

Doctorate in  
Clinical Psychology



Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology,

July 2019

**Doctoral Thesis**

*A qualitative exploration of how people with bipolar disorder consider risk-taking in  
everyday decisions*

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## Word Counts

	<b>Main Text</b>	<b>Appendices (including tables, figures and references)</b>	<b>Total</b>
Thesis Abstract	298	-	298
Literature Review	7052	10,417	17,469
Research Paper	7721	7097	14,818
Critical Appraisal	3968	799	4,767
Ethics Section	2349	2509	4,858
<b>Total</b>	<b>21,388</b>	<b>20,822</b>	<b>42,210</b>

## Thesis Abstract

Bipolar Disorder (BD) is characterised by shifts between episodes of mania, hypomania and depression. BD is considered a lifelong diagnosis and individuals with BD are estimated to be symptomatic for almost half their life. Individuals with BD can have excessive involvement in activities that have a high potential for adverse consequences. Such activities include spending sprees, sexual indiscretions, shoplifting and aggression. The consequences of these actions can often have a severe impact on their social, educational, occupational and daily functioning.

Section 1 is a qualitative systematic literature review that explored how self-management strategies are perceived by individuals with BD. A meta-ethnography approach was used to synthesise 18 qualitative research studies. Three themes were identified; “The Process of Successful Self-Management Skills”, “Self-management: *Symptom*-management or *Lifestyle*-management” and “The Fear of a Relapse”. Implications of the findings suggest that self-management strategies should encourage individual adjustments so that the individual can adapt their behaviour in different contexts. It may also be helpful to change the focus on lifestyle rather than symptoms. Finally, an underlying fear may be impacting the adherence to self-management strategies.

Section 2 is a qualitative research study that explored how individuals with BD consider risk in everyday decisions. Eight participants were interviewed. Interpretative phenomenological analysis was used to analyse the interviews. Four themes were identified that impacted an individual’s consideration of risk: identity, control, fear and supporting network. Implications include individual explorations of how the four themes may be impacting on the risk-taking decision-making process.

Section 3 is a reflexive critical appraisal of the thesis process. It gives a summary of the two papers before reflexively discussing three topics that involved key decisions and learning points. The three topics explain why I chose this topic, how I ensured quality and trustworthy findings and my reflections on the thesis process.

## **Declaration**

This thesis records work undertaken for the Doctorate in Clinical Psychology at Lancaster University from July 2018 to July 2019

The work presented here is the author's own, except where otherwise stated. The work has not been submitted for the award of a higher degree elsewhere.

Name: Andrew Wah

Signed:

Date:

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I would like to thank my Saviour and Lord, Jesus Christ. Without his grace, I would not have been able to complete this course and the thesis. My life and everything I do is for your glory.

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To the 2016 cohort. I am so glad to have met you, worked with you and to have grown personally and professionally with you over the past three years. You are all amazing!

Finally, thank you to my wife, Fiona, and children, Reuben and Rheyra. You have been with me throughout this course, supporting me and encouraging me through the tough moments. Most of all, thank you for making me smile and laugh and continuing to love me. I love you.

## Contents

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	Page
<b>Section 1: Systematic Literature Review</b>	
<i>An exploration of how people with bipolar disorder perceive their self-management strategies. A meta-synthesis of qualitative studies.</i>	
Abstract	1-2
Introduction	1-3
Method	1-8
Results	1-14
Discussion	1-21
Conclusion	1-27
References	1-28
Tables and Figures	
Table 1: SPIDER Search Terms	1-42
Table 2: Inclusion and Exclusion Criteria	1-43
Figure 1: Flowchart of Selected Studies	1-44
Figure 2: First, Second and Third-Order Constructs	1-45
Figure 3: Extract of Subordinate Themes Grid	1-46
Table 3: Quality Appraisal of Selected Studies	1-47
Table 4: Third-Order Constructs and Subthemes	1-51
Appendices	
Appendix 1-A: Search Strategy	1-52
Appendix 1-B: Modified Quality Appraisal Tool	1-58
Appendix 1-C: Journal Author Guidelines	1-63

---

**Section 2: Research Paper**

*A qualitative exploration of how people with bipolar disorder consider risk-taking in everyday decisions.*

Abstract	2-2
Introduction	2-3
Method	2-7

---

---

Results	2-12
Discussion	2-21
Conclusion	2-29
References	2-30
Tables	
Table 1: Inclusion and Exclusion Criteria	2-39
Table 2: Participant Characteristics	2-40
Table 3: Participant Examples of Everyday Decisions	2-41
Table 4: Example of Subordinate Themes	2-42
Table 5: Contribution to Major Themes	2-43
Appendices	
Appendix 2-A: Extract of Coded Transcript	2-44
Appendix 2-B: Major Theme Development	2-46

---

### **Section 3: Critical Appraisal**

Introduction	3-2
Summary of the Thesis Findings	3-2
Why I chose this research	3-5
Ensuring Quality and Trustworthy Findings	3-7
My Reflections of Thesis Process	3-11
Conclusion	3-14
References	3-15

---

### **Section 4: Ethics Section**

FHMREC Ethical Approval Letter	4-2
FHMREC Ethics Application Form	4-3
Research Project Protocol	4-14
Appendices	
Appendix 4-A: Participation Information Sheet	4-26
Appendix 4-B: Email Invitation Template	4-30
Appendix 4-C: Project Advert	4-31

---



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Appendix 4-D: Consent Form

4-32

Appendix 4-E: Interview Schedule

4-34

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**Doctoral Thesis**

Section 1: Systematic Literature Review

*An exploration of how people with bipolar disorder perceive their self-management strategies. A meta-synthesis of qualitative studies.*

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Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

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### **Abstract**

**Purpose:** To conduct a qualitative meta-synthesis that explores how individuals with Bipolar Disorder perceive their self-management strategies.

**Methods:** On the 5<sup>th</sup> November 2018, a systematic search of six relevant databases (PsychINFO, CINAHL, MEDLINE, EMBASE, Scopus and the past year only on PubMed) was performed. The search terms “bipolar disorder”, “self-management and perceptions” and “interviews or qualitative” were used. Screening and full-text reads were completed followed by citation and google pearl searches. Meta-ethnography was used to synthesis the 18 selected studies.

**Results:** Three themes were identified. The first theme, A Process of Successful Self-Management was identified. The process started at diagnosis and how the individual accepted it. The process then moved through increasing knowledge and skills, awareness and insight, responsibility, and discipline to adhere to the strategies. Finally, the definitive aspect of successful self-management strategies was the adjustment phase. The second theme, Self-Management: Symptom-Management or Lifestyle-Management, regarded the focus of the self-management strategy. It appeared that the preferred focus should be on lifestyle-management. The final theme was the Fear of a Relapse. Individuals with BD often fear a relapse, and this can impact whether they adhere to their self-management strategy or not.

**Conclusions:** Self-management strategies should enable individuals with BD to learn about BD and themselves, before empowering individuals to learn adjustments so they can adapt to changing contexts. The self-management strategies could also focus on lifestyle changes that emphasise on improving their quality of life. Finally, fear of a relapse should be considered.

Bipolar disorder (BD) is considered a lifelong condition characterised by periods of mania and depression (The National Institute for Health and Care Excellence (NICE), 2016; 2015). For the individual, BD can have significant negative effects on education, occupation, social and intimate relationships, and daily functioning (Walsh, Corcoran, Crooks, Cooke, & Cummings, 2017). It has been estimated that, because of the recurrent and cyclical nature of BD, individuals with BD are symptomatic for almost half their life (Malhi et al., 2012). Furthermore, it is likely that individuals with BD will come into contact with secondary care mental health services (Pontin, Peters, Lobban, Rogers, & Morriss, 2009) which contributes to the considerable cost of managing BD for the UK healthcare system (Young, Rigney, Shaw, Emmas, & Thompson, 2011). To help manage their BD, interventions offered include pharmacology, psychotherapy, psychoeducation, family and peer support, self-help or a combination of these (NICE, 2016; Pontin et al., 2009; Rogers & Taylor, 2017; Simon, Budge, Price, Goodwin, & Geddes, 2017).

Medication is emphasised as the primary intervention for BD and can reduce symptoms, the number of relapses and time between relapses (NICE, 2016; Gitlin & Miklowitz, 2017). Nevertheless, a challenge exists between balancing the efficacy of medication and its tolerable side-effects (Ketter et al., 2014). The complexity of pharmacological choice rises as approved treatments are tailored to target the different phases of BD (Gitlin & Miklowitz, 2017; Ketter, Citrome, Wang, Culver, & Srivastava, 2011), however, this can result in combinations that are not supported by evidence (Malhi et al., 2012). Furthermore, a study found that for every beneficiary of medication for BD symptoms, there were more that did not benefit from their medication (Ketter et al., 2011). The ceiling effect of pharmacological treatments has meant that adjunctive pharma-psychotherapeutic interventions have widened and can improve efficacy (Crowe & Porter, 2014; Goodwin et al., 2016).

For some people, a psychological, non-pharmacological approach that explores a person's identity and belief about BD has been helpful (Cappleman, Smith, & Lobban, 2015). A psychologically informed way of exploring a person's BD would develop a personal formulation that would impact goals, interventions and management strategies (Johnstone & Dallos, 2014). The formulation should develop a personal understanding of the key psychological processes involved at the different stages across BD (Searson, Mansell, Lowens, & Tai, 2012). NICE guidelines (NICE, 2016) recommends manualised cognitive behaviour therapy (CBT) that focusses on how thinking styles and behaviours maintain symptoms (Searson et al., 2012). There has also been an emergence of evidence for alternate psychotherapies that focus on other psychological processes of BD. For example, cognitive analytic therapy explores interpersonal relationships (Evans, Kellett, Heyland, Hall, & Majid, 2017) or acceptance and commitment therapy facilitates acceptance of difficulties and focusses on personal values (O'Donoghue et al., 2018). The early evidence of alternate psychotherapies does appear encouraging (Chadwick, Kaur, Swelam, Ross, & Ellett, 2011; Evans et al., 2017; O'Donoghue et al., 2018), however, there are interpretation difficulties within psychotherapy research that makes it hard to define what aspects of psychotherapy are actually effective (Goodwin et al., 2016). While the focus of psychological processes may change, psychoeducation and self-management tools are aspects that are consistently promoted within psychotherapy for BD. Psychoeducation is considered to be an essential aspect of clinical management for BD as it appears that knowing what to do and why facilitates action (Goodwin et al., 2016). Furthermore, self-management tools that involve individuals to be mindful of their mood and potential triggers, such as staying well plans, could be helpful (Murray et al., 2011; Russell & Browne, 2005).

As a relatively low-cost option, group psychoeducation has been shown to have effective results in reducing the time between relapses, especially for those with seven

relapses or less (Morriss et al., 2016). Individual perceptions also suggest that group psychoeducation can build confidence regarding their diagnosis and their understanding of their symptoms (Poole, Smith, & Simpson, 2015). Etain et al. (2017) suggest that it could be a change in illness perception that is the key mediator in effective psychoeducation. Although appearing to be an effective intervention at a relatively low cost, accessing group psychoeducation can be difficult due to availability, location, and individuals being uncomfortable in group settings (Smith et al., 2011). To increase accessibility, many developers have tried to utilise the internet by producing psychoeducation interventions for BD via internet and smartphone platforms (Bardram, Frost, Szántó, & Marcu, 2012; Fletcher, Foley, & Murray, 2018; Gliddon, Barnes, Murray, & Michalak, 2017; Lauder et al., 2011; Nicholas, Boydell, & Christensen, 2017; Nicholas, Larsen, Proudfoot, & Christensen, 2015; Poole, Simpson, & Smith, 2012; Todd, Jones, & Lobban, 2013). Whilst these interventions can remove some barriers to psychological treatment, further development is needed to enhance the experience for users. For example, Gliddon et al. (2017) explain how social support is appreciated by users, yet it is limited on smartphone platforms.

Irrespective of the intervention, pharma or psychotherapy, treatment adherence can be problematic for individuals with BD (Gaudiano, Weinstock, & Miller, 2008; Jawad, Watson, Haddad, Talbot, & McAllister-Williams, 2018; Russell & Moss, 2013; Sajatovic, Davies, & Hrouda, 2004). Treatment non-adherence is associated with increasing re-lapses that can reduce the quality of life of the individual and increase the cost to the healthcare system (Ng-Mak et al., 2018). Ample research has been conducted to formulate reasons for non-adherence. For example, the complex and fluctuating symptomology of BD could require different strategies at different times (Janney, Bauer, & Kilbourne, 2014); or with medication, there is a balance of benefits and potential side effects to consider (Ketter et al., 2014). Additionally, the diagnosis itself may cause a sense of psychological loss of self and evoke

emotions that make it difficult to monitor and describe their feelings (van Bendegem, van den Heuvel, Kramer, & Goossens, 2014). For others, it may be that the intervention given was not their choice (Fisher, Manicavasagar, Kiln, & Juraskova, 2016). For adolescents, it may be that the strategy requires a more engaging platform, such as on a smartphone, or that it didn't meet their specific needs (Nicholas et al., 2017). Furthermore, it may be the daily adherence to medication or constant monitoring of symptoms may raise additional burdens in their life that are difficult to maintain (van Bendegem et al., 2014). This is not an exhaustive list but does show the variety of considerations needed to maintain treatment adherence in BD.

Thus, effective long-term management of BD relies heavily on an adherence to self-management strategies, defined as an increased responsibility to learn about their symptoms and to develop skills and strategies that enable a person to observe, anticipate and preside over their difficulties (Jones, Deville, Mayes, & Lobban, 2011; Weiner, 2011). Self-managing their BD could be an adherence to medication, mood tracking or maintaining social rhythms, such as having a regular sleep cycle or recording their first contact with another person (Fisher et al., 2016; Janney et al., 2014; Suto, Murray, Hale, Amari, & Michalak, 2010). In their seminal study, Russell and Browne (2005) discuss with individuals with BD their self-management strategies to stay well. Accepting of and learning about BD were both influential aspects of staying well. Yet, even when individuals understand their condition and what may help, some people do not continue to use their strategies. Some self-management strategies are taught and guided by clinicians or informed workers who provide coaching to develop skills in the use of the strategy (Simon et al., 2011). Having a guided self-management strategy was also shown to have greater adherence (Proudfoot et al., 2012), which could be due to the individual feeling accountable to continue to use it.

The idea of guided self-management is to reduce the frequency of and dependency on contact from clinicians to reduce the cost and strain on the healthcare system (Bernecker, 2014). Although initially self-management strategies could be guided, when support is removed, the self-managing strategy becomes “unguided” in that no-clinician is involved. Treatment adherence to the self-management strategy appears to reduce when no support is involved (Van den Heuvel, Goossens, Terlouw, Van Achterberg, & Schoonhoven, 2015). It could be that the self-management strategy was directed by clinicians and the individual themselves had little autonomy in using the intervention (Fisher et al., 2016; van Bendegem et al., 2014). It has been proposed that innovative approaches are needed to support unguided self-management strategies leading to advances in technology such as sending automated reminders to monitor moods as well as sleep trackers that automatically record sleep data (Janney et al., 2014). Furthermore, Davenport, Hardy, Tai, and Mansell (2018) discussed how interventions for BD are not a one-size-fits-all as there are individual differences and complexities to consider. The individual complexities may be hard to capture without the support of clinicians who can provide advice and alternative informed options (Bernecker, 2014).

To deepen knowledge about self-management strategies and potentially inspire innovative approaches, this review aims to explore individuals’ perspectives of unguided self-management strategies. To our knowledge, there are no qualitative meta-syntheses that have explored unguided self-management strategies from the perspectives of individuals with BD. Exploring individual’s perspectives on unguided self-management strategies could help to find why some strategies may work, and why for some people they don’t work. It could deepen understanding to enable individuals with BD to develop self-management strategies that they are more likely to continue with, which may increase their quality of life and reduce the cost to the healthcare system.



## Methods

### Methodology

The exploratory epistemological stance of the study leans towards a social constructionist point of view. This means that we create meaning through our perceptions in coordination with other human beings (Willig, 2019). However, as a BD diagnostic framework is used, this could mean that a positivist view is taken. A positivist view of BD would suggest that an individual's behaviour is governed by BD (Corry, Porter, & McKenna, 2019). This study aimed to explore individual perceptions within the diagnostic framework of BD, and with contrasting epistemological stances, the study adopted a pragmatic epistemological position to further understanding (Huffman, 2017) and search for knowledge that works on a practical level (Hannes & Lockwood, 2011). The study aimed to find knowledge, that would be meaningfully different, and that would inspire action (Huffman, 2017).

When using a pragmatic epistemological position for a meta-synthesis, Hannes and Lockwood (2011) discuss that a meta-aggregate approach is helpful as it is sensitive to the practical and usefulness of its findings. A limitation with a meta-aggregate synthesis is that it does not offer much interpretation. Similarly, thematic synthesis, an approach without an epistemological position, brings together individual experiences through themes that are more descriptive to explain similarities or differences without much interpretation (Thomas & Harden, 2008). For this review, the synthesis of individual perceptions sought an interpretative systematic analysis. This systematic review aims to go beyond a description of data to further understand individuals' experiences of self-management strategies. Staying true to the personal experiences of individual participants but also considering the perspective of the authors is key to synthesise how the studies fit together in a useful way for individuals

with BD. Therefore, this study used the meta-ethnography approach to explore the lived experiences of self-management strategies for BD in search of practical findings (Noblit & Hare, 1988).

A meta-ethnography goes further than describing data by conceptualising participant experiences and interpreting the author's interpretations of their participant experiences (Britten et al., 2002; Holt & Tickle, 2014; Valavanis, Thompson, & Murray, 2019). The key strength of a meta-ethnography is the attempt to preserve the original meaning of the primary studies by synthesising the studies in three ways; reciprocal, refutational or line-of-argument (Mohammed, Moles, & Chen, 2016; Noblit & Hare, 1988). Reciprocal synthesis explores similarities within the studies. Refutational discusses conflictual data and how the studies may contest one another, and line-of-argument combines the studies to bring about new meaning (Holt & Tickle, 2014).

### **Search Strategy**

University librarians were consulted to ensure a thorough search strategy was formed and conducted (Appendix 1-A). The SPIDER search strategy (Cooke, Smith, & Booth, 2012) was used to formulate the search terms (Table 1).

[Insert Table 1]

Original searches using the PICo, a qualitative adaptation of the PICO search strategy (Boland, Cherry, & Dickson, 2014), resulted in an unmanageable number of identified articles. Adapting the PICo format into The SPIDER format narrowed the searches to a manageable number by grouping self-management with perceptions (PI AND E). Deciding to use selectivity rather than sensitivity (OR R) in the search provided with a manageable number of studies (Cooke et al., 2012). Thus, creating the search terms “bipolar disorder”,

“self-management and perceptions” and “interviews or qualitative” (S AND (PI AND E) AND (D OR R)).

On the 5<sup>th</sup> of November 2018, five databases were searched without publication time limits. These were PsychINFO, CINAHL, MEDLINE, EMBASE and, Scopus. In addition, PubMed was searched using the past year only to avoid repetition from MEDLINE. The searching of the literature included; relevant subject headings for each database, a natural language search of title and abstracts consistent across the databases and combined using Boolean operators. For the selected studies, a hand search of the reference list and a citation pearl search using Google Scholar were completed to ensure that any relevant papers had not been missed within the electronic search.

### **Inclusion and Exclusion**

To help select the studies we used the terms guided and unguided. Self-management strategies are broad and can come from many experiences, but for this synthesis the source of the self-management strategy was irrelevant. The focus of the study was why and how the self-management strategies were used and their helpfulness without guidance from clinicians or professionals. Therefore, guided was defined as a self-management strategy that's use was overseen by a clinician or professional. This could be from services or within a research study. The self-initiating use of the self-management strategy was described as unguided. Therefore, this review aimed to synthesise the perceptions of unguided self-management strategies. For example, Dodd, Mallinson, et al. (2017) was excluded because the use of the self-management tool ERPonline was part of a study with regular contact from researchers which may have provided motivation to continue using it. In contrast, Daggenvoorde, Goossens, and Gamel's (2013) study was included even though the participants had also been involved in a study. The difference in Daggenvoorde et al.'s (2013) study was that the

participants were interviewed after the study having been given time to continue or stop using the self-management tool on their behalf.

[Insert Table 2]

### **Selection of Studies**

Following the searching of the databases, the results were collated, and duplicates removed. A comprehensive screening of titles and abstracts was completed by the lead researcher. The studies that have been deemed potentially relevant were selected for full-text reading and evaluated against the inclusion and exclusion criteria. A reference list and citation pearl-search were completed. The additional relevant papers identified then went through the same process of full-text reading, eligibility, and reference and citation searches. Selected studies were quality appraised.

[Insert Figure 1]

### **Quality Appraisal**

This study used and adapted the Critical Appraisal Skills Programme (CASP) checklist (Public Health Resource Unit, 2006) (Appendix 1-B). It was adapted by the lead researcher as the 10 questions in the CASP can appear to be vague. Without a “gold standard” quality assessment tool for qualitative reviews (Boland et al., 2014; Tong, Flemming, McInnes, Oliver, & Craig, 2012), it has been suggested that reviewers can adapt quality appraisal tools to make it more relevant to their study (Thomas & Harden, 2008). By comparing two other qualitative appraisal checklists (O'Brien, Harris, Beckman, Reed, & Cook, 2014; Tong, Sainsbury, & Craig, 2007), details that were pertinent for this synthesis were selected and used as checkpoints within each CASP question. For example, for an

idiographic study, an important aspect is the use of participant quotes (Smith, 2011). The CASP does not request this, but both O'Brien et al. (2014) and Tong et al. (2007) have this as a quality criterion, therefore, as it is relevant for this study, it was included in this study's quality appraisal.

Overall, the CASP appraisal is intended to provide a framework for critically considering the studies and not to exclude them based on quality (Murray & Forshaw, 2013). Possible "weaker" studies were included, but the appropriate weight of results given (Atkins et al., 2008). An important aspect of this study was to identify the relevant themes within the selected studies (Tong et al., 2012). Although some studies met the inclusion criteria, only a small section of their results were relevant to answering this review's question. Therefore, not all the results sections for each selected paper have been used. Selected themes are recorded within the quality appraisal table (Table 3).

### **Selected Studies**

Eighteen studies were selected for the meta-ethnography using their result sections only. Three of the selected studies had only partially relevant themes and as such, only the relevant themes were extracted (for relevant themes please refer to table 3). There were two pairs of studies that used the same sample and interview for their study (2 & 3, 14 & 15). Both studies were included as they had different research questions. Their results had different themes evidenced by using different participant quotes. However, because they were from the same sample, and to avoid giving too much weight to that sample, the results were collated and were viewed as one study.

### **Synthesis of Selected Studies**

The meta-ethnography followed the seven steps described by Noblit and Hare (1988). Step one is to formulate the research question and step two is developing the search strategy. The analysis begins from step three when the relevant results from selected studies were read and re-read. Step four is to determine how the studies are related. This was done by key concepts, metaphors and themes being highlighted using three constructs (Figure 2). The first-order construct is the participant's account and interpretations of their experience. The second-order construct is the author's interpretations of the participant's account. After the first and second-order concepts were annotated, another reading was done to interpret how the first two order constructs relate to the wider context of that study's results. This created third-order constructs, the views and interpretations of the synthesist (Britten et al., 2002; Holt & Tickle, 2014; Valavanis, Thompson, & Murray, 2019). This step was completed for all selected studies. The third-level constructs were then systematically extracted and grouped to form subordinate themes. For step five, translating the studies into one another, the subordinate themes and the first and second-order constructs were placed into a grid to view how each study impacts the subordinate themes (Figure 3). This is to further ensure that the key themes are grounded within the majority of studies (Atkins et al., 2008). Each subordinate theme and its relevant first and second-order constructs were extracted and grouped to view how they fit together. The translation across studies could be either reciprocal (similar), refutational (contrasting) or line-of-argument (expand on another) (Noblit & Hare, 1988). Step 6 is to name the translations to be used as the overarching synthesis themes. Finally, step seven is to express the synthesis, as this review tries attempts to do.

## Results

[Insert Table 3]

Through the exploration of the 18 studies and the concepts that arose within them, the synthesis uncovered three dominant themes. Each of the three themes related to one of the reciprocal, refutational or line-of-argument syntheses. The first theme described is a line-of-argument relationship as it appeared to be a process of successful self-management. Thus, the theme was called The Process of Successful Self-Management Skills. The process had seven aspects and although this study will present it linearly, the process itself may not be. At each point, we will discuss how this may impact self-management strategies. The seven aspects of the process are: Receiving the Diagnosis, Acceptance, Knowledge and Understanding, Awareness and Insight, Responsibility, Discipline, and Adjustment.

The second theme is the refutational synthesis which described the focus of self-management. This theme is called Self-management: *Symptom-management* or *Lifestyle-management*? This theme discusses the focus of self-management strategies being on a symptom change or a lifestyle change. The theme discusses the difficulties that constantly monitoring symptoms can bring with an alternative that focussing on lifestyle may reduce symptoms.

Finally, the third theme presents a reciprocal synthesis as it appears to be an underlying theme throughout all studies. This theme was called The Fear of a Relapse. We will present how fear may impact a person's self-management of their BD as individuals can perceive to have a lack of control over their symptoms.

[Insert Table 4]

## **The Process of Successful Self-Management Skills**

### **Receiving the Diagnosis**

Receiving a diagnosis of BD came as a shock and brought resistance and denial. The vast amount of information available regarding BD from several sources can be overwhelming. Too much information too soon could be detrimental for self-managing their BD.

*“Sometimes the service user information, as provided by CPN, often seemed to come too soon or too much at once, because the service users struggled with the emotional impact of being diagnosed” (17, p805).*

### **Acceptance**

Accepting how the diagnosis would impact their life appeared to be an important and early step in the process. Before accepting a BD diagnosis, recognising symptoms was described as a confrontation that brought further feelings of resistance and denial. These feelings may be leading to an avoidance of enacting a self-management strategy. Although the participants may not want the symptoms, accepting that they may occur was important. Accepting that symptoms would be a part of their life that enabled participants to recognise that they had to do something about it.

*“Learning to recognise early symptoms of relapse (i.e., prodromes) is experienced as a confrontation with one’s illness” (6, p238).*

### **Knowledge and Understanding**

Individuals stated the importance of knowledge and understanding. This step was crucial in learning about BD generically and then more specifically their own unique BD. For some participants gaining knowledge and understanding was a self-management strategy



from the beginning. They would research for themselves and find the information that they identified with. For others, they needed guidance to learn and understand what having BD meant for them. It is important that individuals with BD do not just gather knowledge but understand how it may impact them so they can make the changes they need for their life.

*“Another participant indicated that she learned a lot by reading about BD, and this helped her to manage her condition more effectively” (13, p5).*

### **Awareness and Insight**

Knowing and understanding what BD is helped individuals to recognise their moods and behaviours. This awareness of their symptoms can lead to insight so they can implement the appropriate self-management strategy. In addition, self-management strategies can also help individuals to become more aware of their triggers and early warning signs. Self-management strategies that enabled a person to gain awareness and deepen their insight appeared to be effective.

*“Most service users said that they started managing their illness once they learned how to identify, recognise and respond adequately to early warning signs and triggers in everyday situations” (17, p805)*

### **Responsibility**

As individuals learnt about themselves, their BD and how it affects them, studies described how they realised that they need to take responsibility for it. A successful self-management strategy requires self-responsibility. Nobody can do it all for them, and individuals spoke about having autonomy for their lives, which could inform their self-management strategies.

*“Establishing life regimens is described as a complex learning process of discovering what is good and what is harmful, with the help of others, but which in the end it is something ‘you have to do yourself’ (1, p650).*

### **Discipline**

Self-management strategies can be strenuous to complete, difficult to continue and easily forgotten. Other difficulties could be due to the “nice phase” of improved mood, energy and the creative and productive self that can occur before mania. The hard aspect of this is to be motivated to say “enough is enough” before they slip into mania. This stage takes discipline to stay motivated to enact the self-management strategy. However, even the risk of mania or depression sometimes was not enough motivation to enact their self-management strategy. One individual described having the discipline to adhere to their self-management strategy is like a battle between mother and daughter on a carousel;

*“The child wants to take another ride on the carousel, but the mother says it’s been enough for today: we have to go home now and take a good night sleep. Tomorrow we can go for that ride again if you like. You know for me, this is a kind of self-management” (17, p807).*

### **Adjustment**

The final phase of an effective self-management strategy is its ability to be adjusted. Individuals discussed how unique their BD is and that no two people experience the same symptoms. Individuals discussed how personal their BD is to them and their self-managing strategies should also be personal to them. Self-management strategies could be a constant trial and error exercise by referring to their knowledge base and adjusting the information using their insight to consider how it may affect them across contexts. Having confidence in

their self-management strategy and their adjustment abilities may enable the individual to draw on a resource that will help them within their mood, even when unexpected incidents occur.

*“I sort of see now that with the bipolar illness it’s kind of like I’ve got a dashboard that’s got a lot of knobs on it. And they constantly need a little bit of adjusting, you know?” (10, P162).*

### **Self-management: Symptom-management or Lifestyle-management?**

There were a vast amount of strategies and practices used that described how to help a person stay well. However, it was noticed that there were two main focal points of self-management strategies. Most self-management strategies focused on how to manage symptoms, with suggestions that more should focus on how to manage lifestyle.

*“...altering the emotional state, so if you’re feeling low anything that makes you feel good and if you’re feeling high anything that’ll calm you down if you’re paranoid anything that’ll make you feel safe....” (4, p245).*

The difference in focus could be developed from an apparent conflict in what professionals and participants perceived “staying well” to mean. The professional’s focus was perceived to be on self-management strategies that reduced symptoms or prevented a relapse. Whereas participants discussed how having a focus on managing their symptoms can help to live a fulfilling life. Participants described that monitoring symptoms were challenging and that they were constantly working on maintaining a balanced mood.

*“It was clear that service users placed less emphasis on becoming symptom-free and more on living a personally fulfilling life alongside their condition” (14, p118).*

Furthermore, a self-management strategy was often to reduce activities to stop arousal of symptoms, however, this would come at a price, as it was not what the participant wanted to do. In contrast, some participants discussed that doing more and experiencing more gave them the confidence that they could lead an autonomous and independent life. Even when they experience early warning signs in places they may not expect, they can adapt their strategies that resulted in a controlling of symptoms. Having self-management strategies that were varied, attention-grabbing and not boring enabled ownership of their life and improved their well-being.

*“In addition to trying to maintain a healthy lifestyle, participants described making specific changes in their lives to stay well” (11, P191).*

Along with lifestyle, participants described how they did not want their BD to define them and they did not want to be confined by it. It was important that the self-management strategies separated their sense of self from their symptoms. To live a fulfilling life, participants spoke about rebuilding themselves in the context of BD. Having a personal identity and values element within self-management strategies appeared to help monitor their BD and live a fulfilling life.

*“It was also explicitly pointed out that the RPP describes the symptoms of the illness and it does not reflect the character of the participant himself/herself. It was experienced as very annoying when people mixed these up” (6, P239).*

### **Fear of a Relapse**

There appears to be an underlying fear of a relapse when implementing self-management strategies. The participants perceived that BD was an uncontrollable beast that

could strike at any moment and felt they were at the mercy of the disorder. Participants discussed how self-management strategies lacked the power to manage the arousal of mood states. Even when they can follow their plan participants described that the plan can be ineffective.

*“...I don't know, it's just, it's too lightweight, it's not meaty enough as a strategy. Tough times require tough things...” (10, P163).*

Self-management strategies did enable participants to become mindful of their mood and how situations may affect them. However, participants became hyper-sensitive to their moods that may have increased anxiety over mood arousal. This underlying fear impacted participants to avoid enjoyable activities or avoid the unknown to evade potential arousals of mood. In contrast, some participants embraced their BD and described it as “dining with BD” or developed useful strategies such as managing their workload to reduce a build-up of stress. It seemed that they had a cost-benefit analysis of their decisions and consequent behaviour. The phase before mania was explained to be an enjoyable phase that increased productivity, creativity and was valued by participants. However, this phase came with a fear that it could lead to a manic phase.

*“...but at the back of my head there is always the worry that it might go a little too far and I'll go manic...I allow myself to be energetic to a certain degree, but I won't allow myself to go above a certain level, because that would be dangerous, you know” (9, p204).*

For some participants even with the monitoring and self-management strategies, they were worried that they may be unaware of changes in their behaviour. There was a belief that too much of a good thing would inevitably result in mania or manic-depression. This was

evident when they went to meetings with services or speaking to caregivers as there could be changes unknown, unseen or unnoticed to them.

*“I’m terrified to death at times. When I get into the nurse’s office or, going to the doctor, I’m really terrified to death and I don’t know what they are going to tell me” (2, p1332).*

A valued aspect of managing their BD is to develop a support network and learning to talk about their moods. Having a support network was seen as a positive aspect of self-managing their BD but developing the support network was difficult, to begin with. Talking to others about their mood caused anxiety for participants as they were unsure about how it may be received. Participants explained the fear of sharing their BD with others as they perceived it to carry much stigma. They believed that others would not understand, resulting in rejection and isolation.

*“I have learned to not be so ashamed to talk about it. When I talk about it it’s not such a big deal. I have found I have to talk about it” (5, P240)*

## **Discussion**

This qualitative systematic literature review explored how individuals with BD perceive their unguided self-management strategies. The review adopted a meta-ethnography approach (Noblit & Hare, 1988) to interpret and synthesise 18 selected studies. Three key themes were identified: The Process of Successful Self-Management Skills, Self-management: *Symptom*-management or *Lifestyle*-management? and the third theme that was an underlying theme across studies called The Fear of a Relapse.

The process of successful self-management skills starts when first receiving the diagnosis, moves through acceptance, knowledge and understanding, awareness and insight, responsibility, discipline and ends with the individual being able to adjust self-management strategies across their life. Current literature recommends that sharing knowledge early on in diagnosis is important to help individuals to recognize early warning signs for relapse prevention (Davenport et al., 2018). This review complements the importance to share and understand knowledge, however, it recognises that consideration to the individual receiving and accepting of the diagnosis may be required first. The individuals who received a diagnosis of BD can find it a shock and difficult to accept. This shock brought resistance to recognising symptoms and rejecting information. Further, it may be that too much shared knowledge too soon can be overwhelming. Thus, services must be considerate in how much information is shared by considering the personal reaction to the diagnosis.

Accepting the diagnosis often brought a desire to obtain more knowledge about BD. There is a wealth of information and resources available, but the information can become confusing as they may have contrasting perspectives and opinions (Goodwin et al., 2016; Janney et al., 2014; Jones et al., 2011). Having a general understanding of BD helped the participants to become aware and develop insight into their presentations of BD. Having insight into their presentations and the consequences of such presentations are helpful to create strategies that help the person (Murray et al., 2011). Personal responsibility to look after themselves and discipline to initiate self-management strategies was needed.

To add further complexity, BD is characterised by a presentation of two opposing mood states, depression and mania, that can occur acutely, co-currently or a rapid cycle between the two (Goodwin et al., 2016). The individual experience of BD is just that, individual. This means that adjusting their strategies to manage their symptoms is another

important skill to master as each person's experiences will differ and the adjustment needed will be personal. The adjustment stage of the process found in this review compliments other research. Michalak et al. (2012) describe developing the "art of managing" that involves finessing a complex set of skills. Yet, a limitation to self-management strategies could be in the lack of flexibility of a one-size-fits-all approach that self-management tools can be (Davenport et al., 2018). Self-management tools could be helpful as individuals with BD travel through the process, however, as moods fluctuate it may be that the self-management tools do not fluctuate with them (Janney et al., 2014). At this point, self-management strategies may need to empower individuals to be agents of their symptoms and adjust their management skills according to the situation they are in (Davenport et al., 2018).

Empowering individuals to adjust their self-management strategy may be difficult. The underlying fear expressed in this literature review shows the lack of confidence participants may have in their strategies. The emphasis of medication in the management of BD (NICE, 2016) could be sending out a narrative that BD is uncontrollable and medication adherence is a crucial self-management strategy. Similarly, psychological self-management strategies that focused on symptom-management may also perpetuate the perceived lack of control (Etain et al. (2017). Learning to become more aware and attuned to early warning signs implies that the symptoms should not be aroused as they are uncontrollable. Furthermore, as pharma or psycho-interventions tend to aim to limit moods from going too high or too low, another side-effect may be that medication dulls a person's senses that can give a blurred view of self (Mansell, Powell, Pedley, Thomas, & Jones, 2010).

In contrast to focussing on symptom management, this study perceived that a focus on lifestyle may empower individuals to believe they can live a fulfilling life. Empowerment could result in greater adherence to intervention and management of symptoms. Self-



management strategies that have a focus on lifestyle management do have some positive outcomes. Morton, Michalak, Hole, Buzwell, and Murray (2018a) explored how quality-of-life is perceived through self-management strategies. Their participants used a “reference point” that they compared their life too. When the reference points were compared to how life “used to be”, QoL was deemed more negative. However, as the participants adopted a new reference point of “what is normal for BD”, this was associated with a positive QoL, as this was perceived as being kinder to oneself. Self-care has also had positive results for QoL in individuals with BD (Wynter & Perich, 2018). The authors describe self-care as the activities performed by a person to support their health and wellbeing. The results suggest that the higher frequency of self-care activities positively correlated with improved QoL. The authors further described the relationship of self-care activities with their symptoms of BD. Self-care was associated with reduced symptoms of depression but not a reduction in symptoms for mania. It could be argued that QoL may be improved by increasing self-care activities which reduces depressive symptoms, but an improved QoL may not necessarily mean a reduction in symptoms of mania.

However, just like any intervention for BD, successful self-management will also require adherence to their strategies. Treatment adherence is a recognised difficulty in BD (Sajatovic et al., 2011). Studies designed to better understand this non-adherence pattern have verified that it usually happens when there is a lack of comprehension regarding the nature, severity and chronicity of the disorder, as well as a negative attitude towards the medication, and a perception of control over the disorder (Cardoso et al., 2014). To promote treatment adherence, a shared decision-making process, between individual, family and clinician, to elicit individual preferred choices has been proposed (Fisher, Manicavasagar, Sharpe, Laidsaar-Powell, & Juraskova, 2017, 2018). Findings from this literature review resemble with Fisher et al.’s (2017, 2018) three phases of information exchange, discussion of

intervention preferences and deciding on management strategies. Information exchange mirrors the first four steps to successful self-management. Discussing and acceptance of the diagnosis followed by increasing knowledge and personal insight would inform the information exchange. Increased responsibility and motivation could come from a discussion of intervention preferences. Finally, implementation would be part of the deciding on management strategies phase. The adjustment phase of this review extends Fisher et al.'s (2016) third phase by suggesting that adjustment strategies could also be discussed during the decision phase. Fisher et al. (2016) warns clinicians that checking understanding and engagement throughout discussions because the cyclical nature of BD can impact individual preferences through different phases.

Another discussion to have with individual's with BD that could increase treatment adherence and what may work for individuals could be regarding what "recovery" means to them. There are different views on the meaning of recovery, for example clinical recovery often differs from personal recovery (Michalak et al., 2012). The clinical perspective of recovery appears to be a reduction in symptoms and greater time between relapses (Gitlin & Miklowitz, 2017; Ketter et al., 2014). A personal perspective of recovery appears to focus on psychological processes such as beliefs and control to enable a fulfilling life (Lobban, Solis-Trapala, Tyler, Chandler, & Morriss, 2013; Michalak et al., 2012). For the participants in this study, rebuilding their identity and personal values in the context of BD appeared to be an aspect of self-management that was appreciated. The self-regulation model (SRM) (Leventhal, Nerenz, & Steele, 1984) has been adapted for individuals with BD (Lobban et al., 2013). The SRM is a framework that considers the cognitive beliefs and emotional reactions for individuals with BD when symptom arousal occurs. The beliefs people hold about their identity, perceived consequences, controllability, and causes of experiences impacted on the time between relapses (Lobban et al., 2013). Negative self-appraisals were negatively

correlated with recovery, whereas normalising appraisals of symptom arousals were positively correlated with recovery (Dodd, Mezes, Lobban, & Jones, 2017). Furthermore, exploring identity and improving self-appraisals relative to control and understanding of symptoms may help to improve treatment adherence (Averous, Charbonnier, Lagouanelle-Simeoni, Prospero, & Dany, 2018).

### **Limitations and Future Research**

This study has some limitations. Robust qualitative analysis suggests the reliability of the results can be improved by having a team of coders to analyse the text. For this study, due to time and resource constraints, the analysis was completed by the lead researcher only. Furthermore, the pragmatic epistemological position may have been enhanced by consulting with individuals with lived experience to analyse, code and produce themes from the studies. The expert by experience input would be beneficial to gain a perspective on what would help in the self-management of BD (Maassen, Regeer, Bunders, Regeer, & Kupka, 2018).

A further limitation could be the quality appraisal of the selected studies. Appraising the quality of qualitative studies is not a unified topic as there are numerous appraisal tools and suggestions for appraising qualitative studies (Dixon-Woods, Shaw, Agarwal, & Smith, 2004). The assessment of the reported rigor, trustworthiness, reliability or acknowledging bias (Noble & Smith, 2015) can be challenging in qualitative studies due to author preferences and journal restrictions (O'Brien et al., 2014). Further, some authors suggest that quality appraisals should exclude some studies due to obtaining a “weak” score during appraisal (Hannes, 2011). There may be little to gain by including “weaker” studies and therefore a sensitivity test has been suggested (Carroll, Booth, & Lloyd-Jones, 2012). In contrast, this review’s quality appraisal did not compute a score to rank the studies. The ranking score of studies is subjective to the appraisal tool used and for this review, the

important aspect of the selected studies was that their results included relevant information that enhanced understanding of the aims for this review.

The adjustment phase appears a key element for successful self-management skills however, the underlying fear of a relapse captured in this study could be impacting an individual's confidence to implement adjustments. If fear is underlying throughout, it would also be underlying within the adjustment phase of BD. Further research could explore the fear of personally adjusting self-management strategies which may increase knowledge of successful self-management strategies.

## **Conclusion**

Self-management strategies are key to support an individual with BD to manage their presentations. The results from this meta-synthesis suggest that successful self-management occurs through a process. The process results in an individual being able to adjust their management strategy across mood and environment. It may be that self-management strategies focus on symptoms as the individual learns about their BD, but also adjusts to focus on lifestyle and wellbeing as well as symptoms. The adjustment in focus may increase QoL. Finally, it may be that a fear of a relapse is impeding implementation of self-management strategies.

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**Tables****Table 1: SPIDER Search Terms**

Table 1. SPIDER Search Terms

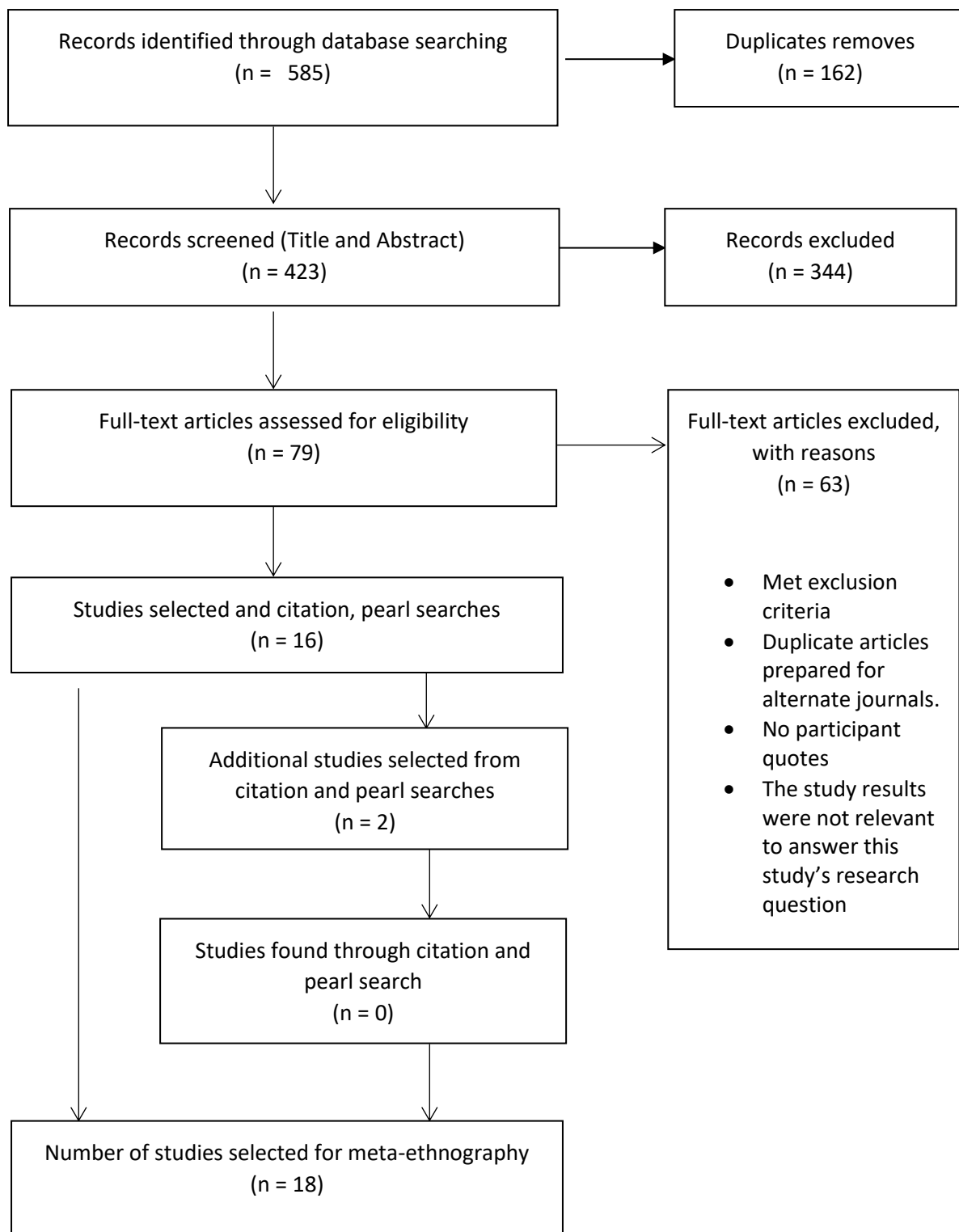
SPIDER	Search Terms
Sample	Bipolar Disorder
Phenomenon of Interest	self-management strategies
Design	Interviews
Evaluation	Perceptions
Research Type	Qualitative

**Table 2: Inclusion and Exclusion Criteria**

Table 2. Inclusion and exclusion criteria

<b>Inclusion</b>	<b>Exclusion</b>
Studies that have qualitatively explored experiences of using “unguided” self-management strategies for BD.	Guided self-management strategies or self-management strategies when in crisis.
Participants of the studies were adults aged 18+	Any papers that includes participants under 18 years of age.
The study participants had been given or self-reported having a diagnosis of BD.	Explores mental health generically. Results incorporates interviews from individuals that have other mental health difficulties; such as schizophrenia, depression, psychosis.
Qualitative explorations could be from interviews, focus groups, blogs, qualitative sections of surveys.	Results include perspectives of other people e.g. family, caregivers, clinicians.
Peer reviewed papers	Book chapters, thesis, case studies, commentaries, grey research
Primary papers only	Not translated into English.

**Figure 1: Flowchart of Selected Studies**



**Figure 1. Flowchart of selected studies**

**Figure 2: First, Second and Third Order Constructs**

Extract from Morton et al. (2018)	First and second order constructs	Third order constructs
<p>3.2.1. SM for BD is empowering</p> <p>This theme captured the prominent sense of <u>empowerment</u> participants described as arising from <u>learning about or engaging in SM</u>. Individuals described SM strategies as fostering an <u>active role</u> in the management of BD, with an according increase in self-reliance: “It’s <u>important</u> to self-manage and it’s great to have people that you can reach out to and rely on, but sometimes it’s good to <u>know how to handle yourself</u> because <u>you need to know that you know yourself best</u>” (F, 25–34, Rapid cycling BD-II).</p> <p>Further, SM was seen <u>as restoring a sense of control</u> to the consumer by <u>lessening dependence</u> on healthcare workers or medication. One participant shared,</p> <p><i>I thought it was really empowering because even though we’re in the midst of it here, we’re trying to <u>gain autonomy</u> over our situation and not have to rely on the doctors, I’m not on medication but you know, we’re trying to take back the reins.</i> (F, 45–54, BD-I)</p>	<p>SM empowers people</p> <p>Learning first</p> <p>Responsible to engage</p> <p>Active role - responsibility</p> <p><i>Important</i></p> <p><i>How to handle yourself -</i></p> <p>control over life</p> <p>Less dependence on healthcare</p> <p>Gain autonomy</p>	<p><b>Autonomy</b> – <i>This extract is describing how SM empowers individuals to live independent lives. They can reduce the burden on healthcare systems.</i></p> <p><b>Learning</b> – <i>Learning about yourself is important so that you can become independent and know “how to handle yourself”</i></p> <p><b>Adjustment</b> – <i>Instead of relying on others, knowing themselves meant that they could use their SM appropriately and by knowing how it impacts them in this situation.</i></p>

The text highlighted in orange denoted the first order construct – participant quotes. The text highlighted in green denoted the second order construct – author interpretations. The blue text is third order construct – lead researcher’s interpretations and explanation of the subordinate theme. To develop subordinate themes the lead researcher used the original text along with the initial first and second order annotations to develop interpretations from the wider context. Using original words for example “gain autonomy” helped to keep the theme rooted in the participant experience.

**Figure 3: Extract from Subordinate Themes Grid**

This first column was a list of subordinate themes from all the results of the selected studies.

Each column I listed all the first and second order constructs that were annotated. I then colour coded the first and second order construct to match the subordinate theme.

1	Number	1	2	3
2	Author	Bart	Blixen coping	Blixen barriers
3	M of life or symptoms	self-responsibility	exercise	stigma, difference, othering
4	The process	coping with my susceptibilities	remembering the bad experiences	fear of people knowing
5	cost-benefit analysis	sm empowering	routines	fear of isolation
6	fear of mania/relapse	cannot change genes, or traum, but can change effect or trauma	reminders to help routines	understanding before awareness
7	self-esteem and identity	expressing feeling	lifestyle habits	answers
8	answers	comparing to others	increasing knowledge	own fault?

I then extracted each subordinate theme and the connecting constructs. As I did this, I looked for reciprocal subordinate themes, contrasting subordinate themes and also line of argument subordinate themes.

Subordinate themes were linked together to create an overall major theme.

**Table 3: Quality Appraisal of Selected Studies**

Study Number	Authors (Year)	Research Question(s)	Identified and relevant	Qualitative Approach	Justification of approach	Selection Process	No. (Female: Male)	Diagnosis	Ages	Nationalities	Data Collection Length	Bias and Ethics discussed	Data recording	Data entry	Data verification	Participant Quotes used	Relevant Themes
1	Baart and Widdershoven (2013)	Yes	Thematic Content Analysis	Yes	Purposeful Sampling	40 (18:12) BDI, BDII	19-67	Netherlands	Focus Groups	Yes	Audio	TV	Audio	Yes	“Managing life”	Yes	“Managing life”
2	Blixen et al. (2016)	Yes	Thematic Content Analysis	Yes	Sample from RCT	21 (15:6) BDI, BDII	Mean 47.29	USA	ISSI 1 hour	Yes	Audio	TV	Audio	Yes	All	Yes	All
3	Blixen et al. (2016)	Yes	Thematic Content Analysis	Yes	Sample from RCT	21 (15:6) BDI, BDII	Mean 47.29	USA	ISSI 45-60mins	Yes	Audio	TV	Audio	Yes	All	Yes	All
4	Cappleman et al. (2015)	Yes	Grounded Theory	Yes	Theoretical Sampling	10 BDI, BDII, BDNOS, MD	29-50	UK	ISSI 60-105mins	Yes	Audio	TV	Audio	Yes	3.2 – 3.7.1	Yes	3.2 – 3.7.1
5	Crowe and Inder (2018)	Yes	Thematic Analysis	Yes	Sample from RCT	30 (25:5) BDI	20-40	New Zealand & Maori	ISSI DNS	Yes	Audio	TV	Audio	Yes	All	Yes	All

Continued



Table 3. (Continued)

Study Number	Authors (Year)	Research Question(s) Identified and relevant	Qualitative Approach	Justification of approach	Selection Process	No. (Female: Male) Diagnosis	Ages Nationalities	Data Collection Length	Bias and Ethics discussed	Data recording	Data entry verification	Participant Quotes used	Relevant Themes
6	Daggenvoo rde et al. (2013)	Yes	Phenomenological Inquiry	Yes	Outpatient Database	15 (8:7) BDI, BDII	32-62 Netherlands	ISSI Max 60mins	Yes	Audio TV 1 C, MC	Audio	Yes	All
7	Jönsson et al. (2008)	Yes	Content Analysis	Yes	Purposive Sampling	18 (9:9) BDI, BDII	18-57 Sweden	ISSI 51-97mins	Yes	Audio TV 1C, 2R	Audio	Yes	“managing illness”
8	Mandla et al. (2017)	Yes	Thematic Analysis	Yes	Blog Selection criteria	22 (15:4) 3DNS BD	35-50+ USA, South Africa	ISSI NA	Yes	Audio TV 2C, 1R	Audio	Yes	2.2 & 4.3
9	Mansell et al (2010)	Yes	IPA	Yes	Advertisement	13 (9:5) BD	33-61 UK	ISSI 45mins	Yes	Audio TV 1C, Team Review	Audio	Yes	All
10	Morton et al. (2018)	Yes	Thematic Analysis	Yes	Purposeful Sampling	43 (20:12) BD I, BD II	19+ DNS	Telephone ISSI 20-70mins	Yes	Audio TV 2+C, 1R	Audio	Yes	All

Continued

Table 3. (Continued)

Study Number	Authors (Year)	Research Question(s)	Identified and relevant	Qualitative Approach	Justification of approach	Selection Process	No. (Female: Male)	Diagnosis	Ages	Nationalities	Data Collection Length	Bias and Ethics discussed	Data recording	Data entry	Data verification	Participant	Quotes used	Relevant Themes
11	Russell and Browne (2005)	Yes	Yes	Combination of Qualitative Methods	Yes	Self-selection	100(63:37) BDI, BDII BDNOS	18-83 DNS	DNS	ISSI or written data DNS	Yes	Audio TV DNS	Audio TV	Yes	Yes	All		
12	Suto et al. (2010)	Yes	Yes	Thematic Analysis	Yes	Purposeful Sampling	32 (20:12) BDI, BDII	19+ Canada	Canada	ISSI 60-90mins	Yes	Audio TV, MC Team discussion	Audio TV, MC	Yes	Yes	All		
13	Switsers et al. (2018)	Yes	Yes	Deductive and inductive analysis	Yes	Patient Network	16 (9:7) BD	21-69 Belgium (Flemish)	Belgium (Flemish)	Focus Groups 4 hours	Yes	Audio TV	Audio TV	Yes	Yes	All		
14	Todd, Jones and Lobban (2012)	Yes	Yes	Thematic Analysis	Yes	Purposeful Sampling	12 (5:7) BDI, BDII	29-56 UK	UK	ISSI 90-120mins	Yes	Audio TV IC, 2R	Audio TV	Yes	Yes	All		

Continued

Table 3. (Continued)

Study Number	Authors (Year)	Research Question(s) Identified and relevant	Qualitative Approach	Justification of approach	Selection Process	No. (Female: Male) Diagnosis	Ages Nationalities	Data Collection Length	Bias and Ethics discussed	Data recording Data entry Data verification	Participant Quotes used	Relevant Themes
15	Todd et al. (2013)	Yes	Thematic Analysis	Yes	Purposeful Sampling	12 (5:7) BDI, BDII	29-56 UK	Focus Groups 90-120mins	Yes	Audio TV	Yes	All
16	Tse, Yuen, Suto (2014)	Yes	Narrative Inquiry	Yes	Purposeful Sampling	14 (8:6) BDI, BDII, BDNOS	22-65 China	ISSI or written data 60-90mins	Yes	Audio TV MC	Yes	Themes 2 & 3
17	Van den Heuvel et al. (2015)	Yes	Phenomenological analysis	Yes	Purposeful Sampling	16 (8:8) BDI, BDII	23-66 Netherlands	ISSI 45-115mins	Yes	Audio TV MC, Team coding	Yes	All
18	Veseth et al. (2012)	Yes	Hermeneutical Phenomenology	Yes	Purposeful Sampling	13 (7:6) BDI, BDII	27-65 Norway	ISSI 45-110mins	Yes	Audio TV MC	Yes	All

Notes: DNS did not state, ISSI = Individual semi-structured interview, TV transcribed verbatim, MC member checking, Key: C = coders, R = reviewers

**Table 4: Third Order Constructs and Subthemes**

Theme or Subtheme	1	2 & 3	4	5	6	7	8	9	10	11	12	13	14 & 15	16	17	18
The Process of Successful Self-Management Skills																
Receiving the Diagnosis	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Acceptance	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Knowledge and Understanding	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Awareness and Insight	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Responsibility	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Discipline	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Adjustment	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Self-management: <i>Symptom-management or Lifestyle-management?</i>	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
The Fear of a Relapse	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*

Note: \* denotes the study contributed towards the third-order construct and subthemes.

## Appendices

### Appendix 1-A

#### Search Strategy

##### PsychINFO

S1 - DE "Bipolar Disorder" OR DE "Euthymia" OR DE "Mania"

S2 - TI "Bipolar\*" OR "Mania\*" OR "Manic\*" OR "Mood Disorder\*" OR "Euthymia"

S3 - AB "Bipolar\*" OR "Mania\*" OR "Manic\*" OR "Mood disorder\*" OR "Euthymia"

S4 - S1 OR S2 OR S3

S5 - DE "Treatment" OR DE "Rehabilitation" OR DE "Self-care" OR DE "Self-management" OR DE "Prevention" OR DE "Recovery (Disorders)" OR DE "Relapse Prevention" OR DE "treatment compliance" or DE "treatment refusal" or DE "treatment barriers"

S6 - TI "self-care" OR "self-help" OR "self-management" OR "self-regulation"

S7 - AB "self-care" OR "self-help" OR "self-management" OR "self-regulation"

S8 - TI "perce\*" OR "experience\*" OR "view\*" OR "belief\*" OR "opinion\*"

S9 - AB "perce\*" OR "experience\*" OR "view\*" OR "belief\*" OR "opinion\*"

S10 – S5 OR ((S6 OR S7) AND (S8 OR S9))

S11 - DE "Qualitative Research" OR DE "Interviews" OR DE "Grounded Theory"

S12 - TI "qualitative\*" OR "explor\*"

S13 - AB "qualitative\*" OR "explor\*"

S14 – S11 OR S12 OR S13

S15 – S4 AND S10 AND S14

Narrow by SubjectAge: - young adulthood (18-29 yrs)

Narrow by SubjectAge: - thirties (30-39 yrs)

Narrow by SubjectAge: - middle age (40-64 yrs)

Narrow by SubjectAge: - adulthood (18 yrs & older)

TOTAL RESULTS – 33

## CINAHL COMPLETE

S1 - MH "Bipolar Disorder" OR MH "Affective disorder"

S2 - TI "Bipolar\*" OR "Mania\*" OR "Manic\*" OR "Mood Disorder\*" OR "Euthymia"

S3 - AB "Bipolar\*" OR "Mania\*" OR "Manic\*" OR "Mood disorder\*" OR "Euthymia"

S4 - S1 OR S2 OR S3

S5 - MH "Rehabilitation" OR MH "Self-care" OR MH "Self-Management" OR MH "Support Groups"  
OR MH "Medication Compliance" OR MH "Prevention" OR MH "Recovery" OR MH "Recurrence" OR  
MH "Patient Compliance" OR MH "Treatment Refusal"

S6 - TI "self-care" OR "self-help" OR "self-management" OR "self-regulation"

S7 - AB "self-care" OR "self-help" OR "self-management" OR "self-regulation"

S8 - TI "perce\*" OR "experience\*" OR "view\*" OR "belief\*" OR "opinion\*"

S9 - AB "perce\*" OR "experience\*" OR "view\*" OR "belief\*" OR "opinion\*"

S10 – S5 OR ((S6 OR S7) AND (S8 OR S9))

S11 - MH "Qualitative Research" OR MH "Interviews" OR MH "Grounded Theory"

S12 - TI "qualitative\*" OR "explor\*"

S13 - AB "qualitative\*" OR "explor\*"

S14 – S11 OR S12 OR S13

S15 – S4 AND S10 AND S14

Narrow by SubjectAge: - middle aged: 45-64 years

Narrow by SubjectAge: - adult: 19-44 years

Narrow by SubjectAge: - all adult

Total found – 22

## MEDLINE

S1 - (MH "Bipolar Disorder") OR (MH "Mood Disorders")

S2 - TI "Bipolar\*" OR "Mania\*" OR "Manic\*" OR "Mood Disorder\*" OR "Euthymia"

S3 - AB "Bipolar\*" OR "Mania\*" OR "Manic\*" OR "Mood Disorder\*" OR "Euthymia"

S4 - S1 OR S2 OR S3

S5 - (MH "Rehabilitation") OR (MH "Self Care") OR (MH "Self-Management") OR (MH "Medication Therapy Management") OR (MH "Self Medication") OR (MH "Medication Adherence") OR (MH "Self-Help Groups") OR (MH "Mental Health Recovery") OR (MH "Recurrence") OR (MH "Treatment Adherence and Compliance") OR (MH "Patient Compliance")

S6 - TI "self-care" OR "self-help" OR "self-management" OR "self-regulation"

S7 - AB "self-care" OR "self-help" OR "self-management" OR "self-regulation"

S8 - TI "perce\*" OR "experience\*" OR "view\*" OR "belief\*" OR "opinion\*"

S9 - AB "perce\*" OR "experience\*" OR "view\*" OR "belief\*" OR "opinion\*"

S10 - S5 OR ((S6 OR S7) AND (S8 OR S9))

S11 - MH "Qualitative Research" OR MH "Interviews" OR MH "Grounded Theory"

S12 - TI "qualitative\*" OR "explor\*"

S13 - AB "qualitative\*" OR "explor\*"

S14 - S11 OR S12 OR S13

S15 - S4 AND S10 AND S14

Narrow by SubjectAge: - young adult: 19-24 years

Narrow by SubjectAge: - middle aged: 45-64 years

Narrow by SubjectAge: - adult: 19-44 years

Narrow by SubjectAge: - all adult: 19+ years

TOTAL FOUND = 190

## EMBASE

1. \*"bipolar disorder"/ or \*mania/ or \*"mood disorder"/ or \*"mixed mania and depression"/
2. (Bipolar\* or Mania\* or Manic\* or 'Mood Disorder\*' or Euthymia).ti.
3. (Bipolar\* or Mania\* or Manic\* or "Mood Disorder\*" or Euthymia).ab.
4. 1 or 2 or 3
5. \*patient compliance/ or \*rehabilitation/ or \*self care/ or \*self help/ or \*prevention/ or \*relapse/ or \*recurrent disease/ or \*treatment refusal/ or \*medication compliance/
6. ((self-care or self-help or self-management or self-regulation).ti. or (self-care or self-help or self-management or self-regulation).ab.) and ((perce\* or experience\* or view\* or belief\* or opinion\*).ti. or (perce\* or experience\* or view\* or belief\* or opinion\*).ab.)
7. 5 or 6
8. \*qualitative research/ or \*interview/
9. (qualitative\* or explor\*).ti.
10. (qualitative\* OR explor\*).ab.
11. 8 or 9 or 10
12. 4 and 7 and 11

Total found = 175



Scopus

( TITLE-ABS-KEY ( "bipolar disorder" OR manic\* OR mania\* OR euthymia ) )

AND

(( TITLE-ABS-KEY ( rehabi\* OR self-care OR self-help OR self-management OR self-regulation ) )

AND ( TITLE-ABS-KEY ( perce\* OR view OR experience OR belief OR opinion ) ) )

AND

( TITLE-ABS-KEY ( qualitative\* OR explor\* OR interview\* ) )

Total Found = 140

## PUBMED

(((((("bipolar disorder"[MeSH Terms]) OR "mood disorders"[MeSH Terms])))

OR

(((((("bipolar disorder"[Title/Abstract]) OR ("mania"[Title/Abstract]) OR ("manic"[Title/Abstract]) OR ("mood disorder"[Title/Abstract]) OR ("euthymia"[Title/Abstract])))

AND

((((((("self management"[MeSH Terms]) OR "self care"[MeSH Terms]) OR "rehabilitation"[MeSH Terms]) OR ("treatment adherence and compliance"[MeSH Terms]) OR "medication therapy management"[MeSH Terms]) OR (("self help devices"[MeSH Terms] OR "self help groups"[MeSH Terms] OR "self medication"[MeSH Terms])) OR "treatment refusal"[MeSH Terms]) OR "medication adherence"[MeSH Terms]))

OR

(((((("self care"[Title/Abstract]) OR "self help"[Title/Abstract]) OR "self management"[Title/Abstract]) OR "self regulation"[Title/Abstract]))) AND (((("perception"[Title/Abstract]) OR "experience"[Title/Abstract]) OR "view"[Title/Abstract]) OR "belief"[Title/Abstract]) OR "opinion"[Title/Abstract]))

AND

(((((("qualitative research"[MeSH Terms]) OR "interview, psychological"[MeSH Terms]) OR "grounded theory"[MeSH Terms]))

OR

((("qualitative"[Title/Abstract]) OR "exploration"[Title/Abstract])

Filters: Publication date from 06/11/2017 to 05/11/2018

Total Found: 25

## **Appendix 1-B**

### **Modified Quality Appraisal Tool**

The following quality appraisal tool is a modified version of the Critical Appraisal Skills Programme (CASP) (Public Health Resource Unit, 2006). The purpose of amending the CASP was to highlight and appraise the relevant data for this specific review. It lists the 10 questions of the CASP with additions and amendments that have been taken from both the Standards of Reporting Qualitative Research (SRQR) (O'Brien et al., 2014) and the Consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007). The concluding question was used as a summarised answer for the purpose of the report.

#### Index

S# = Number from SRQR, C# = Number from COREQ

#### CASP Question 1

**Was there a clear statement of the aims of the research?** Consider;  
What was the goal of the research? Why it was thought important? Its relevance?

S3 Problem Formulation - review of relevant theory and empirical work; problem statement.  
S4 Purpose or research question - Purpose of the study and specific objectives or questions

Comments:

Conclusion:

**Research Questions identified and Relevant? *Yes/No***

#### CASP Question 2

**Is a qualitative methodology appropriate?** 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.

S5 Qualitative approach and research paradigm - (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale

C9. What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis

Comments:

Conclusion:

**Qualitative Approach**

### CASP Question 3

**Was the research design appropriate to address the aims of the research?** Consider; If the researcher has justified the research design (e.g. have they discussed how they decided which method to use).

S5 - Qualitative approach and research paradigm - (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale

Comments:

Conclusion:

**Was the justification of approach appropriate? Yes/no**

### CASP Question 4

**Was the recruitment strategy appropriate to the aims of the research?** 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).

S8 Sampling Strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale

C10. Sampling - How were participants selected? e.g. purposive, convenience, consecutive, snowball.

C11 Method of approach – How were the participants approached? E.g. face-to-face, telephone, mail, email

Comments:

Conclusion:

**Selection Process**

### Demographic Information relevant for this review

S12 Units of Study - Number and relevant characteristics of participants

S7 Context – Setting/site and salient contextual factors; rationale.

C12 Sample size - How many participants were in the study?

C16 Description of sample - What are the important characteristics of the sample? e.g. demographic data

Comments:

Conclusion:

**Number of participants (Female:Male):**

**Diagnosis of participants:**

**Ages of participants:**

**Nationality or participants:**

#### CASP Question 5

**Was the data collected in a way that addressed the research issue?** Consider;

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 the form of data is clear (e.g. tape recordings, video material, notes etc.)

S10 Data Collection Methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale

C21 Duration - What was the duration of the interviews or focus group?

Comments:

Conclusion:

**Data Collection:**

**Length:**

#### CASP Question 6

**Has the relationship between researcher and participants been adequately considered?**

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

C8 Interview Characteristics – What characteristics were reported about the interviewer/facilitator? E.g bias, assumptions, reasons and interests in the research topic

Comments:

Conclusion:

**Was researcher bias discussed? Yes/no**

#### CASP Question 7

**Have ethical issues been taken into consideration?** 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:

Conclusion:

**Was ethical approval discussed? Yes/No**

#### CASP Question 8

**Was the data analysis sufficiently rigorous?** 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.

S13 Data Processing – Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding and anonymization/deidentification of excerpts.

S14 Data Analysis – Process by which inferences, themes etc., were identified and developed, including the researchers involved in data analysis, usually references a specific paradigm or approach; rationale.

C24 Number of data coders – How many data coders coded the data?

C28 Participant checking – Did participants provide feedback on the findings?

Comments:

Conclusion:

**Data recording:**

**Data entry:**

**Data verification:**

#### CASP Question 9

**How valuable is the research?** 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.

S17 Links to empirical data – Evidence (e.g. quotes, field notes, text excerpts, photographs) to substantiate analytic findings.

C29 Quotations Presented – Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? E.g. participant number

C31 Clarity of Major Themes – Were major themes clearly presented in the findings?

C32 Clarity of Minor Themes – Is there a description of diverse cases or discussion of minor themes?

Comments:

Conclusion:

**Participant Quotes Used:**

**List of Relevant Themes:**

CASP Question 10 was not used.

## Appendix 1-C

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#### Psychology and Psychotherapy: Theory, Research and Practice

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doi:[10.1176/appi.ajp.159.3.483](https://doi.org/10.1176/appi.ajp.159.3.483)

### *Book*

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Doctorate in  
Clinical Psychology



**Doctoral Thesis**

Section 2: Research Project

*A qualitative exploration of how people with bipolar disorder consider risk-taking in everyday decisions.*

Andrew Wah

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

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### **Abstract**

**Objectives:** The study qualitatively explored how individuals with Bipolar Disorder (BD) consider risk in everyday decisions during their euthymic phase.

**Design:** Semi-structured interviews were completed, and audio recorded. The interviews were transcribed verbatim with personal identifiers removed.

**Methods:** Eight participants were interviewed. Interpretative Phenomenological Analysis was used to analyse the data.

**Results:** Four themes were identified. The first theme, “Who I Really Am”, discusses how their identity impacts on the risk individuals with BD take. The second theme, “Taking Back Control of my Life”, explored what risks individuals with BD will take as they tried to keep control of their life. The third theme, “Fear of the ‘What Ifs’”, represents how the fear that negative consequences from taking risks impacts their decisions. Finally, the fourth theme, “The Role of Family and Friends”, highlights the important role that a supporting network has.

**Conclusions:** The study highlights four aspects that can impact on an individual with BD’s consideration of risk during euthymia. Identity, control, fear and support all play a role when a person considers risk in their decision-making process. The study highlights how these four themes could be considered when exploring risk with individuals with BD.

Bipolar disorder (BD) is characterised by shifts between episodes of mania or hypomania, and depression (National Institute for Health and Care Excellence, 2016). In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), BD is described as a bridge between depressive disorders and schizophrenia and has been split into multiple categories depending on severity, pervasiveness and duration; bipolar I, bipolar II, cyclothymic, substance-induced bipolar disorder and unspecified bipolar disorder (American Psychological Association (APA), 2013).

Mania refers to the presence of an abnormal, and persistently elevated and energetic mood for seven days or more, that is often accompanied by a lack of sleep, multiple ideas, racing thoughts and distractibility. Hypomania is the presence of abnormal and elevated mood for four days or more. In contrast, depression in BD is characterised by a marked lack of interest, fatigue or loss of energy, insomnia and recurrent thoughts of death or suicidal ideation (APA, 2013). Changes in daily functioning must also occur to meet the threshold for mania, hypomania or depression in BD (APA, 2013; Gitlin & Miklowitz, 2017). For its part, the term euthymia refers to an absence of manic or depressive symptoms and has been described as clinical recovery (Olley et al., 2005). Nevertheless, individuals in a euthymic phase of BD consistently present with subsyndromal symptoms that can also impact on their daily functioning (Samalin, Chazeron, Vieta, Bellivier, & Llorca, 2016).

The diagnostic labels of BD and its categories may imply that it is an illness to which individuals diagnosed with BD suffer from and thus need to be treated (Bobo, 2017). Other perspectives suggest that the presentations of BD could be explained as human reactions to life stressors (Division of Clinical Psychology, 2010). Arguing the aetiology of BD is out of the scope of this project, however, what is important to understand are the difficulties that BD presentations can cause. For the individual, BD can have significant negative effects on education, occupation, social and intimate relationships and daily functioning (Kleinman et

al., 2003; Walsh, Corcoran, Crooks, Cooke, & Cummings, 2017). Psychologically, BD can have a detrimental effect on a person's identity, self-esteem and independence (Folstad & Mansell, 2019). Furthermore, individuals with BD are at an increased risk of making a suicide attempt and, although completion rates vary between studies, Plans et al. (2019) estimate that completion rates are 20-30 times higher in BD than in the general population.

A clinical feature of BD is the excessive involvement in activities that have a high potential for adverse consequences (APA, 2013). Such activities may include spending sprees, shoplifting, sexual indiscretions, and aggression (Martino, Strejilevich, Torralva, & Manes, 2011; Reinharth, Braga, & Serper, 2017). For example, all 20 participants in one qualitative study reported that BD had negatively impacted social experiences including damaging and breaking of relationships and a loss of social control (Owen, Gooding, Dempsey, & Jones, 2017). The excessive involvement in activities with high potential for adverse consequences has been used as evidence that individuals with BD may have a decision-making impairment that impacts their ability to consider the risks involved (Adida et al., 2011).

The general decision-making process is already complex with emotional and cognitive processes impacting the decisions we make (Milkman, Chugh, & Bazerman, 2009). For individuals with BD, the fluctuating mood phases of BD increases the complexity of decision-making (Inder et al., 2010). The fluctuating mood states in BD can mean that individuals with BD may perceive information differently resulting in different decisions across their mood states (Adida et al., 2011). Thus, Alexander, Oliver, Burdine, Tang, and Dunlop (2017) questioned which aspects of decision-making are phase-dependent (only present in mania or depression) versus which aspects are trait-dependent (persisting even during periods of euthymia). They implied that their results showed an impaired decision-

making style in BD depression that improved significantly with treatment suggesting that impaired decision-making could be phase-dependent.

Researchers have considered the role of other factors when explaining problems in decision making, such as impulsivity, reduced working memory, significant disinhibition, poor judgement or a lack of consideration for long term consequences. However, the results of investigations regarding the role of these factors have been inconclusive (Burdick, Braga, Gopin, & Malhotra, 2014; Cáceda, Nemeroff, & Harvey, 2014; Reinharth et al., 2017; Yechiam, Hayden, Bodkins, O'Donnell, & Hetrick, 2008). Although, there does appear to be an agreement about general decision-making difficulties within the manic and depressive phases of BD (Murphy et al., 2001; Reinharth et al., 2017). Interestingly, researchers are not in agreement regarding general decision-making difficulties for the euthymic phase (Adida et al., 2011; Martino et al., 2011; Olley et al., 2005).

Olley and colleagues (2005) explored possible subtle impairments during euthymia that would impact decision-making and highlighted deficits in executive functioning. Specifically, a deficit in working memory and mental flexibility meant that individuals in the euthymic phase struggled to hold in mind the end goal, and potential sub-goals, to flexibly come to a decision. In addition, Adida et al. (2011) used the Iowa Gambling Task to report impaired decision-making in euthymia that did not vary across mania or depressive phases. Therefore, the authors suggested that a decision-making impairment should be considered a trait abnormality in BD. The Iowa Gambling Task can analyse choices based on previous results and consistency of card selection. A limitation of the task is that it does not measure the frequency of risky choices or offer variation in the types of risky behaviour people may engage in (Reinharth et al., 2017). Further, it is a computer-generated gambling game that does not offer real wins or losses. This could mean that participants may make riskier decisions than they normally would (Fernandez-Duque & Wifall, 2007).

In contrast to supporting a decision-making impairment in euthymia, a systematic review concluded that BD individuals in a euthymic state may not have decision-making impairments (Samame, Martino, & Strojilevich, 2012). The authors' analysis of 20 studies suggested that decision-making abilities are preserved in euthymia. Adding an element of risk, that is an element of loss or consequence to the individual, means the decision-making process can become more complex (Ibanez et al., 2012). Risk-taking in BD is predominantly conceptualised by problems with impulsivity (Holmes et al., 2009), however, a recent study has offered a more complex framework (Sicilia, Lukacs, Jones & Perez Algorta, 2019). The authors suggest that risk-taking in BD could be driven by a faulty processing rather than impulsivity. Individuals with BD appear to have an increased likelihood of engaging in risk-taking behaviours, even in euthymia (Chandler, Wakeley, Goodwin, & Rogers, 2009). In addition, Reinharth et al. (2017) state how individuals with BD are making decisions that involve an element of risk almost every day. Nevertheless, it has also been argued that individuals with BD can make important decisions, including decisions involving an element of risk, in everyday contexts even in highly demanding situations (Martino et al., 2011).

The increased likelihood of risk-taking decisions in euthymia along with the severity of potential adverse consequences highlights the importance to explore this issue. To our knowledge, there are no qualitative studies that explore how euthymic BD individuals specifically consider risk-taking in everyday decisions and the impact this may have on their individual experiences. Research involving risk-taking in euthymia is scarce and that has led this study to qualitatively explore the experiences of individuals with BD as they consider risk during periods of euthymia. Furthermore, a qualitative study could contribute to the understanding of personal experiences, perceptions and the impact of risk-taking behaviours during periods of euthymia (Mansell, Powell, Pedley, Thomas, & Jones, 2010). Using this

knowledge could inform research and clinical practice with BD individuals and may enhance clinicians' ability to engage with individuals on this important topic (Alexander et al., 2017).

Therefore, with calls to qualitatively explore personal experiences of BD (Fisher, Manicavasagar, Kiln, & Juraskova, 2016), this study explores how risk-taking is considered within everyday decisions for people living with BD during their euthymic phase. As risk will have different meanings within different contexts and between individuals, risk-taking is defined in this study as any decision that has the potential for negative consequences (Holmes et al., 2009). For example, some individuals may consider the risk of self-harm or suicide daily and therefore that is an everyday risk for that person. Alternatively, it may be speeding or going to social events that can carry a risk of negative consequences for them. Overall, discussing personal experiences could provide rich, and potentially unexpected, data regarding risk-taking in the euthymic phase of BD.

## **Method**

### **Epistemological Approach**

The study aimed to explore the lived experiences of individuals with BD regarding their consideration of risk in everyday decisions during euthymia. By conducting the study within a BD diagnostic framework, the researchers assumed that a concept called BD and its mood states exist, leaning towards a positivist position (Madill, Jordan, & Shirley, 2000). In contrast, the exploration of how individuals make sense of risk and how risk in BD has been conceptualized could lend itself to a social constructionist position (Willig, 2019). Therefore, with two contrasting positions, the study took a critical-realist epistemological stance (Pilgrim, 2013).

Critical-realism allows researchers to make use of the tension between positivist and social constructionist approaches (Hood, 2016). Critical-realism proposes that it is the researcher's task to investigate the relationship between observable reality and unobservable structures of reality (Willig, 2019). The critical-realist position allows interpretation of individual experiences to explore change and being, rather than experiences that are represented by causal patterns (Pilgrim, 2013). Exploring risk-taking in this way may help to understand the underlying experiences of the participants within the different contexts they occur (Willig, 2012).

### **Study Design**

Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009) will be used to attempt to hypothesise how each participant, in their context of BD (their observable reality) considers risk in everyday decisions (their unobservable reality) (Willig, 2019). IPA explores how participants make sense of their world, with emphasis on the meaning of the experience for the individual (Smith & Osborn, 2015). IPA is committed to an idiographic approach which allows for the results to stay rooted within the differing contexts of the participants' lives and experiences. To do this, each individual interview was analysed to generate subordinate themes that were then collated for the researcher to interpret the whole data set. The purpose of IPA is to shed light on a phenomenon and guide readers to possibilities and considerations for the phenomena of interest (Hefferon & Gil-Rodriguez, 2011; Smith & Osborn, 2015).

This study used semi-structured interviews as it enables the researcher and participant to engage in a detailed dialogue whilst giving the flexibility to explore prominent issues that are brought up in the conversation (Galletta, 2013). The active involvement of the researcher is described as the double hermeneutic as the researcher is interpreting the participants' interpretations of their experiences (Smith et al., 2009). Recognising this active role, the IPA



process aims to observe and reduce any researcher bias by keeping reflective journals and utilising supervision (Lobban, Taylor, Murray, & Jones, 2012).

A person with lived experience of BD and experience in academia was approached to review the content and design of the study. A key aspect of the consultation was regarding the language and terminology used within the study. It was acknowledged that the terms used in academic writings of bipolar can appear clinical and not commonly used within the general population. For example, it was agreed that the term euthymia was most highly likely to be an academic term and unknown to potential participants. During the consultation we agreed on a definition that would be used on the advertising materials and within interactions with potential participants.

### **Recruitment**

Following ethical approval by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University, the study was advertised by The Spectrum Centre for Mental Health Research (Spectrum). Spectrum is a network that connects researchers and people with an interest in BD so that valuable contributions can be made in the growth of BD knowledge. Spectrum has a member network of over 400 people across the world. The project invited participants who self-report having a diagnosis of BD and were currently in a euthymic phase to register their interest with the researcher. The researcher initially discussed the project during telephone and email communications to discuss participant interest. If verbal or written consent was given, then a telephone screening interview was scheduled.

The Mini-International Neuropsychiatric Interview (MINI) (Sheehan et al., 1997) was used as the screening interview to provide clinical evidence of a BD diagnosis and euthymic mood state. The MINI is a short structured clinical interview that has been designed for

research settings. It has been shown to be a well-validated measure that can also identify a euthymic mood state (Syan et al., 2018). To be eligible for the full interview the participant had to score within range for a BD diagnosis and in euthymic phase. Mood states can change quickly so the interviews were scheduled within two weeks of the screening interview.

[Insert Table 1]

### **Procedure**

Recruitment was completed on a first-come-first-serve basis in order of contact with the researcher. Sixteen people responded to the initial advert from a broad range of locations including the north and south of UK, USA and other countries abroad. After discussing the project with them, 10 participants volunteered for the screening interview with nine participants meeting the inclusion criteria. One participant was deemed to have been in a depressive phase. One other participant withdrew from the study close to their interview day. In total, eight participants were interviewed (Table 2).

[Insert Table 2]

The eight participants, all located in the UK, were interviewed between November 2018 and January 2019. The participants were offered face-to-face, telephone or skype interviews, with all eight participants opting for a face-to-face interview (Smith et al., 2009). Interviews were completed in a convenient location for the participant that included public libraries, community centres or their own homes.

On the interview day, the lead researcher and the participant discussed the study and made sure that the participant was still interested. The discussion involved sharing information about the project and providing the participant opportunities to ask any questions

they may have. It was also explained that they had no obligation to proceed with the project and, if they did take part, they may withdraw up to two weeks post-interview. The researcher also checked in on mood and confirmation that the participant was in a euthymic phase by asking about low and elevated mood over the past two weeks (Sheehan et al., 1997). The participation consent form was signed before any recording took place. Interviews were recorded digitally and transcribed verbatim. Any personally identifiable data, i.e. names, services, places etc., were replaced with pseudonyms. The interviews lasted between 45 and 62 minutes. An example of an everyday decision that involved an element of risk for each participant has been described in table 3.

[Insert Table 3]

### **Analysis**

The analysis followed the procedure outlined by Smith and Osborn (2015). The lead researcher became immersed in the data by reading the transcript several times, annotating and making notes each time (Appendix 2-A). The first level annotations of interesting remarks and comments on the phenomena of interest were made. The second level of annotations reduce the initial comments to create emerging themes. To develop emerging themes, the lead researcher re-read the transcripts in conjunction with the first level annotations. Sections of the transcript were grouped to hypothesise and interpret the underlying psychological processes that may be occurring. The emerging themes allowed theoretical connections across the interview but grounded in the specific experience of the participant. The emerging themes were then extracted and clustered into a set of subordinate themes for the participant (Table 4). This process occurred for each interview individually to ensure the themes stayed closely linked to the participant's account. After all the interviews

had been analysed, the subordinate themes from each interview were collated to develop major themes for the whole data set (Smith & Shinebourne, 2012) (Appendix 2-B).

[Insert Table 4]

The lead researcher completed the analysis and interpretations. Trustworthiness of the analysis was ensured by consensus (Goodell, Stage, & Cooke, 2016). Due to supervisor time and limitation on input, supervision was utilised to ensure IPA procedures had been adhered to. During supervision, interpretations were checked by asking IPA informed critical questions such as; what is the participant trying to achieve here? Do I have a sense of something going on here that maybe the participants themselves are less aware of? (Smith & Osborn, 2015).

## **Results**

The analysis of the eight interviews resulted in four themes regarding how individuals with BD consider risk in everyday decisions. The first theme was about their identity which was titled “Who I Really Am”. The second theme was about regaining control and was titled “Taking Back Control of my Life”. The third theme discussed the impact of fear on taking risks and was titled “Fear of the ‘What Ifs’”. Finally, the fourth theme explored the impact and support of their supporting network as they considered risk in everyday decisions. The theme was titled “The Role of Family and Friends”.

[Insert Table 5]

### **Who I Really Am**

Identity and personal values appeared to have an impact as the participants considered risk during euthymia. The participants' risk-taking choices in euthymia were more aligned to their real self and expressed the person they are.

There appeared to be a loss of identity when diagnosed with BD. During mania or depression, the participants described not feeling their true selves and because of the risky actions they took, they were given identities from others that they did not want or appreciate. Kate was perceived to be "the performer" by her peers and Mary was perceived to be "the drama-queen" by her sister. Other participants described confusion over what was BD symptoms and what was their personality. Furthermore, BD was adjudged to have "tripped up" participants which resulted in a misjudgement of the risk involved in the situation. Having quick fluctuations in mood in BD meant that participants were often worried about their ability to assess risk and make their decision as they thought they may be misjudging the situation. Their confidence was often reduced, further hindering their risk decision-making process.

*"I was in a world, it was like, I was there but I wasn't there" (Sarah)*

To counter this experience, participants expressed that their risk-taking choice during their euthymic phase reflected their true self. Participants described being able to think clearly, weigh up the pros and cons and take the time to assess the risk involved in the decisions that they were making. Participants would assess the risk by considering if the consequences would reflect their identity, if the risk gave a sense of purpose in life and if the risk were aligned with their personal values.

*"We have always managed a spiritual and moral life between us. We go to mass of a Sunday and through the week with confession there and it is*

*all therapeutic. It causes you to think about what you are doing, why you are doing it and what was wrong and all the rest of it” (Frank)*

During their euthymic phase, the participants appeared to be able to understand their relationship with risk-taking and how it might impact on their identity. Some participants described themselves to not be a risk-taker, identifying as sensible, logical, and careful. For some participants, they enjoyed taking risks as they perceived it to be exciting and interesting, yet during euthymia, they were still able to balance what risks were worth taking.

*“If you are going to learn something or it makes you feel alive, exciting, vibrant, stimulate you then I would probably say do it” (Kate)*

Participants also talked about being reflective during euthymia. They were able to think about the behaviours they had displayed during mania or depression, reflect on them, and apply their reflections during the euthymic phase. Their reflections enabled them to consider the risks that reflect their identity. Participants were able to “mindfully push” themselves to make risky decisions that would be best for them, even considering the impact the decision may have on their mood. It was during the mania or depression when their reflective capabilities appeared to stop.

*“It all depends on what mood I am in that moment. If I am tired or restless or something like that then I’ll just have coke and that, but if I’m off work the next day or whatever and I’m drinking, I don’t overdo it cos of my medication, I just enjoy it” (Rob)*

Finally, perfectionism appeared to have an impact when making risky decisions in euthymia. There appeared to be an additional consequence of being wrong and how they are then perceived. Ensuring that they made the correct choice had both positive and negative

consequences. The positive consequences meant that participants were able to create contingency plans for the negative consequences of the risk or prepare themselves to reduce the severity of the consequence. Perfectionist thinking also has a negative impact if they were overthinking or overpreparing for every decision. Unfortunately for some, even during euthymia, the perfectionist identity meant that assessing risk became challenging. With much to consider, the potential rewards versus the potential triggers or consequences meant that they found it difficult to come to a conclusion.

*“It makes the risk-taking feel less, because the undesired consequence is lessened by that so I am more happy. In some way it might be overpreparing to make sure you have got all these answers. But it is not, it is enabling me to be freer because I don’t have to over-prepare each individual thing as much. It is letting myself be aware that if I don’t know something that is alright, this is what I do” (Michelle)*

### **Taking Back Control of my Life**

Taking back control of their life was identified when participants assessed the risks and made autonomous decisions that were in their best interest. Similarly to the first theme, participants felt a sense of loss of control over their lives after being diagnosed and then again each time symptoms escalated. All participants shared their stories of how their BD presentation had caused much distress and impacted on their social, occupation and family lives so when their symptoms escalated, they appeared less confident in their decision-making ability when considering risk.

*“Unfortunately, everything I learn when I am well doesn’t play out when I am unwell, at all!” (Helen)*

Yet, when in euthymia, participants wanted to keep a balance and would make decisions to keep control of their moods. The participants were able to assess the risks and balance out decisions by analysing potential outcomes and their rewards and consequences. Even with incomplete information, participants took control over their decisions and made the choice that best meets their needs. A positive aspect of risk-taking in euthymia was how risk-taking shouldn't prevent individuals from enjoying life but that risks can be taken to live life to the full. After taking risks and having positive outcomes the participants were empowered to live autonomous lives and to achieve their goals. For example, taking the risk to travel the world helped Rob to develop the self-confidence to live independently when he returned home. At times, participants may have been feeling controlled by BD but their risk-taking during euthymia could satisfy the urges whilst not putting their life in jeopardy.

*“oh yeah, if you satisfy the urge. Of course, there is. You calm down, hormone balance returns and you are not bothered by it anymore” (Frank)*

At times other people tried to control their decisions as they were worried or concerned that the participants' mood may be escalating. In an attempt to keep control over their decisions, participants had to justify their considerations of the risks involved. On some occasions they did this by providing evidence or taking the time to think carefully before they did respond. Participants described how they were aware of and showed consideration to the other person's interpretation. Ultimately, even after input from family and friends, it was their own decision whether to take the risk or not.

*“I felt the need to justify and well “I have got it for ID plus why not?” If I am capable of driving and taking lessons, that's up to me. He had no right to tell me I can't afford it” (Rob)*



Another way to gain control over their lives was to continue to work, have a voluntary job or engage in charitable works. Continuing to work, voluntary or paid, provided the participants with a sense of purpose and achievement. Although, within work, participants described the risk of taking on too much responsibility which could lead to arousal of mood. During their euthymic phase, participants were better positioned to be able to weigh up the risks of taking on more responsibility and the impact that the extra responsibility may have. Further, during euthymia, they could assess the risks and adapt their behaviour so that the severity of the risk would reduce. For example, Mary explained that if she wanted to go to a work event but was worried it may trigger her manic symptoms then she may reduce the time she spent at the event:

*“I would probably have the presence of mind and the positivity to ask my husband “do you think this is a good idea?” and to have a conversation with him. Probably agree and I can manage, or we could go an hour later and come home an hour earlier to sort of balance everything out” (Mary)*

### **Fear of the “What ifs?”**

Considering risks during euthymia brought on fear for participants as they were able to think about more potential consequences. The participants appeared to have a clearer mind that allowed them to think about the consequences for themselves, their family and peers. Having this clarity of mind, however, brought on fear to take risks as the decisions became more complex with more potential consequences to consider. Participants feared the “what ifs?” What if they make the wrong decision? What if there are consequences for myself? What if it impacts my family or other people? What if I am perceived to be something I am not? The most prominent what if was What if it triggers an episode and I end up being admitted into hospital?

*“I tend to think of risk assessment, so you try and put your black hat on and think “what could go wrong in this situation?” (Mary)*

Before taking a risk, the participants described having to wait until the time was right. The right time was identified through a gut feeling, thinking about the correct response, or collecting enough evidence to justify their choice. Making sure the time was right was a challenge for the participants. The participants feared slight changes in mood or minor altercations which could lead to severe consequences. Sometimes the fear of slight changes meant that the time wouldn't feel right and so the participant would not make the decision. In addition, avoiding the decision could also trigger a mood change and so the risk of this occurring also had to be considered. Balancing fear and avoidance provided a challenge even during euthymia. For example, Sarah found it difficult to decide whether to go to the shops or not as she feared meeting somebody that would trigger an episode.

*“Something as small as that could trigger a slight episode, not a major one, a slight one in that I could be feeling alright and then quite poorly the next”*  
*(Sarah)*

Several of the participants discussed how they would not take risks because they would worry about the impact on their family. They were unwilling to take risks that may put financial, occupational or relational distress on their lives. Participants were able to hold in mind future consequences and the regret that they may feel if a risky-decision did not work out.

*“You see, the reason I don't normally when I am well is that I know that it puts myself and my family at risk” (Helen)*

The biggest fear participants had when making decisions was if the consequence triggered an episode and they ended up in a psychiatric hospital. Being in a psychiatric hospital was described as the worst part of their life, and one participant described it as the “gates to hell”. While the hospital was deemed to be the place that should save them, the hospital was unable to save them from their BD. Thus, staying mentally well was often prioritised as being mentally unwell would inevitably lead to a psychiatric hospital admission. The need to stay mentally well meant that in some situations risky choices had to be made. It was deemed that not taking a risk, was, paradoxically, riskier for their mental wellbeing. For example, Kate explained a dilemma she had been involved in. She was aware that staying where she was had a heightened risk of triggering her BD symptoms, however, there were risks to her physical safety if she was to leave. Kate prioritised her mental health over her physical health due to a fear of “what if it makes me ill again?”.

*“I just think “I have just got to stay well.” I know that is ironic because I am probably doing something risky but I just think “I need to sleep, I have got to sleep, I don’t feel comfortable with this person or where I am, I have to get home” (Kate)*

### **The Role of Family and Friends**

The participants support network, mainly their family and close friends, had an important role to play when considering risk in everyday decisions. Participants described initiating discussions regarding risks with family and friends because it was important to hear their perspective. Conversely, it was noted as just as valuable for family and friends to initiate and identify other risks that the participant had not considered. Although both interactions were important, they could, at times, be perceived as unsupportive.

When family and friends supported participant's risk-taking decisions this was perceived as extremely positive. The participants described considering risk as a team effort. The team supports each other, uses each other's skills and complements each other. A supportive role for their family and friends was to politely suggest when they noticed subtle mood changes or if they believed the participant was taking on too much responsibility. This was to protect the participant from making choices that may have negative consequences. For example, Mary explained how arguments with her husband occur when she becomes irritable. Mary has learnt to read her husband's indirect ways of acknowledging her irritability:

*"I can also test my husband reactions to me quite easily. If I say "we could do with doing some housework, it looks a bit of a mess" he will hear my tone of voice and say "ok, lets have a coffee and do it together in half an hour, is that ok?" and then that gives me an indication that he has picked up on some kind of irritability" (Mary)*

Another positive of having family and friend's support was how they can empower participants to make decisions. During euthymia, participants were able to take their advice and think rationally about it. The participants were then able to make the decision that would be best for them. Empowering the participants didn't necessarily mean going along with what was suggested. For example, Michelle explained how her friends would often encourage her to take risks as they believed that she is a competent person. Michelle does find this encouraging but she is also aware of her limitations and can balance the size of the risk that is needed.

*"My friends probably the best sort of support. They are very good. I mean sometimes they can be overly supportive like I had an opportunity to do a three-day course and they said "you know you can" and massively boosting*

*my confidence. But in fact, I know three days would be too much for me as tiredness tends to set me off” (Michelle)*

At times, the support offered when considering risk was perceived to be unsupportive. The participants still appreciated having the support, however, it could have negative influences when considering risk. Participants described the expectation that was put on them by family and friends. The added pressure to make the correct decision affected their consideration of risk. This expectation could lead to a misjudgement of risk. It could also prompt a desire to not disappoint their family and friends thus putting themselves at risk. Family and friends would also undermine the participants by putting in place contingency plans. The participants felt patronised as they perceived that their family and friends did not have confidence in their risky decision-making ability.

*“patronising really, because I feel that I know myself better than she does. She has a sense of embarrassment” (Sarah)*

### **Discussion**

This study is the first of its kind to qualitatively explore how individuals with BD consider risk in everyday decisions during their euthymic phase. IPA was used to analyse and interpret eight participant interviews. Four themes were presented. Identity (“Who I Really Am”), control (“Taking Back Control of my Life”), fear (“Fear of the ‘What ifs’”), and their supporting network (“The Role of Family and Friends”) were identified as important influences that were considered when risky decisions are made.

Decision-making has been researched across the different phases of BD to ascertain if a trait or phase impairment exists that would impact on risk-taking

decisions (Alexander et al., 2017). Thus far, literature has been inconclusive as mixed results have been found (Adida et al., 2011; Samame et al., 2012). Yet, there is an agreement that individuals with BD can find decision-making difficult across the phases of BD (Fisher et al., 2016). The themes presented in this study offer an insight into the difficulties and considerations that individuals with BD face when there is an element of risk involved in their decisions.

A diagnosis of BD can often leave individuals with confusion over their identity. It can become difficult to differentiate between what is their BD symptoms and what is their “real self” (Inder et al., 2008). BD can also become intertwined and a part of their identity (Folstad & Mansell, 2019). How individuals are embracing the identity that BD can bring, could be influencing their decisions around risk. For those who want to identify as sensible and logical, may be rejecting the BD identity and become risk-averse during euthymia. Embracing the identity of BD could mean that they are willing to take more risks because that is what is expected from BD. The risks they take in euthymia were seen to reflect the person that they are or want to be perceived as. Therefore, exploring the impact of BD on their identity and personal values should be an important process to consider (Folstad & Mansell, 2019).

Aligning risky decisions to their identity and personal values could also be an expression of control over their BD. Taking back control over their lives was deemed to be important and so adaptive strategies were utilised. Assessing risk and making individualised choices kept control over their BD and could be perceived as empowering (Morton, Michalak, Hole, Buzwell, & Murray, 2018). Empowerment in euthymia could encourage more calculated and individualised risks being taken so that they could live a fulfilling life. However, if a risky choice did have negative

consequences then a sense of loss of control could be experienced. Loss of control over their BD has been described as one of the most distressing aspect for those with BD (Warwick, Mansell, Porter, & Tai, 2019). The distress could be from the desire for stability in their lives that lacking control over their moods interferes with (Folstad & Mansell, 2019). The need for stability, and thus control, was experienced by balancing their decisions relative to the assessed risk. During euthymia, a clarity of mind enabled a more balanced assessment of risk.

The clarity of mind that occurred during euthymia was a surprising feature within the themes of the study. The findings in this study could shed light on self-reflection capabilities that may be present during euthymia that may not be present during mania or depression. These findings appear to contradict a study that has researched self-reflection in BD. Van Camp and colleagues (2018) used objective measures to assess self-reflection with participants diagnosed with BD from an inpatient facility. The average age of the sample was 42 years and average length since diagnosis was 17.6 years. The results of Van Camp et al.'s (2018) study suggested that reduced self-reflection is a trait that is consistent throughout all mood phases of BD. Yet, it was apparent that when euthymic, the participants in this study could retrospectively reflect on their experiences and behaviour that occurred during mania and depression. There are some key differences between the studies. First, Van Camp et al. (2018) used objective measures over a period of eight months. Second, the participants were recruited from an in-patient facility and at the time of the study they were experiencing acute symptoms. In contrast, this study's qualitative approach could only highlight a possibility within a small sample of euthymic participants. While the participants expressed self-reflection capabilities in conversation, it cannot be determined how their scores would compare if object measures were used.

Specific studies researching self-reflectiveness in BD are scarce, however, previous research has discussed cognitive insight. Cognitive insight is a person's ability to be aware of and evaluate their symptoms and how their symptoms can impact their life (Van Camp et al., 2018). Cognitive insight has two main components, self-reflectiveness, the ability to reflect on past experiences, and self-certainty, the amount of confidence in one's decisions (Beck, Baruch, Balter, Steer, & Warman, 2004). Cognitive insight in BD was shown to be affected by the severity of mood symptoms especially in mania (Varga, Magnusson, Flekkoy, Ronneberg, & Opjordsmoen, 2006). In addition, the most current mood state appears to have the greatest influence on cognitive insight abilities (de Assis da Silva et al., 2017). Even in euthymia, cognitive insight was mildly affected which may suggest subsyndromal symptoms being present (Varga et al., 2006).

The second aspect of cognitive insight is self-certainty (Van Camp et al., 2018). Higher self-certainty is associated with lower cognitive insight (Beck et al., 2004) and has been theorised to be linked with a sense of control. If individuals with BD feel their lives are out of control, then a higher self-certainty gives them a false sense that they can regain some control (Stopa, Brown, Luke, & Hirsch, 2010). If cognitive insight is increased during euthymia, then self-reflection capabilities are increased resulting in more accurate risk assessments. Conversely, this could result in more uncertainty as more risks are apparent. Subsequently, self-certainty is lowered as they have more worry about making the wrong choice. This would mean that all the aspects of the decision had to be right, creating fear to make a choice. Ultimately delaying the decision or making no decision at all. This avoidance of making a decision can also cause difficulties for individuals with BD (Chandler et al., 2009).



Overall, cognitive insight might be helpful during euthymia, but only if the fear of the consequences is also lowered.

To further complicate the decision-making process, the different mood states of BD can elicit different perspectives for the individual depending on the mood phase they are in (Fisher et al., 2016). Even during euthymia, regular and fluctuating subsyndromal symptoms can make it more difficult for individuals with BD to notice subtle mood changes (Samalin et al., 2016). This may be creating additional fear of not recognising mood changes and thus creating doubt in their assessment of risk (Chandler et al., 2009). Therefore, it may be more helpful to consider the severity of symptoms, or subsyndromal symptoms, as influences rather than the specific mood states of depression, mania or euthymia (Martino et al., 2011).

The importance of an individual's supporting network was apparent in this study. Family and friends were relied on for support even when they were perceived to be unsupportive. These findings further highlight the importance to have effective communication in order to understand how BD can impact both the individual and their close friends and family (Owen et al., 2017). A systematic review found that caregivers to individual's with BD often experience considerable burdens that can result in a loss of social and occupational functioning in their own lives (Pompili et al., 2014). To facilitate the difficulties BD can present for both individual and their supporting system, Fisher, Manicavasagar, Sharpe, Laidsaar-Powell, and Juraskova (2018) recommend individuals with BD invite family or friends to their appointments so that joint learning can occur together. The involvement of family members or friends could lead to a reduction in potential relapses and greater social, occupational and daily functioning (Miklowitz & Chung, 2016; Reinares et al., 2016).

### **Limitations**

This study had some limitations. Firstly, the participants were all aged over 45 years and had at least 10 years experience of BD since diagnosis. Older-adults have been shown to outperform younger adults for history-dependent tasks (Cooper, Worthy, Gorlick, & Maddox, 2013) and this could impact the participants when considering risk. It may be that reasons for taking risks change through the years resulting in fewer risks being taken for older adults (Duell & Steinberg, 2019). Finally, adolescents and young adults are already more likely to engage in risk-taking behaviour, therefore, exploring how adolescents or young adults with BD consider risk could provide rich data for interventions (Maslowsky, Owotomo, Huntley, & Keating, 2019).

Another limitation is the diagnosis of the participants. BD is split into multiple categories that are dependent on different criteria (APA, 2013) however, in this study only an overarching diagnosis of BD was required. For example, if hypomanic symptoms are experienced that don't lead to mania, then bipolar II diagnosis is given. Often, hypomania is described as the "nice phase" of BD that enables individuals to be more creative and less inhibited (Lobban et al., 2012). Having the self-reflection ability with moderate self-certainty may impact decision-making with risk.

The definition of risk was narrow and focused on the negative aspects of risk. It is acknowledged that there are positive aspects of taking risks (Folstad & Mansell, 2019; Robertson & Collinson, 2011). This study focused on the negative aspects of risk as they could have severe consequences that impact an individual's social, occupational and daily functioning.

One final limitation is validity in qualitative analysis. The lead researcher of this study transcribed and analysed all the interviews. Supervision was sought to quality check analysis; however, limited input of interpretation was given. The study could have benefitted from other interpreters that could include individuals with BD. This would give an informed interpretation and add depth to the analysis (Mjosund et al., 2017). This limitation is discussed further in the critical appraisal section of the thesis.

### **Further Research**

The study highlights the need for more qualitative research regarding risk and decision-making for individuals with BD. With the different perspectives on the debate about decision-making impairments, hearing the personal experiences of risk-taking can add invaluable knowledge. Further, exploring age differences in the consideration of risk in decisions could help individuals and clinicians be more informed for each individual depending on their position in life.

Cognitive insight and more specifically self-reflection and self-certainty were a surprising element in this study. Further research could explore how individuals with BD reflect on their life experiences and how these impact future decisions involving the risk of negative consequences. It could also explore how confident they are when making such decisions and what impacts their confidence.

### **Clinical Implication**

The aim of the study was not to argue the aetiology of BD or provide evidence for an impairment in decision-making. Nevertheless, the study aimed to explore and consider individual experiences of the difficulties that individuals with BD experience. The

exploration highlighted four themes that could have clinical implications for therapy. It has been suggested that advances in therapy will depend on an improved understanding of the factors responsible for the development and maintenance of BD symptoms (Palmier-Claus, Dodd, Tai, Emsley, & Mansell, 2016). When individuals with BD consider the risks in their decisions it may be these four themes may have an impact on decision-making and as such it may be helpful to consider and explore the four themes during therapy.

There are several therapeutic approaches for BD (Meyer & Hautzinger, 2012), with manualised cognitive-behavioural therapy (CBT) and family-therapy being two options available and recommended by NICE (NICE, 2016). Both have modest results for individuals with BD (Miziou et al., 2015; Reinares, Sanchez-Moreno, & Fountoulakis, 2014). To further improve effectiveness of CBT for BD, authors have suggested an individualised, formulation-driven CBT (Jones et al., 2015) or psychotherapy that targets specific aspects of BD (Miziou et al., 2015). The four themes highlighted in this study could help to conceptualise the specific difficulty of considering risk for individuals in BD in a formulation-based approach. Discussing and exploring a person's identity, sense of control, fear and supportive network could enhance a CBT informed formulation.

The supporting network theme highlights the helpfulness that a supportive family member or friend can have in the consideration of risky decisions-making and may suggest that a family therapy element is incorporated within all therapeutic modalities. Family therapy approaches to BD have often worked on educating family members to the understandings of BD so that they can better equipped to offer their support (Fredman, Baucom, Boeding, & Miklowitz, 2015). Discussing the impact of risk with family members may facilitate action by facilitating an understanding of helpful support and when its appropriate for the family member to be involved.

**Conclusion**

The present study highlights important factors that impact an individual with BD's consideration of risk. During euthymia, the risks that individuals take are more aligned to their identity and personal values. Control over their life is sought by managing BD symptoms and balancing the risks taken. However, fear has an impact as individuals often believe that a wrong decision could trigger a mood state that requires hospitalisation. This can result in an avoidance of taking risks. Finally, the importance of a supporting network is expressed as they can provide another perspective and alternative solutions to risk-taking decisions.

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**Tables****Table 1: Inclusion and Exclusion Criteria**

Table 1. Inclusion and Exclusion Criteria

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<u>Inclusion Criteria</u>	<u>Exclusion Criteria</u>
Self-report having a diagnosis of BD and in euthymic phase.	Does not meet criteria for a BD diagnosis and euthymic phase on the MINI.
Over 18-years old	Under 18-years-old
Score within range for a BD diagnosis and euthymic phase on the MINI.	Requires an interpreter

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**Table 2: Participant Characteristics**

Table 2. Participant Characteristics

Interview Number	Pseudonym	Gender	Results of the MINI	Time since diagnosis	Length of Interview
1	Rob	M	Bipolar I Disorder – No current episode	10 years	49 minutes
2	Helen	F	Bipolar I Disorder – No current episode	40 years	45 minutes
3	Kate	F	Bipolar I Disorder – No current episode	11 years	60 minutes
4	Hillary	F	Bipolar I Disorder – No current episode	30 years	56 minutes
5	Mary	F	Bipolar I Disorder – No current episode	Unknown	58 minutes
6	Sarah	F	Bipolar I Disorder – No current episode	17 years	61 minutes
7	Frank	M	Bipolar I Disorder – No current episode	12 years	55 minutes
8	Michelle	F	Bipolar I Disorder – No current episode	10 years	62 minutes



**Table 3: Participant Examples of Everyday Decisions**

Interview Number	Pseudonym	Examples of everyday decisions
1	Rob	Rob discussed how he considers the risk when going for drinks after work. He understands how both alcohol or fizzy drinks affect him and so is careful when he decides if he should go for drinks and then what drinks he will choose.
2	Helen	Helen discussed how she wanted to be perceived as a “sensible and logical” person and used examples such as speeding when late, parking on the zig-zags outside of school and when making purchases for the house. Helen explained how she considers how she may be perceived in the decisions she makes which can impact her bipolar.
3	Kate	Kate explained how she finds using the IT system in work extremely stressful and how this can impact her bipolar. When she encounters IT problems, she will consider the impact of a colleague’s reaction if she was to ask for help.
4	Hillary	Hillary has several carers who she interacts with regularly. She often considers how much information to tell them and whether they will use this information for her benefit or may twist her words.
5	Mary	Mary attends regular social events in her community. She often must weigh up what mood she is in and decide whether she feels well enough to go, or if she needs to reduce her time at the event. She considers how other people may impact her mood.
6	Sarah	Sarah discussed how she considers going out each day. For example, when she goes the shops, a person who looks at her the “wrong way” could impact her mood.
7	Frank	Frank volunteers as a treasurer. He must make regular financial decisions for the benefit of the centre. He acknowledges his own tolerance of financial risk and has strategies to make sure he is not being too risky with the community centre’s money.
8	Michelle	Michelle explained her ambivalence regarding work. She wants to work but also understands how her work impacts her mood. She is often given opportunities at work to increase her hours and so she considers how the additional hours will affect her mood.

**Table 4: Subordinate Themes Summary Example**

Summary – For Rob, it appeared that his risk-taking decisions were impacted by his sense of achievement, to develop his identity and feeling empowered to make his own decisions. The breakthrough for Rob, occurred when he was travelling. This gave him a new perspective on life and who he was.

- Travelling – The Breakthrough
  - Gave him a perspective on life
  - Taste of freedom
  - Confidence to be himself
  - Sense of achievement
  - An identity that meant he was doing something different in his family
  - Control over his decisions
  - Empowered him to try new things
- A sense of Achievement – Life off the production line
  - For Rob, travelling gave him a sense of achievement. It gave him something that others have not done. It may be that going to London provided him that sense of achievement but with a financial cost.
  - His siblings had moved to London, and this was received well by his family and he wanted to prove himself.
  - His job provided a sense of achievement. Production line did not offer him achievement, his new job does. He is trained, developed and his skills utilised. His team relies on him and this gives him purpose.
  - Achieved independence and confidence to make own decisions
- Identity – A longing to belong
  - He now longer relies on others to make decisions for him. Risks he was taking to prove himself to others or to break free from others control.
  - Understanding his bipolar has helped him to accept who he is and what he needs to do to keep himself well.
  - Acceptance of his bipolar has helped him to learn his triggers, coping strategies and ways to consider these to make his own decisions
  - He knows who he needs in his life for support and to say no to others.
- Empowerment – This is my life
  - Empowered to take control of his own life
  - Empowered to take control of his finances
  - Empowered to make his own decisions and to take risks
  - Empowered to be independent

**Table 5: Contribution to Major Themes**

Table 4. Contribution to Major Themes

Participant	1	2	3	4	5	6	7	8
Who I Really Am	*	*	*		*	*	*	*
Taking Back Control of my Life	*	*	*	*	*	*	*	*
Fear of the “What Ifs”	*	*	*	*	*	*		*
The Role of Family and Friends	*		*	*	*		*	*

\*Denotes contribution to the major theme

**Appendices**

**Appendix 2-A**

**Extract of Coded Transcript**

Interview Transcript	Initial Thought	Researchers Interpretations
<p>P: because I have done a lot of travelling you see [external distraction and laughter from interviewer and participant]</p> <p>I: yes, go on</p> <p>P: I have done a lot of travelling, and in 95 I went to Hong Kong on my own. For a week. And that was like <u>the breakthrough with my bipolar</u>. When I come back <u>a year later I was in hospital, and I think if I had not gone there then I wouldn't of got better. I would have ended up harming myself and that, but I had insight through going so far away.</u></p> <p>I: ok, so how did that give you insight? And what was the insight?</p> <p>P: because I was on my own, you know 5000 miles away, <u>I was like strong</u>. It just reminded me of the past, <u>because I have been twice</u>. I went 10 years ago as well. <u>I just got insights in my life and sometimes I have laugh about it otherwise I'll go mad [laughs]. That's how I cope, you know, not that I avoid it, I just think I didn't know I was ill then.</u></p> <p>I: so going to Hong Kong, was that a positive experience, or negative experience? What's it been like?</p>	<p>breakthrough</p> <p>Travelling gave confidence of independence and motivation to look after himself.</p> <p>Strength of character. ?trapped in his life, travelling gave freedom</p>	<p>The Breakthrough travelling provided new <b>perspective and purpose</b> for his life. This gave an insight into his life that provided <b>understanding</b> of diagnosis</p> <p>travelling brings achievement in life</p>

<p>P: I think the first time I went it was <u>kind of a bit of both</u>, because when I come back I was like “so what I have been to Hong Kong” you know and people were saying “<u>your good at this</u>” and <u>im going “oh, no I’m not”</u> and a year down the line I was in hospital. I weren’t actually sectioned but I was quite bad looking back. Because I was like on medication <u>I couldn’t get it in my head that I weren’t on the medication before I was in hospital</u> and how come I have ended up in hospital with medication.</p> <p>I: have you been able to work that out? P: yeah</p> <p>I: over time that has happened for you? P: it has taken a long time but when I got diagnosed, the mental health team told me. It wasn’t the psychiatrist. I had outpatient appointments with my psychiatrist and I said “<u>why didn’t you tell me I was bipolar when I was in hospital?</u>”. He said “oh well, we couldn’t because we don’t like putting</p>	<p>Difference of culture may have provided a different perspective on life.</p> <p>Positive – insight, sense of independence Negative – coming home to feeling trapped</p> <p>Why does he need medication if he is not ill?</p> <p>Professionals hiding the truth.</p>	<p>Travelling – achieving something others haven’t</p> <p>Acceptance of medication – acceptance of bipolar</p> <p>Process of sharing diagnosis</p> <p>No understanding so rejects diagnosis</p>
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## Appendix 2-B

### Major Theme Development

Table 4: Theme Development

Who I really Am		
Participant	Subordinate Theme	Supporting Evidence
Rob	Job satisfaction provides purpose	<p>“I am constantly learning on the job, training courses, meeting people, going places. Whereas previously to this I was working in a food factory for 17 years and it was just doing my bipolar in. I was doing the same thing every day. On the production line”</p> <p>“I was stuck on a production line, I wasn’t achieving anything, you know”</p>
	The breakthrough from travelling	<p>“because I was on my own, you know 5000 miles away, I was like strong”</p> <p>“Because I can just be my real self, I am not saying I am confident. I don’t think I have got a confidence to meet people there, I like it because I just do my own thing and nobody looks at me and nobody bothers”</p> <p>“I would go next week if I could. Because I know how good the two times I have been, helped me with my bipolar”</p>
Helen	It is my bipolar that takes risks	<p>“my bipolar came back strong and fast and I had lots of suicidal periods and suicide attempts”</p> <p>“I suppose it means doing things that might be harmful to myself, which I wouldn’t do if I thought about them”</p> <p>“I don’t think I ever consciously ever think about taking a risk because I am risk averse on the whole. So me when I am well, I don’t take risks. I am a careful person”</p> <p>“I have a view of myself as being a bright and logical person”</p>
Kate	Risk gives “the performer” identity	<p>“People would be asking if I was on drugs. I would be on the floor body popping and things like that but really, really like “the performer has arrived” and a really theatrical performance.”</p> <p>“I just think in something like that, there is more chance in being able to do it than not so lets see if we can. It is like a little game or something”</p>
Mary	My best self is hard to continue	<p>“I flew too high in the teaching profession and crashed”</p> <p>“they never knew where they were with me. I was like two different people. People would be disappointed obviously when you first meet people, like a job interview, you present your best self, but I could never live up to that all the time”</p>
	The bipolar license – license to react	<p>“I would probably have the presence of mind and the positivity to ask my husband “do you think this is a good idea?” and to have a conversation with him.</p>

		Probably agree and I can manage or whether we could go an hour later and come home an hour earlier, sort of balance everything out” “bipolar people are like weathervanes. We pick up on things very early, before other people do. Particular types of things. It is almost our job to do it, we have license to do it”
	Tripped up by bipolar	“it is probably the bipolar has tripped me up. I have been a bit too cheerful and misjudged what kind of state I am in. “my state of mind switches. It can be sudden and abrupt”
Sarah	Bipolar performance	“This is how bizarre I was. I got bankers draft and I was more interested in drinking the coffee in the showroom. More interested in coffee and teddy bears with Landrover on them, and the pens. I went for a bankers draft and put it in my bra. Went into the sales room and they said “have you got your bankers draft?” Pulled it out and slapped it on the table” “she doesn’t realise how desperate I was. So I get upset about that. I don’t raise it but deep down I want to say “why don’t you believe me? Do you think I would make up a story like that?” she would probably say “yes because you are a drama queen”
	Is it bipolar or is it me?	“I was there, but I wasn’t there” “I nearly walked in front of a train. I can’t see normal people doing the same things as I did and I look back when I am in euthymic stage and they wouldn’t risk the sleeping around, talking to strangers, going off with strangers” “every morning I wake up and think “I have go bipolar” It never leaves me”
	Perfectionism – the loss from bipolar	“When I am in a euthymic mood, I look back on what I did with horror” “there is a risk to losing your family, risk losing your friends, risk losing your sense of purpose” “yeah they may have contingency plans, but people with bipolar don’t think about the consequences”
Frank	The bipolar in me	“well it is like “hey what am I doing?” and pull yourself up short and just consider the consequences that might happen” “you have to make a decision. Trouble is, I know with Bipolar to make a rational decision, it is not always possible with the way the illness stops you being rational at times” “When I did a psychometric test, 10 was high risk and ability to absorb high risk. Zero risk averse. I came out with 8 out of 10. He says “ho ho ho, that is fine if that is how you are, but I would strongly advise you, infact I wont let you go to that level. I

		will let you go to a 6 ... I could say “that is me and that is sense”
	My boundaries limit my bipolar	“the spiritual and the moral thing always wins except in one case, that is when your hormones start driving” “of course, going back to the spiritual and moral thing. That makes you pull in the reigns yourself”
Michelle	Taking the perfect risk	“I am not a particularly risk-taking person. I am a careful person, yeah I am a perfectionist. I hate upsetting other people or pissing people off so I am a careful person most of the time” “I don’t want the consequences of it being wrong. It is all down to perfectionism. I find it difficult about the thought that if I don’t get a positive response it is because of something I have done” “I was trying to do the right thing. That was because it was a carefully thought about decision” “Like I say, I don’t do much. It’s only really minor stuff. Take the thing like sending an email to a potential employer or something. Normally, it is just less careful. Normally I would look at it, re-read it, save it as a draft and when I am high I am like “sod it” and send it off”
	Contingency plans	“I suppose I still feel the loss of status and role that I had, but those things, the loss of my position and status, I don’t just mean status, I mean identity, the loss of my identity as a doctor, that still gets me down, although it is fading”  “make the risk, not the risk less, but if bad things did happen to make them less bad”

Taking back control of my life

Participant	Subordinate Theme	Supporting Evidence
Rob	Breaking free from others control	they kept saying “oh, you can go home if you want” and I am going “right then, I’ll get my stuff and I’ll go” and they saying “well if you do that, you might be brought back by police”  “When she controlled me and just had her as a friend and nobody else. And it’s just like when I have a drink sometimes I think “am having a good time? Am I with good company and that?” but yeah”
	My life, my choice.	“do I want to be lonely or do I want to be alone? There is a difference. At the moment I am alone, I wouldn’t say I am lonely. When you live on your own it can take a while to get used to it. I have got used to it now. But I am abit choosey about the people who I hang round with now.”



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		<p>“I just think, kind of think how I am feeling in that moment and then I think “should I or should I not?””</p>
Helen	The expert opinion	<p>“it helped me explain and put into perspective what I saw were just character flaws or me being badly behaved”</p> <p>“it was to do with recovery and staying well and taking control of your own life”</p> <p>“I use meditation, I am a Buddhist. Meditation does help, again it is remembering to do it. When you are too unwell it can be hard to do”</p> <p>“I trust my judgement and assessment of risk more than his. I override his decisions”</p> <p>“I heavily rely on authority and science to tell me what is risky”</p> <p>“my support system is I trust science, I trust experts, I trust authority”</p>
Kate	Risk shouldn't stop life	<p>“if I think about the word risk, I see it as a positive thing. I think it's exciting or something”</p> <p>“one thing that I seriously cannot stand in any part of my life is things that are boring. And people that are boring and rule, conventional, cautious and all that. I wouldn't say I was a great risk taker though”</p> <p>“I can hold my own with most people. I am not intimidated by people, bored maybe, but not intimidated at all”</p> <p>“the risk involved is looking a fool, but I take that for granted and I stand up for myself”</p>
	Learn to take risks	<p>“I think I have tried to learn risk-taking”</p> <p>“I don't think we learn without risk, I think it is important to learn and grow and experience other things”</p>
Hillary	Collecting the evidence to control outcomes	<p>“I plan my day, morning, afternoon, evening. And one part of that I take as being relaxation and thinking time. That is how to think about different strategies and where they are coming from. Sometimes you are dealing with very difficult people”</p> <p>“People's interpretation of that because people have not written down the rules about what is allowable and what isn't allowable. You are on drifting sands as people will change their position. Getting them to write it down lessons the risk, and you have evidence. Evidence discredits belief”</p> <p>“I went through the document and highlighted them and wrote a letter out... When I emailed it they said “it's straight and to the point, well done”</p>
Mary	Regaining the power position	<p>“that is verbal power, word power. I don't enjoy putting people down, I would rather they didn't say it in the first place. So the feeling of having more wisdom than them gives me a buzz”</p>

Sarah	Pushing self mindfully	<p>“I know plenty of people who lived in obscurity and very narrow lives but tremendously productive. If you are creative then it doesn’t stop you”</p> <p>“people go “I read your book, it is really good!” well why wouldn’t it be? Or they ask my opinion on something and I deliver it. They take my advice and go “I took your advice. It really made a difference”</p> <p>“yes well huh!”</p> <p>“my confidence is slowly coming back, because I am managing my illness”</p> <p>“I think I am at the point where I have two voluntary roles that I am managing. Week in, week out sometimes very difficult for me because sometimes I am a little bit elevated and I have to control the elevation mindfully”</p>
Frank	Satisfying the urge	<p>“it was just there, I damn well needed it. Of course, since the medication that need has not been there”</p> <p>“you might say, you have not got enough pills and I will say “no thank you very much, I will manage it”</p> <p>“urge of the flesh, desire isn’t it? The body produces hormones to prepare you to do what you are planning to do. They it becomes harder to decline from that behaviour”</p> <p>“it’s all the same isn’t it? I might sometimes tut my head sort of thing, but I don’t take it to heart although I might not be happy”</p>
Michelle	It is under my control	<p>“I have a realisation that my experiences are valid and if it doesn’t fit in a particular, it doesn’t have to fit in a particular model. What matters is the experience and how to deal with that”</p> <p>“They wouldn’t understand the reasons why I wanted to do it, they would just see the reasons why I shouldn’t do it”</p> <p>“I thought I had enough control over it. Then I realised I didn’t so I decided to give up my job”</p>

Fear of the “what ifs”		
Participant	Subordinate Theme	Supporting Evidence
Rob	Why not take Risks	<p>“an opportunity to get out innit? I just think “why not” and that has altered from London because I decide not to go London, and then someone asks to make way in [town] or whatever and I say yeah or majority of times I say yeah”</p>
	What if I am lonely again?	<p>“I think the risk would be, if I fell out with my friends, I would have nobody again and I would fear of meeting Emma again.”</p>
Helen	Appearing the fool	<p>“how I am seen or how I appear. So appearances. I wouldn’t want to appear foolish”</p> <p>“I do a lot of self-criticism so I go over and over “why didn’t I do this? Or what if I had done that?” “I</p>

Kate	Stay out of hospital at all costs	<p>knew I should have done it that way” “I have always made that mistake aren’t I stupid”</p> <p>“the worst thing for me was that I was in and out of psychiatric hospital and the most terrifying thing of my life because I was told I was only going to hospital for one night, all I can remember is that had this nightlight that was red. To me that was a thing of hell, the burn of hell”</p> <p>“if I feel a deep emotional reaction to something, that is the priority in my mind. Me keeping emotionally well”</p>
Hillary	Careful awareness	<p>“I just feel like “I don’t care”. I don’t care at all. The thing is for me when I feel that fear that way, it makes me think “I am going to be ill”</p> <p>“I see where they are coming from. I find that then I calculate what I have to do”</p> <p>“when you are in a risky situation your stomach rumbles and you feel quite tense around your diaphragm”</p>
Mary	Risk assessing life	<p>“I have got something on hold and the time has to be right and I have to feel right before I go forward”</p> <p>“I know it is easy to forget you have got to do a new risk assessment every time”</p>
	What if I get it wrong?	<p>“respect for the other person. Fear of pushing them in one direction or another. Like I said being partly responsible for the outcome. They would come back saying “you know what you said to me to do... ahhhhhhh” never asking you again.”</p>
Sarah	Hospital doesn’t save me	<p>“the illness has been stabilised, for four years I have been out of hospital”</p> <p>“Police took me in on a 136, they saved my life”</p> <p>“Sometimes I cannot decide to go to the supermarket or not. I can’t make that decision, something as simple as that”</p> <p>“if someone was not nice, then that would make me feel bad. Make me feel not good about myself, something as small as that could trigger a slight episode”</p>
	What if I got a job?	<p>“I think it gives you, working voluntary is quite difficult to keep up because you haven’t got the drive or the fear of losing your house. When you are employed, you would possibly drive yourself that little bit further because you knew if you didn’t go into work, you wouldn’t have a roof over your head. But there again, to be in that scenario you would end up with another episode, or well I would. I know I would.”</p> <p>“fear of ending up in hospital again. Confidence of whether I would be able to do it given I have been out of work for so long. I know I probably could do it, but I would do it 110%, being a perfectionist, staying up all hours, I am not a very good sleeper anyway.”</p>

Kate            Fearing the consequences            “The thing that stops me taking risks when I am stable is I am afraid of the consequences. So spending, I would always think of like “what if we end up with no money”. Driving in a fun manner, I would think about “what if I lose control and I crash?”. I am always aware of the consequences. I am always aware of the consequences at all times but in the high and low I don’t care.”

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The role of Family and Friends

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Participant	Subordinate Theme	Supporting Evidence
Rob	I will do it for you	I said to her “I’ll keep on the medication to please you, I can’t do it for myself”  “well I have a job and its not about the money, it is about the feelings. Because I am a support worker like, and its good because I don’t want to get up in the morning and then I force myself and I think “I don’t want to let the team down”
	Other’s empower you to take risks	“when I went to Hong Kong for the first time, this is how good it was, I rang her from Manchester airport and I said “sorry mum I can’t go, I am sorry I have let you down” she says “what do you mean?” I said “I said I can’t go, I’ve not got the confidence” cos Ive never flown before and she turned round and says “get gone, if you want to come back earlier, just ring airline and come back earlier” I will always remember her for that”
Helen	I don’t need rescuing, others do.	“if it was a risk to somebody else, that would matter much much more than if it was a risk to me” And I said “well come and stay at our house while you figure out” because I didn’t want her on the streets or going home with somebody else who isn’t safe. And I knew we were safe so” “because they thought it was risky, because what if she stole things or ran into the street or set fire to the house or what have you. To me, she can steal all my things, if she needs my things or wants my things, a financial loss to someone who is at need is not a risk”
Kate	Rebelling compassionately	“I sometimes feel like my catholic upbringing has something to do with it...rebelling against it mainly, but also taught me to be compassionate to people”
Mary	The beauty of teamwork	“we are a pretty good team so I would involve him in the decision” “That is just the most, the biggest thing. I don’t know if it is in everybody’s life, but when you have somebody who loves you unconditionally and proves it time and time again” “completely different from me but we make an amazing team”
Sarah	Family ambivalence	“keep the peace of the family. I nearly lost my family when I got ill. The only person who stood by me was my Mum”

Frank	Family Balance	<p>“bless her, Mum, she used to stay in the same bed as me to try and keep me in it. She was a good Mum”</p> <p>“I would probably ring my sister up but it would make me feel a little bit more “yes I can do this”</p> <p>“When I am depressed she can handle me. When I am hypomanic she doesn’t want to know me. She steps away”</p> <p>“my wife says if you take anything else on I will have to decide something to drop”</p> <p>“if I booked a holiday and tell her where we are going then there is no rewards. You get jumped on. Today, together we book holidays, the rewards are perfect. You both get rewards”</p>
Michelle	The impact on and from others	<p>“accepting that their feelings are their feelings and they are not necessarily all to do with what I have done”</p> <p>“the fact that my husband had bought a motorbike and a Porsche, so it was all along like “quid pro quo, this is mine!”</p> <p>“I think I am seen as quite sensible and level headed”</p> <p>“my friends probably, the best sort of support. They are very good, I mean sometimes they can be overly, like I had an opportunity to do a three-day course and I wasn’t sure and they were like “you know you can” and massively boosting my confidence which is lovely. In fact it wouldn’t of been a good decision because three days is too much and tiredness tends to set me off”</p>

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**Doctoral Thesis**

Section 3: Critical Appraisal

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Word Count: 3968 words

(excluding References)

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My critical appraisal offers a reflexive account of the thesis process. I will start by giving a summary of the two qualitative research studies and I will then reflexively explore three areas that involved key decisions and learning points. Firstly, I will discuss why I chose this research project and how some of my own bias, assumptions and experiences influenced the research design. Secondly, I will explain how I ensured that quality and trustworthy qualitative findings were produced. Thirdly, I will discuss my experience of the thesis process and present some considerations to improve the research process.

### **Summary of the Thesis Findings**

This thesis comprises two qualitative research studies in Bipolar Disorder (BD). The first is a qualitative systematic literature review (SLR) that synthesised how individuals with BD perceive their self-management strategies. The second study is a qualitative research project that explored how risk is considered in everyday decisions during euthymia for individuals with BD.

#### **Systematic Literature Review**

The SLR explored how individuals with bipolar disorder (BD) perceive their self-management strategies. A meta-ethnography methodology (Noblit & Hare, 1988) was used to synthesise 18 studies. Three themes were identified that were “The Process of Successful Self-Management Skills”, “Self-management: *Symptom*-management or *Lifestyle*-management?” and “The Fear of a Relapse”.

The main finding of the meta-synthesis was an apparent process of successfully self-managing BD. The process started with how the diagnosis was received and consequently, how the individual accepted it. The process moved through the development of knowledge and skills, awareness and insight, responsibility, and discipline to adhere to the strategies. Finally, the definitive aspect of successful self-management strategies was the adjustment

phase. Through adjustment, individuals with BD were able to recognise subtle mood changes and have the self-management skills to be able to adapt and respond so that they could live a fulfilling life.

The second theme was called “Self-Management: Symptom-management or Lifestyle-management?” and referred to the focus of the self-management strategies. Some of the self-management strategies focused on the symptoms by recognising early warning signs or triggers. The self-management strategy often aimed to reduce such symptoms. Other self-management strategies aimed at encouraging a better quality of life such that the person could continue with the activities they enjoy. It was hypothesised that these activities, in turn, would reduce the symptoms of BD. Overall, it appeared that individuals with BD prefer to focus on improving quality of life rather than symptom reduction.

Finally, the third theme referred to the underlying fear of a relapse. It became apparent that even when using self-management strategies, individuals with BD were influenced by the fear of a relapse. It appeared that individuals knew what strategies to use but even with positive experiences of using it, they didn’t always apply the strategy as they were fearful of it not working and thus resulting in a relapse. This suggests that the self-management strategies were sometimes perceived to lack the necessary power to control the symptoms.

### **Research Project**

The research project explored how individuals with BD consider risk in everyday decisions. A semi-structured interview was completed by eight participants. The interviews were transcribed verbatim and analysed using interpretative phenomenological analysis (IPA) (Smith, Flowers, & Larkin, 2009). Four themes were identified that influenced individuals with BD’s consideration of risk. They were identity, control, fear and supporting network.



When considering risk in decision-making during euthymia, participants appeared to consider how it may impact their identity. They believed that their consideration of risk aligned with the identity that they wanted or how they wanted to be perceived. For example, identities such as sensible and logical were reflected along with being an exciting and interesting person.

The participants' risk-taking decisions also reflected their desire to control their symptoms and their lives. During euthymia, participants would balance what they wanted to achieve with what will be best for them. Keeping this balance sometimes meant that they adapted the activity or the amount of time they allocated to it so that they could stay in control of their symptoms and continue to live a fulfilling life.

Furthermore, when in the euthymia stage, participants seemed able to consider more possible consequences of their decision making, which at times increased the level of risk. With more aspects to consider, fear heightened as the participants were worried about getting it wrong, hurting others or triggering their symptoms. The fear of triggering their symptoms often caused much distress as they believed that arousal in symptoms would inevitably lead to hospital admission.

The fourth theme represented how their supporting network of family and friends impacted their consideration of risk. Support was often sought but the outcome could be either positive or negative. When positive support was given, participants were able to think about the reasons for their family and friends' opinions and balance them against their own. Alternatively, family and friends could notice subtle changes in their mood and therefore minimise the risk within decisions. However, unsupportive family or friends could impact risk-taking by suggesting decisions that were not in the best interest of the participant.

### **Why I Chose this Research Project**

This thesis was conducted as a requirement on the doctorate in clinical psychology training course and aims to contribute to the theory and practice of clinical psychology.

While I had my research interests, the thesis also provided me with a unique and privileged opportunity to broaden my professional and academic knowledge in an area that I had little previous experience in. Prior to this thesis, I had limited knowledge, understanding and experience of working with people with BD. I had worked, clinically, with one person who had a diagnosis of BD while on placement at an adult community mental health team. This experience gave me an insight into the difficulties that individuals with BD can face, however, I was still a novice in my understanding of BD.

When reviewing the literature on the topic of risk in BD, it was apparent how the risks that individuals with BD take can often lead to severe and negative consequences that impact on their personal relationships and their social, occupational and daily functioning (Martino, Strejilevich, Torralva, & Manes, 2011; Reinharth, Braga, & Serper, 2017). As I searched through the literature on BD, I noticed an upcoming trend of qualitative research studies that had explored individual experiences of BD with a demand for more. However, there did not appear to be any qualitative studies exploring risk with individuals with BD.

As I was learning about a new topic, I thought it would be overwhelming to also learn about a new research methodology. Having previous IPA experience (Khullar, Scull, Bhatti, Wah, & Al-Zouman, 2019), and having already completed qualitative assignments on the doctorate course, I decided that I would complete a qualitative study. I am often surprised by my preference for qualitative research. My undergraduate degree is in Mathematics, and historically, I have had a preference of numbers over words. However, I am curious about individual experiences and it is this curiosity that attracted me to a career in clinical

psychology. Similarly, I find qualitative studies also hold this curious position that enables participants to share their individual experiences and allows researchers to interpret their experiences to shed light on the underlying structures of a phenomenon (Smith & Osborn, 2015; Willig, 2019). Therefore, as BD was a topic that I wanted to learn about, and with a need for qualitative research regarding risk in BD, I believed that I had a novel topic that could contribute to the theory and practice of clinical psychology.

As I was designing the study, I found myself considering my assumptions of BD. With a limited understanding and experience of BD, I was concerned that my views of BD may have been influenced negatively by how BD can be portrayed by the media (Hawke, Parikh, & Michalak, 2013; Suto et al., 2012). Similarly, I was also considering how BD may be portrayed academically. My initial perception was that the language used and focus of the literature suggested that BD is an illness and that medication was needed to treat it (National Institute for Health and Care Excellence, 2016). In contrast, in my role as a clinical psychologist, I am often critical of the medical model and I would prefer to offer an alternate perspective, such as BD could be a human reaction to adverse life experiences (Division of Clinical Psychology, 2010). I thought how my biased position may be generating a sensitive and critical perspective to the medical views within the literature.

With these contrasting views, I felt that the voice of individuals may be getting lost. Thus, I wanted to be guided by and learn about BD from the individuals with BD and this was reflected in the designs on the studies. The SLR and the research project took neutral and pragmatic approaches that would enable the voice of individuals with BD to be heard. Therefore, I set out to ensure that the language I used in interactions with participants, project materials and the subsequent write up would be non-stigmatising and helpful for individuals with BD. One way I did this was to organise a service user consultation to review the project. The person had been diagnosed with BD and had an interest in academia and so was familiar

with the different terminology used. For example, we discussed the term “euthymia” and how it was perceived by individuals with BD. We understood euthymia to be an academic term to describe the “stable” phase of BD, however, we were not sure how well known this term was. During the service user consultation, we agreed on a definition that could be used for the project materials to help potential participants understand the concept. However, it became apparent through speaking with individuals with BD in the initial conversations and interviews that the term euthymia was not well known. The definition I used in the project materials also did not appear to clarify the term. The term is a vital aspect in the study, so during conversations with potential participants, I explicitly asked about euthymia and what it meant for them. As I asked for clarification on how they describe this phase, I listened to the terminology each individual used and, in my attempt to be non-stigmatising, I followed their lead.

### **Ensuring Quality and Trustworthy Findings**

A challenge of qualitative research is ensuring that quality and trustworthy results are produced (Tuffour, 2017). The subjective nature of a qualitative study makes it difficult to objectively measure the quality and trustworthiness of a qualitative study (Gough & Madill, 2012). A difficulty arose for this thesis as there are no specific guidelines for assessing the quality of a meta-ethnography (France et al., 2016). For a quality IPA study, Smith (2011) provides four criteria that the study should meet; 1. Adhere to the theoretical principles of IPA; 2. Transparent reporting; 3. Coherent, plausible and interesting analysis; 4. Use sufficient evidence from participants in each theme. I will explore how I used these criteria when assessing the trustworthiness of my both my SLR and RP.

The theoretical principals of IPA are phenomenology, hermeneutics and idiographic (Smith, 2011). Phenomenology explores experience, and hermeneutics is the interpretation of

the experience. The two approaches, meta-ethnography in the SLR and IPA in the research project, used an interpretative phenomenological approach that aims to move beyond the individual experience to reflect on how it fits within the wider context of the person's life (Willig, 2012). The importance of researcher reflexivity (Korstjens & Moser, 2017; Willig, 2019) is vital in IPA as a double hermeneutic is recognised. Firstly, the participant is trying to make sense of and interpret their experience of the phenomena of interest. Then, the double hermeneutic exists as the researcher is making sense of the participant's interpretation of their experience. For example, as I was listening to and analysing the interviews, I found myself wanting to challenge the medical perspective of BD and the impact that it has on a person's life. Hearing how experiences had shaped their life further strengthened my view that the symptoms of BD could be seen as a human reaction to life adversities (Division of Clinical Psychology, 2010). However, I did not want to influence the interview or analysis and so I was mindful not to give my perspective.

It is also important to be mindful of the double hermeneutic during analysis as my biases can influence my interpretations of the interviews. By using an inductive approach, I compared the interview transcript and the initial annotations with the wider context of the participants shared experience, this ensured that the themes developed originated in the data rather than from my biases (Thomas, 2006). Similarly, in a meta-ethnography, I interpreted both the original participants' experiences through the quotes used and the author's interpretations of their participants' experiences. It often felt that I was interpreting the double-hermeneutics within the studies thus producing a meta-hermeneutic (Edwards, 2013).

The idiographic aspect of IPA keeps the themes rooted in the individual experience minimising my bias and assumptions on the results (Smith, 2011). I expressed this in two ways. Firstly, each interview was coded and analysed individually to produce subordinate themes for that interview. Subordinate themes from each interview were collated collectively

to analyse the full data set. Using the subordinate themes of each individual interview ensured that I produced interpretative themes that were grounded in individual participant experience. This process also occurred in the SLR. Instead of using interviews, the data set was the individual study's results section. Furthermore, another idiographic approach was to use participant quotes verbatim to evidence the major themes and explanations of the themes. To further evidence my interpretations were idiographic, I produced a figure for each major theme and how it was developed from each paper. This approach also ensured that I was meeting Smith's (2011) criteria of using sufficient participant evidence.

Rigour in qualitative research refers to the thoroughness of the analysis and interpretation (Smith et al., 2009) and can be used to assess trustworthiness. When assessing rigour in my study it should be noted that I was, for the most part, the only person who analysed and interpreted the data. I utilised supervision to review my coding, interpretations and write up of my results, however, due to the thesis constraints of supervisors (discussed further below) limited interpretive input was given. Therefore, I ensured that my reporting was transparent, and I explicitly expressed my rationale for what was done and, importantly, how it was done (Nowell et al., 2017). The reader should be able to follow my steps and understand how I came to the conclusions that I did.

On reflection, I believe that a more rigorous analysis could occur in consultation with other people, such as service users who can give an informed perspective and interpretation (Wagstaff & Williams, 2014). The IPA team I had been involved with met over six consecutive weeks to discuss and analyse the interviews (Khullar et al., 2019). Prior to each meeting we would individually code and analyse one interview before discussing it and agreeing on subordinate themes as a team. In the final meeting, we collated the themes from all the interviews to produce the overarching themes for the study. It was particularly helpful that one team member had an informed perspective and offered personal perspectives and

interpretations. In my opinion, the mix of informed and non-informed perspectives enhanced the quality of interpretation. Unfortunately, a limitation for this research project is that it occurred in the context of training as a clinical psychologist. Other clinical and academic demands meant that deadlines, funding and input are often limited resulting in interpretations that were predominantly my own. In future studies, I would endeavour to organise an analysis team to enhance the interpretation of the data.

Conducting the thesis within the context of clinical psychology training did bring its benefits. I believe that my clinical skills provided a solid framework to produce rich interviews, however, I did have to be mindful that this was not a clinical session. I was informed by the common factors approach to psychotherapy (Norcross & Wampold, 2011) that suggests how common factors such as genuineness, warmth and curiosity can develop a therapeutic relationship. The therapeutic relationship is then enhanced by a psychological framework. Both the therapeutic relationship and psychological framework is needed for effective therapy (Norcross & Wampold, 2011). During the interactions and interviews with participants, I utilised my personal characteristics of genuineness, warmth and curiosity from a non-judgemental position to help to create a comfortable environment for the participant to discuss their personal and, at times, distressing experiences. I found the semi-structured interview provided the framework so that consistent topics were discussed across participants, but with the flexibility to explore the experiences pertinent to each participant (Cross & Galletta, 2013). Using the common factors approach to interview style, I believed enabled rich and thorough interviews to be completed.

Through listening and transcribing the interview and supervision, I noticed at times I slipped into a therapist style. I had been cautious of this and had made notes on the interview schedule to help me to keep to IPA interviewing style. For example, summarising and interpreting experiences is helpful in therapy, however, may not necessarily deepen the

participants' story. I noticed how I had used summarising and interpretations in the earlier interviews. Pezalla, Pettigrew, and Miller-Day (2012) discussed how an interpretative response was not as effective for deepening responses as a neutral response. In subsequent interviews, I used more neutral responses such as "ok" and non-verbal nodding of the head to assure the participant that I was listening to their story. Other responses such as "tell me more" helped me to stay curious and interested in the participant story which enabled further detail being shared (Rubin & Rubin, 2005).

### **My Reflections on the Thesis Process**

As I reflect on the thesis process, two main issues come to mind. First, is how the thesis process is predominantly an individual piece of work. The second point regards personal confidence in my ability of academic writing and how I overcame this.

The aim of the thesis is not only to contribute to knowledge but to assess the researcher's ability to undertake and present research to a publishable standard. The thesis being an aspect of a doctoral training course also means that it has strict deadlines and supervisory input as determined by university policies. As I consider the context of the thesis, I also think about the ethical stance to produce quality work for the participants involved. I wonder whether the contextual restraints of the thesis limit the quality of work that can be produced and question if this could be improved.

My thesis is predominantly my work. Throughout the process I have strived to, with a small example given in the section above, meet doctoral standards to produce a high-quality piece of work. Yet a limitation is that it is only my piece of work. For qualitative research, the data analysis is the most complex aspect yet in my thesis it comprises of my interpretations only (Thorne, 2017). My interpretations are just that, *my* interpretations. Even though a reflexive process attempts to minimise bias, it can still influence the results. As



previously mentioned, supervisor input is limited and there may not be enough time for service user involvement, so another way to improve data analysis and thus the quality of the research could be to have joint projects with other trainees.

Some academics have already suggested that the individualised project set up is outdated as most research is now completed in teams (Gould, 2016). Further, co-authorship has also been recommended to improve the quality of research published (Kamler, 2008). In my research project, I interviewed eight participants. I developed the interview guide and followed it flexibly. However, during the interviews, it may have been helpful to have another person to utilise their interview characteristics to deepen the information given (Pezalla et al., 2012). Another person may have heard things that I didn't during the interview to uncover other information. After each interview, a reflective de-brief could have occurred to suggest what had gone well and what did not, in order to further develop our interview skills. For analysis, a team approach offers more interpretations and may reduce researcher bias further (Thorne, 2017).

Alternate research designs would be available for a team approach to the thesis. A mixed-method of qualitative and quantitative could be organised with each trainee specialising in their preferred method but also learning and being directed in the other (Yauch & Steudel, 2003). Also, a mixed-method qualitative project could enhance themes and generalisability of results by analysing the data from two perspectives and combining the results (Hood, 2016). For trainees, team projects would enhance the development of other transferable skills pertinent to the doctorate in clinical psychology, such as team-working and organisation (Gould, 2016).

With the demands of producing doctoral quality research, comes the necessity to express the work through doctoral standards of writing. I found this aspect the most

challenging part of completing the thesis and often I found my confidence hindering my work. Hemmings (2012) identified four themes to improve doctoral students' confidence; having an encouraging supervisor, working with like-minded academics, using time-management effectively, and receiving a vote of confidence through an incident or event. I personally related themes and experienced them through the thesis process.

I found my confidence was often boosted following a discussion or feedback from my supervisor. He has provided support when I needed it, with genuine positive feedback along with constructive criticism to improve my work. I found this to be an invaluable asset and would encourage anybody completing a thesis to build an honest working relationship with their supervisor.

The amount of work involved in a thesis requires competent time-management skills. There are times throughout the thesis that require you to work on multiple aspects at a time. For example, during my allocated study block, my goal was to complete the SLR. However, it was during this time that I received ethical approval for my research project. When I advertised the study, I was surprised by the response that I received. I had more potential participants than was required. I felt overwhelmed at this point. Having confidence in my time-management skills meant I could prioritise and work through the challenges at my own pace.

I received a boost in confidence following the presentation day at university. Another requirement for our doctoral course is to present our research project to our peers, research staff and members of the community who are interested in the topic. After completing my presentation, I received a piece of unexpected, positive feedback, which I associate with receiving a vote of confidence theme. The positive feedback boosted my confidence to think "I have done a good job" and "I can do this".

Finally, the other theme Hemmings (2012) suggests is working with like-minded academics. When working in a team, confidence could be built by working together and seeing the results. Hemmings' (2012) theme could be another argument for joint working. As mine was an individual project, my like-minded academics were my peers who were completing their thesis. I found their support invaluable and it has encouraged me to consider completing a research project with them in the future.

### **Conclusion**

My critical appraisal is a reflexive account discussing three areas of the thesis that involved key decisions and learning points. I explained how my unique and privileged position to learn a new psychological concept directed me to research BD. I then expressed some of the steps I took to ensure that quality and trustworthy studies were conducted. Finally, I reflect on the whole thesis process and suggested of a joint trainee project to further improve the quality of a thesis for the doctorate in clinical psychology.

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Doctorate in  
Clinical Psychology



**Doctoral Thesis**

Section 4: Ethics Section

Andrew Wah

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**FHMREC Ethics Approval Letter**

Applicant: Andrew Wah  
Supervisor: Guillermo Perez Algorta  
Department: Health Research  
FHMREC Reference: FHMREC18

20 November 2018

Dear Andrew

**Re: A qualitative exploration of how people with bipolar disorder consider risk-taking in everyday decisions.**

Thank you for submitting your research ethics amendment application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for the amendment to this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 593987

Email:- [fhmresearchsupport@lancaster.ac.uk](mailto:fhmresearchsupport@lancaster.ac.uk)

Yours sincerely,

A handwritten signature in cursive script that reads "R. E. Case".

Becky Case  
Research Ethics Officer, Secretary to FHMREC.

## FHMREC Ethics Application

Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

*for additional advice on completing this form, hover cursor over 'guidance'.*

**Guidance on completing this form is also available as a word document**

**Title of Project:** A qualitative exploration of how people with bipolar disorder consider risk-taking in everyday decisions.

**Name of applicant/researcher:** Andrew Wah

**ACP ID number (if applicable)\*:**

**Funding source (if applicable)**

**Grant code (if applicable):**

**\*If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [\[link\]](#).**

### Type of study

Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, two and four of this form**

Includes *direct* involvement by human subjects. **Complete sections one, three and four of this form**

### SECTION ONE

**1. Appointment/position held by applicant and Division within FHM** Trainee Clinical Psychologist, Doctorate in Clinical Psychology Department.

**2. Contact information for applicant:**

**E-mail:** a.wah@lancaster.ac.uk

**Telephone:** [REDACTED] (please give a number on which you can be contacted at short notice)

**Address:** [REDACTED]

**3. Names and appointments of all members of the research team (including degree where applicable)**

Research Supervisor

Dr Guillermo Perez Algorta

Health Researcher, Lancaster University

Field Supervisor  
 Professor Steve Jones  
 Co-director of The Spectrum Centre for Mental Health Research

Methods Supervisor  
 Dr Suzanne Hodge  
 Lecturer in Research Methods, Lancaster University

**3. If this is a student project, please indicate what type of project** by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the [FHMREC website](#))

PG Diploma  Masters by research  PhD Thesis  PhD Pall. Care   
 PhD Pub. Health  PhD Org. Health & Well Being  PhD Mental Health  MD   
 DClinPsy SRP  [if SRP Service Evaluation, please also indicate here: ] DClinPsy Thesis

**4. Project supervisor(s), if different from applicant:**

Research Supervisor - Dr Guillermo Perez Algorta  
 Field Supervisor - Professor Steve Jones  
 Methods Supervisor - Dr Suzanne Hodge

**5. Appointment held by supervisor(s) and institution(s) where based (if applicable):**

Research Supervisor  
 Dr Guillermo Perez Algorta  
 Health Researcher, Lancaster University

Field Supervisor  
 Professor Steve Jones  
 Co-director of The Spectrum Centre for Mental Health Research

Methods Supervisor  
 Dr Suzanne Hodge  
 Lecturer in Research Methods, Lancaster University

## SECTION TWO

**Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants**

1. Anticipated project dates (month and year)  
 Start date: \_\_\_\_\_ End date: \_\_\_\_\_
2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

**Data Management**

For additional guidance on data management, please go to [Research Data Management](#) webpage, or email the RDM support email: [rdm@lancaster.ac.uk](mailto:rdm@lancaster.ac.uk)

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms'  no

4c. If yes, where relevant has permission / agreement been secured from the website moderator?  
 no

4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users?  no

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain?  no

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

### 8. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?  yes

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

### SECTION THREE

**Complete this section if your project includes *direct* involvement by human subjects**

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

This study will explore how people with bipolar disorder consider risk-taking in their everyday decisions when in the euthymic phase. The euthymic phase has been described as a period with reduced manic or depressive symptoms subsequently returning to their usual lifestyle. It has been consistently shown that people with bipolar have difficulties with risk-taking decisions when they are in manic or depressive phases. Yet for euthymia, research is inconsistent. The impact of risk-taking in euthymia can have adverse consequences for the personal safety, social and occupational functioning, finances and relationships. The study will aim to interview 6-10 people with bipolar disorder in the euthymic phase to explore the perception, meaning and impact of risk-taking in their lives. The aim of the study is to deepen understanding about the consideration of risk-taking for people with bipolar disorder. This could inform future interventions and future research.

2. **Anticipated project dates (month and year only)**

Start date: October 2018

End date: May 2019

#### **Data Collection and Management**

*For additional guidance on data management, please go to [Research Data Management](#) webpage, or email the RDM support email: [rdm@lancaster.ac.uk](mailto:rdm@lancaster.ac.uk)*

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

We will be aiming to recruit 6-10 participants who have self-reported having a diagnosis of Bipolar Disorder and are currently in a euthymic phase. People who are interested will be asked to complete a short telephone screening interview to provide additional evidence of a diagnosis of bipolar and in euthymic phase. They will be over the age of 18.

Participants will have to be English speaking due to a lack of funds available for an interpreter.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

We will be advertising the study through social media, twitter and Instagram, as well as sending emails to colleagues within that field. We have the support of The Spectrum Centre for Mental Health Research (Spectrum), who can send the project information out through their mailing list and regular letter. Spectrum is a network of people who are interested in bipolar research.

Potential participants can express their interest to the lead researcher by email or phone. Those who want to participate and self-report having a diagnosis of bipolar and in a euthymic state will be asked to complete a short telephone interview. Participants will be asked to complete The Mini International Neuropsychiatric Interview (MINI) (Sheehan et al., 1997) over the telephone. This will provide additional evidence of a bipolar diagnosis and a euthymic phase. For participants who scores within the desired range on the MINI will be invited for an interview. The interview will be scheduled as soon as possible following the screening as mood states can change quickly. Those potential participants who do not meet the criteria during the telephone screen will be told sensitively that they cannot participate in the project.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

Interviews will be face-to-face semi structured interviews using interpretative phenomenological analysis (IPA) to analyse the data. Interviews of around an hour long are recommended for IPA (Smith & Shinebourne, 2012). The advantages of having semi-structured interviews are that it enables the researcher and participant to engage in a detailed dialogue whilst giving flexibility to explore prominent issues that are brought up in the conversation.

Specifically for this study, the concept of risk-taking in everyday decisions may change for each participant and may even change within different contexts for the same participant. It would then be important to consider the context when interpreting the experiences of the participant. IPA is committed to an idiographic approach which allows for the results to stay rooted within the lived-experience of the participants. IPA emphasises the perceptions of the individual participants which are then interpreted by the researcher. For this study, it will attempt to understand how each participant, in their own context, understands their own consideration of risk in every day decisions before the researcher interprets the whole data set for more general claims.

The analysis in IPA involves the researcher becoming immersed in the data. They do this by reading and rereading the transcripts, annotating and making notes each time. The researcher then reviews the notes and looks for emerging themes in the data. The emerging themes are then collected and clustered into clustered themes. This process occurs for each interview and thus the development of major themes using the clustered themes.

The themes from the first interview will influence the coding of the remaining interviews, however it is important that the research keeps an open mind for the possibility of new themes emerging.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

Interviews will be recorded on an Audio device and promptly saved onto Lancaster University's secure personal storage system (H:Drive). The audio recording may enter the public domain before it may be possible to transfer the recording securely. As the audio device does not encrypt the recording, it will be the responsibility of the lead researcher to keep the audio recording on their person until the transfer of the recording to the H:Drive. The audio recording will be deleted off the audio device once the transfer has been completed. The audio recordings will be kept on the H:Drive until the project has been examined and/or published and then destroyed. The lead researcher will be responsible for destroying the files.

The audio recordings will be transcribed anonymising any identifiable data. The anonymised transcriptions will be stored on the H:Drive. Lancaster University have another secure system, LU BOX, which enables sharing of files. Although LU BOX is a secure system, it is not as secure as the H:Drive. Therefore, it will be used for transferring of files only. For quality control during the analysis, the audio recordings and anonymised transcriptions will be transferred to the relevant supervisors through LU BOX. The supervisor will transfer and store the data onto their H:Drive, and delete it from LU BOX, whilst they are analysing it. Once the analysis process is completed for that specific interview, then it will be transferred back to LU BOX and then to the lead researchers H:Drive. The data will then be removed from the supervisor's H:Drive and LU BOX. It will be the responsibility of the supervisor to delete the data from their own personal H:Drive. Data will only be stored on LU BOX for a short duration during the transfer between the research team. It will be the responsibility of the lead researcher to remove the data from LU BOX. The lead researcher is responsible for the data during the project until submitted for examination and/or publication when it will be deleted or passed onto the DClInPsy Admin team.

7. Will audio or video recording take place?  no  audio  video

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

I will be using Lancaster University's secure personal storage system to store any identifiable data. The only time that data may be in the public domain will be after the interview has been completed and is on the audio device. The interview will be transferred from the audio device to the H:drive as soon as possible after the interview and deleted off the audio device.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

The audio recordings will be stored on the H:Drive and deleted once the thesis has been passed.

The transcriptions will be stored on H:Drive. Once examination of the study has been completed and/or a decision on publication has been made, the transcriptions will be transferred to the DClInPsy admin team. They will securely store this data and they will be destroyed by a member of the DClInPsy course admin staff under the direction of the programme or research director

The transfer of the audio recordings and transcriptions between researchers will be done through LU BOX. The researcher will store the data in their own personal H:drive. It will be removed from LU BOX as soon the transfer has been completed.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

The recordings will be kept until after examination and/or publication and then destroyed. The transcripts will be stored securely by the DClInPsy and destroyed by a member of the DClInPsy admin team under the direction of the programme or research director. Following the DClInPsy policy, the transcripts will be stored on the programme file space for 10 years.

8b. Are there any restrictions on sharing your data ?

Data can be shared upon request after publication.

9. Consent

a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law?  yes

b. Detail the procedure you will use for obtaining consent?

Potential participants will give verbal consent before completing the interview screen.

On the interview day, the participant and researcher will discuss the project and answer any questions that the participant may have. If the participant wants to proceed with the interview then a consent form will be signed prior to the interview commencing. It will be explained to participants that they are under no obligation to take part in the interview. They may change their mind and withdraw their interview up to two weeks after the interview.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

The interview may ask sensitive questions regarding the impact and experiences that risk-taking has had on a person's life. It may be distressing to retell the story and any painful consequences of their actions. They will be reminded that they are under no obligation to answer question they feel uncomfortable answering. If the participant becomes distressed then the interview may cease. The researcher can discuss with the participant, what their safety strategies may be. This is to remind them of what they should do if they become distressed after the interview. If the participant becomes distressed at the interview and immediate action is needed, then the researcher may call emergency services.

The participant has up to two weeks after their interview to withdraw from the project. After the two week point, the transcription and analysis will begin making it more difficult to remove their data from the project.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

The researcher may contact their supervisor if they feel distressed by an interview.

The interviews will be face-to-face and will occur at a public place within a private room.

At the request of the participant, the interviews may take place within their own homes. This could be due to accessibility reasons. Lancaster University's lone working policy will be adhered to as the researcher will contact their supervisor on arrival and leaving the interview location. The researcher will inform the supervisor of the location and an expected time for when the interview should finish.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.



There are no direct benefits to participants in this study. They may feel some satisfaction for participating in the project with the aim that it will benefit another person who may be going through similar difficulties as themselves

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

Travel expenses will be provided, upon receipt, up to the value of £20.

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?  yes

b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

Confidentiality will be maintained by the strict adherence of the Data Protection Act. The information gathered will only be discussed by the research team. If there are concerns over the participant's safety or safety of others, confidentiality may be broken. In this instance, the lead researcher will be as transparent and honest with the participant as possible, where appropriate they will ensure that the participant is aware of the steps being taken.

During transcription, all identifiable information will be anonymised. Pseudonyms for all names, places and other services will be used. The lead researcher will be transcribing the interview, with research supervisor reviewing the transcriptions.

Another limit to confidentiality may be within the report writing however anonymity will be assured. For example, if a quote is used then confidentiality cannot be said to have been kept as the quote could be identified, however the information will be anonymised.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

The protocol and accompanying research materials have been reviewed by a member of the service user advisory panel for Lancaster University research. The member was a person who has a diagnosis of bipolar and self-reported to be in a euthymic phase and had experience within research. The SU reviewed the content and e-mailed over their feedback. The feedback points were discussed, through email, with the SU agreeing with any changes.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

The research project will be part of the doctoral thesis on the Lancaster University Doctorate in Clinical Psychology programme. Examiners and relevant programme staff will see the report.

A presentation for all Lancaster DCLinPsy trainees and staff will be completed in the summer of 2019.

A summary report can be developed for The Spectrum Centre of Mental Health Research.

The project may be submitted in an academic/professional journal.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

The interviews will take place in a public location that has a private room that is free to use or cheaply available. If a location cannot be accessed, then the interview can occur using Skype for Business.

Although the lead researcher has clinical skills as a Trainee Clinical Psychologist, their role in this project is a researcher. If the participant would become distressed, the lead researcher would use clinical skills to respond to the participant in the moment but then remind them to contact their own clinical support that may be needed.

The lead researcher will keep a reflective journal as a recommended aspect of an IPA research project. This is to try to become aware of and identify any potential biases that may arise from the interview or analysis.

**SECTION FOUR: signature**Applicant electronic signature: 

Date 20/11/18

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review

Project Supervisor name (if applicable):   

Date application discussed

**Submission Guidance**

1. **Submit your FHMREC application by email to Diane Hopkins** ([fhmresearchsupport@lancaster.ac.uk](mailto:fhmresearchsupport@lancaster.ac.uk)) as two separate documents:
  - i. **FHMREC application form.**  
Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line*.
  - ii. **Supporting materials.**  
Collate the **following materials for your study, if relevant, into a single word document:**
    - a. **Your full research proposal (background, literature review, methodology/methods, ethical considerations).**
    - b. Advertising materials (posters, e-mails)
    - c. Letters/emails of invitation to participate
    - d. Participant information sheets
    - e. Consent forms
    - f. Questionnaires, surveys, demographic sheets
    - g. Interview schedules, interview question guides, focus group scripts
    - h. Debriefing sheets, resource lists

**Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.**

2. Submission deadlines:
  - i. Projects including direct involvement of human subjects [**section 3 of the form was completed**]. The *electronic* version of your application should be submitted to [Becky Case](#) by the **committee deadline date**. Committee meeting dates and application submission dates are listed on the [FHMREC website](#). Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.

- ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required]**. Those involving:
  - a. existing documents/data only;
  - b. the evaluation of an existing project with no direct contact with human participants;
  - c. service evaluations.
3. **You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application**

### **Research Project Protocol**

Bipolar disorder (BD) is characterised by extreme shifts in episodes of mania, low-mood and euthymia (National Institute for Health and Care Excellence, 2016; Samalin, Chazeron, Vieta, Bellivier, & Llorca, 2016). Described as a bridge between other depressive disorders and schizophrenia, BD has been split into multiple categories such as bipolar I, bipolar II, cyclothymic and unspecified bipolar disorder (American Psychological Association (APA), 2013). BD is associated with significant disinhibition and poor judgement (Reinhardt, Braga, & Serper, 2017; Yechiam, Hayden, Bodkins, O'Donnell, & Hetrick, 2008) with risk-taking behaviour a clinical feature of BD (APA, 2013). Individuals with BD are likely to make impulsive risky decisions, such as increased spending and hypersexual activity, without consideration of the long term-consequences (Adida et al., 2011; Burdick, Braga, Gopin, & Malhotra, 2014; Chandler, Wakeley, Goodwin, & Rogers, 2009). The consequences of these decisions can have an adverse impact on the persons safety, social and occupational functioning, finances and relationships (Kleinman et al., 2003).

Quantitative research literature suggests that individuals with BD may have decision-making impairments affecting their risk-taking decisions (Adida et al., 2011; Alexander, Oliver, Burdine, Tang, & Dunlop, 2017; Yechiam et al., 2008). This viewpoint appears consistent within the manic and depressive phases of BD, (Murphy et al., 2001; Reinhardt et al., 2017) yet it is inconclusive for the euthymic phase (Martino, Strejilevich, Torralva, & Manes, 2011). In their experimental paradigm, Adida et al. (2011) found that individuals presenting with manic and depressive symptoms scored lower than their control group for risk-taking decisions. The authors state that during mania individuals with BD may have a lack of insight that make it difficult to make advantageous long-term decisions. Within the depressive phase, the authors suggest individuals tend to make punishment-sensitive choices. Even for euthymic individuals with BD, the authors suggest a decision-making impairment affecting risk-taking decisions. Yet, a systematic review concluded that BD

individuals in an euthymic state may not have decision-making impairments (Samame, Martino, & Strejilevich, 2012) and that BD individuals can make important risk-taking decisions in every day contexts even in highly demanding situations (Martino et al., 2011). Adida et al. (2011) conclude that there are subtle mood-state sensitivities that influence risk-taking decision making.

Impulsiveness may be a subtle mood-state difference that impacts on risk-taking decisions. Impulsiveness can be characterised by a quick action, without planning, to satisfy a desire (Holmes et al., 2009). It has been linked with BD and is one of the DSM diagnostic criteria for mania (American Psychological Association, 2013; Newman & Meyer, 2014; Swann, Anderson, Dougherty, & Moeller, 2001). Impulsiveness in depression has been correlated with hopelessness (Swann, Steinberg, Lijffijt, & Moeller, 2008). This could be an important risk factor for suicide. Yet again, there is little evidence regarding the impact of impulsiveness on risk-taking for euthymic individuals with BD (Newman & Meyer, 2014).

Qualitative research literature has explored what strategies BD individuals use to stay well, that is to have reduced depressive and manic symptoms or to be able to make informed choices. These include managing stress, sleep and diet, education, social networks and medication (Cappleman, Smith, & Lobban, 2015; Murray et al., 2011; Russell & Browne, 2005). Yet to our knowledge, there are no qualitative studies that explore how euthymic BD individuals specifically consider risk-taking in everyday decisions and the impact this may have on their individual experiences. Furthermore, a qualitative study could contribute to the understanding of personal experiences, perceptions and the impact of risk-taking behaviours in their lives during periods of euthymia for people with BD (Holmes et al., 2009; Martino et al., 2011; Newman & Meyer, 2014). Exploring personal experiences could increase our understanding of patterns common to individuals in a euthymic period of BD (Mansell, Powell, Pedley, Thomas, & Jones, 2010). Using this knowledge could inform clinical practice with BD individuals in a phase of euthymia.

Therefore, with calls to qualitatively explore personal experiences of BD individuals in a euthymic phase (Fisher, Manicavasagar, Kiln, & Juraskova, 2016; Reinharth et al., 2017; Russell & Browne, 2005), I propose a qualitative study that explores how risk-taking is considered within everyday decisions for people living with BD during their euthymic phase. As risk will have different meanings within different contexts and between individuals we will define risk-taking as a decision that has high potential for negative consequences (Holmes et al., 2009). The term euthymia refers to an absence of manic or depressive symptoms subsequently resuming normal functioning (Olley et al., 2005). Overall, discussing personal experiences could provide rich data regarding risk-taking in the euthymic phase of BD.

## **Method**

### **Participants**

I will be aiming to recruit 6-10 participants (Smith & Shinebourne, 2012). I will advertise the project through various social media outlets, eg Twitter, Instagram and Facebook, whilst also contacting colleagues in this field who may be able to access participants through member networks. One such source could be The Spectrum Centre for Mental Health Research (Spectrum). Spectrum is a network that connects researchers and people with an interest in BD so that valuable contributions can be made in the growth of BD knowledge.

Participants who self-report having a diagnosis of BD and currently in a euthymic state will be screened prior to interview. The screening process is to provide additional evidence of a bipolar diagnosis and euthymic mood state. This will be done by the completion of the Mini-International Neuropsychiatric Interview (MINI) (Sheehan et al., 1997) via the telephone. The MINI is a short structured clinical interview that has been designed for research settings. It has been shown to be a well validated measure that can

also identify a euthymic mood state (Syan et al., 2018). If the potential participant scores within range for a BD diagnosis and in euthymic phase, then they will be invited to an interview. Mood states can change quickly so the interview will be scheduled as soon as possible after the telephone screening.

<u>Inclusion Criteria</u>	<u>Exclusion Criteria</u>
Self-report having a diagnosis of BD and in euthymic phase.	Does not meet criteria for a bipolar diagnosis and euthymic phase on the MINI.
Over 18-yearsold	Under 18-years-old
Score within range for a bipolar diagnosis and euthymic phase on the MINI.	Requires an interpreter

### **Design**

The study will use semi-structured face to face interviews (Smith, Flowers, & Larkin, 2009). The interviews will be around an hour long. The advantages of having semi-structured interviews are that it enables the researcher and participant to engage in a detailed dialogue whilst giving flexibility to explore prominent issues that are brought up in the conversation (Galletta, 2013).

### **Analysis**

The consideration of risk-taking in everyday decisions may change for each participant and may even change within different contexts for the same participant. This study aims to explore how the participant makes sense of their experiences within the differing contexts of their lives. Interpretative Phenomenological Analysis (IPA) is committed to an idiographic approach which allows for the results to stay rooted within the lived-experience of the participants. IPA emphasises the perceptions of the individual participants which are then interpreted by the researcher. For this study, it will attempt to



understand how each participant, in their own context, understands their own consideration of risk in every day decisions before the researcher interprets the whole data set for more general claims.

The analysis in IPA involves the researcher becoming immersed in the data. They do this by reading and rereading the transcripts, annotating and making notes each time. The researcher then reviews the notes and looks for emerging themes in the data. The emerging themes are then collected and clustered into clustered themes. This process occurs for each interview and thus the development of major themes using the clustered themes (Smith & Shinebourne, 2012).

The themes from the first interview will influence the coding of the remaining interviews, however it is important that the research keeps an open mind for the possibility of new themes emerging. The lead researcher will keep a reflective journal to help observe any bias that may arise.

### **Materials**

The Participation Information Sheet (PIS) (Appendix A) will have the full details of the project and can be sent along with the e-mail invitation of the project (Appendix B). For other interested participants, the PIS can be sent to those who may come across the project through advertisement on social media (Appendix C) and register their interest.

The MINI (Sheehan et al., 1997) will be used to screen the participants.

The consent form (Appendix D) will be completed with the participant prior to the main interview.

Data will be collected via a semi structured interview (Appendix E).

All materials have been reviewed by a service user. A consultation took place between the lead researcher and a service user to discuss the documents within the study. The main issue regarded the term 'euthymia' and its meaning. We decided that the term needed to be defined clearly within the protocol and on all participant forms. The wording of the definition was agreed to be appropriate and understandable.

### **Procedure**

The study will be advertised via social media and through contacting known colleagues within the field. Spectrum can support the project by advertising through their mailing list and regular letter. Interested members can express their interest and discuss the project with the lead researcher, via email and phone.

If the participant agrees then verbal consent will be requested to complete the screening process over the telephone. If the participant meets the inclusion criteria then they will be invited to the interview, as soon as possible after the phone call. The lead researcher will contact the participant to inform whether they meet the criteria for study or not. If they do, then they will organise a time, date and location for the interview for as soon as possible post screen.

On the interview day, the lead researcher and the participant will discuss the study and make sure that the participant is still interested. The discussion will involve sharing information about the project and providing the participant opportunities to ask any questions they may have. It will also be explained that they have no obligation to proceed with the project and, if they do take part, they may withdraw up to two weeks post interview. Access to future services will not be affected by involvement or non-involvement of this project. A consent form will then be signed before any recording takes place. Once the consent form has been signed, the interview can begin.

The interview will be audio recorded and stored on an Lancaster University's secure personal storage system (H:Drive). The transfer from the audio recording device to the H:Drive will happen as soon as possible.

The interviews will be transcribed verbatim and anonymised by the lead researcher. Any personal identifiable data, i.e. names, services, places etc., will be changed using pseudonyms. The transcriptions will be stored on the H:Drive. Lancaster University have a secure cloud storage, LU Box, which enables the secure transfer of data to other researchers. Shared folders will be created for relevant research team members.

### **Practical issues**

The location of the interviews will be organised by the lead researcher and the participant. Travel expenses will be offered. The location of the interviews will be venues within the community that offer a private space that is free or cheaply available. Interviews may also be offered using Skype for business if community venue cannot be accessed. Skype for business is an encrypted communication tool that is supported by Lancaster University.

The audio recording device has been provided by Lancaster University Doctorate in Clinical Psychology (DClinPsy) course. Confidentiality may be put at risk as the audio recording may enter the public domain before it may be possible to transfer the recording securely. As the audio device does not encrypt the recording, it will be the responsibility of the lead researcher to keep the audio recording on their person until the transfer of the recording to the H:Drive. The transfer of the audio recordings to secure storage will occur as soon as possible after the interview.

### **Dissemination**

The research project will be submitted for examination as part of the doctoral thesis on the DClInPsy at Lancaster University.

A research presentation will be presented to Lancaster University's DClInPsy staff and trainees.

A summarised report of the findings and presentation will be offered to Spectrum Connect. Spectrum Connect may wish to disseminate the results on their website.

A summarised report of the findings will also be sent to participants who request it. This will outline the results and possible implications whilst thanking the participants for their time and honesty.

The research project will be submitted for publication in an academic peer-reviewed journal. For example, The Journal of Affective Disorders is a multi-disciplinary peer-reviewed journal that has recently published qualitative studies in BD.

### **Ethical Concerns**

Participants may be asked sensitive questions during the interview. The participants will be reminded that they are under no obligation to answer any question they do not want to. If for any reason the participant becomes distressed during the interview the researcher will draw on their clinical decision-making skills and may stop the interview if necessary. Participants will be reminded to contact their support network. The lead researcher may contact emergency services if more urgent support is needed.

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## Timescales

5<sup>th</sup> September 2018 - Submit ethics application

October-December 2018 - Data Collection

October 2018 - March 2019 - Data Analysis

December 2018 - First Draft of Introduction and Methods sections

March 2019 - First draft of results and discussion sections

April 2019 - Second draft of research paper

10<sup>th</sup> May 2019 - Submit Thesis

July 2019 - Viva Voce

August 2019 - Submit for publication

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**Appendix 4-A****Participant Information Sheet**Doctorate in  
Clinical Psychology

Doctoral Thesis



Doctorate of Clinical Psychology, Lancaster University.

**Participant Information Sheet*****A qualitative exploration of how people with bipolar disorder consider risk-taking in everyday decisions.***

My name is Andrew Wah and I am conducting a research project as a student in the Doctorate of Clinical Psychology (DClinPsy) programme at Lancaster University, Lancaster, United Kingdom. The research project will form part of my doctoral thesis.

**What is the study about?**

The purpose of this study is to explore how people with bipolar disorder consider risk-taking when they are in their euthymic phase. This information will help to deepen understanding of risk-taking behaviour for people with bipolar disorder.

**Why have I been approached?**

You have been approached because the study requires personal experiences from people who have been given a diagnosis of bipolar disorder and are currently in a euthymic phase.

**What do we mean by the euthymic phase?**

The euthymic phase refers to a reduction of manic or depressive symptoms. It also means that you are currently living your usual lifestyle.

**Do I have to take part?**

No. It's completely up to you to decide whether or not you take part. Even if you consent now, you may withdraw up to two weeks after your interview.

**What will I be asked to do if I take part?**

If you decide you would like to take part, you would be asked to complete a short telephone interview to assess your suitability for the project. This will be a short set of questions that have produced a score. If you score within the desired range, then you will be invited to take part in an interview. The interview will discuss your perspective and experiences on risk-taking. I will be facilitating the interview which will be approximately one-hour long.

We will arrange a suitable location for the interview. It will likely be a community-based venue with a private space to talk. The interview can be done via Skype for Business.

### **Will my data be Identifiable?**

The information you provide is confidential. We will be adhering to Lancaster University code of confidentiality. All data collected for this study will be stored securely and only the researchers conducting this study will have access to this data:

- Audio recordings will be destroyed and/or deleted once the project has been passed by the examiners.
- Interviews will be transcribed verbatim.
- The typed version of your interview will be made anonymous by removing any identifying information including your name. Pseudonyms will be used for any names, places and services that are mentioned. Anonymised direct quotations from your interview may be used in the reports or publications from the study, but your name will not be attached to them.
- All electronic data (the audio recordings, transcribed interviews) will be stored on Lancaster University's secure personal storage system.
  
- Lancaster University's data protection policy meet the requirements for the EU General Data Protection Regulation (GDPR) and the UK Data Protection Act 2018. It is the responsibility of the lead researcher and supervisors to comply with Lancaster University's data protection policy. This enables the data to be as secure as possible during the storage and transfer of the data.
- All your personal data will be confidential and will be kept separately from your interview responses.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to my supervisor as first line of reporting, unless in an emergency when I would call the emergency services. Where possible, I will tell you if I must do this.

Anonymised quotes will be used when writing the report

### **What will happen to the results?**

The research will be written up and will be submitted to Lancaster University as part of my Doctoral Thesis. This may be submitted for publication in an academic or professional journal.

A presentation to Lancaster University DClInPsy trainees will be done as part of the assignment.

A summarised report and presentation will be offered to Spectrum Connect for them to disseminate.

A summarised report will also be offered to participants.

### **Are there any risks?**

The interview may consist of some personal and sensitive questions. Talking about some difficult and distressing experiences can cause distress. You will be under no obligation to answer any questions and can refuse to answer questions you do not want to. If the interview does cause you distress during or

following participation then you are encouraged to inform the researcher, contact your support network or call emergency services.

### Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part.

### Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

### Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the researchers below.

#### Lead Researcher

**Andrew Wah**

Trainee Clinical Psychologist,  
Lancaster University,

Clinical Psychology,  
Div. Of Health Research,  
Lancaster University  
Lancaster, LA1 4YG  
Phone: 01524 592754  
[a.wah@lancaster.ac.uk](mailto:a.wah@lancaster.ac.uk)

#### Research Supervisor

**Dr Guillermo Perez Algorta**

Health Researcher,  
Lancaster University

Div. Of Health Research      Lancaster  
University  
Lancaster, LA1 4YG

Phone: 01524 594711  
[g.perezalgorta@lancaster.ac.uk](mailto:g.perezalgorta@lancaster.ac.uk)

#### Field Supervisor

**Professor Steve Jones**

Co-director The Spectrum Centre for  
Mental Health Research.  
Lancaster University, Lancaster, LA1 4YG

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#### Methods Supervisor

**Dr Suzanne Hodge**

Lecturer in Research Methods  
Clinical Psychology  
Div. Of Health Research  
Lancaster University  
Lancaster, LA1 4YG

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[s.hodge@lancaster.ac.uk](mailto:s.hodge@lancaster.ac.uk)

**Lancaster University data protection policy**

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage:

[www.lancaster.ac.uk/research/data-protection](http://www.lancaster.ac.uk/research/data-protection)

**Complaints**

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

**Professor Bill Sellwood**

Research Director and Chair of the Exam Board  
Clinical Psychology, Div. Of Health Research,  
Lancaster University, Lancaster, LA1 4YG  
01524 593998

[b.sellwood@lancaster.ac.uk](mailto:b.sellwood@lancaster.ac.uk)

If you wish to speak to someone outside of the DClinPsy Programme, you may also contact:

Professor Roger Pickup Tel: +44 (0)1524 593746

Associate Dean for Research Email: [r.pickup@lancaster.ac.uk](mailto:r.pickup@lancaster.ac.uk)

Faculty of Health and Medicine

(Division of Biomedical and Life Sciences)

Lancaster University

Lancaster

LA1 4YG

Thank you for taking the time to read this information sheet.

**Appendix 4-B**  
**E-mail Invitation Template**

Dear [colleagues],

My name is Andrew Wah. I am a trainee clinical psychologist at Lancaster University. As part of my thesis, I am leading a research project that is exploring how risk-taking is considered by people with bipolar disorder.

I am aiming for 6-10 people to participate in the project. To participate will need to self-report having a diagnosis of bipolar and be currently in a euthymic phase.

We have defined the euthymic phase as:

- A reduction of manic or depressive symptoms
- Living your usual lifestyle

Interested participants will be asked to complete a short screen over the telephone. Eligible people will be invited to take part in an interview lasting about an hour. The interview will be exploring their experiences and perceptions of risk-taking in their euthymic phase.

Please share with people who may be interested. Any interested person can contact Andrew Wah via email or phone.

Email: [a.wah@lancaster.ac.uk](mailto:a.wah@lancaster.ac.uk)

Phone: XXXXXXXXXXXX

Kind Regards,

Andrew

## Appendix 4-C

### Project Advert

#### Advert tagline

“Can you help with my DClInPsy Thesis research project? I am looking for participants, over 18, to explore their experiences and perceptions of risk-taking when in the euthymic phase of bipolar. Please email for more info.”

#### Advert poster

The poster is a rectangular graphic with a light blue background and a dark blue border. At the top right, it features the text 'Doctorate in Clinical Psychology' and the 'Lancaster University' logo, which includes a red shield with a white cross and a white lion. The main title is 'RISK-TAKING IN EUTHYMIC PHASE OF BIPOLAR', with 'RISK-TAKING IN EUTHYMIC PHASE' on one line and 'OF BIPOLAR' on the line below, both in bold blue capital letters and underlined. Below the title, the text 'What is Euthymia?' is written in a smaller, purple font. This is followed by a bulleted list of two items: 'A reduction of manic or depressive symptoms' and 'living your usual lifestyle', both in purple. The next section is 'Would you like to participate in research?' in bold black text. Below this, it says 'I am looking for people who:' followed by a bulleted list of three items: 'Self-report having a diagnosis of bipolar disorder.', 'Are currently in a euthymic phase.', and 'Over 18 years old'. The final section asks 'Are you willing to take part in an interview to explore your experiences and perceptions of risk-taking when in the euthymic phase of bipolar?' in black text. At the bottom, it says 'Please email [a.wah@lancaster.ac.uk](mailto:a.wah@lancaster.ac.uk) for more information' in black text.

Doctorate in  
Clinical Psychology | Lancaster  
University 

## RISK-TAKING IN EUTHYMIC PHASE OF BIPOLAR

*What is Euthymia?*

- *A reduction of manic or depressive symptoms*
- *living your usual lifestyle*

**Would you like to participate in research?**

I am looking for people who:

- Self-report having a diagnosis of bipolar disorder.
- Are currently in a euthymic phase.
- Over 18 years old

Are you willing to take part in an interview to explore your experiences and perceptions of risk-taking when in the euthymic phase of bipolar?

Please email [a.wah@lancaster.ac.uk](mailto:a.wah@lancaster.ac.uk) for more information

**Appendix 4-D  
Consent Form**Doctorate in  
Clinical Psychology***A qualitative exploration of how people with bipolar disorder consider risk-taking in everyday decisions.***

We are asking if you would like to take part in a research project exploring the personal experiences of how people with bipolar consider risk-taking.

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree.

If you have any questions or queries before signing the consent form please speak to the principal investigator, Andrew Wah.

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study.
2. I confirm that I have had the opportunity to ask any questions and to have them answered.
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript.
4. I understand that audio recordings will be kept until the research project has been examined.
5. I understand that all electronic data will be stored on Lancaster University's secure personal storage system.
6. I understand that the lead researcher will discuss and share data with their supervisors as needed.
7. I understand that my participation is voluntary and that I am free to withdraw at any time up to two weeks after my interview without giving any reason, without my medical care or legal rights being affected.
8. I understand that after the two-week post-interview period my data will have been analysed and incorporated into themes which means it will not be possible for my data to be withdrawn.
9. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published.
10. I consent to information and quotations from my interview being used in reports, conferences and training events.
11. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or

others, in which case the lead researcher will need to share this information with their research supervisor.

12. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.

Please sign below to consent to take part in this research project.

Name of Participant \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Name of Researcher \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Summarised report of the findings

If you would like to receive a report of the findings, then please fill in your details below.

By email	By post
email address:	Name: Address:  Post Code:



### Appendix 4-E Interview Schedule

**Research Question: How do people with Bipolar Disorder make sense of their risk-taking behaviours during their euthymic phase?**

#### Getting to know the participant

1. Can you tell me a little bit about yourself? Name, age, occupation...
2. Can you tell me a little bit about your diagnosis of bipolar? When did you receive your diagnosis and when did you first experience it?

#### About Risk-taking

3. What does risk mean to you?  
*What do you think it means to other people? (family, friends, professionals?)*
4. What is risk-taking behaviour?  
*What do you other people think risk-taking behaviour is?*
5. What is the difference between a risk-taking behaviour and just normal behaviour?

#### Your own Risk-taking behaviours

6. Let's think about your own risk-taking behaviours...Can you give me an example of risk-taking behaviour when you were in a euthymic phase?  
*Prompt: an activity that has the potential for negative consequences...leaving car unlocked or bag on show. Walking home late at night, one-night stand, purchasing expensive items/spending a lot of money / gambling*
7. How do you weigh up risk versus reward?
8. How do you consider the long-term consequences for your decisions?
9. What happens when you make a bad/good decision? How do you feel? What do you think?
10. What are other people's perceptions of your risk-taking behaviour?  
*Do they think you take too many? Are they worried about your ability to make risky decisions?*
11. Do you use any support to help with making decisions?

#### Deepening Questions

*Can you tell me more about that?*

*What do you mean by "x"?*

*what you were thinking about when you were making your decision?*

*How were you feeling at the time?*

*Has this changed over time?*

*Notice 'stuff' that is 'leaking' out throughout the interview*

Phenomenological  
Think/say/do

Hermeneutics  
How do they make sense of it?

idiographic  
their context