolar threatens his future, including his freedom to make choices, and to live the life he expected to. When discussing a place of respite, the expansive grounds of an abandoned psychiatric hospital (Figure 5), Ted spoke of the threat of hospitalisation imposed by Bipolar:

Figure 5. Ted's photograph (threat)

> "*I've got quite a fear of being admitted into the hospital umm but it is something that my psychiatrist likes to talk at length about… I am quite glad that it's not a regular occurrence anymore that people are kinda locked up in asylums for prolonged periods of time um 'cause it does always kind of worry me what my future is going to be like*" *(Ted)*

2c. Ripple effects. Half of the participants described ways in which consequences of mood episodes created difficulties of their own. As such, whilst major mood symptoms may not be present, these ‘ripple effects’ can increase the chances of experiencing sub-syndromal symptoms of depression. For these participants, a detrimental impact on relationships was common, limiting the availability of support networks.

For Steve, episodes of depression have had a wide range of impacts. As well as the impact on his familial relationships, the frequency and duration of his depressive episodes have left him without employment. Due to the long periods of time spent socially withdrawn, he also described a loss of confidence, exacerbated by weight gain linked to ‘comfort eating’ (Figure 6):

Figure 6. Steve’s photograph (ripple effects)

> “…*because now I’m in a good place – I’m not in a great place but I’m in a good place, I’m getting better – and I’m now stuck with two extra stone in weight and I look at myself and it reminds me that I’ve done this because I wasn’t well, I’m not how I used to be and it’s a reminder every time I look at myself. So I can style my hair, I can trim my beard, but I don’t feel good about how I look because of my excess weight…*” *(Steve)*

His hesitance to describe his mood as ‘good’ emphasises the way in which euthymia can be hard to define for him. The contrast between listing things he has control over, and the ultimate lack of change, brings a sense of hopelessness to his account suggesting that depressogenic cognitions may also remain present.

3. Managing Goes Beyond a List of Strategies

Though many photographs were about helpful practical strategies, the subsequent sense-making of the participants revealed the strategies themselves are only one part of the process. All of the participants described the importance of feeling supported, and most described how being part of something beyond themselves can be helpful. For practical strategies themselves to work, some highlighted the need for the 'right tools'.

3a. The importance of feeling supported. Though not captured exclusively by many of the photographs, all of the men spoke about the value of feeling supported. For some this was positively framed (i.e. feeling supported is helpful), for others it was negatively framed (i.e. not feeling supported is unhelpful). Emphasis on what it meant to feel supported varied between participants, including acceptance, understanding, a sense of community or connection, and an ability to rely on others. For example, Jamie expressed how being given space during depressive episodes can feel supportive, whereas Sam spoke about acceptance from his wife and church community as being the foundation of his mood management.

The importance of feeling supported was illustrated powerfully by Ted, whose photograph of an empty armchair (Figure 7) was used to represent the profound sense of loneliness he felt after receiving his diagnosis:

Figure 7. Ted's photograph (the importance of feeling supported)

> "*[The photograph] was to try and convey how alone I felt after I got diagnosed… by the time I actually went and got help most people had left my life already because of some of the stuff I'd been doing… then when I got my diagnosis it was kind of a 'right we've decided you're Bipolar umm here's medication we'll see you again in 3 months' and then that was kinda me sent on my way with a prescription for pretty strong medication and I was just kinda like I don't know what to do with this information or myself" (Ted)*

Ted drew attention to a distinction between the act of receiving professional input and the experience of feeling supported. Though he had been seen by healthcare professionals for assessment, Ted describes initially feeling directionless and uncontained by his diagnosis. He seems perplexed by the juxtaposition of being "*sent on [his] way*", which indicates not being in need of regular professional contact, and the strength of the medication, indicating that something must really be wrong.

> "*I think it is mostly just doing it alone [pause] or that's how it feels that I manage it alone*" *(Ted)*

3b. Part of something bigger. Most of the men also spoke about the importance of being part of something beyond themselves. Examples ranged from having a duty of care for their pet, a commitment to a loved one, and using their own experiences to help others. Jamie spoke about his dog (Figure 8), and how a sense of duty to look after him superseded the absence of motivation during depressive episodes, which helped him to get out of bed and get some exercise:

Figure 8. Jamie's photograph (part of something bigger)

> “*…when I’ve not been well mentally umm and I’ve been spending a lot of time at home struggling to get outside… having the dog has made me go out the house, makes me get up in the morning, makes me walk at least two times a day…” (Jamie)*

3c. Right tools for the job. A focus on having the ‘right tools for the job’ was part of the sense-making process for most participants. Fred reported a personal “*fascination*” with Bipolar, which he saw as key to maximising his attendance at Bipolar groups. For Jamie, mindfulness only became accessible when it was facilitated by a smartphone application, providing him with a way to be guided through the process without feeling overly self-conscious about being observed.

Nelson spoke about existing skills in developing and adhering to routines, following his service in the Royal Navy, as well as having work colleagues with shared interests with whom he could socialise. He acknowledged the benefits of social activity when experiencing low mood, but explained how the benefits of this are dependent on a number of factors, including the ‘right’ activity (Figure 9):

Figure 9. Nelson’s photograph (right tools for the job)

> *"…even when you're low y'know it's good to try and push yourself to go out and socialise … the benefit of a gig is you don't have to interact with people… the feeling and emotion and everything else comes from all the people around you... everyone else is jumping up and down and excited so their emotion is coming from other people… it doesn't take me going putting my hands up for everyone else to start putting their hands up*" *(Nelson)*

When low in mood, the pressure to perform socially can be a key barrier for Nelson, particularly if asked to attend social activities such as going out for dinner, in which maintaining conversation is a central component. It is therefore important for him to access activities where the need to 'do something' is met whilst removing the pressure to contribute to others' enjoyment.

4. Medication is a Necessary Evil

Most participants took a photograph of their medication. There was a general consensus that medications were a necessary part of life with Bipolar, however their benefits were not without considerable downsides.

4a. Side effects are a misnomer. Participants described how side effects can become primary concerns; superseding their initial mood symptoms. Since his diagnosis three years ago, Steve has struggled to find medication that has felt helpful (Figure 10). He reported side effects including weight gain, sexual dysfunction, emotional blunting, and cognitive impairment, all of which have profound implications:

Figure 10. Steve's photograph (side effects are a misnomer)

> "…*I know I need to take some form of medication but the side effects… are really depressive. I don't feel like myself anymore, I don't feel like I can articulate myself anymore, I don't feel like I uh I feel very foggy all the time, I [pause] even now I have brain fog when I'm trying to speak uhh [pause]…*" *(Steve)*

His description of a 'loss of self' reflects the way in which side effects can create depressogenic conditions, exacerbating the mood symptoms he was trying to alleviate.

The significance of side effects appears to be linked to their personal significance. Both Nelson and Steve have experienced weight gain on their current medications. As a former model, Steve found this particularly distressing as the additional weight impacted considerably on his sense of self-worth. However, this was not important to Nelson.

4b. Medication isn't just taking pills. As well as side effects, some participants drew attention to the processes involved in taking medication. When discussing his choice of photo (Figure 11), Ted described feeling overwhelmed by the number of pills he has to take. He also described medication to be a series of processes which in itself can feel exhausting:

Figure 11. Ted's photograph (medication isn't just taking pills)

"*I initially was thinking of laying out all of my pills umm but I find it really difficult when I lay them all about because I just have to take so many of them…*" *(Ted)*

"*…there's just times where it's just exhausting and I would much prefer not to have to go to appointments and much prefer not to have to go t- to take medication and not to have to go and get tests and stuff like that trying to make sure that everything's fine*" *(Ted)*

Discussion

This study aimed to explore how men make sense of managing mood symptoms following a diagnosis of Bipolar. A total of six participants, recruited purposively, took part in a photo-taking task and a semi-structured interview. Four super-ordinate themes were identified: (1) 'managing symptoms: living with the enemy' (2) 'we're not just managing mood episodes' (3) 'managing goes beyond a list of strategies' and (4) 'medication is a necessary evil'.

'Managing symptoms: living with the enemy' complements findings of previous research using mixed gender samples (Murray et al., 2011; Russell & Browne, 2005) to provide a more nuanced understanding of the ways in which particular strategies, such as self-monitoring or exercise, may be used to support management. A key finding was that, for some men, part of managing symptoms is to accommodate disruption in their lives, rather than seeking only to avoid it. Warwick et al. (2019) found that an important aspect of 'recovery' in Bipolar is the ability to tolerate difficult feelings, in the knowledge they would not always lead to mood episodes. The current findings extend this understanding; a willingness to experience mood episodes themselves can be helpful, as well as an acceptance that there may be triggers outside of one's control. Strategies were secondary to taking the symptoms seriously, facilitated by the diagnosis itself. The importance of the diagnosis is consistent with previous research focusing on 'recovery' in Bipolar (Mansell et al., 2010; Warwick et al., 2019). Channelling elevated moods into something desirable has been described by those managing without medication (Cappleman et al., 2015). In the current study, some participants described ways of making space for symptoms of low mood too, reflecting a more open stance towards experiencing mood states. In addition, though positive elements to life with a Bipolar diagnosis have been reported (e.g. Lobban, Taylor, Murray & Jones, 2012; Russell & Moss, 2013b) references to such were largely absent from the sense-making of participants in this study.

Michalak, Yatham, and Lam (2005) found that quality of life can be impaired markedly between mood episodes. Indeed, at least sub-syndromal symptoms are experienced persistently by many people diagnosed with Bipolar (Judd et al., 2002; Judd et al., 2003) and recovery of functional impairment has been shown to be slower than symptomatic recovery (Gitlin & Miklowitz, 2017). ‘We’re not just managing mood episodes’ presents experiential accounts for factors which may contribute to such disruption for men. These include ‘ripple effects’ following mood episodes, in which a range of areas of life are impacted, including support networks. It also includes ‘living with stigma’, and the sense of ‘threat’ as Bipolar looms over many aspects of daily life. The prominence of these accounts in a study focused on managing mood symptoms indicates their importance for how men make sense of such experiences. These findings are consistent with service users describing ‘recovery’ in Bipolar to mean more to them than the absence of symptoms (Todd, Jones, & Lobban, 2012) as well as a review of what people diagnosed with Bipolar experience as distressing (Warwick, Mansell, Porter, & Tai, 2019).

The significance of side effects in the lives of those diagnosed with Bipolar is consistent with existing qualitative research (e.g. Mansell et al., 2010; Mortensen, Vinberg, Mortensen, Jorgensen, & Eberhard, 2015; Vargas-Huicochea et al., 2014). ‘Medication is not just taking pills’ represents a novel finding; that the processes involved in taking medication can themselves be burdensome and create further barriers. These factors, combined with a belief that medication is a crucial component of mood management, means that medication can be understood as a ‘necessary evil’ for those more recently diagnosed. A recent Delphi method study found that medication was seen as a ‘net positive’ by both healthcare professionals and people diagnosed with Bipolar (Michalak et al., 2016). Whilst medication was seen as necessary here, the present findings support a more nuanced account of the negative aspect of such cost-benefit analysis. Though both reported taking it, there was an absence of discussion about medication from the two participants diagnosed over five years ago. It is therefore possible that people's sense-making about medication changes over time. However, it is difficult to draw more meaningful conclusions here due to the absence, rather than divergence, of data relating to medication.

Consistent with previous research (Murray et al., 2011; Russell & Brown, 2005; Warwick et al., 2019), participants described support to be an important aspect of managing mood symptoms. The present findings emphasise the need to '*feel* supported'. What it meant to be supported, as well as the mechanisms through which support may be accessed, varied between participants. Murray et al. (2011) reported that volunteering was a way for participants to 'connect with others'; 'part of something bigger' emphasises how such activities can contribute to a sense of purpose. However, such purpose may also be facilitated by being part of a meaningful relationship, through a sense of duty towards a pet, or using one's own experiences to help others. 'Right tools for the job' highlights how particular strategies e.g. 'socialising' cannot be prescriptive; their usefulness is often mediated by a number of idiographic influences. This echoes Murray et al.'s (2011) reminder for practitioners to appreciate the personal meaning of strategies and how they may be applied in the lives of service users.

An absence of male identity or masculinity in participants' sense-making was noted. Whilst previous research found that men with Bipolar rated themselves as less masculine than the general population (Sajatovic et al., 2011) participants in the present study did not reflect upon this in the context of managing mood symptoms. It is therefore possible that, even if differences in perceived masculinity exist, such differences are not seen as an important aspect of managing.

Clinical Implications

‘Making room: accommodating disruption’ may be of interest to practitioners using psychological therapies to work with people diagnosed with Bipolar. The Integrative Cognitive Model (ICM) proposes that relinquishing control of moods, and focusing on independent goals, may be of benefit to some people diagnosed with Bipolar. The model posits that symptom management is disrupted by extreme personal significance being applied to typical fluctuations in mood (Mansell, Morrison, Reid, Lowens, & Tai, 2007). However, for some men in the present study, such cognitive distortions were not part of their sense-making. Rather than simply a tolerance for typical fluctuations in mood, they described a tolerance for encountering triggers and experiencing mood symptoms. Closer parallels can be drawn between their accounts and the principles of Acceptance and Commitment Therapy (ACT) wherein people are invited to embrace even unpleasant experiences with openness (Hayes, 2019). ACT’s focus on behaviour guided by values, rather than driven by goals (Hayes, Levin, Plumb-Vilardaga, Villatte, & Pistorello, 2013), may also help to circumvent difficulties associated with feelings of failure during depressive episodes. As such, at face value, ACT may be a helpful therapeutic approach for some men diagnosed with Bipolar.

‘Managing goes beyond a list of strategies’ and ‘we’re managing more than just mood episodes’ highlight how more holistic and systemic approaches may be of considerable value to those diagnosed. Approaches aimed at improving life beyond mood episodes may be of particular importance, especially as research indicates that sub-syndromal symptoms of depression significantly increase the chance of a major episode (e.g. Tohen et al., 2006). ‘Part of something bigger’ represents an invitation for practitioners to consider ways in which service users may be able to engage in valued and meaningful activities. It is important not to restrict ideas as to how to achieve this, however one option may be using their lived experiences to support the development of services, including delivering courses with local Recovery Colleges (McGregor, Repper, & Brown, 2011). Practitioners should avoid attempts to ‘prescribe’ strategies such as exercise or socialising without exploring the personal significance and meaning of these activities with service users, as well as the barriers to them.

‘Medication is a necessary evil’ illuminates a potential role for clinical psychology to work alongside medical colleagues as a routine part of medication prescription and review. Psychological formulations can facilitate both sense-making and decision-making for service users and professionals (Division of Clinical Psychology [DCP], 2010). Given that the diagnosis itself can be important for making sense of mood management, clinical psychologists may therefore play an important role in engaging with, and enhancing, the biomedical model by promoting understanding of the psychosocial factors contributing to the development and maintenance of Bipolar symptoms. Such understanding may include exploring service users’ concerns about medication and side effects. Formulations should also facilitate more collaborative working with service users; promoting greater transparency in the development of treatment plans, as well as greater parity between clinicians and service users. This may go some way to meeting the need for service users to ‘feel supported’. These suggestions are consistent with clinical psychology’s increasing move towards formulation within multidisciplinary team working (DCP, 2011) and recent findings encouraging a combination of medicalised and non-medicalised approaches in Bipolar (Michalak et al., 2016).

Considerations for Future Research

A key limitation of this study was that men were only interviewed at one point in time, providing a cross section of their meaning-making. Indeed, men reflected on their experiences whilst not experiencing a mood episode. Given the chronic nature of Bipolar (Goodwin & Jamison, 2007), future research may benefit from exploring the ongoing meaning of management, including the ways in which the concept may be reconstructed over time.

Whilst the study did not set out to exclusively recruit those who are ‘higher functioning’, the sample consisted of men who were all in relationships, many had completed higher education qualifications, and half of them were in full-time employment. As such, these findings may better represent the experiences of those considered to be ‘higher functioning’.

Despite concerns about the richness and depth of qualitative data gathered via telephone, research evidence does not indicate it to be an inferior method of data collection (e.g. see Novick, 2008). Nevertheless, it is acknowledged that access to non-verbal information was not available during the telephone interviews. Future research should therefore consider the option to conduct remote interviews via videoconferencing.

Though the current findings indicate ACT may be a helpful therapeutic approach for some, current evidence for the efficacy of ACT for Bipolar is limited to one uncontrolled pilot study (Pankowski, Adler, Andersson, Lindefors, & Svanborg, 2017). Furthermore, in the absence of undergoing an ACT intervention themselves, it is possible that the men in the present study are naturally inclined towards its principles, thus finding such approaches beneficial in a way that being introduced to them through therapy may not. Further research to explore the acceptability, feasibility, and efficacy of ACT for Bipolar may be particularly valuable, including the development of practice-based evidence by practitioners.

Conclusion

This qualitative study used photo-elicitation methods, and IPA, to explore how men diagnosed with Bipolar make sense of managing mood symptoms. A community sample of six men took photographs reflecting important aspects of their experiences, including what is helpful and unhelpful when managing mood symptoms. A semi-structured interview about the meaning of these photos then took place. A novel finding was that for some men, managing mood symptoms is supported by making room for life to be disrupted by triggers and mood episodes. Consistent with the literature, participants described ways that life with Bipolar means managing more than discrete episodes of mood disturbance. The importance of feeling supported was emphasised by participants, and some described being part of something beyond themselves as providing a sense of purpose. Medication was seen as a key component to mood management for many, though side effects disrupting important aspects of their lives were described as very challenging. A novel finding for the qualitative literature base was that barriers to medication extend beyond side effects. Notions of masculinity or male identity were absent from participants' sense-making. Whilst this does not negate that these may be important aspects of living with Bipolar more broadly, these findings suggest that for these men it was not a meaningful component of their experience of managing symptoms.

References

Altman, E. G., Hedeker, D., Peterson, J. L., & Davis, J. M. (1997). The Altman Self-Rating Mania Scale. *Biological psychiatry*, *42*(10), 948-955. https://doi.org/10.1016/S0006-3223(96)00548-3

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.

Arnold, L. M. (2003). Gender differences in bipolar disorder. *The Psychiatric Clinics of North America*, *26*(3), 595-620. https://doi.org/10.1016/s0193-953x(03)00036-4

Bambole, V., Johnston, M., Shah, N., Sushma, S., Desouza, A., & Shrivastava, A. (2013). Symptom overlap between schizophrenia and bipolar mood disorder: Diagnostic issues. *Open Journal of Psychiatry, 3*, 8-15. http://dx.doi.org/10.4236/ojpsych.2013.34A002

Barber, S., & Thornicroft, G. (2018). Reducing the mortality gap in people with severe mental disorders: the role of lifestyle psychosocial interventions. *Frontiers in Psychiatry, 9.* https://doi.org/10.3389/fpsyt.2018.00463

Burton, A., Hughes, M., & Dempsey, R. C. (2017). Quality of life research: A case for combining photo-elicitation with interpretative phenomenological analysis. *Qualitative Research in Psychology*, *14*(4), 375-393. https://doi.org/10.1080/14780887.2017.1322650

Cappleman, R., Smith, I., & Lobban, F. (2015). Managing bipolar moods without medication: A qualitative investigation. *Journal of Affective Disorders, 174*, 241-249. http://dx.doi.org/10.1016/j.jad.2014.11.055

Chatterton, M. L., Stockings, E., Berk, M., Barendregt, J. J., Carter, R., & Mihalopoulos, C. (2017). Psychosocial therapies for the adjunctive treatment of bipolar disorder in adults: Network meta-analysis. *British Journal of Psychiatry, 210*(5), 333-341. https://doi.org/10.1192/bjp.bp.116.195321

Corrigan, P., & Matthews, A. (2003). Stigma and disclosure: Implications for coming out of the closet. *Journal of Mental Health*, *12*(3), 235-248. https://doi.org/10.1080/0963823031000118221

Cook, J. (2004). Mental illness self-management through wellness recovery action planning. *Mental Health Recovery Newsletter*, *5*(3), 6–7.

Coulston, C. M., Tanious, M., Mulder, R. T., Porter, R. J., & Malhi, G. (2012). Bordering on bipolar: The overlap between borderline personality disorder and bipolarity. *Australian & New Zealand Journal of Psychiatry, 46*(6), 506-521. https://doi.org/10.1177%2F0004867412445528

Diflorio, A., & Jones, I. (2010). Is sex important? Gender differences in bipolar disorder. *International Review of Psychiatry, 22*(5), 437-452. https://doi.org/10.3109/09540261.2010.514601

Division of Clinical Psychology (2010). *The core purpose and philosophy of the profession*. Leicester, UK: British Psychological Society.

Division of Clinical Psychology (2011). *Good practice guidelines on the use of psychological formulation*. Leicester, UK: British Psychological Society.

Dolman, C., Jones, I. R., & Howard, L. M. (2016). Women with bipolar disorder and pregnancy: Factors influencing their decision-making. *BJPsych Open*, *2*(5), 294-300. https://doi.org/10.1192/bjpo.bp.116.003079

Fernandez, M. E., Breen, L. J., & Simpson, T. A. (2014). Renegotiating identities: experiences of loss and recovery for women with bipolar disorder. *Qualitative Health Research, 24*(7), 890‐900. https://doi.org/10.1177/1049732314538550

Fletcher, A. J. (2017). Applying critical realism in qualitative research: Methodology meets method. *International journal of social research methodology*, *20*(2), 181-194. https://doi.org/10.1080/13645579.2016.1144401

Fletcher, K., Parker, G., & Manicavasagar, V. (2013). A qualitative investigation of hypomania and depression in bipolar II disorder. *Psychiatric Quarterly, 84*(4), 455-474. https://doi.org/10.1007/s11126-013-9259-1

Geddes, J. R., & Miklowitz, D. J. (2013). Treatment of bipolar disorder. *The Lancet*, *381*(9878), 1672-1682. https://dx.doi.org/10.1016%2FS0140-6736(13)60857-0

Gitlin, M. J., & Miklowitz, D. J. (2017). The difficult lives of individuals with bipolar disorder: A review of functional outcomes and their implications for treatment. *Journal of Affective Disorders*, *209*, 147-154. https://doi.org/10.1016/j.jad.2016.11.021

Goodwin, F. K., & Jamison, K. R. (2007) *Manic-depressive illness: Bipolar disorders and recurrent depression* (2nd ed.). New York, NY: Oxford University Press.

Hayes, S. C. (2019). *A liberated mind: How to pivot toward what matters*. New York, NY: Avery.

Hayes, S. C., Levin, M. E., Plumb-Vilardaga, J., Villatte, J. L., & Pistorello, J. (2013). Acceptance and commitment therapy and contextual behavioral science: Examining the progress of a distinctive model of behavioral and cognitive therapy. *Behavior Therapy*, *44*(2), 180-198. https://doi.org/10.1016/j.beth.2009.08.002

Hirschfeld, R. M., Williams, J. B., Spitzer, R. L., Calabrese, J. R., Flynn, L., Keck Jr., P. E., ...Zajecka, M. D. (2000). Development and validation of a screening instrument for bipolar spectrum disorder: The Mood Disorder Questionnaire. *American Journal of Psychiatry*, *157*(11), 1873-1875. https://doi.org/10.1176/appi.ajp.157.11.1873

Janney, C. A., Bauer, M. S., & Kilbourne, A. M. (2014). Self-management and bipolar disorder – a clinician's guide to the literature 2011-2014. *Current Psychiatry Reports, 16*, 485. https://doi.org/10.1007/s11920-014-0485-5

Jawad, I., Watson S., Haddad, P. M., Talbot, P. S., & McAllister-Williams, R. H. (2018). Medication nonadherence in bipolar disorder: a narrative review. *Therapeutic Advances in Psychopharmacology, 8* (12)*,* 349-363. https://dx.doi.org/10.1177%2F2045125318804364

Jones, S. H., Akers, N., Eaton, J., Tyler, E., Gatherer, A., Brabban, A., …Lobban, F. (2018). Improving access to psychological therapies (IAPT) for people with bipolar disorder: Summary of outcomes from the IAPT demonstration site. *Behaviour Research and Therapy, 111*, 27-35. https://doi.org/10.1016/j.brat.2018.09.006

Jones, S. H., Deville, M., Mayes, D., & Lobban, F. (2011). Self-management in bipolar disorder: The story so far. *Journal of Mental Health, 20*(6), 583-592. https://doi.org/10.3109/09638237.2011.600786

Judd, L. L., Aliskal, H. S., Schettler, P. J., Endicott, J., Maser, J., Solomon, D. A., …Keller, M. B. (2002). The long-term natural history of the weekly symptomatic status of bipolar I disorder. *Archives of General Psychiatry, 59*(6), 530- 537. https://doi.org/10.1001/archpsyc.59.6.530

Judd, L. L., Akiskal, H. S., Schettler, P. J., Coryell, W., Endicott, J., Maser, M. D., …Keller, M. B. (2003). A prospective investigation of the natural history of the long-term weekly symptomatic status of bipolar II disorder. *Archives of General Psychiatry, 60*(30), 261-269. https://doi.org/10.1001/archpsyc.60.3.261

Kriegshauser, K., Sajatovic, M., Jenkins, J. H., Cassidy, K. A., Muzina, D., Fattal, O., ...Singer, B. (2010). Gender differences in subjective experience and treatment of bipolar disorder. *The Journal of Nervous and Mental Disease*, *198*(5), 370-372. https://dx.doi.org/10.1097%2FNMD.0b013e3181da8ef7

Lam, D. H., Jones, S. H., & Hayward, P (2010). *Cognitive therapy for bipolar disorder: A therapist's guide to concepts, methods and practice.* Chichester, UK: John Wiley and Sons Ltd.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in*

Psychology, *3*(2), 102-120. https://doi.org/10.1191/1478088706qp062oa

Lobban, F., Taylor, K., Murray, C., & Jones, S. (2012). Bipolar disorder is a two-edged sword: A qualitative study to understand the positive edge. *Journal of Affective Disorders, 141*(2-3), 204-212. https://doi.org/10.1016/j.jad.2012.03.001

Mansell, W., Morrison, A. P., Reid, G., Lowens, I., & Tai, S. (2007). The interpretation of, and responses to, changes in internal states: an integrative cognitive model of mood swings and bipolar disorders. *Behavioural and Cognitive psychotherapy*, *35*(5), 515-539. https://doi.org/10.1017/S1352465807003827

Mansell, W., Powell, S., Pedley, R., Thomas, N., & Jones, S. A. (2010). The process of recovery from bipolar I disorder: A qualitative analysis of personal accounts in relation to an integrative cognitive model. *British Journal of Clinical Psychology, 49*(2), 193-215. https://doi.org/10.1348/014466509X451447

McGregor, J., Repper, J., & Brown, H. (2014). “The college is so different from anything I have done”. A study of the characteristics of Nottingham Recovery College. *The Journal of Mental Health Training, Education and Practice, 9*(1), 3-15. https://doi.org/10.1108/JMHTEP-04-2013-0017

Michalak, E. E., Suto, M. J., Barnes, S. J., Hou, S., Lapsley, S., Scott, M. W., …CREST.BD. (2016). Effective self-management strategies for bipolar disorder: A community-engaged Delhi Consensus Consultation Study. *Journal of Affective Disorders, 206*, 77-86. https://doi.org/10.1016/j.jad.2016.06.057

Michalak, E. E., Yatham, L. N., & Lam, R. W. (2005). Quality of life in bipolar disorder: A review of the literature. *Health and Quality of Life Outcomes, 3*(1), 72. https://doi.org/10.1186/1477-7525-3-72

Miziou, S., Tsitsipa, E., Moysidou, S., Karavelas, V., Dimelis, D., Polyzoidou, V., & Fountoulakis, K. N. (2015). Psychosocial treatment and interventions for bipolar disorder: A systematic review. *Annals of General Psychiatry, 14*(1), 19. https://doi.org/10.1186/s12991-015-0057-z

Mortensen, G. L., Vinberg, M., Mortensen, S. L., Jorgensen, B. M., & Eberhard, J. (2015). Bipolar patients’ quality of life in mixed states: A preliminary qualitative study. *Psychopathology, 48*(3), 192‑201. https://doi.org/10.1159/000381479

Morton, E., Michalak, E. E., Hole, R., Buzwell, S., & Murrary, S. (2018) ‘Taking back the reigns’ – A qualitative study of the meaning and experience of self-management in bipolar disorder. *Journal of Affective Disorders, 228,* 160-165*.* https://doi.org/10.1016/j.jad.2017.12.018

Murray, G., Suto, M., Hole, R., Hale, S., Amari, E., & Michalak, E. E. (2011). Self-management strategies used by ‘high functioning’ individuals with bipolar disorder: From research to clinical practice. *Clinical Psychology & Psychotherapy*, *18*(2), 95-109. https://doi.org/10.1002/cpp.710

National Institute for Health and Care Excellence. (2014). *Bipolar disorder: Assessment and management.* (NICE Clinical Guideline No.185). Retrieved from: https://www.nice.org.uk/guidance/cg185/chapter/Key-priorities-for-implementation

Nivoli, A. M., Pacchiarotti, I., Rosa, A. R., Popovic, D., Murru, A., Valenti, M., ...Colom, F. (2011). Gender differences in a cohort study of 604 bipolar patients: the role of predominant polarity. *Journal of Affective Disorders*, *133*(3), 443-449. https://doi.org/10.1016/j.jad.2011.04.055

Novick, G. (2008). Is there a bias against telephone interviews in qualitative research? *Research in Nursing & Health, 31*(4), 391-398. https://doi.org/10.1002/nur.20259

Oliffe, J. L., & Bottorff, J. L. (2007). Further than the eye can see? Photo elicitation and research with men. *Qualitative Health Research*, *17*(6), 850-858. https://doi.org/10.1177%2F1049732306298756

Oliffe, J. L., Broom, A., Popa, M., Jenkins, E. K., Rice, S. M., Ferlatte, O., & Rossnagel, E. (2019). Unpacking social isolation in men's suicidality. *Qualitative Health Research*, *29*(3), 315-327. https://doi.org/10.1177%2F1049732318800003

Oud M., Mayo-Wilson, E., Braidwood, R., Schulte, P., Jones, S. H., Morriss, R., …Kendall, T. (2016). Psychological interventions for adults with bipolar disorder: Systematic review and meta-analysis. *British Journal of Psychiatry, 208*(3), 213-222. https://doi.org/10.1192/bjp.bp.114.157123

Pankowski, S., Adler, M., Andersson, G., Lindefors, N., & Svanborg, C. (2017). Group acceptance and commitment therapy (ACT) for bipolar disorder and co-existing anxiety–an open pilot study. *Cognitive Behaviour Therapy*, *46*(2), 114-128. https://doi.org/10.1080/16506073.2016.1231218

Perich, T., Ussher, J., & Parton, C. (2017). "Is it menopause or bipolar?": a qualitative study of the experience of menopause for women with bipolar disorder. *BMC women's health*, *17*(1), 110. https://doi.org/10.1186/s12905-017-0467-y

Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied psychological measurement*, *1*(3), 385-401.

Russell, L., & Moss, D. (2013a). A meta-study of qualitative research into the experience of 'symptoms' and 'having a diagnosis' for people who have been given a diagnosis of bipolar disorder. *Europe's Journal of Psychology, 9*(2), 385-405. https://doi.org/10.5964/ejop.v9i2.560

Russell, L., & Moss, D. (2013b). High and happy? Exploring the experience of positive states of mind in people who have been given a diagnosis of bipolar disorder. *Psychology and Psychotherapy: Theory, Research and Practice, 86*(4), 431‐446. https://doi.org/10.1111/j.2044-8341.2012.02064.x

Russell, S. J., & Browne, J. L. (2005). Staying well with bipolar disorder. *Australian and New Zealand Journal of Psychiatry, 39*, 187-193. https://doi.org/10.1080%2Fj.1440-1614.2005.01542.x

Sajatovic, M., Micula-Gondek, W., Tatsuoka, C., & Bialko, C. (2011). The relationship of gender and gender identity to treatment adherence among individuals with bipolar disorder. *Gender medicine*, *8*(4), 261-268. https://doi.org/10.1016/j.genm.2011.06.002

Sandhu, A., Ives, J., Birchwood, M., & Upthegrove, R. (2013). The subjective experience and phenomenology of depression following first episode psychosis: a qualitative study using photo-elicitation. *Journal of Affective Disorders*, *149*(1-3), 166-174. https://doi.org/10.1016/j.jad.2013.01.018

Saunders, K. E., Bilderbeck, A. C., Panchal, P., Atkinson, L. Z., Geddes, J. R., & Goodwin, G. M. (2017). Experiences of remote mood and activity monitoring in bipolar disorder: A qualitative study. *European Psychiatry*, *41*, 115-121. https://dx.doi.org/10.1016%2Fj.eurpsy.2016.11.005

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London, UK: Sage Publications.

Tamminga, C., Ivleva, E. I., Keshavan, M. S., Pearlson, G. D., Clementz, B. A., Witte, B., …Sweeney, J. A. (2013). Clinical phenotypes of psychosis in the bipolar-schizophrenia network in intermediate phenotypes (B-SNIP). *American Journal of Psychiatry, 170*(11), 1263-1274. https://doi.org/10.1176/appi.ajp.2013.12101339

Timimi, S. (2014). No more psychiatric labels: Why formal psychiatric diagnostic systems should be abolished. *International Journal of Clinical and Health Psychology, 14*(3), 208-215. https://doi.org/10.1016/j.ijchp.2014.03.004

Todd, N. J., Jones, S. H., & Lobban, F. A. (2012). "Recovery" in bipolar disorder: How can service users be supported through a self-management intervention? A qualitative focus group study. *Journal of Mental Health, 21*(2), 114-126. https://doi.org/10.3109/09638237.2011.621471

Tohen, M., Bowden, C. L., Calabrese, J. R., Lin, D., Forrester, T. D., Sachs, G. S., ...Grunze, H. (2006). Influence of sub-syndromal symptoms after remission from manic or mixed episodes. *The British Journal of Psychiatry*, *189*(6), 515-519. https://doi.org/10.1192/bjp.bp.105.020321

Twiss, J., Jones, S., & Anderson, I. (2008). Validation of the Mood Disorder Questionnaire for screening for bipolar disorder in a UK sample. *Journal of Affective Disorders*, *110*(1-2), 180-184. https://doi.org/10.1016/j.jad.2007.12.235

Vargas-Huicochea, I., Huicochea, L., Berlanga, C., & Fresán, A. (2014). Taking or not taking medications: psychiatric treatment perceptions in patients diagnosed with bipolar disorder. *Journal of Clinical Pharmacy and Therapeutics*, *39*(6), 673-679. https://doi.org/10.1111/jcpt.12210

Venkataraman, M., & Ackerson, B. J. (2008). Parenting among mothers with bipolar disorder: strengths, challenges, and service needs. *Journal of Family Social Work*, *11*(4), 389-408. https://doi.org/10.1080/10522150802441825

Walsh, J., Corcoran, J., Crooks, P., Cooke, N., & Cummings, C. (2016). The lived experience of bipolar disorder: A systematic review and meta-synthesis. *Journal of Psychiatry and Mental Health. 1*(2), 1-7. http://dx.doi.org/10.16966/2474-7769.102

Warwick, H., Mansell, W., Porter, C., & Tai, S. (2019). ‘What people diagnosed with bipolar disorder experience as distressing’: A meta-synthesis of quality research. *Journal of Affective Disorders, 248,* 108-130. https://doi.org/10.1016/j.jad.2019.01.024

Warwick, H., Tai, S., Mansell, W. (2019). Living the life you want following a diagnosis of bipolar disorder: A grounded theory approach. *Clinical Psychology & Psychotherapy, 26*(3), 362-377.

Willig, C. (2008). *Introducing qualitative research in psychology* (2nd ed.). Maidenhead, UK: Open University Press.

Appendix A: Author Guidelines for Clinical Psychology & Psychotherapy

1. SUBMISSION

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Clinical Psychology & Psychotherapy aims to keep clinical psychologists and psychotherapists up to date with new developments in their fields. The Journal will provide an integrative impetus both between theory and practice and between different orientations within clinical psychology and psychotherapy. *Clinical Psychology & Psychotherapy* will be a forum in which practioners can present their wealth of expertise and innovations in order to make these available to a wider audience. Equally, the Journal will contain reports from researchers who want to address a larger clinical audience with clinically relevant issues and clinically valid research. The journal is primarily focused on clinical studies of clinical populations and therefore no longer normally accepts student-based studies.

This is a journal for those who want to inform and be informed about the challenging field of clinical psychology and psychotherapy.

Submissions which fall outside of Aims and Scope, are not clinically relevant and/or are based on studies of student populations will not be considered for publication and will be returned to the author.

2. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Research articles: Substantial articles making a significant theoretical or empirical contribution (submissions should be limited to a maximum of 5,500 words excluding captions and references).

Reviews: Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies (review submissions have no word limit).

Assessments: Articles reporting useful information and data about new or existing measures (assessment submissions should be limited to a maximum of 4,500 words excluding captions and references).

Practitioner Reports: Shorter articles (a maximum of 2,000 words excluding captions and references) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e. be innovative).

3. PREPARING THE SUBMISSION

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The manuscript should be submitted in separate files: title page; main text file; figures.

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Preferred formats for the text and tables of your manuscript are .doc, .docx, .rtf, .ppt, .xls. LaTeX files may be submitted provided that an .eps or .pdf file is provided in addition to the source files. Figures may be provided in .tiff or .eps format.

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Please refer to the journal’s **Authorship** policy in the Editorial Policies and Ethical Considerations section below for details on author listing eligibility.

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Conflict of Interest Statement

Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the **Conflict of Interest** section in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

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References

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in-text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

For more information about APA referencing style, please refer to the **APA FAQ**.

Reference examples follow:

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry, 159,* 483–486.
doi: **10.1176/appi.ajp.159.3.483**

Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from *http://www.youtube.com/watch?v=Vja83KLQXZs*

Endnotes

Endnotes should be placed as a list at the end of the paper only, not at the foot of each page. They should be numbered in the list and referred to in the text with consecutive, superscript Arabic numerals. Keep endnotes brief; they should contain only short comments tangential to the main argument of the paper.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted. Click **here** for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Figures submitted in color may be reproduced in color online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. The cost of printing color illustrations in the journal will be charged to the author. The cost is £150 for the first figure and £50 for each figure thereafter. If color illustrations are supplied electronically in either TIFF or EPS format, they may be used in the PDF of the article at no cost to the author, even if this illustration was printed in black and white in the journal. The PDF will appear on the Wiley Online Library site.

Additional Files

Appendices

Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

General Style Points

The following points provide general advice on formatting and style.

- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.

- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.

- **Numbers:** numbers under 10 are spelled out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
- **Trade Names:** Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.

Wiley Author Resources

Manuscript Preparation Tips: Wiley has a range of resources for authors preparing manuscripts for submission available **here**. In particular, authors may benefit from referring to Wiley's best practice tips on **Writing for Search Engine Optimization**.

Editing, Translation, and Formatting Support: **Wiley Editing Services** can greatly improve the chances of a manuscript being accepted. Offering expert help in English language editing, translation, manuscript formatting, and figure preparation, Wiley Editing Services ensures that the manuscript is ready for submission.

Video Abstracts A video abstract can be a quick way to make the message of your research accessible to a much larger audience. Wiley and its partner Research Square offer a service of professionally produced video abstracts, available to authors of articles accepted in this journal. You can learn more about it by **clicking here**. If you have any questions, please direct them to **videoabstracts@wiley.com**.

4. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Peer Review and Acceptance

The acceptance criteria for all papers are the quality and originality of the research and its significance to journal readership. Except where otherwise stated, manuscripts are single-blind peer reviewed. Papers will only be sent to review if the Editor-in-Chief determines that the paper meets the appropriate quality and relevance requirements.

Wiley's policy on the confidentiality of the review process is available **here**.

Data Sharing and Data Accessibility

The journal encourages authors to share the data and other artefacts supporting the results in the paper by archiving it in an appropriate public repository. Authors should include a data accessibility statement, including a link to the repository they have used, in order that this statement can be published alongside their paper.

Human Studies and Subjects

For manuscripts reporting clinical studies that involve human participants, a statement identifying the ethics committee that approved the study and confirmation that the study conforms to recognized standards is required, for example: **Declaration of Helsinki**; **US Federal Policy for the Protection of Human Subjects**; or **European Medicines Agency Guidelines for Good Clinical Practice**. It should also state clearly in the text that all persons gave their informed consent prior to their inclusion in the study.

Patient anonymity should be preserved. Photographs need to be cropped sufficiently to prevent human subjects being recognized (or an eye bar should be used). Images and information from individual participants will only be published where the authors have obtained the individual's free prior informed consent. Authors do not need to provide a copy of the consent form to the publisher; however, in signing the author license to publish, authors are required to confirm that consent has been obtained. Wiley has a **standard patient consent form** available for use.

Clinical Trial Registration

The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results. Authors are asked to include the name of the trial register and the clinical trial registration number at the end of the abstract. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. **If the authors have no conflict of interest to declare, they must also state this at submission**. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

Funding

Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: **https://www.crossref.org/services/funder-registry/**

Authorship

The list of authors should accurately illustrate who contributed to the work and how. All those listed as authors should qualify for authorship according to the following criteria:

- Have made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data;
- Been involved in drafting the manuscript or revising it critically for important intellectual content;
- Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; and

- Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in the Acknowledgements statement on the title page (e.g., to recognize contributions from people who provided technical help, collation of data, writing assistance, acquisition of funding, or a department chairperson who provided general support). Prior to submitting the article all authors should agree on the order in which their names will be listed in the manuscript.

Additional Authorship Options. Joint first or senior authorship: In the case of joint first authorship, a footnote should be added to the author listing, e.g. ‘X and Y should be considered joint first author’ or ‘X and Y should be considered joint senior author.’

Publication Ethics

This journal is a member of the **Committee on Publication Ethics (COPE)**. Note this journal uses iThenticate’s CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. Read Wiley’s **Top 10 Publishing Ethics Tips for Authors** and Wiley’s **Publication Ethics Guidelines**.

ORCiD

As part of the journal’s commitment to supporting authors at every step of the publishing process, the journal requires the submitting author (only) to provide an ORCiD identifier when submitting a manuscript. This takes around 2 minutes to complete. **Find more information here**.

5. AUTHOR LICENSING

If a paper is accepted for publication, the author identified as the formal corresponding author will receive an email prompting them to log in to Author Services, where via the Wiley Author Licensing Service (WALS) they will be required to complete a copyright license agreement on behalf of all authors of the paper.

Authors may choose to publish under the terms of the journal's standard copyright agreement, or **OnlineOpen** under the terms of a Creative Commons License.

General information regarding licensing and copyright is available **here**. To review the Creative Commons License options offered under OnlineOpen, please click **here**. (Note that certain funders mandate a particular type of CC license be used; to check this please click **here**.)

Self-Archiving Definitions and Policies: Note that the journal's standard copyright agreement allows for self-archiving of different versions of the article under specific conditions. Please click **here** for more detailed information about self-archiving definitions and policies.

Open Access fees: Authors who choose to publish using OnlineOpen will be charged a fee. A list of Article Publication Charges for Wiley journals is available **here**.

Funder Open Access: Please click **here** for more information on Wiley's compliance with specific Funder Open Access Policies.

6. PUBLICATION PROCESS AFTER ACCEPTANCE

Accepted Article Received in Production

When an accepted article is received by Wiley's production team, the corresponding author will receive an email asking them to login or register with **Wiley Author Services**. The author will be asked to sign a publication license at this point.

Guidelines for Cover Submission

One of the best ways to showcase your work is with an eye-catching journal issue cover. After your article is accepted for publication, you can submit your idea for a cover image. If you would like to send a suggestion for cover artwork related to your article, **please follow these general guidelines.**

Proofs

Once the paper is typeset, the author will receive an email notification with full instructions on how to provide proof corrections.

Please note that the author is responsible for all statements made in their work, including changes made during the editorial process – authors should check proofs carefully. Note that proofs should be returned within 48 hours from receipt of first proof.

Publication Charges

Colour figures. Colour figures may be published online free of charge; however, the journal charges for publishing figures in colour in print. If the author supplies colour figures at Early View publication, they will be invited to complete a colour charge agreement in RightsLink for Author services. The author will have the option of paying immediately with a credit or debit card, or they can request an invoice. If the author chooses not to purchase color printing, the figures will be converted to black and white for the print issue of the journal.

Early View

The journal offers rapid publication via Wiley's Early View service. **Early View** (Online Version of Record) articles are published on Wiley Online Library before inclusion in an issue. Note there may be a delay after corrections are received before the article appears online, as Editors also need to review proofs. Once the article is published on Early View, no further changes to the article are possible. The Early View article is fully citable and carries an online publication date and DOI for citations.

7. POST PUBLICATION

Access and Sharing

When the article is published online:

- The author receives an email alert (if requested).
- The link to the published article can be shared for free with your contacts or through social media.
- The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).

- The corresponding author and co-authors can nominate up to ten colleagues to receive a publication alert and free online access to the article.

Promoting the Article

To find out how to best promote an article, click **here**.

Measuring the Impact of an Article

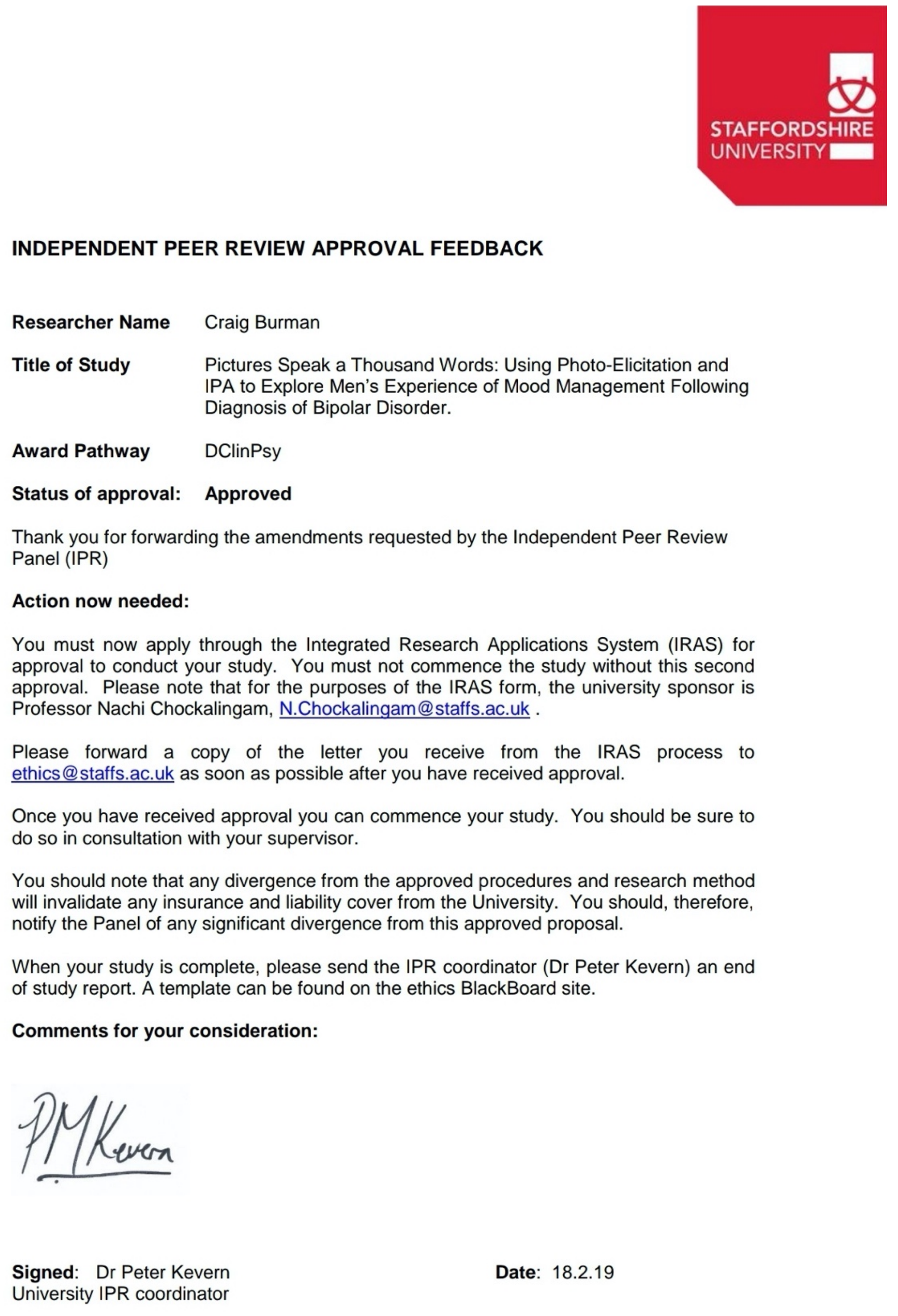
Wiley also helps authors measure the impact of their research through specialist partnerships with **Kudos** and **Altmetric**.

8. EDITORIAL OFFICE CONTACT DETAILS

Email: **CPPedoffice@wiley.com**

Author Guidelines updated 18th April 2018

Appendix B: Staffordshire University Independent Peer Review Approval Letter



STAFFORDSHIRE
UNIVERSITY

INDEPENDENT PEER REVIEW APPROVAL FEEDBACK

Researcher Name Craig Burman

Title of Study Pictures Speak a Thousand Words: Using Photo-Elicitation and IPA to Explore Men's Experience of Mood Management Following Diagnosis of Bipolar Disorder.

Award Pathway DClinPsy

Status of approval: **Approved**

Thank you for forwarding the amendments requested by the Independent Peer Review Panel (IPR)

Action now needed:

You must now apply through the Integrated Research Applications System (IRAS) for approval to conduct your study. You must not commence the study without this second approval. Please note that for the purposes of the IRAS form, the university sponsor is Professor Nachi Chockalingam, N.Chockalingam@staffs.ac.uk .

Please forward a copy of the letter you receive from the IRAS process to ethics@staffs.ac.uk as soon as possible after you have received approval.

Once you have received approval you can commence your study. You should be sure to do so in consultation with your supervisor.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

When your study is complete, please send the IPR coordinator (Dr Peter Kevern) an end of study report. A template can be found on the ethics BlackBoard site.

Comments for your consideration:

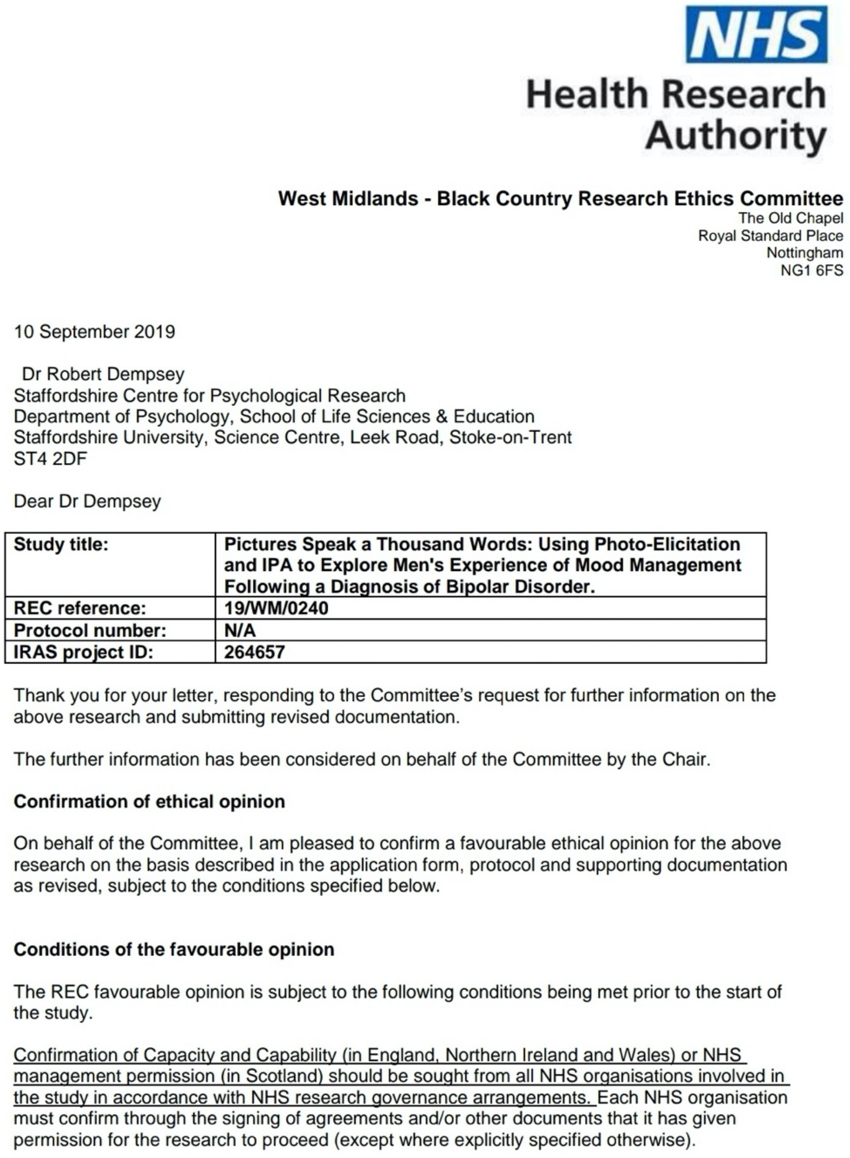
PMKevern

Signed: Dr Peter Kevern
University IPR coordinator

Date: 18.2.19

Appendix C: Research Ethics Committee

Favourable Opinion Letter



NHS
Health Research
Authority

West Midlands - Black Country Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

10 September 2019

Dr Robert Dempsey
Staffordshire Centre for Psychological Research
Department of Psychology, School of Life Sciences & Education
Staffordshire University, Science Centre, Leek Road, Stoke-on-Trent
ST4 2DF

Dear Dr Dempsey

Study title:	**Pictures Speak a Thousand Words: Using Photo-Elicitation and IPA to Explore Men's Experience of Mood Management Following a Diagnosis of Bipolar Disorder.**
REC reference:	**19/WM/0240**
Protocol number:	**N/A**
IRAS project ID:	**264657**

Thank you for your letter, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

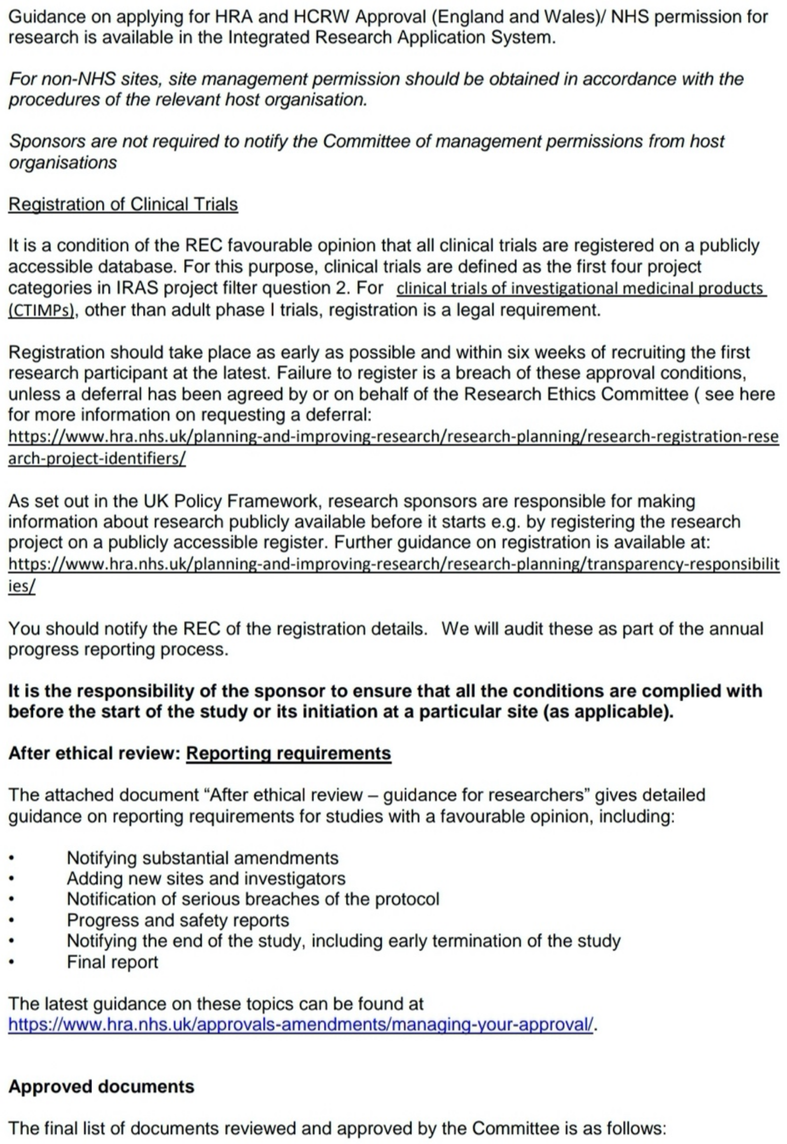
Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).



Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

It is a condition of the REC favourable opinion that all clinical trials are registered on a publicly accessible database. For this purpose, clinical trials are defined as the first four project categories in IRAS project filter question 2. For clinical trials of investigational medicinal products (CTIMPs), other than adult phase I trials, registration is a legal requirement.

Registration should take place as early as possible and within six weeks of recruiting the first research participant at the latest. Failure to register is a breach of these approval conditions, unless a deferral has been agreed by or on behalf of the Research Ethics Committee (see here for more information on requesting a deferral: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/research-registration-research-project-identifiers/

As set out in the UK Policy Framework, research sponsors are responsible for making information about research publicly available before it starts e.g. by registering the research project on a publicly accessible register. Further guidance on registration is available at: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/transparency-responsibilities/

You should notify the REC of the registration details. We will audit these as part of the annual progress reporting process.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

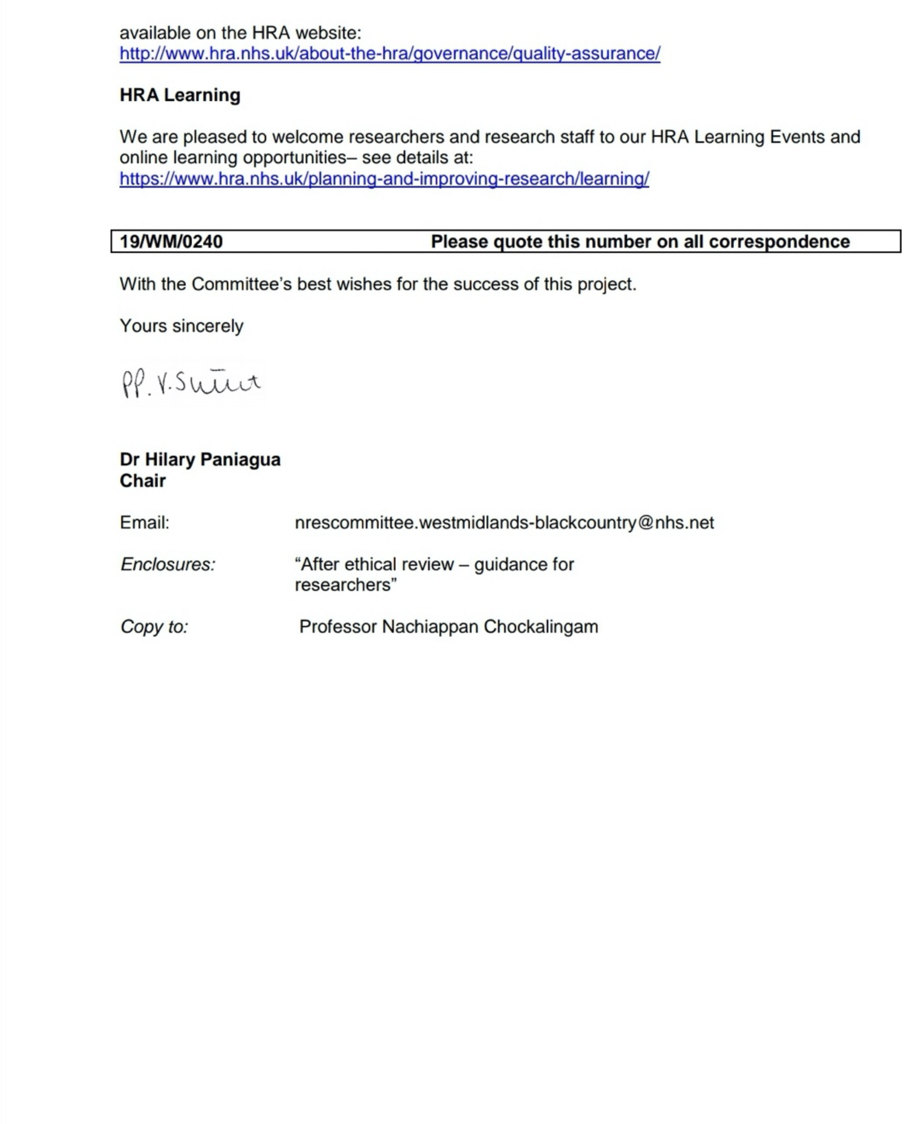
Document	*Version*	*Date*
Copies of advertisement materials for research participants	1	06 May 2019
Copies of advertisement materials for research participants [Research Advert]	1	06 May 2019
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Staffordshire University - Evidence of Sponsor Insurance/Indemnity]	1	16 July 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Staffordshire University - Evidence of Sponsor Insurance/Indemnity]	2	01 August 2019
Interview schedules or topic guides for participants [Interview Questions]	1	06 May 2019
Interview schedules or topic guides for participants [Screening Questions]	1	06 May 2019
Interview schedules or topic guides for participants [Semi-Structured Interview Questions (Re: Photographs)]	1	06 May 2019
Interview schedules or topic guides for participants [Screening Questions (During Initial Contact) Clinical/Sociodemographic Questions (During Semi-Structured Interview)]	2	20 August 2019
IRAS Application Form [IRAS_Form_04072019]		04 July 2019
Letter from sponsor [Independent Peer Review (IPR) Approval Letter]	1	18 February 2019
Other [REC- Further Information Table (Following Provisional Opinion)]	1	02 September 2019
Other [Consent Form (Version 2) Track Change Copy]	2	20 August 2019
Other [PIS - Version 2 - Track Changes Copy]	2	20 August 2019
Other [Screening Qs and Participant Characteristics - Version 2 - Track Changes Copy]	2	20 August 2019
Participant consent form [Consent Form]	2	20 August 2019
Participant information sheet (PIS) [PIS]	2	20 August 2019
Referee's report or other scientific critique report [Indendent Peer Review (IPR) Feedback Form - Approved]	1	05 June 2019
Research protocol or project proposal [Independent Peer Review (IPR) Proposal Form]	1	18 February 2019
Summary CV for Chief Investigator (CI) [Summary CV for CI (Rob Dempsey)]		09 May 2019
Summary CV for student [Principal Investigator Summary CV]	1	10 June 2019
Summary CV for supervisor (student research) [Summary CV for Supervisor (Helena Priest)]	1	05 June 2019
Validated questionnaire [Altman Self-Rating Mania Scale]		
Validated questionnaire [Center for Epidemiological Studies Depression Scale]		
Validated questionnaire [Mood Disorder Questionnaire]		

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form



available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at:
https://www.hra.nhs.uk/planning-and-improving-research/learning/

19/WM/0240 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

PP. V.S

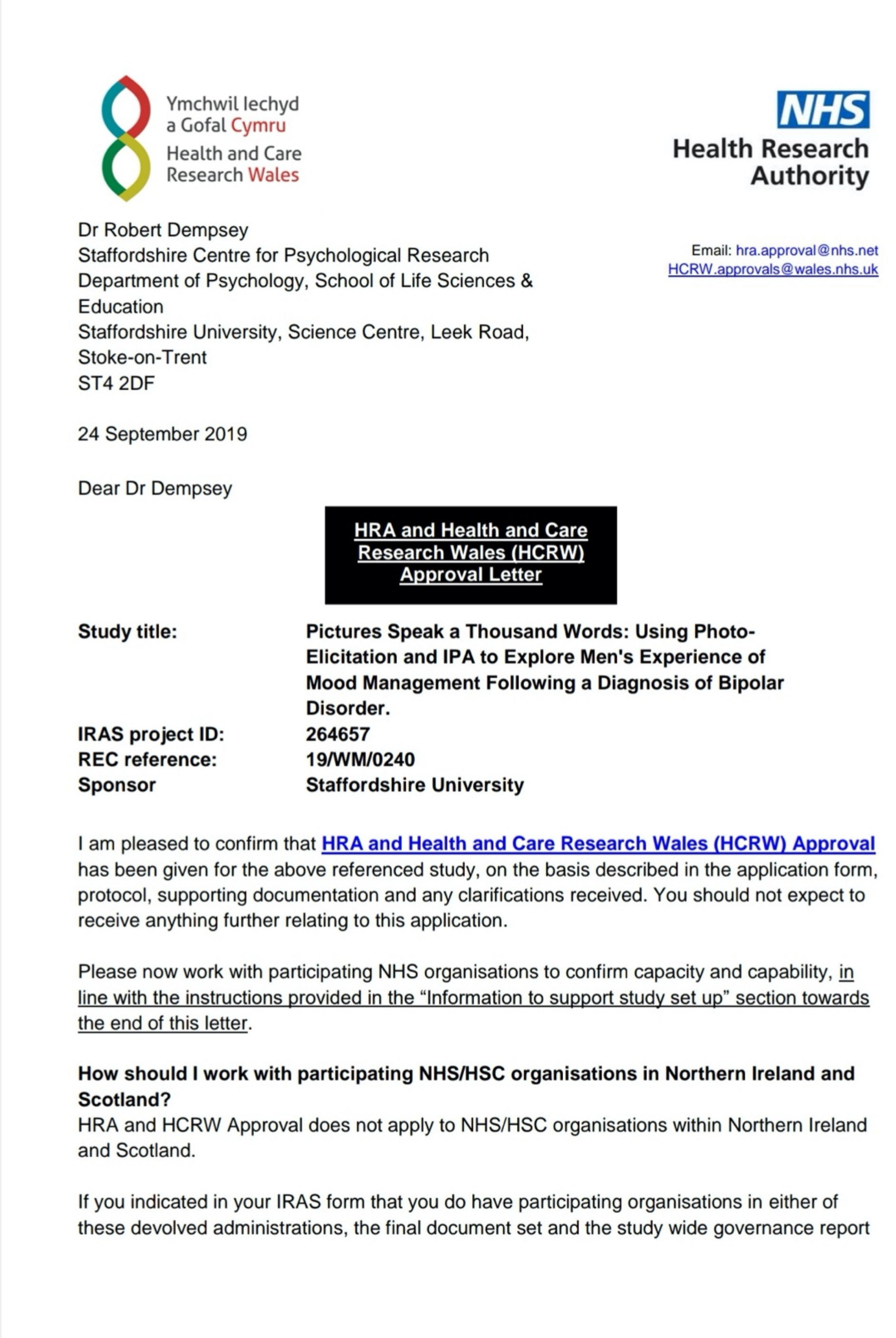
Dr Hilary Paniagua
Chair

Email: nrescommittee.westmidlands-blackcountry@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Professor Nachiappan Chockalingam

Appendix D: Health Research Authority Approval Letter



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email: hra.approval@nhs.net
HCRW.approvals@wales.nhs.uk

Dr Robert Dempsey
Staffordshire Centre for Psychological Research
Department of Psychology, School of Life Sciences &
Education
Staffordshire University, Science Centre, Leek Road,
Stoke-on-Trent
ST4 2DF

24 September 2019

Dear Dr Dempsey

HRA and Health and Care Research Wales (HCRW) Approval Letter

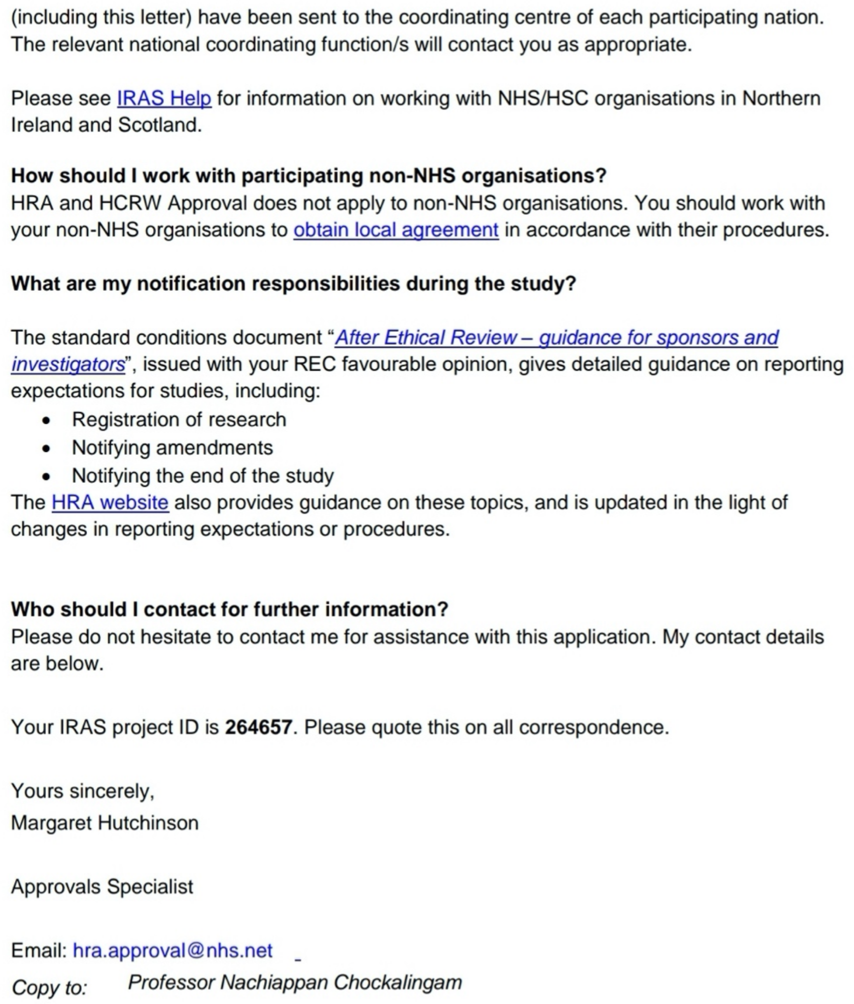
Study title:	**Pictures Speak a Thousand Words: Using Photo-Elicitation and IPA to Explore Men's Experience of Mood Management Following a Diagnosis of Bipolar Disorder.**
IRAS project ID:	**264657**
REC reference:	**19/WM/0240**
Sponsor	**Staffordshire University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report



(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

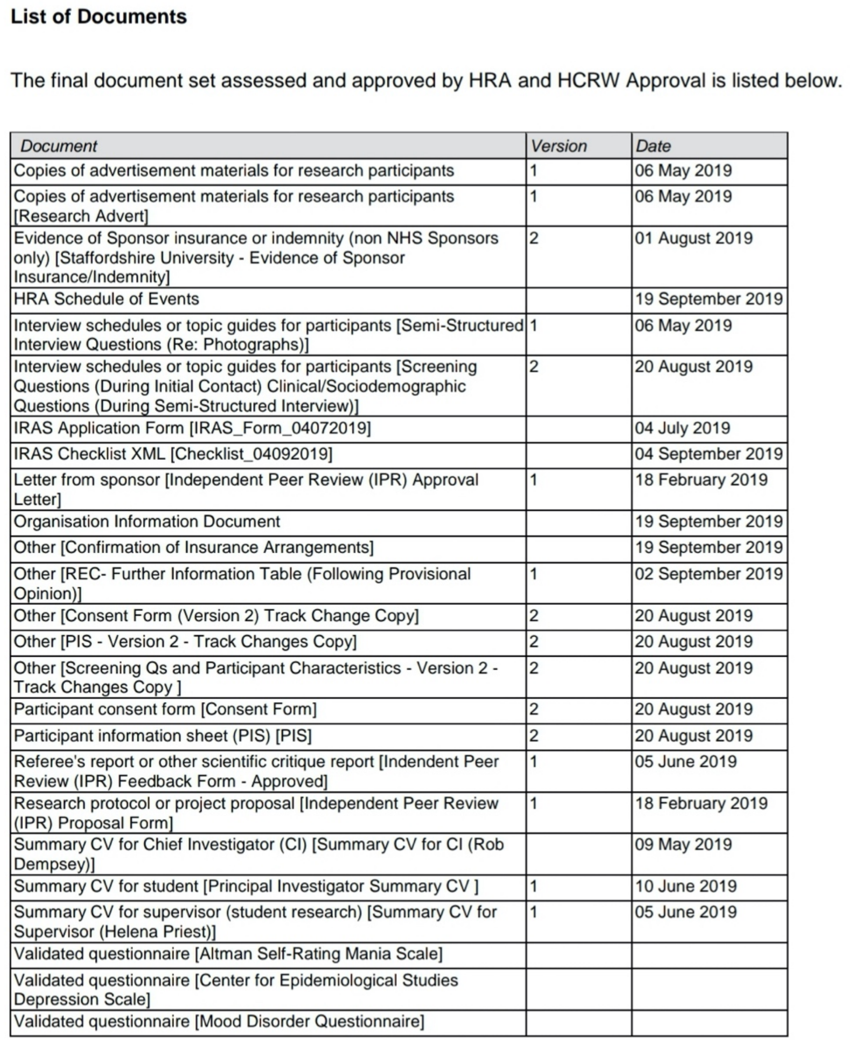
Your IRAS project ID is **264657**. Please quote this on all correspondence.

Yours sincerely,
Margaret Hutchinson

Approvals Specialist

Email: hra.approval@nhs.net

Copy to: *Professor Nachiappan Chockalingam*



List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
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Copies of advertisement materials for research participants [Research Advert]	1	06 May 2019
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HRA Schedule of Events		19 September 2019
Interview schedules or topic guides for participants [Semi-Structured Interview Questions (Re: Photographs)]	1	06 May 2019
Interview schedules or topic guides for participants [Screening Questions (During Initial Contact) Clinical/Sociodemographic Questions (During Semi-Structured Interview)]	2	20 August 2019
IRAS Application Form [IRAS_Form_04072019]		04 July 2019
IRAS Checklist XML [Checklist_04092019]		04 September 2019
Letter from sponsor [Independent Peer Review (IPR) Approval Letter]	1	18 February 2019
Organisation Information Document		19 September 2019
Other [Confirmation of Insurance Arrangements]		19 September 2019
Other [REC- Further Information Table (Following Provisional Opinion)]	1	02 September 2019
Other [Consent Form (Version 2) Track Change Copy]	2	20 August 2019
Other [PIS - Version 2 - Track Changes Copy]	2	20 August 2019
Other [Screening Qs and Participant Characteristics - Version 2 - Track Changes Copy]	2	20 August 2019
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Referee's report or other scientific critique report [Indendent Peer Review (IPR) Feedback Form - Approved]	1	05 June 2019
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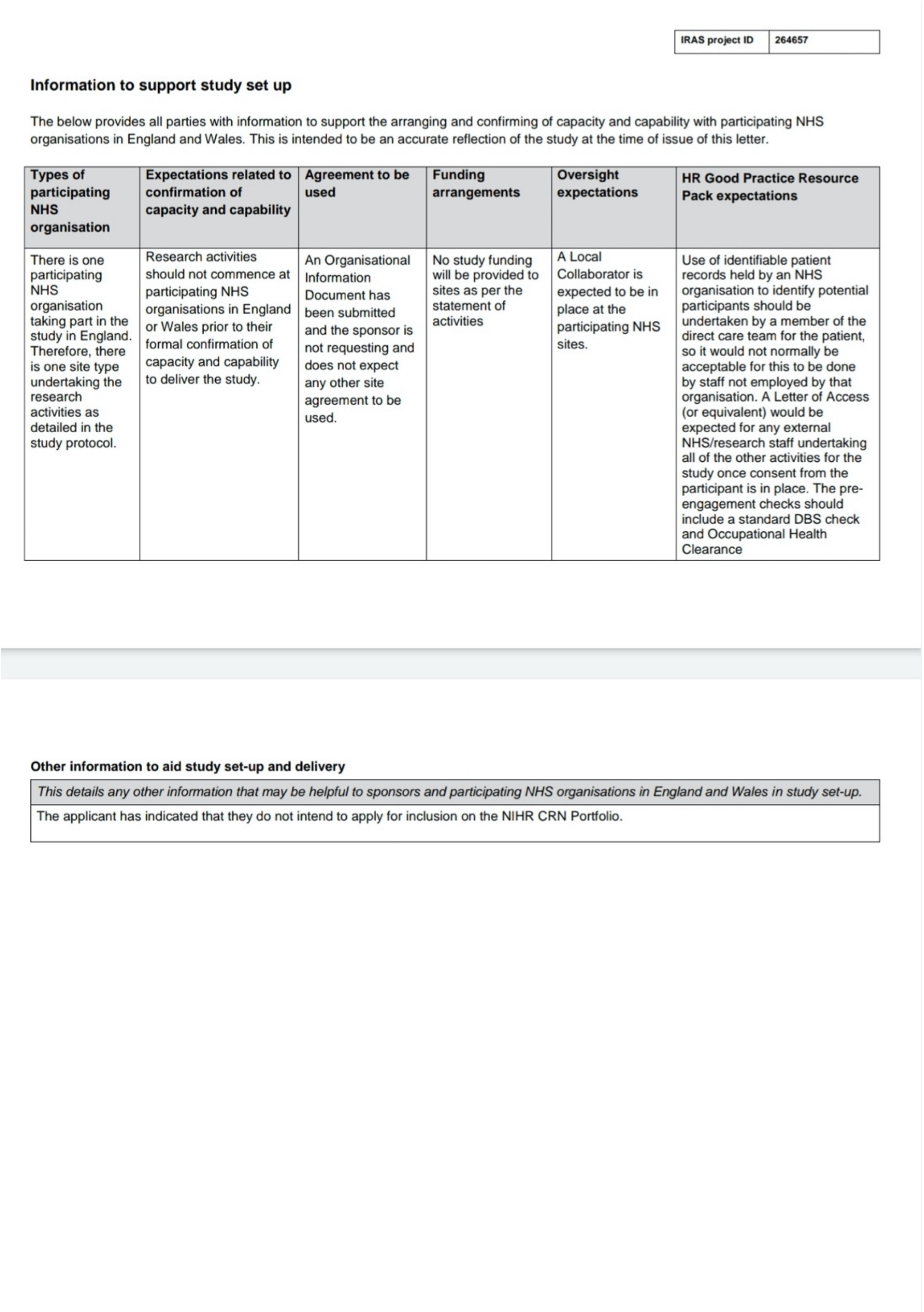
Summary CV for student [Principal Investigator Summary CV]	1	10 June 2019
Summary CV for supervisor (student research) [Summary CV for Supervisor (Helena Priest)]	1	05 June 2019
Validated questionnaire [Altman Self-Rating Mania Scale]		
Validated questionnaire [Center for Epidemiological Studies Depression Scale]		
Validated questionnaire [Mood Disorder Questionnaire]		



IRAS project ID	264657

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
There is one participating NHS organisation taking part in the study in England. Therefore, there is one site type undertaking the research activities as detailed in the study protocol.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organisational Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	No study funding will be provided to sites as per the statement of activities	A Local Collaborator is expected to be in place at the participating NHS sites.	Use of identifiable patient records held by an NHS organisation to identify potential participants should be undertaken by a member of the direct care team for the patient, so it would not normally be acceptable for this to be done by staff not employed by that organisation. A Letter of Access (or equivalent) would be expected for any external NHS/research staff undertaking all of the other activities for the study once consent from the participant is in place. The pre-engagement checks should include a standard DBS check and Occupational Health Clearance

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix E: Permission to Use Mood Disorder Questionnaire

Hirschfeld, Robert <rohirsch@UTMB.EDU>

Sat 09/11/2019 17:09

You have my permission to use the MDQ for this purpose

Robert M.A. Hirschfeld, MD
Professor of Psychiatry
DeWitt Wallace Senior Scholar
Department of Psychiatry
Weill Cornell Medical College

On Nov 9, 2019, at 10:27 AM, BURMAN Craig <c.burman@student.staffs.ac.uk> wrote:

WARNING: This email originated from outside of UTMB's email system. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Dear Dr Hirschfeld,

I am contacting you today to request permission to use the Mood Disorder Questionnaire (MDQ).

I am a Trainee Clinical Psychologist studying towards a Professional Doctorate in Clinical Psychology (DClinPsy) at Staffordshire University, UK. As part of my training, I am undertaking a qualitative research project exploring men's experiences of living with Bipolar Disorder. (More specifically, the study aims to explore men's experiences of managing mood symptoms following diagnosis).

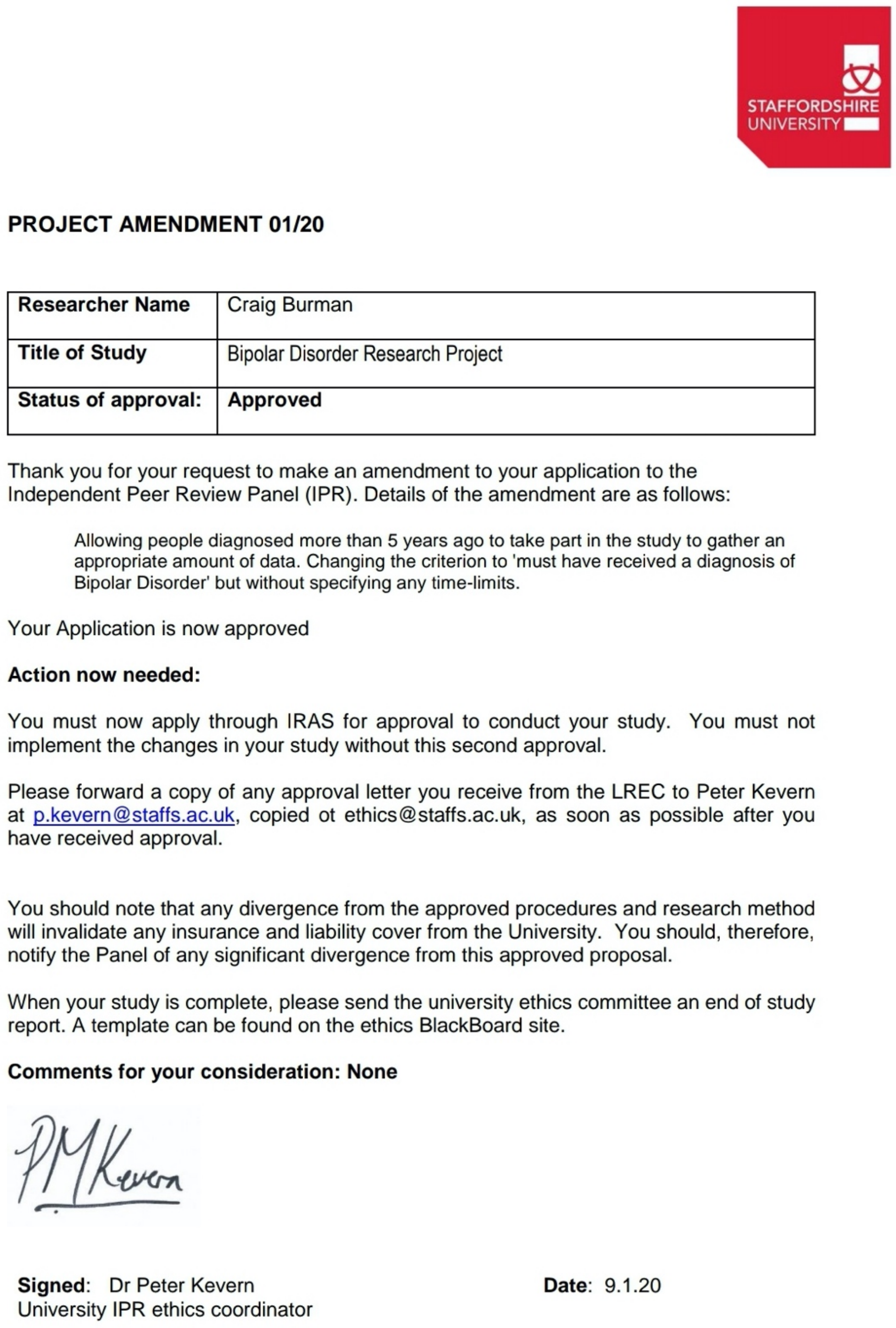
I propose to use the 13 items of 'Question 1' as part of the screening process for potential participants who self-report a diagnosis of Bipolar Disorder. A minimum score of 9 will be used to determine eligibility to take part in the study. This is in line with the findings of Twiss, Jones, & Anderson (2008) who, in their UK sample, concluded: "*the optimal cut-off score in the current sample was a score of 9 or more endorsed symptoms without applying the supplementary questions (sensitivity of 0.90 and 0.88 for bipolar I and bipolar II groups respectively with a specificity of 0.90)*".

I understand that my research supervisor, Dr Robert Dempsey, has used the MDQ in previous research studies (e.g. Dempsey, Gooding, & Jones, 2017). To be honest, I was not sure if this meant that use of the MDQ would be allowed in this study without obtaining your written consent or not. The information I found online regarding usage and copyright stated: "*The MDQ is widely available on the web and is included in several of the papers cited and authored by Dr Hirschfeld... Use requires the permission of the author* *who can be contacted at e-mail: rohirsch@utmb.edu*". However, I wasn't sure how far permission extended once it was granted (e.g. whether permission was limited to each individual research project).

The study has been reviewed by an Independent Peer Review (IPR) panel at Staffordshire University, as well as an NHS Research Ethics Committee (REC). I am not sure how much information you would typically require about a study before granting permission to use the MDQ. As such, please accept my apologies if this overview has been very brief, and do let me know if you would like to know more.

Best wishes,
Craig Burman
Trainee Clinical Psychologist
Staffordshire University

Appendix F: Approvals for Study Amendment



STAFFORDSHIRE UNIVERSITY

PROJECT AMENDMENT 01/20

Researcher Name	Craig Burman
Title of Study	Bipolar Disorder Research Project
Status of approval:	**Approved**

Thank you for your request to make an amendment to your application to the Independent Peer Review Panel (IPR). Details of the amendment are as follows:

> Allowing people diagnosed more than 5 years ago to take part in the study to gather an appropriate amount of data. Changing the criterion to 'must have received a diagnosis of Bipolar Disorder' but without specifying any time-limits.

Your Application is now approved

Action now needed:

You must now apply through IRAS for approval to conduct your study. You must not implement the changes in your study without this second approval.

Please forward a copy of any approval letter you receive from the LREC to Peter Kevern at p.kevern@staffs.ac.uk, copied ot ethics@staffs.ac.uk, as soon as possible after you have received approval.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

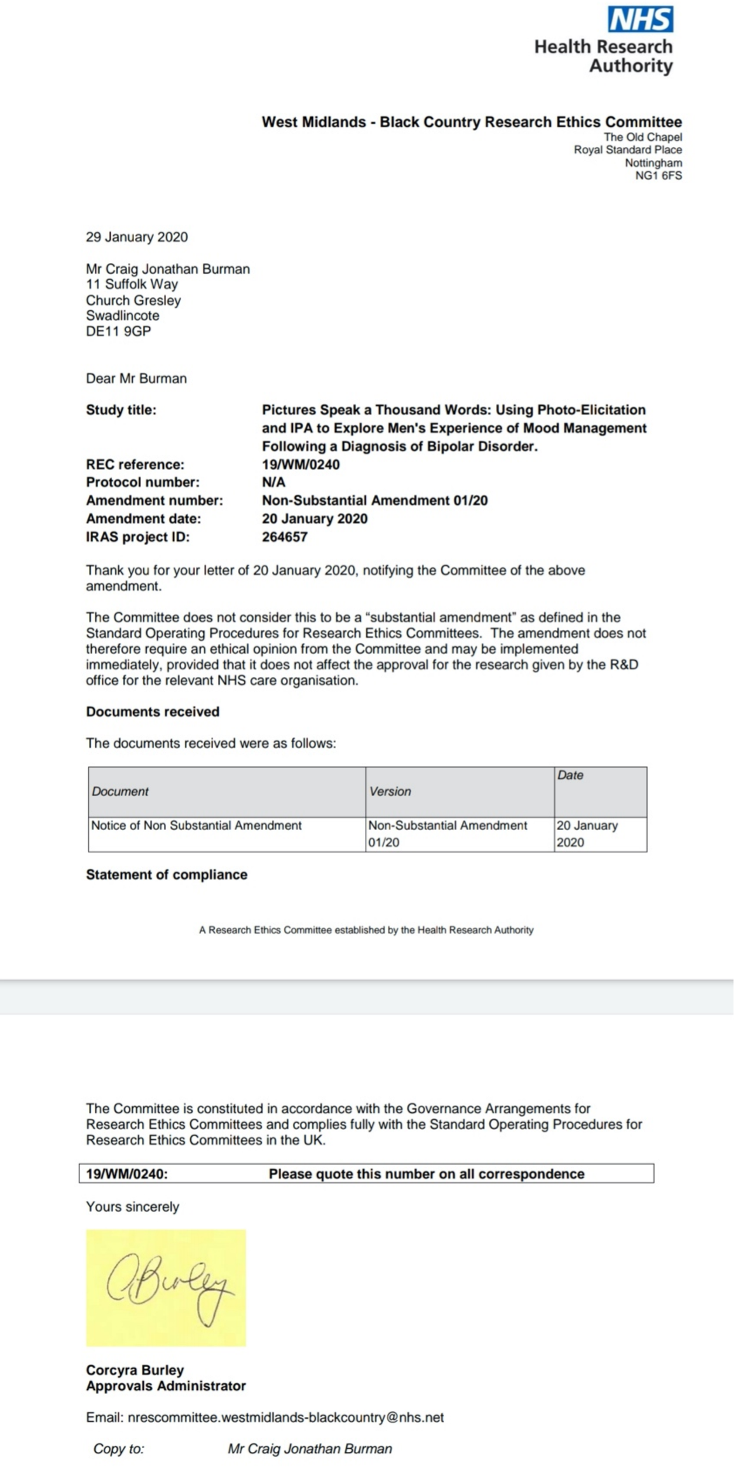
When your study is complete, please send the university ethics committee an end of study report. A template can be found on the ethics BlackBoard site.

Comments for your consideration: None

PM Kevern

Signed: Dr Peter Kevern
University IPR ethics coordinator

Date: 9.1.20



NHS
Health Research
Authority

West Midlands - Black Country Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

29 January 2020

Mr Craig Jonathan Burman
11 Suffolk Way
Church Gresley
Swadlincote
DE11 9GP

Dear Mr Burman

Study title:	**Pictures Speak a Thousand Words: Using Photo-Elicitation and IPA to Explore Men's Experience of Mood Management Following a Diagnosis of Bipolar Disorder.**
REC reference:	**19/WM/0240**
Protocol number:	**N/A**
Amendment number:	**Non-Substantial Amendment 01/20**
Amendment date:	**20 January 2020**
IRAS project ID:	**264657**

Thank you for your letter of 20 January 2020, notifying the Committee of the above amendment.

The Committee does not consider this to be a “substantial amendment” as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Notice of Non Substantial Amendment	Non-Substantial Amendment 01/20	20 January 2020

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

19/WM/0240: Please quote this number on all correspondence

Yours sincerely

CBurley

Corcyra Burley
Approvals Administrator

Email: nrescommittee.westmidlands-blackcountry@nhs.net

Copy to: *Mr Craig Jonathan Burman*

Grocott Chantel-Lea (RRE) MPFT <Chantel-Lea.Grocott@mpft.nhs.uk>
Thu 30/01/2020 17:23

Dear Craig,

RE: IRAS '264657' – Amendment Number 1

Full Study Title: Exploring the Lived Experiences of Men with Bipolar Disorder

Following your review of the above amendment, we have now received all of the necessary approvals and amendment number 1 and can now implement at our site. The site files will be updated with the following documents:

Document	Version	Date
None		

Please do not hesitate to contact me if I can be of any further assistance.

Kind Regards

Tilly

Chantel-lea Grocott
Research and Innovation Governance Administrator

…

Grocott Chantel-Lea (RRE) MPFT <Chantel-Lea.Grocott@mpft.nhs.uk>
Thu 30/01/2020 17:23

All approved for you ☺

Kind Regards

Tilly

Chantel-lea Grocott
Research and Innovation Governance Administrator

Appendix G: Research Advert

Bipolar Disorder Research – Male Participants Needed

- Do you have a diagnosis of Bipolar Disorder?
- Are you male?
- Aged 18+?
- Would you like to take part in a study to help the voices of men diagnosed with Bipolar Disorder be heard?
- Then have your say!

I am a Trainee Clinical Psychologist working in the NHS. I am carrying out a study to further our understanding of men's experiences – particularly about managing mood symptoms after receiving a diagnosis of Bipolar Disorder.

The study involves you taking some photographs which you feel represent your experience of managing mood symptoms – these photographs will then be used to guide a research interview.

Interested?

Please get in touch if you would like to take part (or if you would just like to know a bit more):

Email - c.burman@student.staffs.ac.uk

Text or Call - **07547 330408***

I look forward to hearing from you!

*Please be aware that this phone will only be in operation

Monday – Friday between **9am – 5pm**.

Appendix H: Initial Screening Questions

Date: 20/08/2019
Version Number: 2

Screening Questions

Research Study Title:

Pictures Speak a Thousand Words: Using Photo-Elicitation and IPA to Explore Men's Experience of Mood Management Following Diagnosis of Bipolar Disorder.

- Are you 18 years or older?
- Are you male?
- Do you have a diagnosis of Bipolar Disorder (that was made in the last 5 years)?
- Do you have any other mental health diagnoses?
- Is English your first language?
- Are you able and willing to take photographs using your own device and send these to the researcher via email or post?

Those participants who meet the initial eligibility criteria based on the above questions will later be asked to complete the initial screening measures (MDQ, ASMR, CES-D) to confirm their suitability to take part. However, these measures can only be completed after written informed consent is obtained due to the sensitive nature of the information being collected.

Appendix I: Participant Information Sheet

Date: 20/08/2019
Version Number: 2

Participant Information Sheet

Research Study Title:

Pictures Speak a Thousand Words: Using Photo-Elicitation and IPA to Explore Men's Experience of Mood Management Following Diagnosis of Bipolar Disorder.

Thank you for expressing an interest in taking part in this research study. Before you decide whether you would like to take part, I would like to provide you with some more information about: me, the reason the research is being completed, and what your involvement would look like.

1. Who is doing the research?

As you may have seen in the research advert, my name is Craig Burman. I am completing a Professional Doctorate in Clinical Psychology (DClinPsy) at Staffordshire University and am employed as a Trainee Clinical Psychologist with Midlands Partnership NHS Foundation Trust (MPFT). I am completing this research project as part of the DClinPsy course. I have a professional interest in men's mental health – in particular what men's experiences are of living with mental health diagnoses such as Bipolar Disorder.

2. What is the study trying to do?

This research hopes to gain an understanding of your experience of living with a diagnosis of Bipolar Disorder, particularly thinking about things that have made managing your mood symptoms easier or more difficult. This will be achieved by asking you to take some photographs which represent these experiences for you. These photographs will then be used to guide an interview about these experiences. The interview will take place either face-to-face or over the telephone. In either case, the interview will be **audio recorded** so that it can be typed up and analysed. You will find more information about all of this below.

3. Do I have to take part?

No, you do not have to take part in the study. It is entirely up to you whether you want to be involved in the study or not. I hope that this information sheet will clearly explain what would be asked of you if you decide to take part.

If you think that you would like to participate, then you will be asked to sign a consent form. However, even after signing this form, you are free to change your mind and withdraw from the study without providing a reason.

Your decision to take part in this study **will in no way affect your relationship with your healthcare provider.** As such, if you decide to take part in this study, this will not change your current access to mental health support (for example psychological therapy).

If you do decide to change your mind and want to withdraw from the study at any time, **this will also not affect your relationship with your healthcare provider.** More details regarding your right to withdraw from the study are detailed in question 4 (below).

4. What will happen if I take part?

First, please take **at least 24 hours** to read this information sheet and think about whether you would like to take part. You may want to take some time to talk about this with other people (perhaps family members, friends, or a healthcare professional).

If you **do not** wish to take part:

It would be helpful if you could let me know by sending me an email to say that you are not interested in taking part. However, this is not necessary.

If you **do** wish to take part:

Please contact me via email (my address is provided at the bottom of this form) and tell me that you are interested in taking part (with a contact telephone number). I will then send you a copy of the consent form (either via email or post). Please sign this and return it to me (either via email or post). **If you would like to receive your consent form via post then please include the address that you would like the form to be sent to in your email.**

Once I have received a signed copy of your consent form, I will then contact you via telephone to ask you some questions from 3 short screening questionnaires. The information from these questionnaires will be analysed to confirm whether you are able to take part. This simply involves counting up your scores and seeing if they fall above or below the cut-off scores.

If you are **not eligible** to take part:

If you are not eligible to take part based on these screening questionnaires then you will be informed during this telephone conversation. This is because I would not want to waste any of your time. However, please be assured that your interest in taking part is greatly appreciated.

If you are not eligible to take part in the study, please also know that **your data (including your responses to the screening questionnaires) will not be reproduced in the write-up of the study and will be destroyed when the study is complete.**

If you **are able** to take part:

If you are able to take part based on these screening questionnaires then you will be informed during this telephone conversation. During this telephone conversation we will then arrange a date for the interview to take place. The interview will need to be at least a week after this phone call because you will be asked to complete a photo-taking task in the week leading up to the interview.

The photo-taking task simply involves taking some photographs that you think represent your experience of managing your mood symptoms. It will be helpful to take photographs which represent **things that make this easier** as well **things that make this more difficult.**

You will be asked to take these photographs in the 7 days leading up to the interview. Before the interview you will need to choose the 6 photographs that you feel **best represent your experiences of managing your mood symptoms** that you would be willing to talk about more in an interview. You will need to return these 6 photographs to me either via email or post. These will be used to guide the interview.

The interview itself will take place in a quiet room at either:

- Staffordshire University Campus (Stoke)
- Horninglow Clinic (Burton-on-Trent)
- David Parry Suite, St Michael's Court (Lichfield)
- Andrew Ward, Sir Robert Peel Hospital (Tamworth)
- Other MPFT locations may also be available and these options will be discussed with you when arranging the interview

Alternatively, if it is not practical to travel to one of these sites, it will be possible to complete the interview over the telephone instead. **Whether completed face-to-face or over the phone, the interview will last for approximately one hour, and it will be audio recorded so that it can be analysed.**

Please note - if you do take part in the interview, then your data from the screening measures (i.e. your total scores) will be included in the write-up of the study in the form of a table about 'participant characteristics'.

During the interview you will also be asked some basic sociodemographic questions - such as your age and your relationship status. You will also be asked some brief questions about your clinical history – such as how long it has been since you were diagnosed with Bipolar Disorder etc. This information will also be included in the table.

All of the information/data in this table will be anonymized to protect your identity. This means that you will not be able to be identified from it.

5. What will happen if I don't wish to continue with the study?

You are free to change your mind and withdraw from the study even after signing the consent form. This may even mean that you choose to withdraw from the study before taking part in the interview.

If you do take part in the interview, you may still ask for your data (i.e. your interview responses) to be withdrawn from the study analysis. However, this request must be received within **1 week** of the interview being completed. This will mean that your data can be deleted and it will not be included in the study analysis or the final write up.

If you are concerned about how your personal information and data will be kept safe in the study, please see question 8 (below).

6. Are there any possible disadvantages or risks of taking part in the study?

Due to the ease with which digital images can be easily downloaded, there is a risk that your photographs (if used in the write-up of this study) may be unintentionally repurposed by others online. For this reason, you will be asked to avoid taking photographs that include people (including yourself, family, friends etc.) to ensure confidentiality. If you wish to use such photographs during the interview, please be aware that for the purpose of the write-up and future presentations/publications the photos will have to be edited so that (for example) faces are blurred out.

Whilst there are no identified risks to your physical health by taking part in the study, it is possible that talking about your experiences may be distressing or upsetting for you. This is part of the reason that it is important to speak with other people (perhaps family members, friends, or a healthcare professional) before letting me know if you'd like to take part.

I would like to assure you that you are under no obligation to share any information that you do not feel comfortable doing, and you may refuse to answer any and all questions.

You will also be offered a follow-up telephone call one week after the interview. This will be a chance to discuss any concerns or ask any questions that you may have following the interview.

It may also be worth making a note of the following support services that would be available for you to contact in the meantime:

Service	**Contact Number**	**Availability**
Samaritans	116 123	Everyday 24 Hours a Day
SANE	0300 304 7000	Everyday 04:30am–10:30pm

7. What are the possible benefits of taking part in the study?

By agreeing to share your experiences, you will be helping to further our understanding of men's experiences following a diagnosis of Bipolar Disorder. This will also help to balance out the under-representation of male perspectives in this type of research into Bipolar Disorder. It is hoped that the findings of this study may also be used to guide mental health professionals' understanding so that they may work more effectively with service-users in the future.

In addition, providing participants with the opportunity to talk about their lived experiences within a research interview has often been reported to have therapeutic value.

However, it of course cannot be guaranteed that there will be any direct benefit to you.

8. What do I do if there is a problem?

Please be aware that any complaint about the way that you have been treated during this study, or any possible harm that you might suffer, will be addressed.

If you have any concerns about the study, it is advised that you speak to me in the first instance so that I can do my best to answer your questions or concerns. Alternatively, I will provide you with the details of my research supervisor who will similarly do their best to answer your questions or concerns.

However, if your questions or concerns are not met to your satisfaction, and should you wish to proceed with making a formal complaint, then you can do this by contacting the MPFT Patient Advice and Liaison Service (PALS).

Information about the contact details for PALS, as well as details of how to make a complaint, can be found at the following address:

https://www.mpft.nhs.uk/service-users-carers/complaints-concerns-and-compliments

9. Will my personal information and data be kept secure and confidential?

Yes, your data will be processed in accordance with the Data Protection Act and will comply with the General Data Protection Regulation, 2016 (GDPR). All research using patient data must follow these UK laws and rules.

The data controller for this project will be Staffordshire University. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a 'task in the public interest'.

You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you. You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk

Your Consent Form:
Your signed consent form will be kept in a securely locked cabinet within the Science Centre at Staffordshire University (Stoke Campus). If returned to me via email, the email will be deleted as soon as the consent form has been printed off and stored securely.

Your Interview Data (audio recording and transcribed responses):
Once interviews have been completed, the digital audio data files will be stored in password protected electronic folders on a Staffordshire University computer.
When the interviews are transcribed (i.e. typed up) all identifying information will be removed so that you cannot be personally identified. You will also be able to choose your own pseudonym (false name) to ensure the protection of your identity. After the interviews are typed up, the digital audio recording will be destroyed. The interview transcripts will also be stored in password protected electronic folders on a Staffordshire University computer.

For the purpose of the written publication, anonymised extracts from interviews will be used to provide evidence of key themes (these are things in common that participants reflected on and forms a large part of how the data will be analysed). These anonymised extracts may also be used in subsequent conference presentations and academic journal articles.

In line with university regulations, anonymised interview notes that have been typed up will be stored securely in both paper and electronic format for a period of ten years at Staffordshire University.

Please note that there are limits to confidentiality. If you disclose any information that indicates that you or someone else is at risk of harm, or if you disclose details of any criminal activity, then I am duty bound to pass this information on to the relevant authorities.

Your Photographs (from the photo-taking task):
Your photographs will be stored in password protected electronic folders on a Staffordshire University computer. If they have been returned to me via post, I will scan copies onto a Staffordshire University computer and dispose of the physical copies in the University's confidential waste. For the purpose of the written publication, anonymised photographs will be used to support the evidence of key themes. These photographs may also be used in subsequent conference presentations and academic journal articles. However, the original copies on the above-mentioned

Staffordshire University computer will be deleted following the successful completion of this research project.

Please note - if you are not eligible to take part in the study for any reason, all of your data will be destroyed upon completion of the study.

10. Has anybody reviewed the study?

Yes. All research conducted within the National Health Service (NHS) is reviewed by an independent body – called a Research Ethics Committee. This study has also been reviewed by the Staffordshire University Independent Review Panel.

This panel primarily checks the scientific merit of the study, but also considers ethical issues, in order to protect your interests.

11. Will I get to see the results of the study?

Yes. Once the data has been collected and analysed, it will be written up into a report. Once this has report has been passed by the University, I will post a copy of the executive summary to my Twitter account which will be freely available to view and/or download.

To find this, please search for me on Twitter @CraigBurman91. A copy will also be posted on the Staffordshire University's In-Psych blog (www.blog.staffs.ac.uk/inpsych/)

Further Information and Researcher Contact Information

Please do not hesitate to ask any questions you might have about the study by getting in contact with me using the following contact details:

Name – Craig Burman
Email – c.burman@student.staffs.ac.uk
Telephone – 07547 330408

If you decide that you would be interested in taking part then please get in contact using the email address above. **Remember – please include a contact telephone number in your email that you would be happy for me to contact you on.**

Thank you for taking the time to read this information sheet and for considering participation in this study.

Footnote:

It has come to the author's attention, following completion of the study, that the description of the screening questionnaires provided under question 4 of the participant information sheet is quite vague. The purpose of this footnote is to clarify that prior to completion of the measures, participants were explicitly informed about what the measures were, and why they were being used. Anyone excluded from taking part in the study, for any reason, was immediately, and explicitly, informed of the reason(s) for this.

Appendix J: Consent Form

Date: 20/08/2019
Version Number: 2

IRAS ID: 264657

Participant Identification Number:

Consent Form

Research Study Title: *Pictures Speak a Thousand Words: Using Photo-Elicitation and IPA to Explore Men's Experience of Mood Management Following Diagnosis of Bipolar Disorder.*

Name of Researcher: Craig Burman

Instructions: Please read each of the statements below carefully. If you agree with a statement **please sign your initials into the box** on the right-hand side. Please ask if you have any questions about any of these statements.

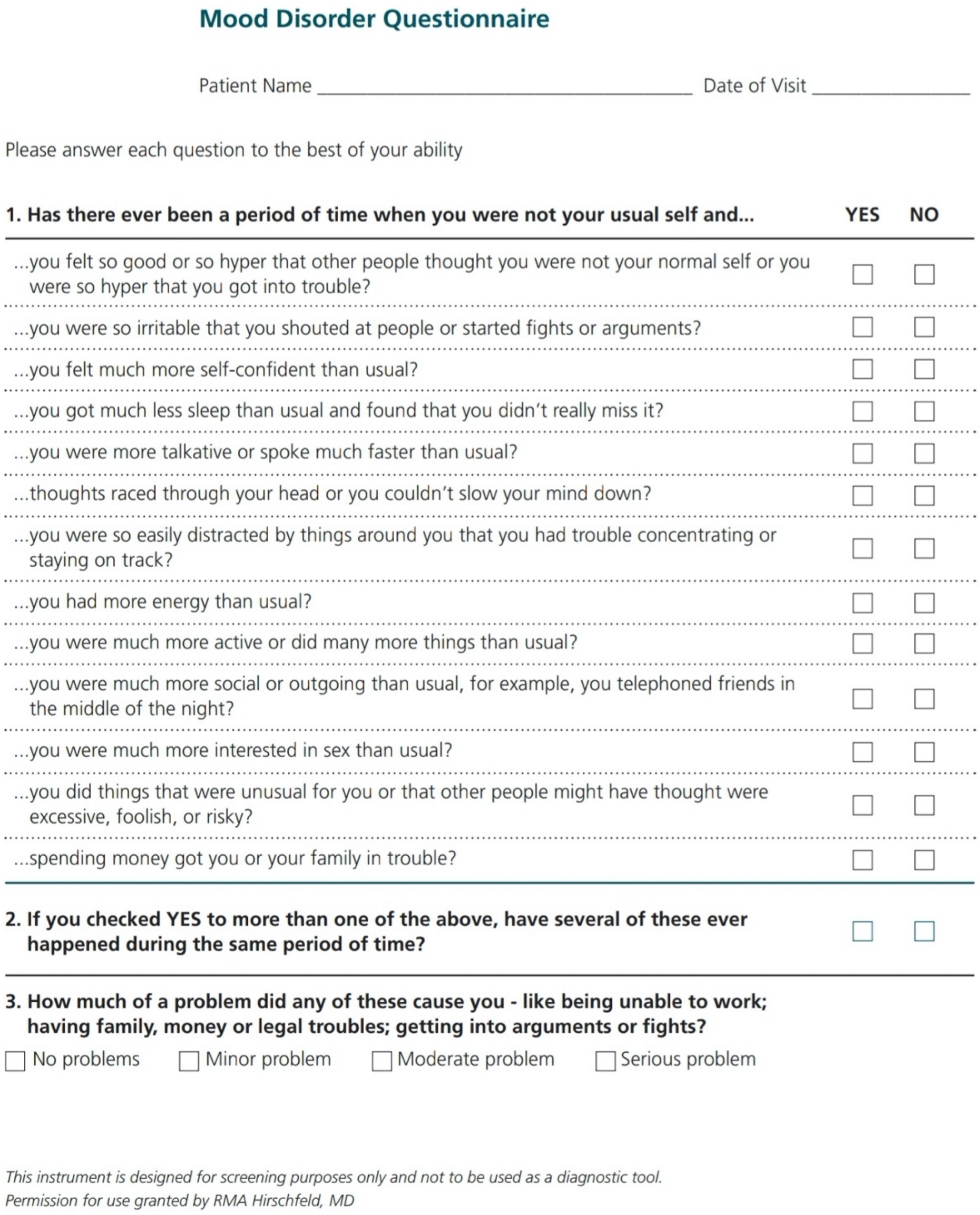
1. I confirm that I have read the Participant Information Sheet (dated 20/08/2019, version 2) for the above study. I have had the opportunity to consider the information and ask questions. ☐
2. All questions that I have asked were answered to my satisfaction. ☐
3. I understand that my participation is voluntary and that I am free to withdraw myself and my data at any time up until one week after the date of the interview. I also understand that I do not need to provide any reason for withdrawing from the study within this period of time. ☐
4. I understand that if I do decide to withdraw myself and my data from this study at any time until one week after the date of the interview, my medical care and legal rights will not be affected. ☐
5. I agree that any photographs taken as part of this study, as well as anonymised extracts of the interview process, may be reproduced in the final write-up of the study, as well as any subsequent presentations or academic publications. ☐
6. I am aware of, and accept, the limits of confidentiality outlined in the Participation Information Sheet (dated 20/08/2019, version 2). ☐
7. I understand, and accept, that the interview will be audio-recorded for the purpose of typing-up and analysis. ☐

8. I understand that after the study has been completed, written up, and passed by Staffordshire University, an executive summary of the results will be available on the following Twitter account (@CraigBurman91) for free viewing and digital download. I understand that the executive summary may also be found on the Staffordshire University's In-Psych blog (www.blog.staffs.ac.uk/inpsych/). ☐

9. I agree to take part in the above study. ☐

______________	______________	______________
Name of Participant	Date	Signature
______________	______________	______________
Name of Lead Researcher	Date	Signature

Appendix K: Mood Disorder Questionnaire



Mood Disorder Questionnaire

Patient Name ______________________________ Date of Visit ____________

Please answer each question to the best of your ability

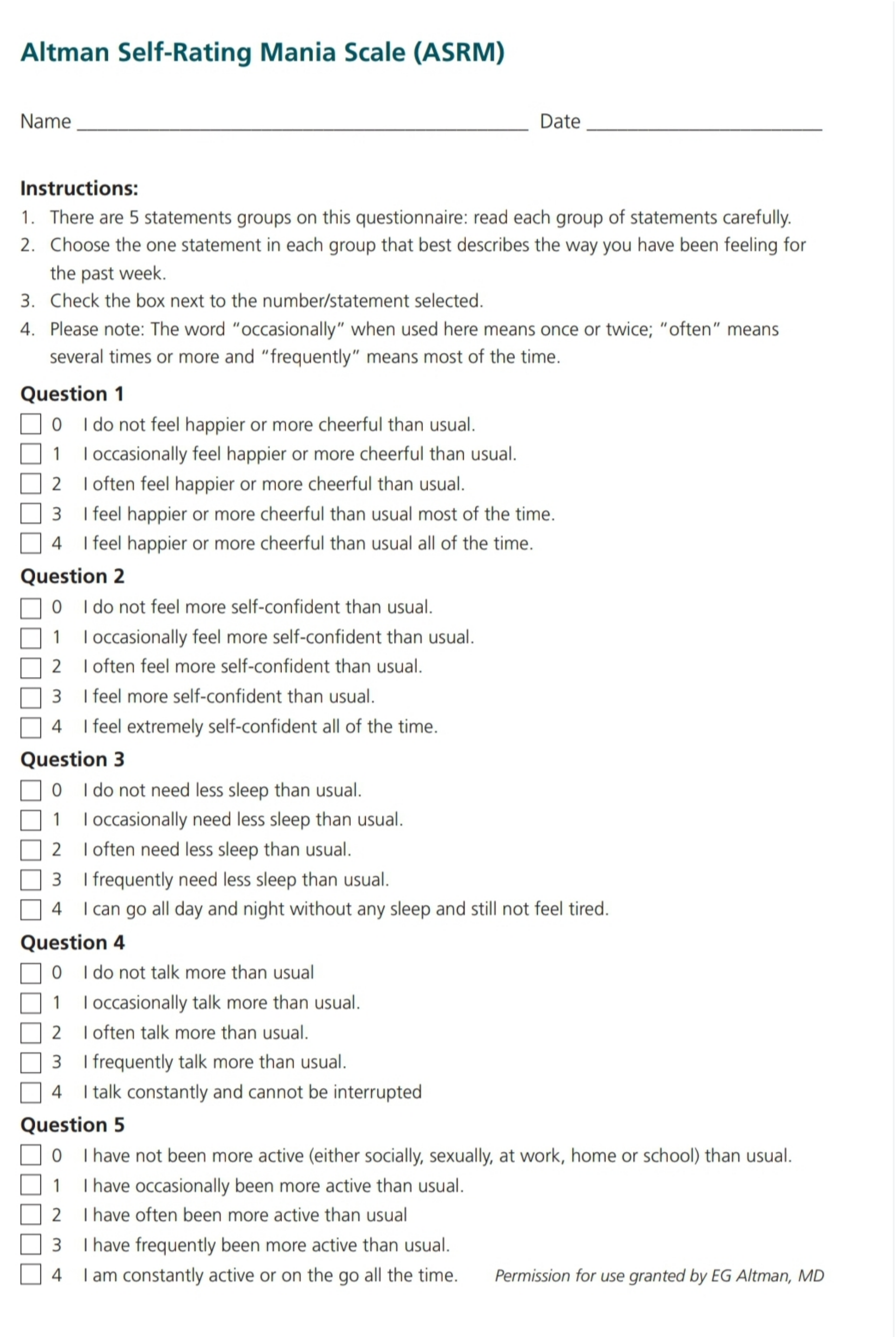
1. Has there ever been a period of time when you were not your usual self and...	**YES**	**NO**
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

Appendix L: Altman Self-Rating Mania Scale



Altman Self-Rating Mania Scale (ASRM)

Name ______________________________ Date ______________

Instructions:

1. There are 5 statements groups on this questionnaire: read each group of statements carefully.
2. Choose the one statement in each group that best describes the way you have been feeling for the past week.
3. Check the box next to the number/statement selected.
4. Please note: The word "occasionally" when used here means once or twice; "often" means several times or more and "frequently" means most of the time.

Question 1

☐ 0 I do not feel happier or more cheerful than usual.
☐ 1 I occasionally feel happier or more cheerful than usual.
☐ 2 I often feel happier or more cheerful than usual.
☐ 3 I feel happier or more cheerful than usual most of the time.
☐ 4 I feel happier or more cheerful than usual all of the time.

Question 2

☐ 0 I do not feel more self-confident than usual.
☐ 1 I occasionally feel more self-confident than usual.
☐ 2 I often feel more self-confident than usual.
☐ 3 I feel more self-confident than usual.
☐ 4 I feel extremely self-confident all of the time.

Question 3

☐ 0 I do not need less sleep than usual.
☐ 1 I occasionally need less sleep than usual.
☐ 2 I often need less sleep than usual.
☐ 3 I frequently need less sleep than usual.
☐ 4 I can go all day and night without any sleep and still not feel tired.

Question 4

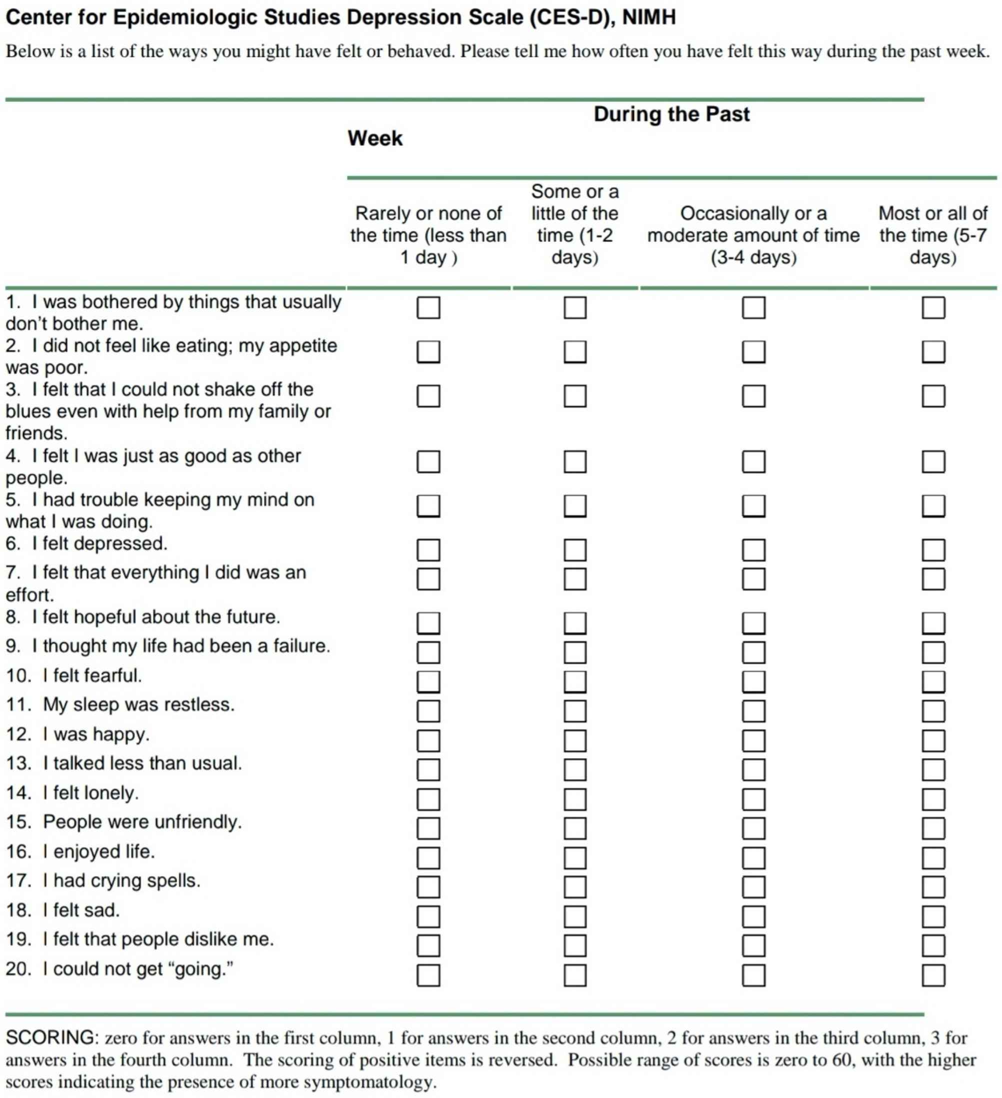
☐ 0 I do not talk more than usual
☐ 1 I occasionally talk more than usual.
☐ 2 I often talk more than usual.
☐ 3 I frequently talk more than usual.
☐ 4 I talk constantly and cannot be interrupted

Question 5

☐ 0 I have not been more active (either socially, sexually, at work, home or school) than usual.
☐ 1 I have occasionally been more active than usual.
☐ 2 I have often been more active than usual
☐ 3 I have frequently been more active than usual.
☐ 4 I am constantly active or on the go all the time.

Permission for use granted by EG Altman, MD

Appendix M: Centre for Epidemiological Studies Depression Scale



Center for Epidemiologic Studies Depression Scale (CES-D), NIMH

Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

	During the Past Week			
	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.	☐	☐	☐	☐
2. I did not feel like eating; my appetite was poor.	☐	☐	☐	☐
3. I felt that I could not shake off the blues even with help from my family or friends.	☐	☐	☐	☐
4. I felt I was just as good as other people.	☐	☐	☐	☐
5. I had trouble keeping my mind on what I was doing.	☐	☐	☐	☐
6. I felt depressed.	☐	☐	☐	☐
7. I felt that everything I did was an effort.	☐	☐	☐	☐
8. I felt hopeful about the future.	☐	☐	☐	☐
9. I thought my life had been a failure.	☐	☐	☐	☐
10. I felt fearful.	☐	☐	☐	☐
11. My sleep was restless.	☐	☐	☐	☐
12. I was happy.	☐	☐	☐	☐
13. I talked less than usual.	☐	☐	☐	☐
14. I felt lonely.	☐	☐	☐	☐
15. People were unfriendly.	☐	☐	☐	☐
16. I enjoyed life.	☐	☐	☐	☐
17. I had crying spells.	☐	☐	☐	☐
18. I felt sad.	☐	☐	☐	☐
19. I felt that people dislike me.	☐	☐	☐	☐
20. I could not get "going."	☐	☐	☐	☐

SCORING: zero for answers in the first column, 1 for answers in the second column, 2 for answers in the third column, 3 for answers in the fourth column. The scoring of positive items is reversed. Possible range of scores is zero to 60, with the higher scores indicating the presence of more symptomatology.

Appendix N: Guidance for Photo-Taking Task

Photo-Taking Task

STAFFORDSHIRE UNIVERSITY

Research Study Title:

Pictures Speak a Thousand Words: Using Photo-Elicitation and IPA to Explore Men's Experience of Mood Management Following Diagnosis of Bipolar Disorder

This study involves you taking photographs which represent your experiences of managing mood symptoms. These will be used to guide the research interview.

In order to do this, please consider the following…

What Questions Am I Answering?

The key questions to ask yourself are:

1. What has it been like managing my mood symptoms since I was diagnosed with Bipolar Disorder?
2. What has made managing my moods easier?
3. What has made managing my moods more difficult?

How Do I Answer These Questions?

Rather than answering these questions with words, your task is to answer these questions with images (photographs, specifically). I have tried to offer some general guidance below but these are just ideas to help start your thinking process.

For example, when considering what has made managing your moods easier or harder, you may want to think about particular **strategies** that are helpful or unhelpful. You may also want to think about the **factors** that influence these strategies. Let's consider the following example of what I mean by this:

If someone was asked about their experience of quitting smoking, they may have found exercise to be a helpful **strategy**. However, the **factors** that influence this may include things such as:

- Having a 'gym buddy' to keep them motivated
- Overcoming social anxieties about exercising in public
- Being able to afford a gym membership
- Having the time to fit in regular gym sessions

As such, there are a number of ways that they might choose to represent this experience in a photograph. It may be that a picture of the strategy alone (e.g. a treadmill or some running shoes) is enough. However, they might feel that this does not fully capture their experience of using exercise to help quit smoking (especially if the factors above were not easy to overcome).

What Exactly Should I Take Photos Of?

As long as your photographs represent something about your experience of managing mood symptoms, then there are no ‘right’ or ‘wrong’ pictures. You may want to take photographs of **particular items** or photographs which are more **symbolic.** It is really up to you!

For example, let’s say someone was asked to take photographs of their experiences of renting a house. They might take a photograph of money being thrown down a drain (to express how it feels to pay lots of money and not own their property). This would be an example of a more **symbolic** image.

As mentioned in the Participant Information Sheet (PIS) **please try to avoid taking photographs including yourself or other people**. This is because any such photographs will have to be edited for the purpose of the study write-up/future presentations to ensure people’s anonymity and confidentiality.

If you have questions about this task, or the information provided here, please get in touch via c.burman@student.staffs.ac.uk or 07547 330408.

Appendix O: Questions to Guide Semi-Structured Interviews

Date: 06/05/2019
Version Number: 1

Semi-Structured Interview Questions

Research Study Title:

Pictures Speak a Thousand Words: Using Photo-Elicitation and IPA to Explore Men's Experience of Mood Management Following Diagnosis of Bipolar Disorder.

Introductory Question

- Tell me a little bit about yourself and your reason for taking part in this study…

Questions Regarding the Photographs

- If we take this [first, second, third etc.] photograph, can you tell me why you chose this picture for the interview?
- What do you think this photograph represents in terms of your experience of managing your mood symptoms?
- How did you feel when you were taking this photograph?
- How do you feel looking at this photograph now?
- Do you think that other people taking part in the research will take photographs similar to this?

Note to REC: these questions are designed to be generic as to enable participants to discuss the importance of each photograph in turn, and to avoid questions being biased by the lead researcher's assumptions about the nature and meaning of these experiences.

Appendix P: Clinical and Demographic Questions

Date: 20/08/2019
Version Number: 2

Clinical and Sociodemographic Questions

Research Study Title:

Pictures Speak a Thousand Words: Using Photo-Elicitation and IPA to Explore Men's Experience of Mood Management Following Diagnosis of Bipolar Disorder.

Sociodemographic

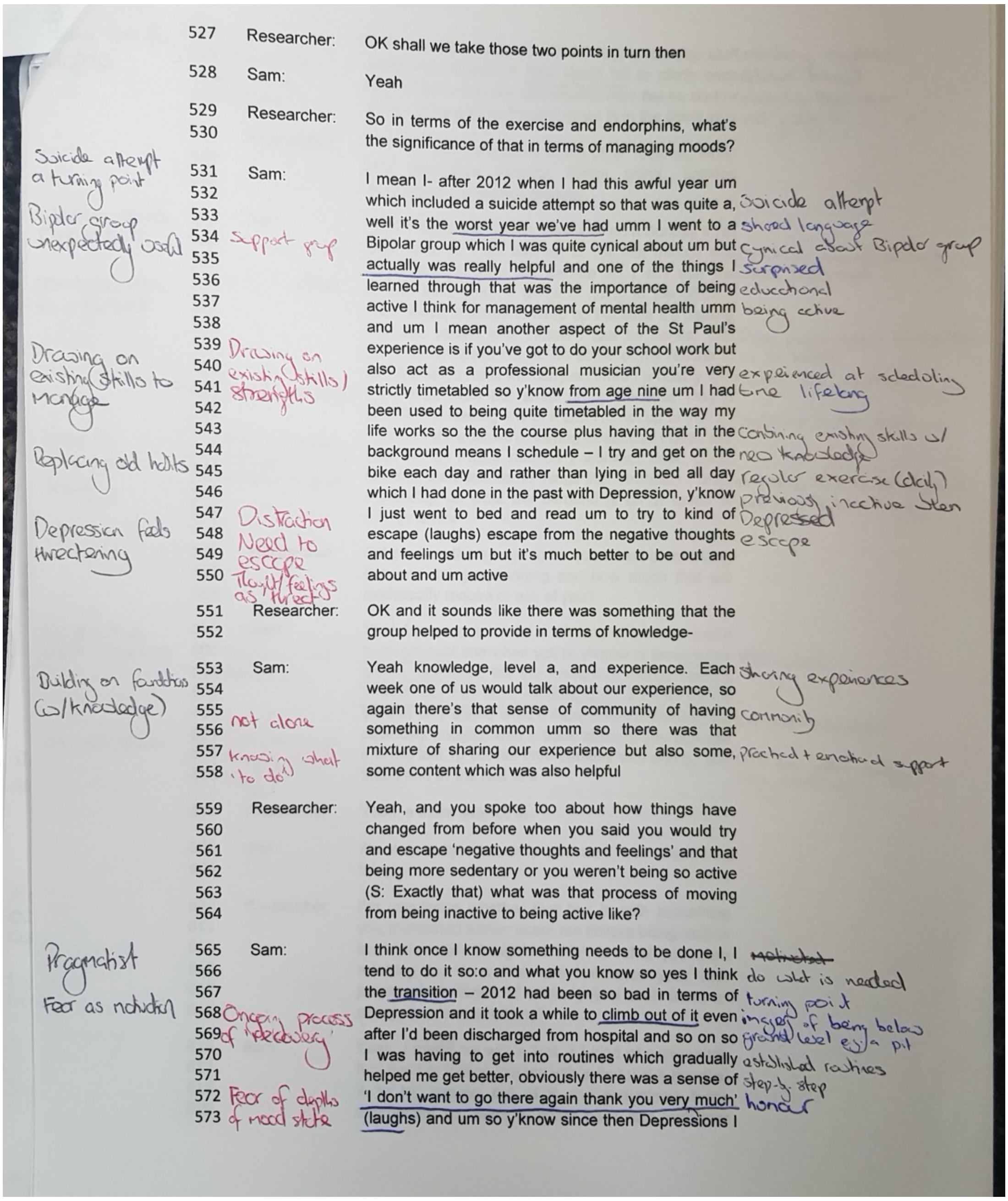
- Age?
- Relationship Status?
- Highest Educational Level Completed?
- Employment Status?
- Where would you typically go for support with mood management? (e.g. GP, secondary mental health services, family, friends, mental health support group)

Clinical

- Length of Time Diagnosed with BD?
- BD Diagnosis (e.g. Type I or Type II)?
- Approximate no. of Depressive Episodes?
- Approximate no. of Manic/Hypomanic Episodes?

Note: these questions were originally viewed by the Research Ethics Committee (REC) as one document alongside the 'Simple Screening Questions'. This document has been separated into Appendix H and P to support the readability of thesis submission.

Appendix Q: Example of Initial Commenting & Generation of Emergent Themes (Sam)



Researcher: OK shall we take those two points in turn then

Sam: Yeah

Researcher: So in terms of the exercise and endorphins, what's the significance of that in terms of managing moods?

Sam: I mean I- after 2012 when I had this awful year um which included a suicide attempt so that was quite a, well it's the worst year we've had umm I went to a Bipolar group which I was quite cynical about um but actually was really helpful and one of the things I learned through that was the importance of being active I think for management of mental health umm and um I mean another aspect of the St Paul's experience is if you've got to do your school work but also act as a professional musician you're very strictly timetabled so y'know from age nine um I had been used to being quite timetabled in the way my life works so the the course plus having that in the background means I schedule – I try and get on the bike each day and rather than lying in bed all day which I had done in the past with Depression, y'know I just went to bed and read um to try to kind of escape (laughs) escape from the negative thoughts and feelings um but it's much better to be out and about and um active

Researcher: OK and it sounds like there was something that the group helped to provide in terms of knowledge-

Sam: Yeah knowledge, level a, and experience. Each week one of us would talk about our experience, so again there's that sense of community of having something in common umm so there was that mixture of sharing our experience but also some, some content which was also helpful

Researcher: Yeah, and you spoke too about how things have changed from before when you said you would try and escape 'negative thoughts and feelings' and that being more sedentary or you weren't being so active (S: Exactly that) what was that process of moving from being inactive to being active like?

Sam: I think once I know something needs to be done I, I tend to do it so:o and what you know so yes I think the transition – 2012 had been so bad in terms of Depression and it took a while to climb out of it even after I'd been discharged from hospital and so on so I was having to get into routines which gradually helped me get better, obviously there was a sense of 'I don't want to go there again thank you very much' (laughs) and um so y'know since then Depressions I

Suicide attempt a turning point
Bipolar group unexpectedly useful
Drawing on existing skills to manage
Replacing old habits
Depression feels threatening
Building on foundations (w/knowledge)
Pragmatist
Fear as motivation

Support grp
Drawing on existing skills / strengths
Distraction
Need to escape
Thought/feelings as threat
not alone
knowing what 'to do'
Ongoing process of 'recovery'
Fear of depths of mood state

Suicide attempt
shared language
Cynical about Bipolar group
surprised
educational
being active
experienced at scheduling time
lifelong
Combining existing skills w/ new knowledge
regular exercise (daily)
previously inactive when
Depressed
escape
sharing experiences
community
practical + emotional support
~~motivated~~
do what is needed
turning point
imagery of being below ground level e.g. a pit
established routines
step-by-step
humour

Key:

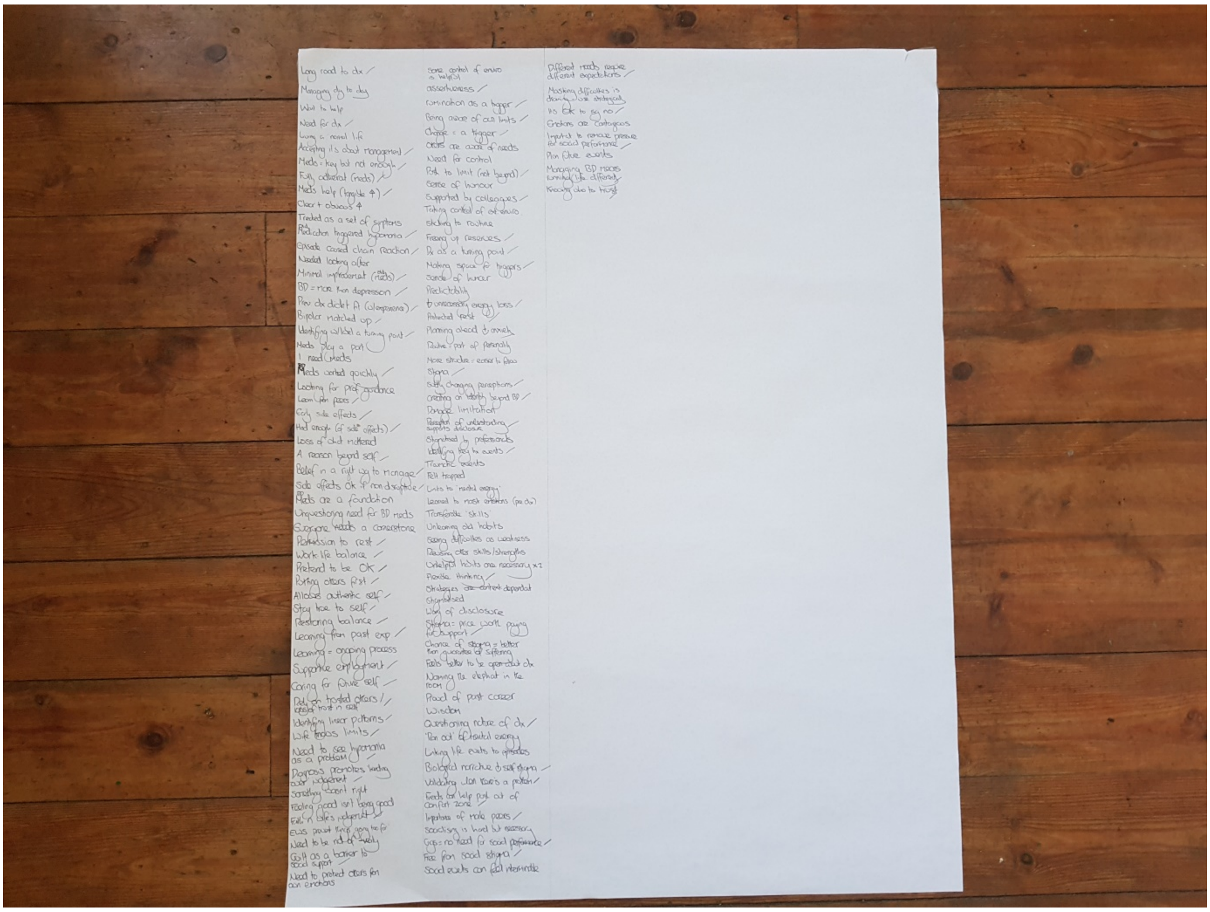
Black ink (immediately surrounding transcript) – descriptive features

Blue ink – linguistic features

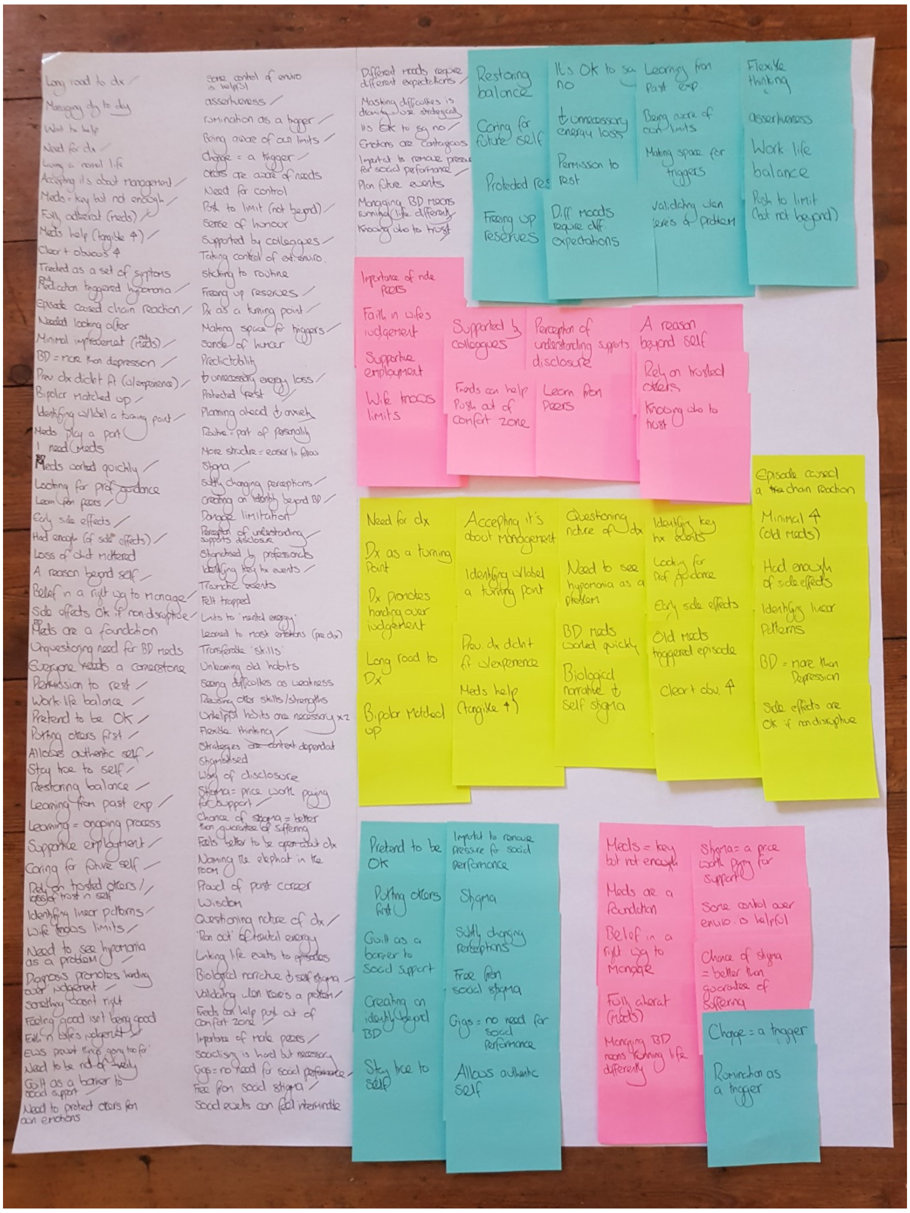
Red ink – conceptual features

Black ink (far left margin) – emergent themes

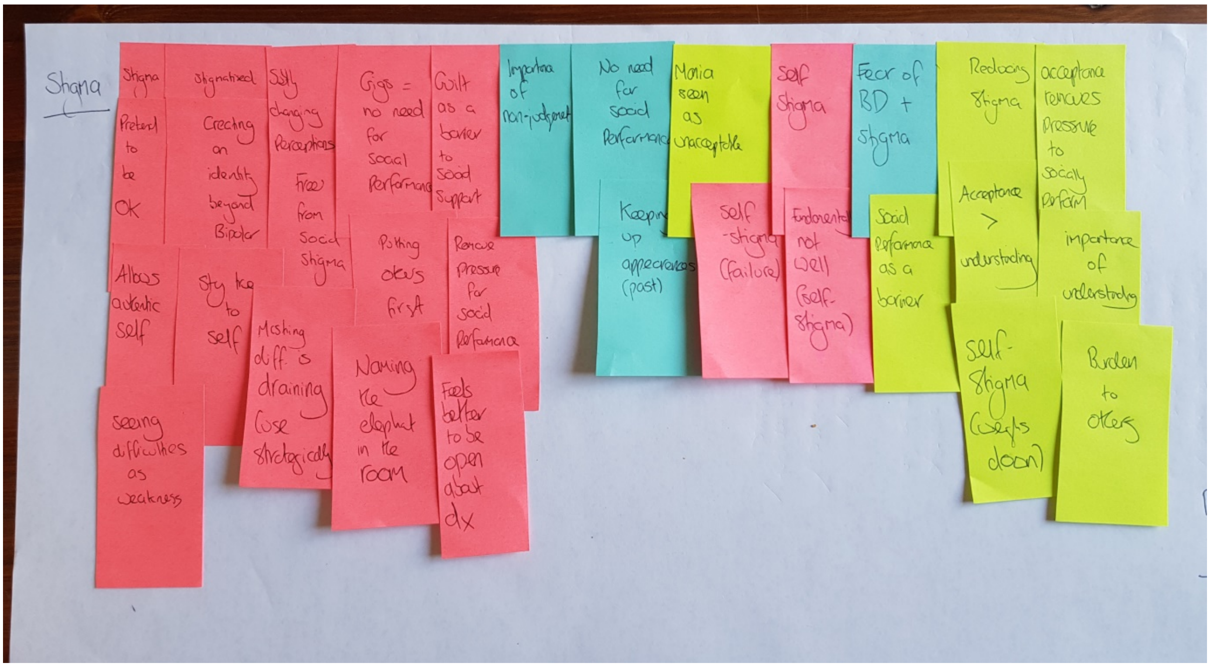
Appendix R: Example of Emergent Themes in Chronological Order (Nelson)

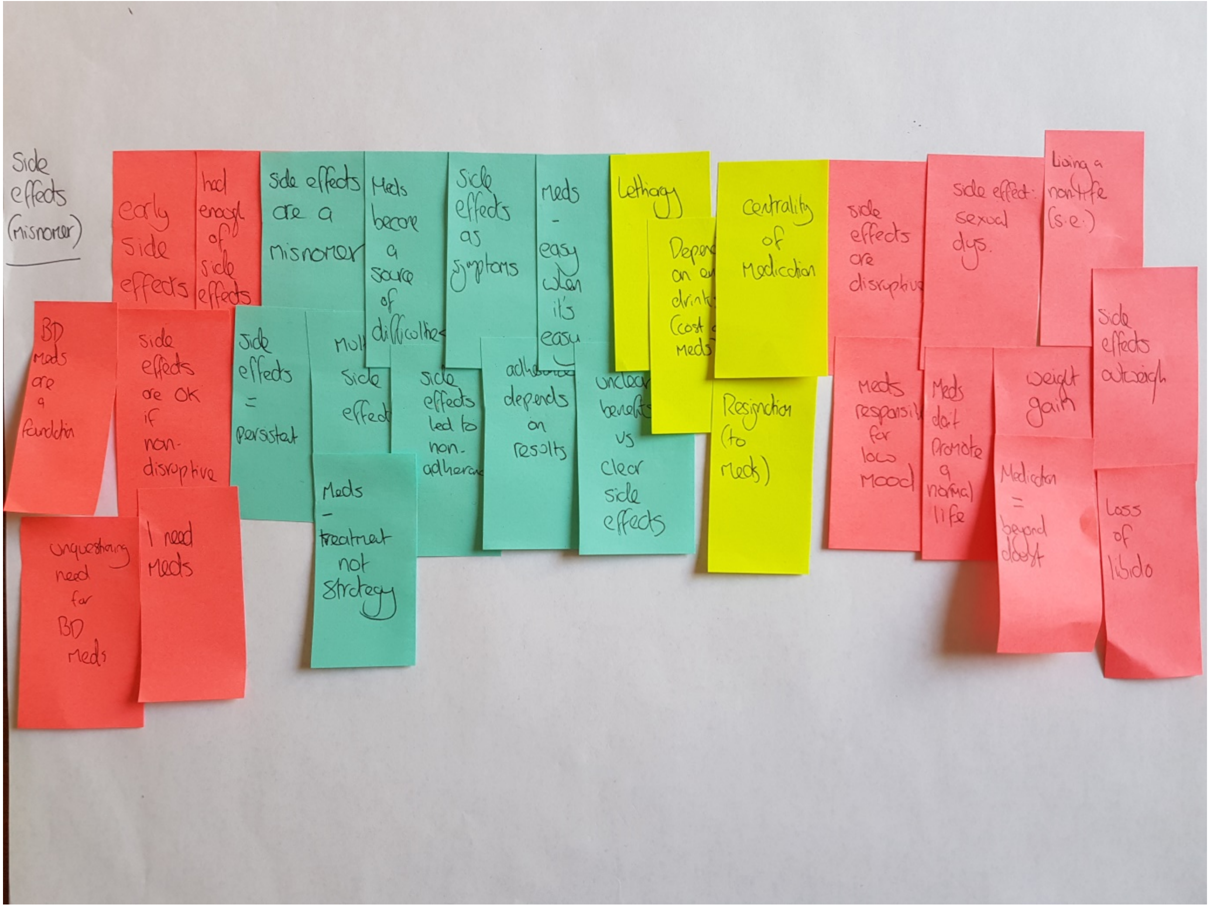


Appendix S: Example of Clustering of Emergent Themes within Participant (Nelson)



Appendix T: Examples of Clustering of Emergent Themes Across Participants





Appendix U: Table of Supplementary Quotes

Super-Ordinate Theme	Sub-Ordinate Theme	Participant	Supporting Quotation
Managing Symptoms: Living with the Enemy	Diagnosis: taking symptoms seriously	Nelson	**“***It’s something that I’ve – after my last episode when I started to try and think of ways to manage [Bipolar] it was something that I’ve adapt- I adopted then*”
			“*…when I was reading about depression and anxiety….nothing seemed to add up*”
			“*I didn’t really know about Bipolar at the time… then when I started reading about that I thought ‘y’know what, this is all starting to fall into place, this makes a lot of sense’ and after that point…when I was really starting to try and manage it uh it worked out a lot better for me, a lot better***”**
			“*…**that was the warning in the past that I totally ignored you know? I just thought I was full of energy and I thought that I could do everything and I wasn’t listening to people…*”
		Ted	**“***I was being umm pretty umm psychotic during my manic episodes and doing quite a lot of really crazy crazy stuff umm which is why I kinda now looking back part of me wishes*

			someone had intervened before”
			“*…I worked crazy crazy amounts of hours umm to the point where I worked that much that I was having HR phoning me to take a day off or they’re going to force me to take days off…[I’ve] stopped doing that now and now I only work my shift umm I don’t do every hour under the sun anymore*”
			“*…I kinda went d’you know what I kinda need help because I can’t keep going through these periods anymore…it’s been quite a lengthy battle to actually get to the Bipolar diagnosis and something that’s actually, actually helpful*”
		Jamie	“*…I was misdiagnosed since I was in my early 20s umm and I was kinda palmed off as having depression umm I don’t blame the health service or my GP for that because I was only going to the GP when I was in a very low mood and that’s how I was presenting so I was given anti-depressants and I was on anti-depressants on and off for uhh over 20 years basically…they didn’t appear to be working and whenever I got umm went back to the GP or went to counselling it wasn’t picked up so it wasn’t until I had a severe episode umm which led to me attempting to complete suicide that things umm took a turn for the worst and I was admitted to a psychiatric hospital and it was there I was diagnosed*”

			“*being prescribed the wrong medication for my condition which was misdiagnosed that kinda exacerbated a lot of my condition uh it exacerbated my condition for a long time…*”
			“*…when I had my elated mood throughout the year, like we said probably two or three times a year umm I thought that was normal because I didn’t know I didn’t know any different…*”
			“*…so I’ve had some interesting chats with them over the last couple of years and they’re saying you know your diagnosis makes sense… this kinda wanting to do more and more and more…so I have had a very different I suppose a different kind of friendship with my friends now…if we were meeting on Saturday afternoon I would usually arrive early and we’d be drinking from then…now it’s a case of we maybe go out of lunch…”*
			“*[Without the diagnosis] I’d probably still be drinking I reckon I’d probably still be in the circle of wanting to be in parties….being extremely sociable as I saw it… I’d probably still be in that pattern actually*”
		Steve	“*…before that I was taking medication and I’ll be honest I wasn’t taking it properly, there would be times where I would miss taking it. I wasn’t taking – I didn’t take my diagnosis seriously*”
	Awareness of	Nelson	“*…you’ve gotta at some point turn your head off to relax and so like this weekend for*

	triggers: avoiding the symptoms		*instance although I was deadly tempted to turn on my work laptop and start doing some work I didn't I just knitted all weekend… you've gotta step back and relax and reset for the next week"*
			"*…those occasions are now few and far between because now I tend to nip it in the bud pretty quick, very quick. There's a fine line you see between it going too far and being manageable…"*
			"*…I don't ever want to come to my desk and go for my hole punch and it's not there or my calculator's no there because then it starts to consume my thoughts 'who's got it?' 'why's it gone?'…it allows me to work in order y'know"*
			"*I couldn't handle my workload if it wasn't ordered… if I fire fight and just leave everything really messy I would- I would break very quickly…the times that I've been off work all have been after periods of major change or upheaval…"*
			"*…that grin and bear it mentality you have to have in the forces...is exactly why I ended up in the hospital to times…I wouldn't bottle everything up as much as I used to…*"
		Ted	"*Sometimes when mania is too bad um there's not much that I can do that'll calm it and I just find everything too much so if I then go to [place] it's calm, there isn't really anything there that can impact my mood and tip me over the edge…"*

			“…I don’t have specific times and days and things like that when I go to it, it is more ‘I’m having a bad day I’m just gonna drive there and go for a walk’…”
		Jamie	*“[Mindfulness] helped me to umm identify I suppose it’s helped me to identify umm some of the feelings I have before they become too great I suppose or some of the individual stressors as well…”*
			“...we’re really careful about what we put into our bodies with regard to eating and drinking and being very mindful about that but when we’re watching things or listening to things we’re not as mindful but it can still… have a really big impact…”
			“…I’ve recently been trying to listen to more upbeat music and I didn’t realise the impact it has ….impacting on my mood by listening to more upbeat music…”
			“…it was a number of things that made me realise that it was having an impact, more of an impact than I would ever have thought…”
		Steve	*“…in the early stages where I’m starting to feel depressed I will use it as a way to change my clothes every[day]…to keep my mood up…kind of dress for something or dress better uh to go to the shops or to see a friend I’ll wear something that’s a bit more presentable than I normally would just to kind of show that I’ve made an effort in myself to try and prevent me from feeling lower…”*

			“*…this works the other way as well that when I – to try and lift my mood I start doing these things…it can have a difference, it can lift me, but like I said I used to be a model so my world revolved around how I looked…*”
			“*...[through] positive self-talk, keeping myself busy, socialising, doing all the things I used to do can bring me out of this lull…”*
		Fred	“*…so I thought right this it’s bothering me this is, so I thought right I’m gonna take a picture of the car, right… so when I see that picture it just reminds me yeah it’s there, OK the car’s there, it’s nothing mega…*”
			“*…I thought well it’s a coping strategy if you like, it’s helping me to acknowledge the problem, know the problem is still there, but I can put it there because I’ve taken a picture of it…*”
			“*…that’s how I see it, that’s why I took it ‘cause I thought… I’m not gonna push it to one side y’know or leave it too long*”
		Sam	“*…obviously part of that is pacing myself, realising I need to rest more than most people so – got to be sensible…*”
			“*… I try and get on the bike each day and rather than lying in bed all day which I had*

			done in the past with Depression….”
			“…it’s too expensive to do if I’m low so y’know I would pull out in those circumstances…”
	Making room: allowing disruption	Nelson	“*...I don’t think about all the little things because I plan all the little things out, lunches all that sort of stuff, and I plan as many little things out that I can do in advance so when the big things hit I’m not overwhelmed by all the little bits and bobs in the background…”*
			“*…I have all [my clothes] ready on the Sunday night. I don’t have to think about it, I just get up in the morning, pick up the shirt, pick up the tie, wear the same cufflinks, off I go to work that’s it…*”
			“*…that signifies me preparing for the rest of the week y’know on the Sunday I get everything ready…*”
			“*…so when I have a little Bipolar blip it, it doesn’t have the massive knock-on effect that it can do”*
		Ted	“*...I find painting really really helpful, particularly if I’m manic, I just find that because I’m constantly moving between colours and brushes and different stuff umm and my brain’s kind of constantly going I find that it gets me really focused on doing something positive…”*

			"…I find that there's times when I can just sit and paint for hours and hours and hours umm and before I kind of found that it was probably uh just be getting up to nonsense most likely and doing something I probably shouldn't be whereas this focuses me on something positive and I can just do this for hours, I can just paint for hours on end and that would be alright…"
			"…I have spoke to other people with Bipolar and they have kinda found the same where they kinda find a niche activity that just kinda satisfies the need to be constantly moving whilst also not being disruptive…"
		Sam	*"...I mean I would say it is about umm I suppose the most important thing is about putting 'cash in the bank' by umm being active*
We're Not Just Managing Mood Episodes	Living with stigma	Nelson	*"…when you've spent all week putting on a face for work…dog's love you unconditionally y'know they don't want nothing off of you y'know so you don't have to put a face on for them or anything like that…"*
			"...what did happen I will say afterwards is when I did open up when I was hospitalised… things did change for me markedly… umm the way people treated me …"

			“*...my wife says to me all the time ‘[Nelson] you don’t need to be so open about it’…I don’t say it to make myself feel better but y’know what I mean it makes me feel better not having to bottle it up all the time’*
		Ted	“*…my work are pretty understanding with mental health, they’re not as understanding with me going out and doing crazy, crazy stuff that involves me breaking the law…”*
		Jamie	“*I suppose [laughs] he, he’s not judgemental [laughs] I suppose, I dunno if that’s a ridiculous thing to say but he’s not judgemental, yeah I think he, he’s non-judgemental, I don’t have to put a happy smiley face on when I’m around about him y’know sometimes y’have to do maybe when you bump into people or when I’m out and about…”*
		Steve	“*...seeing these products or seeing these clothes…reminds me of how I used to be or how I am when I’m in a good place, but it also reminds me…that I’m a failure, that I can’t do these things at the moment…”*
		Fred	“*…one of the thing that I think about sometimes umm there are people that were in the same situation as me, the fear situation, knew they’d got depression or Bipolar, right? They couldn’t deal with it, they had to keep it inside ‘cause of the fear of coming out…*”
		Sam	“*…I think it stabilises to the extent that um you know that people know and they don’t reject you um so y’know they know some of the, if you like, worst things about you*

			[laughs] and you're still accepted anyway…"
			"…I have never had a stigma problem with church…you don't have to feel like you have to be on your best behaviour all the time"
	Threat	Nelson	*"…you can off-load on people so much but you can't off-load on people all the time…I couldn't off-load on my wife every single night, I mean she would end up being ill, so that's why I picked [my dog] because…they don't take on any of your Depression umm or Bipolar or anything like that…"*
		Ted	*"…I would just much prefer to be normal but I also just know that isn't really something that's gonna be a realty for me anymore…"*
			"…it kinda got to the point where it wasn't manageable or sustainable – it was either gonna be go on medication or potentially get sectioned or potentially do a jail sentence…"
		Jamie	*"...sitting in the house can y'know your thoughts can just, you can [become] overcome with your thoughts really…"*
		Steve	*"I'm terrified of…I don't use terrified easily – I'm terrified of becoming unwell again even to the extent that I'm not in severe depression but I'm in low mood because it has such a*

			detrimental effect on me and there's always that worry that that's just around the corner"
			"*…if there's a day when you don't want to look good or you're not feeling great and you decide to stay in your same clothes all day there's always that niggling worry that 'oh, is this the start of a depressive episode?' 'is this me not feeling well?*'
			"*…even when I'm OK I have to kind of keep my mind calm so that I don't overthink things because again that can be a trigger for low mood as well. I didn't ever used to be like this…*"
			"*It's almost without meaning to it's showing to the whole world that I'm not well. I've tried to keep my – well, not many people know about my Bipolar diagnosis it's something I kind of keep to myself…[but] it's like I'm showing the world the properties of someone who's not well, who hasn't looked after themselves, who doesn't care for themselves, and that for something that is normally so hidden it's now out there for everyone to see*"
			"*…I'm feeling in a good place at the moment… but it's upsetting that within such a short amount of time the simplest things to do [are] no longer the norm and being well is no longer the norm…*"
			"*…There was a calmness of my mind before, I don't feel like my mind feels calm now, it feels numb or it feels manic. There's no happy medium…*"

			“Something that I know that I really love doing is gone and at that point I don’t think it’s ever gonna come back – I’m terrified that I’m gonna be stuck in this lull…”
			“*…it’s all making me feel better. But how long will it last?...*”
		Sam	“*…I would say now in terms of my emotional health again it is a bit of a two-edged sword umm on the one hand the fact that I have been unable to work since I was 47 umm and y mental health had um probably quite a significant effect n what I was able to do…*”
			“*…I just went to bed and read um to try to kind of…escape from the negative thoughts and feelings…*”
	Ripple effects	Ted	“*…it was difficult to talk about things with family and friends and things like that because quite a lot of the relationships I had had become uh quite strained just because of how bad my mania kind of got…which kinda compounded me feeling more alone because it was almost kinda like people didn’t care*”
			“*...the last year when my Bipolar got really disruptive umm I’ve been arrested more times than I’d ever like to have been arrested umm which has then started impacting other things…*”
			“*…because my Bipolar got quite bad my partner had to move out of our house umm just*

			because I was just not accepting help and doing some really crazy stuff…"
			"…depending on which mood state I'm in the majority of time my go to is to not eat and just not feel hungry umm so I have to get my blood checked quite regularly 'cause I end up with umm chronic vitamin deficiencies quite regularly…"
		Jamie	*"…my friends aren't as frustrated with me as they were previously…"*
			"…a lot of my umm difficulties I've had recently have been connected to kind of financial difficulties because when I've been in elated moods umm I've been spending and buy a lot of things and kinda put myself into uh severe debt…"
		Steve	*"...when I do become well all those months of not looking after myself feel like such a waste, such a dark period where even the simplest things I'm not doing – it just reaffirms how I feel…"*
			"…it's definitely hard for my sisters because they don't know if they're coming or going, they're just trying to look after me and be helpful…"
			"…my Bipolar diagnosis doesn't just affect me, it really effects my sisters who are the only living members of my family now and it's really disrupted their lives….I didn't realise until now when I'm in a stable point I don't realise how much of an effect my illness has on them. They even said to me, for us to see you looking dishevelled, for us to see you

			unwell, you don’t realise how hard it is for us to see you in such a bad place and also on top of that I’ve been suicidal so they’ve heard the absolute worst things I could say…”
			“*…My periods of depression have prevented me from working. I’ve tried to work and – I used to be such a reliable, confident worker, I used to be really confident in my abilities, I was hardworking, I knew how to work – I’ve gone back to work twice since my diagnosis and I haven’t been able to work. I’m terrified of not being able to work again…*”
Managing Goes Beyond a List of Strategies	The importance of feeling supported	Nelson	“*…my boss is forever telling me not to work all hours of the night because I’m really bad at doing that but umm she does keep saying to me you’ve gotta – and she is right in saying you’ve gotta at some point turn off your head to relax…”*
			“*Well, a lot of the time with me working the way I do…I tend to rely on people around me to say that I need to step back uh because if I don’t listen to people and I do work when I wanna work it leads to it can lead me to being hyper…”*
			“*…if I say to my wife say tonight when she comes home and I say to her I don’t quite feel right she will ask me what I mean and she will tell me her judgement of what I- what she perceives me to look like and feel like and she knows me and if she says ‘oh yeah I think you need to go and see the doctor’ then I’l go to the doctor there and then…”*

			"*I'm quite lucky with my colleagues, my colleagues are really good, really good and they're very supportive of me in general and my condition y'know so I'm lucky in that sense*"
			"*…with my current employer umm and even my previous employers after I left the navy I still them now about it, irrespective of how they would treat me differently y'know… you've got to open up irrespective of what might happen, you have to open up and tell people – if they don't know they can't help ya and they can't support ya… you've just gotta take that gamble y'know…*"
			"*…I would trust in people y'know if they say for instance my mate comes up to me and says 'look I'm a bit concerned about you mate, are you alright, what you doin?' I would have a word with myself and think right OK what's going on here y'know if he said something there must be something up…*"
		Ted	"*...yeah the first appointment really was like that where it was 'here's your medication I'll see you in a few months uh bye'…"*
			"*I did mostly want to capture the loneliness because I think I've found that the most prominent feature umm just how lonely I've felt and I felt that captured what I was trying to put across…*"

			“…*I’ve kind of found that that’s been most of my experiences that tryin to find someone that gets it and is there to kinda understand umm like even my counsellor was just like I’ve only actually ever worked with someone with Bipolar once before and it ended disastrously because the person needed medication not counselling so it ended there, so even my counsellor has never really dealt with Bipolar*…”
			“…*I’ve been in and out of counselling since I was like 15 we decided uh and there’s been times when it has worked really really well where I’ve had really good counsellors… and counselling has had a positive impact on me and then there’s been other times where it was just a waste of both our times so it kinda makes sense but I think I actually really like the counsellor that I have no because she is really honest…from a professional perspective I think she’s finding it quite [laughs] interesting just not knowing what mood I’m going to be in and just dealing with it as it comes*…”
			“*…the CPNs at the time…were just coming round on a daily basis phoning me a few times a day just to make sure that I hadn’t hadn’t done anything umm…*”
			“…there’s also nobody human or otherwise that’s ever as excited for me to come home [than my dog]…the noises that she makes if I don’t come in and immediately go and see her is ridiculous… she knows when there’s something up and will then try and do things to fix it, if she knows I’m sad it will probably go from sitting on my lap to more trying to sit

			on my chest and keep me more protected so yeah she just kinda knows when there's something up and then tries to fix it whichever way is actually possible when you're only a three and a half kilo dog [laughs]…"
		Jamie	"*…I think if it was mainly females in the group I may have felt a bit more reluctant to return because I must admit when I first heard about the support group…I was a bit reluctant to go…I'd quite misconstrued ideas about what I'd be walking into umm but I've been pleasantly surprised there's been such a wide range of people go along umm and we support each other yeah it's been very useful…"*
			"*…having that companionship of the dog as well has been greater than I would ever have expected…there's a kind of emotional link and companionship as well… I wasn't particularly a dog person before but now having him I [laughs] very much am and really feel the benefits from just having him around y'know just from being there…*"
			"*…people who are that that tends to be something that I do, so my family members have said 'are you feeling a bit better? You've been in touch a bit more um we were a bit concerned about you we were giving you space etc.' so people seem to be more aware now that's something that I tend to do…*"
			"*...when I withdrew my mum now understands a bit more about how y'know I will get in touch at some point because before she would phone up if I hadn't phoned and say*

			'what's wrong?' 'are you alright?' things like that whereas now there seems to be a bit of a mutual understanding that y'know if I'm not been in touch for two or three days y'know it's fine y'know I'm just feeling a bit more low or not particularly wanting to talk to people…"
			"…I didn't realise that until late last year, earlier this year, when I took the time out to think about it um and really I think it's after people have said 'I've noticed you've been a bit quiet, have you been OK? Y'know we've been giving you some space' so yeah it's probably been picked up um quicker y people 'round about me than myself….'"
			"…so at the end of last year umm my wife and I went through all my direct debits and said d'you need to keep this, d'you need to keep that etc..".
		Steve	*"…so I live with my sister so I really trust her so if she's telling me to do something – especially in that depressive stage – then it's for my own good. It's like I can rely on her…as horrible as it sounds in that stage I give up on myself so I rely on her or trust her to say if she says something to me it's because she knows I need to do it…"*
			"…I was not in a good place when I started the medication. I had been voluntarily sectioned…I was given these medications, I wasn't told what the medications were at that time, I was just handed medication 'take them'…I wasn't told about side effects, I wasn't told about uh why I was taking these medications what would be the – by taking

			this tablet it will help you with this, this, this and this, it was almost again returning to a child…”
			“*…as horrible as this is gonna sounds and its gonna sound terrible, it’s almost like they enjoy me being ill, I’ve become their pet project again, I’ve gone back to being 12 years old…by having this diagnosis, by being unwell, they now have the right to tell me what to do…*”
			“*I’ve not missed any medication this time round and like I said it’s not out of fear that I’ll go manic, there is a trust, I do trust my doctors and I do trust my health professionals and I do hope they’ve got my best intention, but there’s always that worry that [laughs] if I’m just numbed then I’m not going high, I’m not going low, it’s easier for them. As terrible as it sounds, if I’m high or manic…I have to be in the hospital, I have to use resources. If I’m on medication which numbs me, I might be depressed but I’m no worry to anybody outside of my home…*”
			“*I just feel like it’s brushed off…I feel like it’s almost a ‘well you take medication and there are side effects’. That’s not what I want to hear [laughs] what I’m trying to say to you is I don’t think I can handle my side effects…I get dismissed. I get dismissed. Or more medication is added which I don’t want because I don’t want even more side effects*”

			"…I have a partner, it's very hard, and again that was just dismissed as 'well, you're taking anti-psychotics and sexual dysfunction can come from that… it's almost like 'well you've got Bipolar, you've got to take these medications, tough' not 'OK maybe we can change'…"
			"So I went into this review with the idea that my medication would be changes, but I said this to them and there were like 'no we're not changing it, let's keep it the same' so that went completed against what they said to me before… you're telling me one thing when I'm depressed and I'm clinching onto these kind of comments that give me hope and then when I come and see you the next time it doesn't happen and not only that any kind of concern is dismissed…"
		Fred	*"…I can't remember which year it was, I wish I could, and his name was , yeah I won't give his name out [laughs] and he was an engineer and he said 'it won't go away you know' and I thought 'he's right it won't' and he said well my wife's a nurse y'know and it won't go away he said you y'know you need to make an appointment with your GP and uh I made an appointment with the GP…"*
			"...I had my appointment with the CPN…I saw her for twelve months and uh I used to go I think it was monthly or something like that and uh she says 'oh I think you're a bit better now I'll sign you off' you see and u anyway umm I wasn't so I was really struggling then

			with [work] so what I did was I took uh voluntary redundancy…”
			“*I think one of the things, first things that comes to mind is to see people with a similar disorder…we're all completely different and it's lovely to see them…*”
			“*…the wife and I had a nice little discussion on the Sunday morning about uh different things…she was quite um uh engaging about it all y'know…just mulling it over…so that was really nice*”
		Sam	“*I felt um a kind of spiritual sense of God saying 'I want you'*”
			“*…well I'd analyse it as representing all that our marriage represents…[without her] I wouldn't be here…I don't think, I mean if she'd have left at that point I don't know how I would have coped or what would have happened…*”
			“*...I mean basically she's been essential to managing my moods whether they're high or low or normal…*”
			“*…like when I was in the hospital here, she would visit twice a day y'know when she was allowed to so y'know nobody else was experiencing that. That's just one, one for example…*”
			“*…that's only a very minor caveat, I mean the much more important thing again is the*

			sense of acceptance, the sense of community, it brings both of those things together…it's an atmosphere of acceptance and openness y'know…"
			"*Otherwise you get sucked into your own little world which is, particularly in the current circumstances, something that isn't very helpful*"
			"*Yeah I retired at 47 having managed a Christian medical practice um I almost put a photo in to represent that time because I was with them for 20 years and obviously being in a situation where I was understood medically was helpful*"
			"*…I went to a Bipolar group which I was quite cynical about um but actually was really helpful…each week one of us would talk about our experience, so again there's that sense of community, of having something in common…*"
	Part of something bigger	Nelson	"*...I'll be honest it was a promise I made to my wife uh because both occasions when I had a major episode I run away y'know I just disappeared…I promised my wife when I came back this time that I wouldn't do it again, I would follow my regime, I would speak to my doctors, I wouldn't keep anything to myself…*"
		Ted	"*…one of the photos that you'll see which we'll probably discuss quite a lot is umm so my grandma passed away umm about 18 months ago….she really drummed it into us that if we…don't help students and people training to do jobs then we won't be able to*

			progress in science…and society won't get any better…she spent most of her life volunteering for anything she could…and I decided when she passed that I was going to continue to do the same…I've ended up doing some really random stuff [laughs] but it's been good, I understand why she does it because you do feel like you're helping…"
			"*…[my dog] has also been one of the biggest reasons when I've been suicidal that I haven't killed myself umm especially when I was given [her] I was really really suicidal at the time…*"
			"*...I don't think that [my dog] would particularly cope without me umm…it's just I don't think I could leave her umm I just don't know that she would cope to be honest…*"
		Jamie	"*…if it wasn't for the dog I would be in a low mood for longer and really he has – I wouldn't go as far as saving my life but he's made things umm he's given me a purpose I guess to get out of bed in the morning, yeah*"
		Fred	"*..especially…when we're doing the Bipolar education [group] umm I think it's – I don't know if it's 'cause no one else ever seems to say anything and I've got something to say so I do…and hopefully whatever I say might help the people, and the person running the course…y'know just put it out there…*"
		Sam	"*…I'm keen to do anything I can to help with uh growth of understand of um uh more*

			effective treatments of mental health conditions…”
			“*…obviously in the current situation there’s quite a lot of pressure and she was talking about her anxiety so know it’s umm then you can say well I’ve got mental health problems too…*”
			“*…this is part of faith you try and reach out to people where they’re at and offer comfort where you can…*”
			“*…it is the opportunity to talk to others about Bipolar Disorder, my experience, just answer their questions…it certainly should increase understanding…it’s a sense of having some kind of expertise which is useful to other people…*”
	Right tools for the job	Nelson	“*I’ve always done…as I adopt routines, I tend to be one extreme to another y’know so if I haven’t got a routine in place then I’m quite y’know [shudders] but if I’ve got a routine then it’s a routine…* “
			“*…after my second hospitalisation when I come out and I got my regime – some of the routine of submarine life shall we say – and that management system and I’ve utilised some of those skillsets for now...*”
			“*…now me and [friend] both have the same taste in music and ever since he has been there for the last couple of years now he’s dragged me out to many, many gigs and*

			y'know if he wasn't there and he wasn't saying 'oh come on let's go to this one, let's go to this one' I'd have just been at home every night y'know well like I was for years…"
			"*…I didn't have any friends [here] for years I didn't have any friends because I worked mainly with women and uh having that one person or y'know a friend…*"
		Ted	"*…I find [painting] fairly easy to get into it because I quite enjoy it umm and I like, like the end product and stuff like that as well so I don't find it that difficult to get into it umm…*"
			"*…so I've got an anchor [tattoo] on my wrist, right below my hand…the position it's in is if I have my hand anywhere it's the first thing you see and I got that specifically to uh try and ground me when I was having a particularly bad day…*"
			"*…I live really close to umm [place] which is an old mental asylum and um also a village that's closed down... during the summer I probably walk around it most days um just because the buildings are big, old, beautiful buildings…it's…really really peaceful…there's just something really peaceful about going there…it's just peaceful and quiet and calm which isn't that easy to find in many places…whilst there are people that will go and walk their dogs and stuff…there's never really that many people there so it's almost like a guarantee to go there and just have peace and quiet"*
			"*…there's about 20 buildings that span miles so if I'm just not in a place to be dealing*

			with people there is places where I can go and hide and I just know that people won't go there…"
		Jamie	"…I think reading about it umm or certainly for me I- reading about it umm I got a bit of idea of what it was about but through having having somebody guide you through it from how you should be sitting, how you should be breathing etc. really did help…"
			"…I suppose I see Mindfulness as quite a personal thing…for an instructor or tutor to guide people through it must be quite difficult…I think I'd be quite distracted…people can probably do Mindfulness wherever but umm I prefer to do it somewhere quiet I suppose…without distractions so I think if I was other people in the room I'd be very conscious of that…"
		Fred	"*…perhaps I'm fortunate umm yeah the impression I get – and they can't help this – from some people 'I've got Bipolar, I'm on medication, yeah, I've been advised to go on this course# and they can't help it y'know whatever y'know umm and umm they're perhaps not as open-minded as me and uh I just consider myself fortunate in some respects mainly umm uh because I can just seem to take it on if you like…*"
			"*…the one I learned about on the course was this quick-fire Bipolar [laughs] I call it quick fire, you can go from manic to depressed um so can you can go from high mood to low*

			mood in [snaps fingers]…and that was that was something I learned – fascinated me”
		Sam	“*…I mean the other aspect umm is the privilege of where we live…when I do have a cycle ride for exercise I just go straight along the seafront um looking at [picturesque location] which is nice…I mean it's certainly a contrast to living in London…I mean just the amount of sky we can see and uh yeah fresh air*”
Medication is a Necessary Evil	Side effects are a misnomer	Nelson	“*…I'm trying to remember the first mood stabilizer I was on because it didn't agree with me… it made me feel very flat. It controlled my moods but I just didn't get happy, sad, or anything, I was just flat…then I stopped taking it…*”
			“*…I don't get any side effects from [current medication] apart from I get one from Mirtazapine…it makes me hungry so at night when I take it - because I take it [at night] because of the sedative quality to help me sleep – I get really hungry. And yeah you eat a lot. You eat a lot. And I will say my weight isn't as bad as probably what it could be, I mean but it's not as good as it could be either…*”
		Ted	“*…there is sometimes when I'm sleepy from all the tablets and stuff that I'm kinda like [sighs] 'I used to be able to stay up all night and just get stuff done' whereas now I just sleep because it just makes me so tired…*”
			“*…the only other thing that umm I made sure was in [the photo] umm that wasn't actually*

			painting related is umm the big can of energy juice. I find that has kinda become my life where if I don't have a can of energy juice there's just no [chance] that I'm getting up in the morning, or moving, or doing anything uhh I kinda don't function without caffeine anymore"
		Jamie	"*…so half of the story of that photo was to do with the benefits of medication when you <u>when</u> you have uh the right combination 'cause sometimes that can take a long time for people…the reason that I took that as well is because I've had <u>a lot</u> of side effects from medication over the last seven-eight months…*"
			"*…the reason I've taken the photo was umm because as well as medication providing a positive effect the side effects I've been through have been really really difficult and they've probably prevented me from getting me back to work sooner, mainly because some of the medication I was taking was kinda creating lethargy, I was extremely sleep a lot of the time umm I was gaining a lot of weight on some of the meds uh it was making me crave carbs so in the end y'know I suppose the medication is supposed to make you feel better about yourself but in a roundabout way it [laughs] ended up making me feel more miserable because I was so tired I couldn't do anything…*"
			"*…certainly last year when I was really struggling with the side effects I was very reluctant to keep on taking the medication…and they were very quick acting side*"

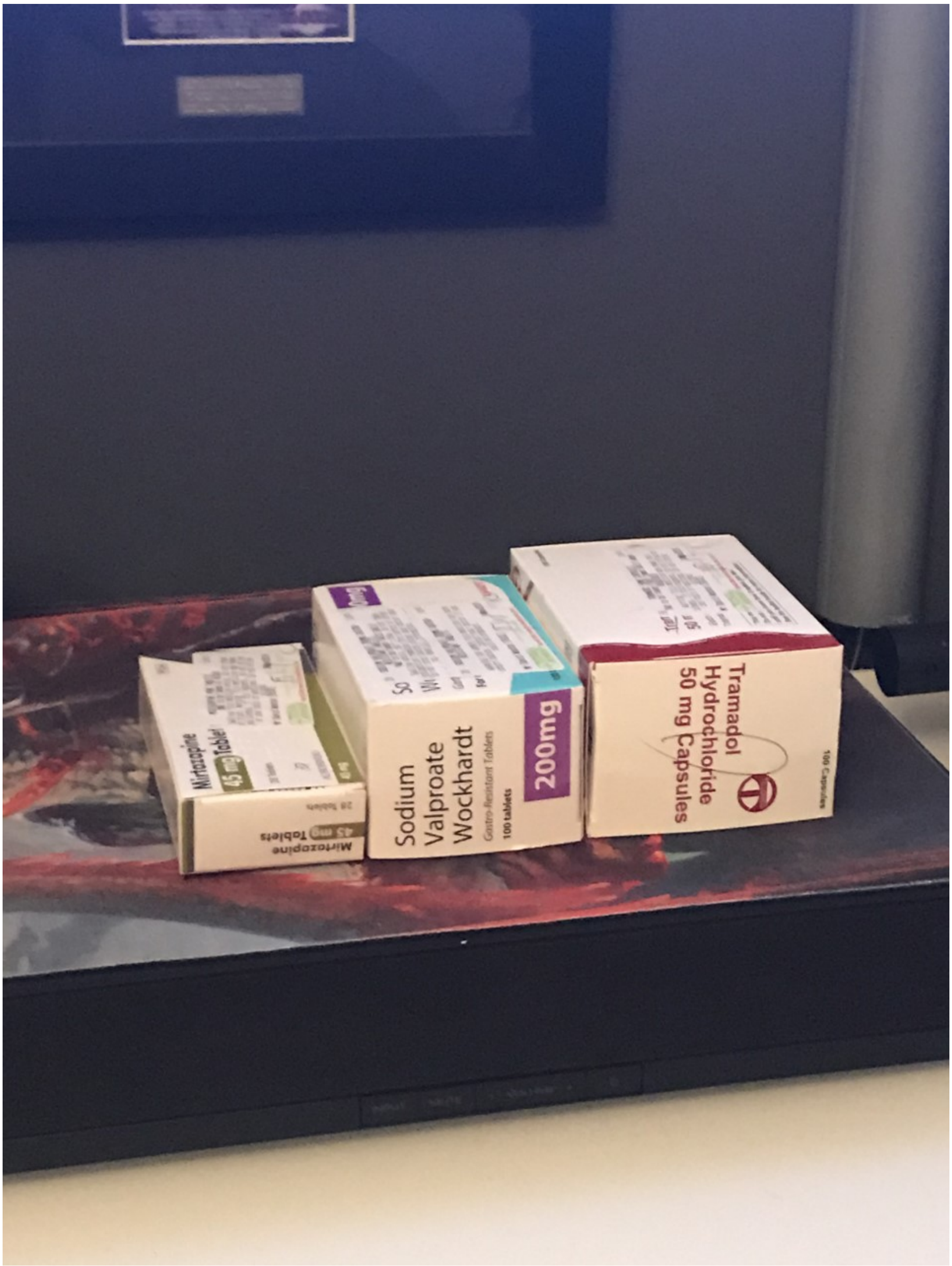
			effects… the medication I was on last year seemed to cause side effects a day or two after I was taking umm but I found out later that was normal for that medication at a later date…”
			“*…I think there was gonna be some benefit, I was starting to feel some benefit umm in mood changing to become more balanced but the side effects were kinda outweighing the benefits of [laughs] of the medication of the kinda pros of the medication…*”
			“*…they do overlap [with mood symptoms] and but they can create such a negative they can have such a negative impact on you y'know if you're already struggling with low mood that ties again with the side effects and you just really really- I've really really struggled to get any peace, any happiness at all at that point…I was in such a low mood and I think a lot of that was caused, I think it was frustration like a lot of it as well was I was quite frustrated as well thinking I should be better by now y'know I've taken all this medication, there should be some kind of relief now but there wasn't…*”
		Steve	“*…so after my last episode I was put on Risperidone and I didn't realise that Risperidone can lead to weight gain and increased appetite…I knew there were certain medications which can lead to increased weight and appetite, I just didn't realise Risperidone was one of them. But since taking Risperidone I've put on two stone…*”

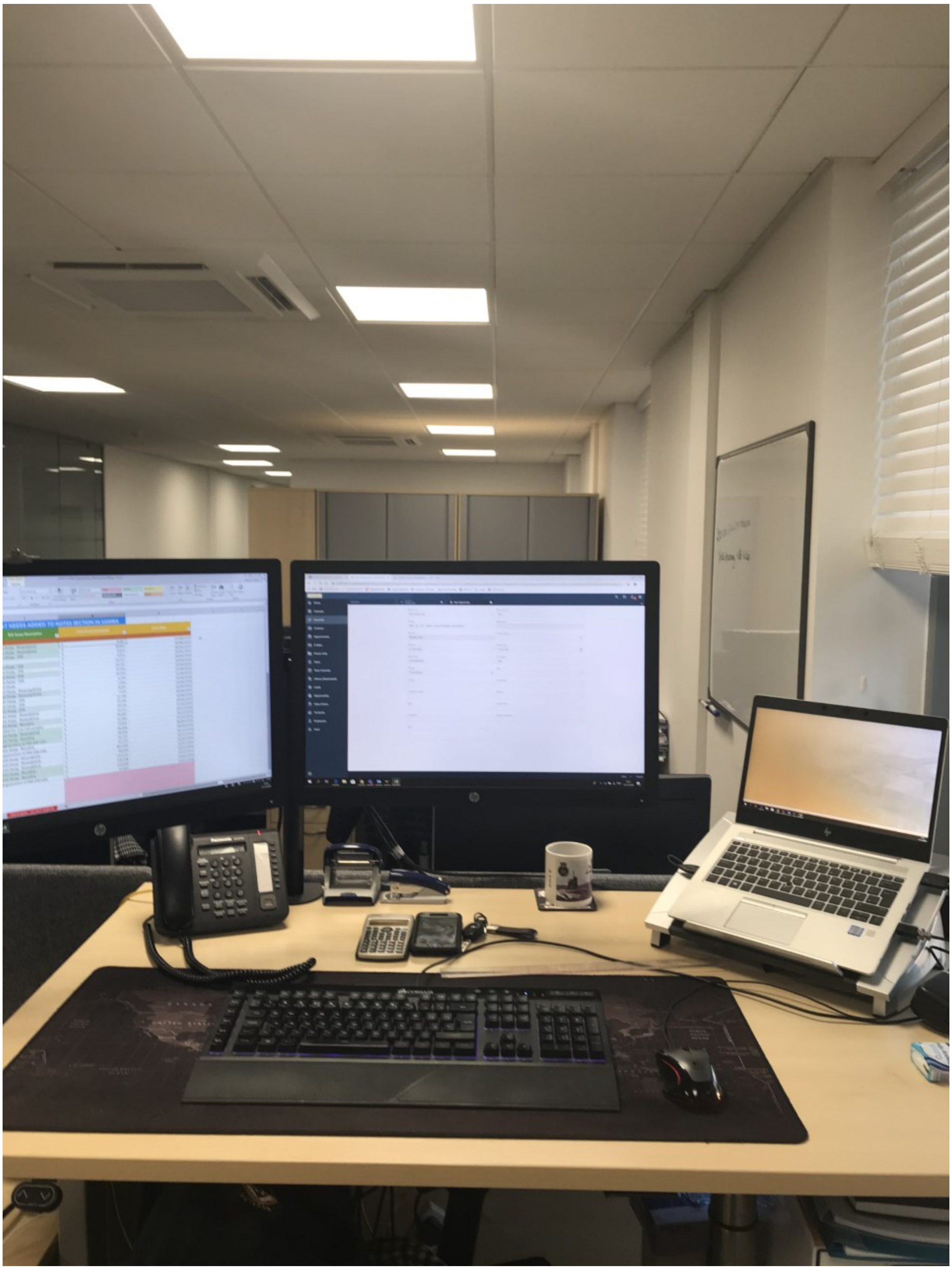
			"…I didn't believe that the medication was helping me, if anything I felt like the medication was causing me huge side effects uhh which were really an obstruction in my life…"
			"…I blame the medication…I've convinced myself it's the side effects of the medication – my low mood is due to the medication. The whole point of taking medication is for you to be kept well and I'd forgotten that because of how I felt…"
			"…I thought when I got the diagnosis I had a moment of joy because… it almost felt like 'oh they now know what's wrong with me then can give me something to help, I can get help' but the medication hasn't helped…the side effects of the medication have greatly outweighed what I see as the reason for taking them…I know I have to take them but I'm no longer who I used to be – I'm living a sedated life now I feel [pause] I feel like my emotions are completely lost, I don't feel happiness the same way I used to, I don't feel sadness the same way I used to – I barely cry now, I can barely feel my emotions and you think to yourself, this is why I came off medication that time, I was like I would rather have ups and downs and feel alive than be in a numbed state, a numbed continual state…"
			"…I've been experiencing sexual dysfunction for a long time now which I raised…how can I lead a normal life, how can I be happy with my partner, if I can't have sex with

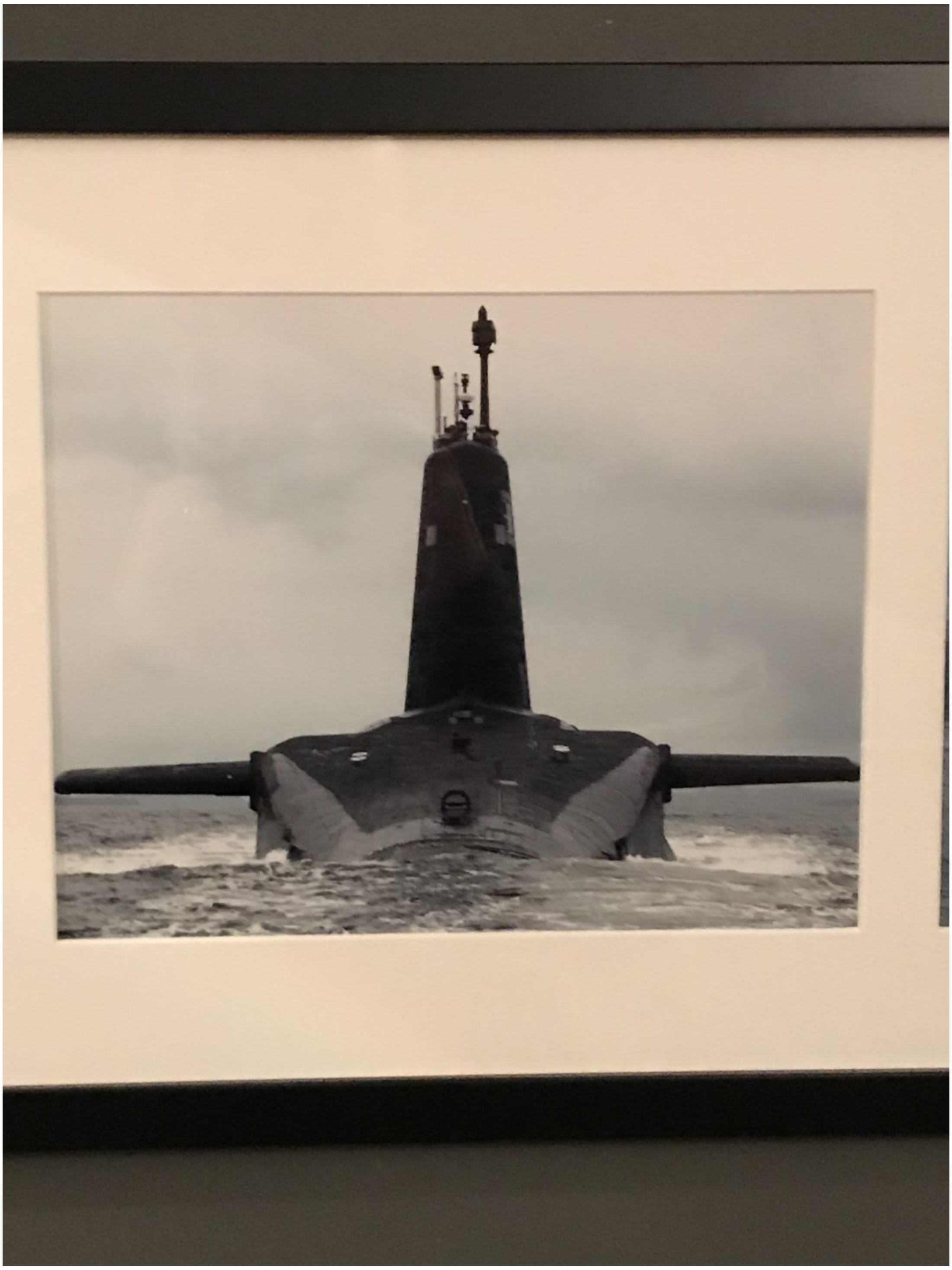
			them? Or there's no desire to have sex?...[my libido] is gone, it's gone…it's a big part of my life and again it's another – I've lost an element of me…"
			"*…I've also felt even more numb since taking it. I take it in the morning – it can cause drowsiness, it can cause uhh fogginess, memory problems. My memory recall has gone out of the window. This is something that day to day has a huge impact on your life…*"
	Medication isn't just taking pills	Ted	"*…so at the moment for my Bipolar I take 300mg of Quetiapine umm so that's just one tablet a day, umm but I'm going up to 350mg of Quetiapine at night and 50mg in the morning and then they're putting me on a mood stabilizer which is three times a day umm management I take Omeprazole for my stomach I take Amitriptyline to help me go to sleep which is two of them umm and then I take uhh vitamin D and folic acid…*"
			"*…it's difficult because I don't mind taking my pain medication as much I think because for me I know for my pain medication ones if I don't take them the consequences are really quick and I'm in a lot of pain really quickly and it really impacts my life – whereas my relationship with my Bipolar ones is a bit different umm because even my partner says that it's difficult because there is actually some positive aspects of being Bipolar…*"
			"*…it is difficult because there isn't going to be a medication that's only going to take away all the bad parts and only keep the good parts…*"

		Jamie	*"…I suppose I was maybe trying to represent the umm I suppose the amount of tablets maybe in some way…it's even things like the preparation of the tablets…I do my tablets umm for two weeks so it does take quite a bit of time to do that y'know it's quite time consuming…"*
		Steve	*"…I've always been a healthy human. I've never uh been in hospital I've I've looked after myself, I don't have Diabetes, I don't have any long-term illnesses, I don't suffer from asthma, so I've never really umm taken medication. The most I've taken is paracetamol and I rarely take paracetamol… so this has been such a huge shift from the moment I first had my episode… when I was admitted, voluntarily admitted into hospital, that day of taking no medication changed and it's become such a big part of my life now. It's strange though because for something which takes less than 30 seconds to do, to physically um to take the medicine, has now become such a huge burden in my life…"*
			"…I still think Risperidone isn't probably the right medication for me but I've gone on Aripiprazole before and I had different side effects to Aripiprazole so unfortunately the link has been cemented in my mind that medication leads to unhappiness, medication leads to I'm not who I used to be…"

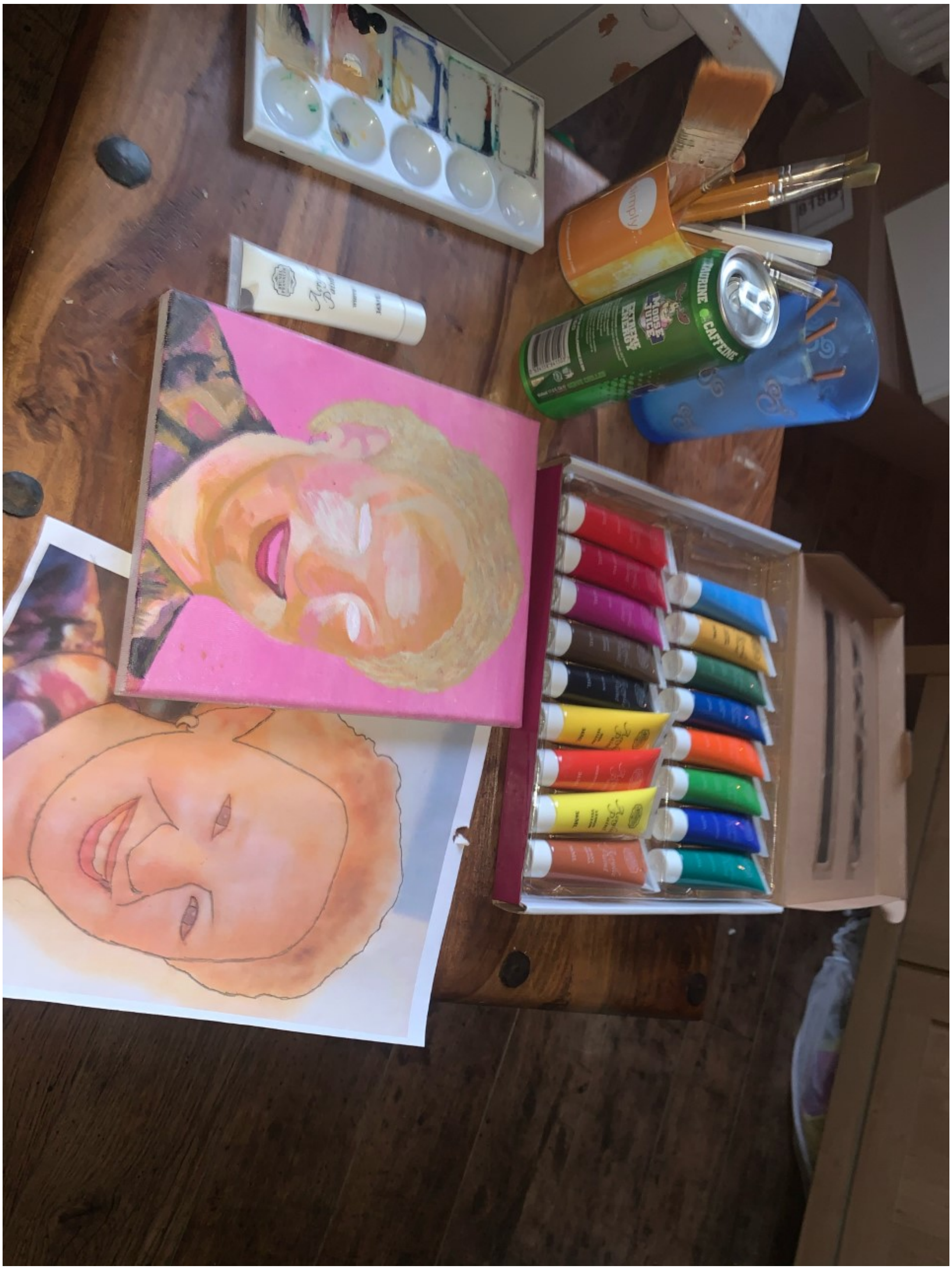
Appendix V: Supplementary Photos (Nelson)





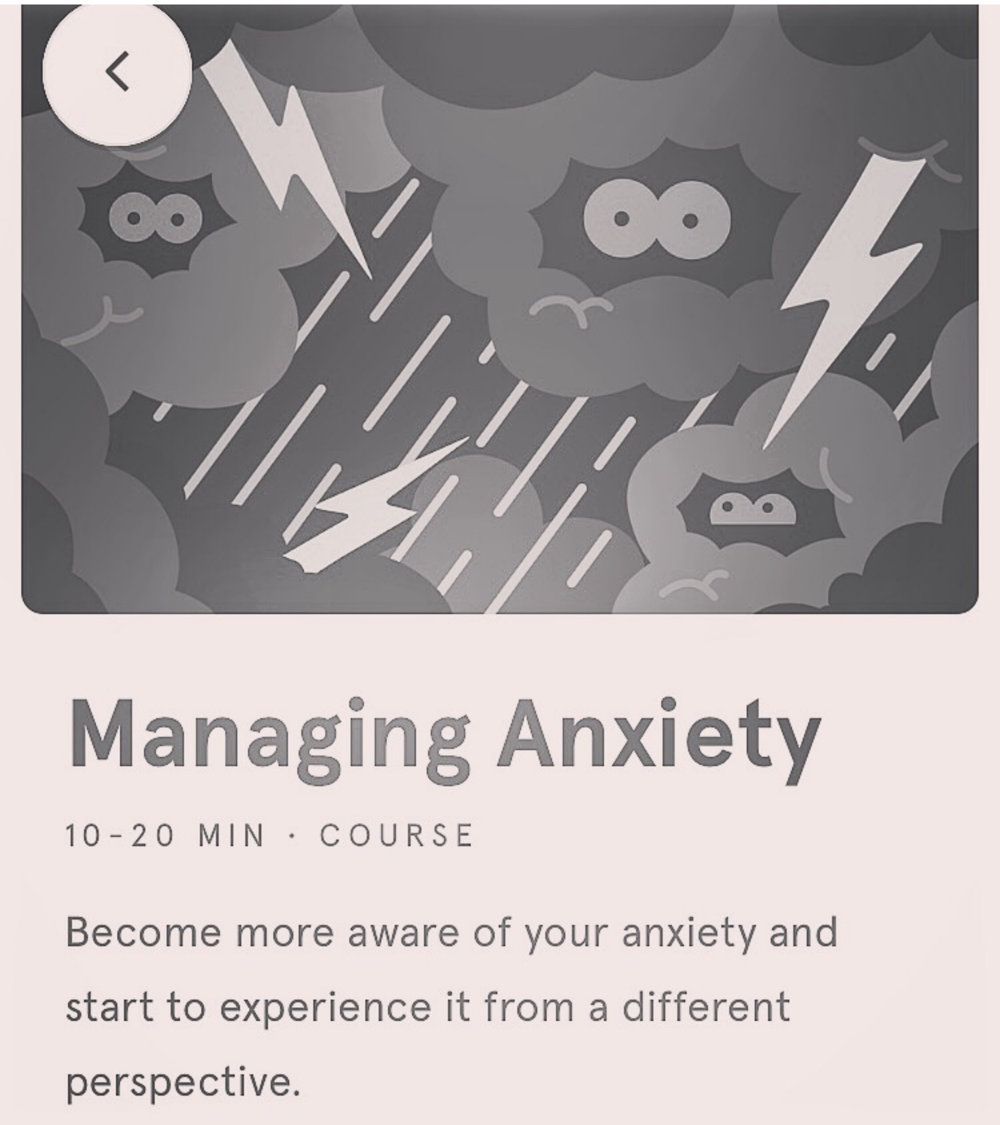


Appendix V: Supplementary Participant Photos (Ted)



Photograph not reproduced here due to issues of anonymity

Appendix V: Supplementary Participant Photos (Jamie)



Managing Anxiety

10-20 MIN · COURSE

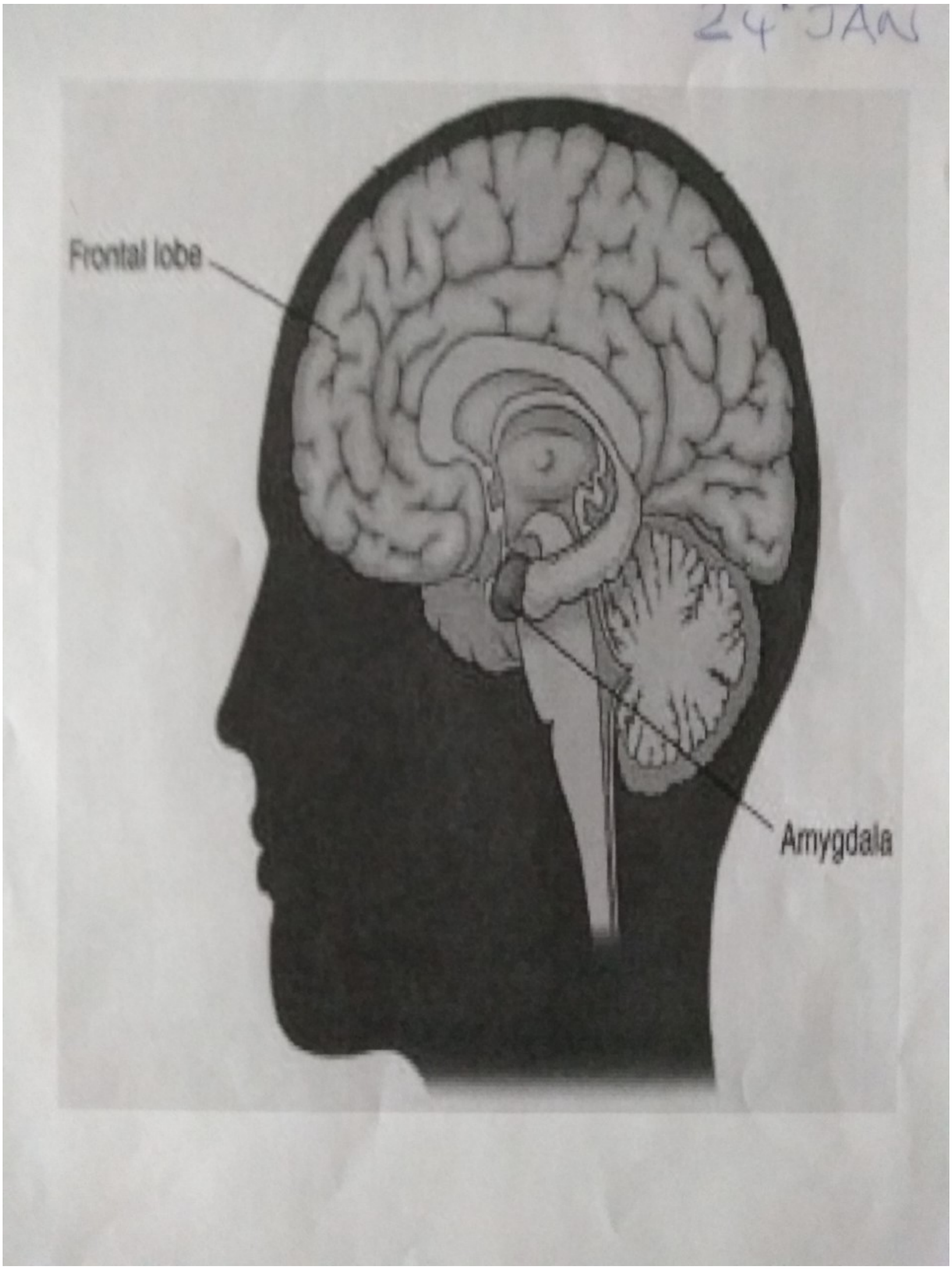
Become more aware of your anxiety and start to experience it from a different perspective.

Appendix V: Supplementary Participant Photos (Steve)

UOMO
MOSCHINO
L'ORÉAL
MEN EXPERT
HYDRA SENSITIVE
SOOTHING BIRCH SAP
FACE WASH
48H
Colgate
Total
BLACKHEAD


itv
LIVE FROM
HOLLYWOOD
08:05
THE OSCARS
'PARASITE' MAKES HISTORY #GMBOscars
South Korean thriller first foreign language film to win Best Picture at Oscars
JOAQUIN PHOENIX WINS BEST ACTOR FOR 'JOKER'
itv NEWS
Good Morning Britain
8:05
SONY

Appendix V: Supplementary Participant Photos (Fred)



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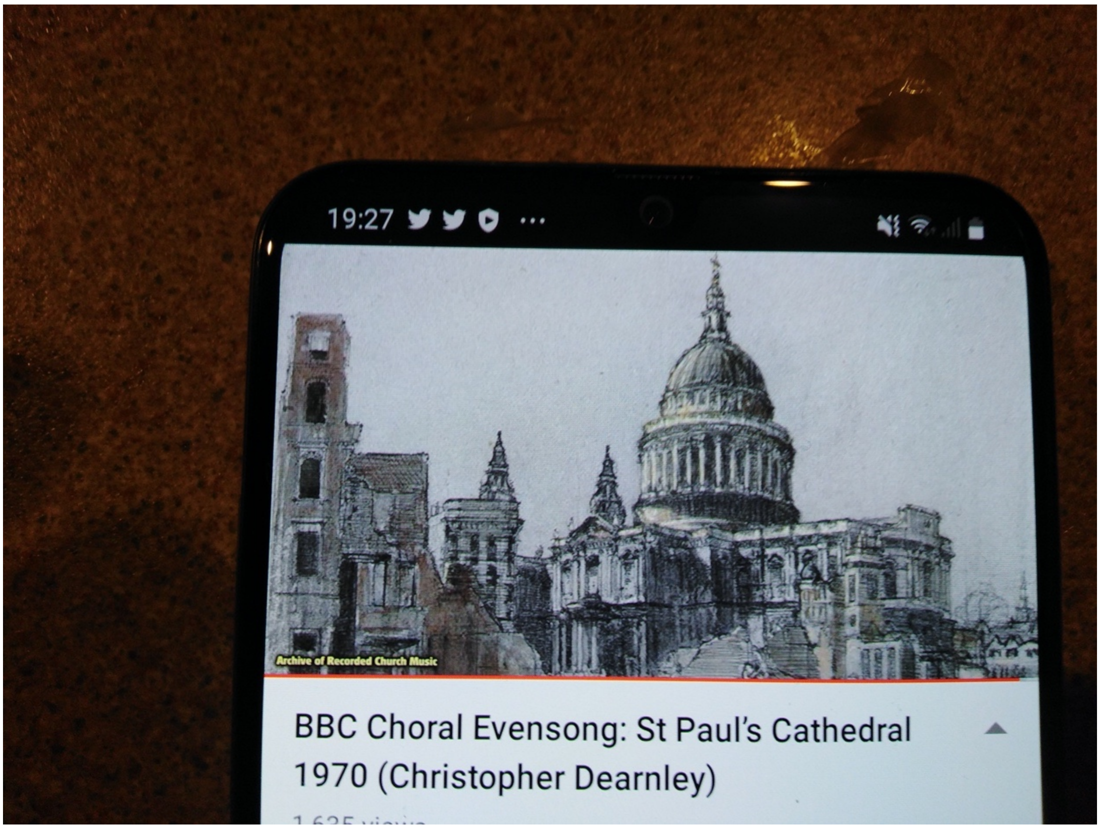
Appendix V: Supplementary Participant Photos (Sam)



BBC Choral Evensong: St Paul's Cathedral 1970 (Christopher Dearnley)


Pearl
Anniversary
30

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Paper Three: Executive Summary

Pictures speak a thousand words: Using photo-elicitation and IPA to explore men's experience of mood management following a diagnosis of Bipolar disorder

WORD COUNT: 2103

Introduction

This paper has been prepared for a target audience of practitioners and service users alike. Feedback from a service user was sought in order to ensure the suitability of the paper for this purpose.

Bipolar disorder (Bipolar) is a mental health condition. People diagnosed with Bipolar sometimes feel very low in energy and mood. At other times, they feel very high in energy and mood. These periods of low and high mood are referred to throughout this paper as ‘mood symptoms’ or ‘mood episodes’. In between these mood episodes, people with Bipolar typically experience periods of ‘normal’ or ‘stable’ mood. Despite being considered a lifelong condition people’s experiences of Bipolar are very varied, with some people having ‘stable’ moods for many years.

To manage their mood symptoms, the National Institute for Health and Care Excellence (NICE) recommends that people diagnosed with Bipolar take medication and receive psychological therapy. However, many people are not offered therapy, and the evidence supporting how useful it is remains limited. It is also common for people diagnosed with Bipolar not to take their medication as prescribed.

When asked about managing mood symptoms, people with Bipolar have reported lots of strategies including eating well and exercising, as well as understanding the things which make mood symptoms more likely. These sorts of studies are often limited to particular sub-groups, such as people who are managing their symptoms well, or have experience of a particular intervention. This means we can be less certain about how well they represent the experiences of other people diagnosed with Bipolar.

Another important issue is that there are no published qualitative studies about Bipolar which look specifically at men’s experiences. This is despite a number of published studies exploring women’s experiences. When comparing men and women diagnosed with Bipolar, studies have found differences such as the methods used to manage symptoms, and the pattern of symptoms. In one study, men diagnosed with Bipolar saw themselves as less masculine than other men, whereas women did not see themselves as less feminine. Therefore, there might be something unique about how men experience Bipolar, and their ways of managing symptoms.

What did the study aim to do?

Explore how men make sense of managing mood symptoms, including what helps and what does not help.

What was done?

The study was first reviewed by a Staffordshire University Ethics Committee, before being approved by the NHS Health Research Authority.

To be included in the study, participants had to be:

- Male, living in the UK
- Aged 18+
- Diagnosed with Bipolar
- Not currently experiencing mood symptoms
- Able to speak English fluently
- Able, and willing, to take photographs and send these to the author

Participants were unable to take part if they also had a diagnosis of:

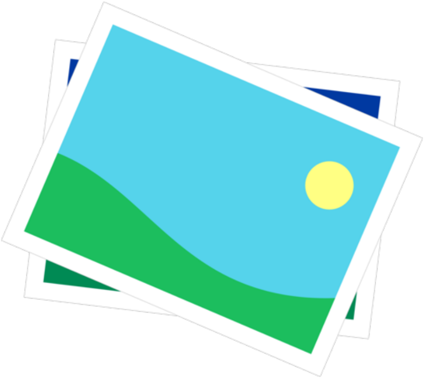
- Schizophrenia
- Schizoaffective disorder
- Borderline personality disorder

Before being able to take part in the study, men answered some screening questions to make sure they met these criteria. This included completing three questionnaires. As they were not asked to provide evidence of their Bipolar diagnosis, one of the questionnaires was used to help confirm that they would likely meet the criteria for a diagnosis. The other two questionnaires were to measure current mood symptoms.

Six men took park in the study. They were aged between 28 and 71, and three were in full-time employment.

They were asked to take photographs which captured something important about managing mood symptoms. They were asked to choose six photographs to bring to an interview where they were asked questions about the photos and what they meant.

This part of the process is known as ‘photo-elicitation’ and is a helpful way of exploring men’s experiences. It allows people taking part in research to be more in control of the interview process and talk about what is most important to them.



Some of the interviews took place face-to-face, and others over the phone, depending on whether it was convenient for participants to travel. The interviews lasted between 71-104 minutes and they were audio recorded so they could be typed up word-for-word. The transcripts were then analysed following a process called Interpretative Phenomenological Analysis (IPA).

IPA tries to explore how people make sense of particular experiences, and the meaning that these experiences have in their lives.

What was found?

Four main themes, consisting of 11 sub-themes, were identified. The four main themes are summarised below.

Managing Symptoms: Living with the Enemy

Most of the men described mood symptoms to be very negative experiences, with very negative consequences. They described the diagnosis as helping them to ‘take the symptoms seriously’ and start doing things differently in their lives. An important part of managing symptoms was about avoiding them. This was often achieved by avoiding situations which can make moods worse (known as triggers), such as working too much.

However, some strategies were about accepting mood symptoms and doing things to accommodate them. For example, finding ways to channel increased energy into something ‘productive’, or keeping exercise routines going so that the effects of Depression were less far-reaching:

> *I have always managed with um trying to keep stuff going then there’s a less sharp hill to climb once you’re better… again it’s this business of not dropping too many things so you don’t have to go through the business of picking them all up again… (Sam)*

We’re Not Just Managing Mood Episodes

All participants spoke about managing more than just mood episodes, in particular living with stigma:

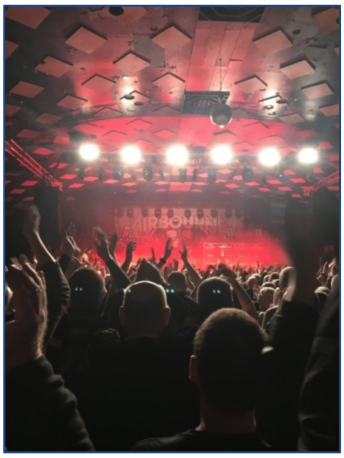
> *…if I actually wanted to… come out if you like, come out, I’m thinking [shudders] y’know? So there were two things: the fear that I’ve got… this thing, Bipolar, and then the fear or the challenge or whatever to actually accept it and… try and get some medication for it or get some somebody that could help me (Fred)*

Some participants described how Bipolar can be a threat in their lives, as well as how life becomes disrupted between mood episodes:

> *I'm now stuck with two extra stone in weight and I look at myself and it reminds me that I've done this because I wasn't well, I'm not how I used to be and it's a reminder every time I look at myself. So I can style my hair, I can trim my beard, but I don't feel good about how I look because of my excess weight… (Steve)*

Managing Goes Beyond a List of Strategies

Some of the photographs taken by the participants were about practical strategies that were helpful, such as exercise or mindfulness. However, when discussing them, participants described the strategies themselves to be only part of the process. As well as knowing helpful strategies, participants felt they needed the 'right tools' for the job. These could include activities being accessible, such as being guided through mindfulness using a smartphone app. For one participant, it was about activities that provide the benefits of socialising without the pressure to 'be sociable':



> *…even when you're low y'know it's good to try and push yourself to go out and socialise with people y'know and the benefit of a gig is you don't have to interact with people…*
>
> *(Nelson)*

Participants also described what they needed beyond the strategies, which included a need to feel supported, and to be part of something bigger than themselves. For some, this meant using their own experiences to help other people. For others, it could include a commitment or duty to someone else:

…having the dog has made me go out the house, makes me get up in the morning, makes me walk at least two times a day as well, the dog needs to be fed in the morning, he needs walks in the morning, he needs walks in the afternoon… (Jamie)

Medication is a Necessary Evil

Four of the participants were diagnosed in the last five years. Each of them brought a photograph of medication to the interview. Though there was a sense that medication was a necessary part of managing Bipolar, the participants described them to be very difficult to live with. The men described how side effects from medication could become their main concern (becoming more bothersome than the symptoms themselves), particularly when the side effects impacted on important aspects of their lives. Some participants also described that taking medication is not ‘just taking some pills’ and that it can be a big part of their life:

…there’s just times where it’s just exhausting and I would much prefer not to have to go to appointments and much prefer not to have to go t- to take medication and not to have to go and get tests and stuff like that trying to make sure that everything’s fine… (Ted)

What do the key findings tell us?

- Although men with Bipolar may see themselves as less masculine, the men in this study did not talk about their gender. It is therefore possible that perceptions about masculinity are not an important aspect of managing Bipolar symptoms.
- Receiving a diagnosis of Bipolar can be helpful for men to start recognising symptoms as ‘a problem’ and begin doing things differently to manage them in the longer term. The benefits of the diagnosis in promoting ‘recovery’ from symptoms has been found in previous research.
- The findings highlight that an important aspect of managing Bipolar can be making room for disruption (caused by triggers and symptoms) rather than only avoiding it.
- Life with Bipolar can mean having difficulties beyond mood episodes e.g. experiencing stigma. These findings are consistent with a recent review of what people find distressing about living with Bipolar.
- The findings build on existing research which identified support networks to be an important aspect of managing. They also highlight how being ‘part of something beyond themselves’, e.g. using their experiences to help others, can provide a sense of purpose which supports managing symptoms.
- Knowledge of helpful strategies is not always enough - there are a number of factors which can impact how helpful strategies are for individuals. For example, whether techniques such as mindfulness are available in a format which supports the way the person learns.
- Recently diagnosed men experience a number of barriers to taking medication, whilst seeing it as an essential part of managing.

What might this mean for practitioners?

The findings suggest that men may be receptive to Acceptance & Commitment Therapy (ACT) which sees strict attempts to control things as a problem in itself, and advocates people embracing even unpleasant experiences openly. However, more research is needed to support the use of ACT with those diagnosed with Bipolar.

Practitioners should be willing to adopt more holistic approaches to working with service users diagnosed with Bipolar; supporting the improvement of life beyond mood episodes.

Opportunities for men diagnosed with Bipolar to take part in valued activities, which promote a sense of purpose, should be explored. This may include opportunities to use their lived experiences to help others or develop services. However, it is important that ideas to facilitate this are not restricted to any one proposal.

Practitioners should avoid ‘prescribing’ strategies (e.g. exercise or mindfulness) for people to manage their mood symptoms. Time should be spent exploring what these activities would mean to service users, and what potential barriers they may face.

Clinical psychologists may play an important role in supporting medical colleagues prescribing and reviewing medication. They could work alongside colleagues and service users to support a better understanding of concerns about medication, as well as psychological and social factors which may be contributing to mood symptoms.

What did the study do well?

By excluding men who also had a diagnosis of Schizophrenia, Schizoaffective disorder, or Borderline personality disorder, the author could be more certain that participants were reflecting on ‘managing Bipolar’ specifically.

What could be improved on in future research?

Men in this study were only interviewed at one point in time, meaning they were only making sense of their experiences at a particular point in time. Indeed, they made sense of their experiences when they were not currently experiencing a mood episode. As Bipolar is understood to be a lifelong condition it may be helpful for future research to consider interviewing participants at more than one time-point. This would help us understand the ways that management of symptoms may change over time.

Even though the study did not set out to recruit men who were 'higher functioning', the men who took part could be seen this way. For example, all of the men were in relationships; most had completed higher education qualifications; and half of them had a full-time job. Future research should consider ways to represent a broader range of views and experiences.

Further Reading

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.

Burton, A., Hughes, M., & Dempsey, R. C. (2017). Quality of life research: A case for combining photo-elicitation with interpretative phenomenological analysis. *Qualitative Research in Psychology*, *14*(4), 375-393. https://doi.org/10.1080/14780887.2017.1322650

Chatterton, M. L., Stockings, E., Berk, M., Barendregt, J. J., Carter, R., & Mihalopoulos, C. (2017). Psychosocial therapies for the adjunctive treatment of bipolar disorder in adults: Network meta-analysis. *British Journal of Psychiatry, 210*(5), 333-341. https://doi.org/10.1192/bjp.bp.116.195321

Fernandez, M. E., Breen, L. J., & Simpson, T. A. (2014). Renegotiating identities: experiences of loss and recovery for women with bipolar disorder. *Qualitative Health Research, 24*(7), 890‐900. https://doi.org/10.1177/1049732314538550

Goodwin, F. K., & Jamison, K .R. (2007). *Manic-depressive illness: Bipolar disorders and recurrent depression* (2nd ed.). New York, NY: Oxford University Press.

Hayes, S. C. (2019). *A liberated mind: How to pivot toward what matters*. New York, NY: Avery.

Jawad, I., Watson S., Haddad, P. M., Talbot, P. S., & McAllister-Williams, R. H. (2018). Medication nonadherence in bipolar disorder: a narrative review. *Therapeutic Advances in Psychopharmacology, 8* (12)*,* 349-363. https://dx.doi.org/10.1177%2F2045125318804364

Jones, S. H., Akers, N., Eaton, J., Tyler, E., Gatherer, A., Brabban, A., …Lobban, F. (2018). Improving access to psychological therapies (IAPT) for people with bipolar disorder: Summary of outcomes from the IAPT demonstration site. *Behaviour Research and Therapy, 111*, 27-35. https://doi.org/10.1016/j.brat.2018.09.006

Kriegshauser, K., Sajatovic, M., Jenkins, J. H., Cassidy, K. A., Muzina, D., Fattal, O., ...Singer, B. (2010). Gender differences in subjective experience and treatment of bipolar disorder. *The Journal of Nervous and Mental Disease*, *198*(5), 370-372. https://dx.doi.org/10.1097%2FNMD.0b013e3181da8ef7

Mansell, W., Powell, S., Pedley, R., Thomas, N., & Jones, S. A. (2010). The process of recovery from bipolar I disorder: A qualitative analysis of personal accounts in relation to an integrative cognitive model. *British Journal of Clinical Psychology, 49*(2), 193-215. https://doi.org/10.1348/014466509X451447

Morton, E., Michalak, E. E., Hole, R., Buzwell, S., & Murrary, S. (2018). 'Taking back the reigns' – A qualitative study of the meaning and experience of self-management in bipolar disorder. *Journal of*

Affective Disorders, 228, 160-165. https://doi.org/10.1016/j.jad.2017.12.018

Murray, G., Suto, M., Hole, R., Hale, S., Amari, E., & Michalak, E. E. (2011). Self-management strategies used by ‘high functioning’ individuals with bipolar disorder: From research to clinical practice. *Clinical Psychology & Psychotherapy*, *18*(2), 95-109. https://doi.org/10.1002/cpp.710

National Institute for Health and Care Excellence. (2014). *Bipolar disorder: Assessment and management.* (NICE Clinical Guideline No.185). Retrieved from: https://www.nice.org.uk/guidance/cg185/chapter/Key-priorities-for-implementation

Nivoli, A. M., Pacchiarotti, I., Rosa, A. R., Popovic, D., Murru, A., Valenti, M., ...Colom, F. (2011). Gender differences in a cohort study of 604 bipolar patients: the role of predominant polarity. *Journal of Affective Disorders*, *133*(3), 443-449. https://doi.org/10.1016/j.jad.2011.04.055

Oliffe, J. L., Broom, A., Popa, M., Jenkins, E. K., Rice, S. M., Ferlatte, O., & Rossnagel, E. (2019). Unpacking social isolation in men’s suicidality. *Qualitative Health Research*, *29*(3), 315-327. https://doi.org/10.1177%2F1049732318800003

Russell, S. J., & Browne, J. L. (2005). Staying well with bipolar disorder. *Australian and New Zealand Journal of Psychiatry, 39*, 187-193. https://doi.org/10.1080%2Fj.1440-1614.2005.01542.x

Sajatovic, M., Micula-Gondek, W., Tatsuoka, C., & Bialko, C. (2011). The relationship of gender and gender identity to treatment adherence among individuals with bipolar disorder. *Gender medicine*, *8*(4), 261-268. https://doi.org/10.1016/j.genm.2011.06.002

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London, UK: Sage Publications.

Warwick, H., Mansell, W., Porter, C., & Tai, S. (2019). ‘What people diagnosed with bipolar disorder experience as distressing’: A meta-synthesis of quality research. *Journal of Affective Disorders, 248,* 108-130. https://doi.org/10.1016/j.jad.2019.01.024