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Research Report

Managing bipolar moods without medication: A qualitative investigation

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ABSTRACT

Objectives: Although many diagnosed with Bipolar Disorder (BD) choose to manage their moods without medication at some point, their experiences of doing so are not well understood. This paper aims to explore the processes by which people manage bipolar moods without medication.
Methods: Ten people diagnosed with BD who do not use medication were interviewed. Analysing their accounts using grounded theory methods led to developing a model of how they perceive the processes involved in managing moods without medication.
Results: Participants engaged in repeated evaluative processes around their strategies for managing moods. Some participants decided not to influence elevated moods due to their perceived advantages. Participants' intentions and actions were influenced by their perceptions of themselves and by the meanings they attached to bipolar moods, which were in turn influenced by feedback from others.
Conclusions: The complexity of the processes described by participants suggests that traditional models of explaining non-adherence may over-simplify some individuals' experiences. Future research could focus on identifying factors predictive of successful attempts to manage moods without medication. Professionals should place more emphasis on non-medication approaches in order to increase engagement with people who do not use medication. This may involve focussing on individual's longer-term goals rather than on modifying moods in shorter-term. Conclusions are based on participants who had experienced significant bipolar moods, but who largely seemed satisfied living without medication.
Limitations: Future research should ascertain whether such processes apply to a wider group of individuals who do not use medication for bipolar moods.

1. Introduction

Clinical guidelines for professionals working with those who experience bipolar moods have traditionally focussed on medication, and continue to devote more coverage to pharmacological interventions than they do to any other approach (e.g. Hirschfeld, 2005; National Institute for Health and Clinical Excellence (NICE), 2014). These guidelines suggest medication should be used for the management of acute episodes, and long-term as a prophylactic. Despite the centrality of medication to current clinical guidance, it is estimated that up to 64% of people diagnosed with Bipolar Disorder (BD) will stop taking medication prescribed for their moods at some point (Leclerc et al., 2013).

This emphasis on pharmacological interventions is reflected by current research into how people manage bipolar moods, which focusses mostly on people who use medication. Research exploring the use of psychosocial interventions in this area focusses on their use as an adjunctive therapy of medication, and interventions frequently include components aiming to increase medication adherence (NICE, 2014). Previous qualitative investigations have explored how people manage bipolar moods alongside medication, for example by understanding more about bipolar moods, associated triggers, warning signs, and lifestyle choices that promote mood stability (Russell and Browne, 2005; Mansell et al., 2010; Murray et al., 2011). However, we are not aware of any research to date that has focussed on the processes involved in managing bipolar moods without medication.

Decisions to manage bipolar moods without medication are frequently seen as a result of an individual's "lack of insight" into the nature of their problems (e.g. Yen et al., 2005). Clatworthy et al. (2009) also suggest that such decisions can be understood as

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the result of inaccurate concerns about the effectiveness and safety of medication. However, current research suggests that such concerns may not be wholly unfounded. A review of the effectiveness of the most frequently prescribed medications for Bipolar Disorder suggests that for each person who benefits from medication, 7–9 people do not (Kettler et al., 2011). This ratio should be considered alongside the severe side effects resulting from lithium (Grandjean and Aubry, 2009; Markowitz et al., 2000), and from the newer atypical antipsychotic medications which are now commonly used (Serretti et al., 2013; Weinmann et al., 2009). Such research undermines the assumption that decisions not to use medication are indicative of a lack of insight or mistaken beliefs about medication's effectiveness.

1.1. Study aims

Models for understanding non-adherence based on lack of insight or inaccurate beliefs about medication do not seem to be fully supported by current research into the safety and effectiveness of medication. Understanding the processes involved in managing bipolar moods without medication might indicate which factors help people when they make this choice, and how they might overcome any difficulties faced. This study aims to be a starting point in addressing this gap in the literature.

A qualitative design was employed as this is most appropriate for exploratory research focussing on subjective experiences and processes (Thompson and Harper, 2012). Grounded theory (GT) methods were used to guide sampling and analyse the data, as they are particularly useful in investigating social and psychological processes (Tweed and Charmaz, 2012).

2. Method

2.1. Design

The authors employed the constructivist approach of Charmaz (2006) to GT, which unlike positivist GT (e.g. Glaser and Strauss, 1967) does not seek to establish or describe an objective "truth" about phenomena. It instead seeks to understand how individuals construct their experiences within the context of "larger and, often, hidden positions, networks, situations, and relationships" (Charmaz, 2006, p.133). This stance is appropriate as the processes related to people's mood-related behaviours can be understood within the context of their experiences in relationships and their wider social environment (British Psychological Society, 2010).

2.1.1. Use of the SCID

The Structured Clinical Interview for DSM-IV (SCID; First et al., 1997) was used prior to research interviews to gather contextual information about each participant's past bipolar experiences and their impact. During the second phase of recruitment the SCID was also used as a tool to guide sampling (see Section 2.3).

2.2. Participants

Ten individuals were recruited. In order to be eligible, participants had to report having received a diagnosis of BD from a mental health professional, had to have been offered medication for their moods, and had to have chosen not to use medication for a minimum of three months at the time they were approached to take part in the study. The criterion of choosing not to use medication for a minimum of three months was chosen following consultation with service users, who identified from their experiences that three months would be the minimum length of time expected to begin adjusting to no longer using medication and begin making any resulting lifestyle changes.

2.3. Procedure

Ethical approval was obtained from Lancaster University's ethics committee. Participants were recruited through: service user groups run by the charity Bipolar UK; advertising the project using the social networking sites Twitter and Facebook; and through sending an e-mail to members of a database of individuals interested in participating in research, held by the host institution. All participants were required to give written informed consent prior to taking part.

2.3.1. Sampling

The first four people who returned consent forms were interviewed. Following this, participants were chosen for interviews using theoretical sampling (Draucker et al., 2007), whereby participants are selected on the basis of having had experiences which will provide data likely to refine developing themes and categories. For example, as the initial interviews were largely with people who mostly experienced low rather than high moods, the SCID was used during the second phase of recruitment (interviews five to seven) to identify three participants who predominantly experienced elevated moods from the pool of individuals who had consented to participate.

Rather than "theoretical saturation" (Strauss and Corbin, 1998), whereby no new codes or elements of a model can be found within data, the authors aimed for criteria of Dey (1999) of "theoretical sufficiency", whereby data is collected until it is possible to construct a coherent model of the phenomenon under investigation. This is because theoretical sufficiency was seen to be more consistent with the authors' constructivist stance, and saturation is in any case unlikely to be achieved in studies where the researchers do not know in advance what types of category will emerge (O'Reilly and Parker, 2013).

2.3.2. Interviews

Participants were interviewed according to a flexible topic guide (see Fig. 1), developed by the authors in collaboration with service users. The interview schedule was adapted as data collection progressed in order to collect data that would refine developing themes and categories. Interviews lasted between 60 and 105 min.

2.4. Analysis

Interviews were analysed according to GT methods described by Charmaz (2006). Transcripts were analysed line-by-line and brief descriptive codes assigned to items of data. The most frequent or significant initial codes were then used to categorise data into broader focussed codes. Relationships between focussed codes were then analysed and used to develop categories that contributed towards an overall theoretical framework. Categories considered to outline key overarching themes within the data were elevated to the status of "concepts". A constant comparative approach was utilised, in which new data was continually compared against codes that had already been developed in order to find points of similarity and divergence within the data, and to ground the developing theoretical model in the data. Throughout this process the first author kept memos of observations and reflections about how a theoretical framework could be developed from the data. These hypotheses were tested against existing data and new data gained from subsequent interviews. This entailed

- I'm interested in understanding why you do not take medication for your bipolar experiences. Could you say a bit about this?
- How is your mood without the medication? Do you have any periods where you feel low in mood? Any times you feel high in mood? What kinds of things do you do?
- Has there been a period of time when you didn't use medication and things went well? Can you tell me about it? What happened?
- Can you tell me about a period of time you weren't using medication and things didn't go so well? What happened?
- What lessons have you learned from not using medication for your bipolar experiences?
- How would you describe the person you are now? How's that different to when you took medication? What helped you get to this point?
- Looking back, are there any other events that stand out in your mind? Could you describe them? (Enquire about following domains: relationships, work, things you do in your spare time). How did this affect you? How did others respond? What did you do?
- Who, if anyone, has been most helpful when you've not been taking medication for your mood? What did they do? Were any people unhelpful? What did they do?

Fig. 1. Sample questions from interview topic guide.

the interview schedule being adapted where necessary in order to elicit information relevant to such hypotheses.

2.4.1. Model development

Lempert (2007) suggests that the development of a visual model of the theory that is developed is an essential part of GT analysis. Following the first stage of data collection the authors developed a graphical model of the hypothesised links between concepts and categories developed from the data. This model was developed through iterative discussion among the authors and tested and refined following subsequent interviews.

2.4.2. Quality checks

The process of data collection and analysis was frequently discussed within the research team in order to ensure transparency and quality. As well as discussing the development of categories and the construction of the theoretical model, the research team listened to recordings of interviews to spot ways in which the interviewer's own views and assumptions may have been influencing questioning. This proved crucial during the first phase of data collection, where such discussion highlighted the interviewer's implicit assumption that participants would act to return mood to a "normal" level. Subsequent to this the interviewer ensured that their follow-up questions remained open and neutral, and more data was gathered about occasions where some participants did not address periods of elevated mood.

Participants received a written summary of the research findings at the end of the project and were invited to give feedback to the researchers with any comments about the veracity of the final analysis. Participants stated that they found the model meaningful, but highlighted the importance of including specific strategies mentioned by participants in the final report (see Table 2), to provide as much helpful information as possible to those experiencing bipolar moods.

3. Results

Demographic information relating to participants' age, received diagnosis, and length of time not using medication is displayed in Table 1. All names used are pseudonyms.

No participant met SCID criteria for a current depressive or manic episode. All participants met criteria for a past manic or hypomanic episode, and one participant (Leanne) met criteria for a current hypomanic episode. Only one participant (Hayley) did not meet SCID criteria for a past depressive episode, as her periods of low mood had not been of long-enough duration. No participant's most recent mood episode had resulted in hospitalisation.

Although advertisements for the study received a lot of interest, considerably fewer people expressed interest in participating once they had received more information about the time commitment involved (i.e. completing the SCID and research interview). Those who chose to participate beyond this point expressed enthusiasm for the topic, and were keen to share their ideas. Several participants requested confirmation at the start of their interviews that the study was not aiming to inform the development of interventions to increase medication adherence. The

Table 1
Participant demographic information.

Name	Age[a]	Length of time since last took medication[b]	Diagnosis received from mental health professional	Employment status	Time since last mood episode (and mood type)[c]	Number of mood episodes	Number of hospitalisations
Andrew	43	1 year	Bipolar I	Self-employed	4 months (hypomania)	25	1
Hayley	50	Never used medication	Manic depression[d]	Employed	1 month: (hypomania)	Too many to recall	0
Katy	31	8 months	Bipolar II	Self-employed	8 months: (depression)	8	0
Kevin	36	18 months	Bipolar I	Student	16 months (depression)	5	2
Leanne	31	9 months	Bipolar I	Unemployed	Current (hypomania)	Approx 65	1
Liam	32	6 months	Bipolar NOS	Employed	3 months (depression)	10	1
Lisa	29	9 years	Bipolar I	Employed	12 months (mania)	9	0
Nick	30	5 years	Bipolar I	Employed	1 month (hypomania)	Too many to recall	2
Nicole	37	8 months	Bipolar II	Unemployed	3 months (depression)	35	0
Simon	42	10 years	Manic Depression[d]	Unemployed	3 months (mania)	12	1

[a] Mean age of sample = 36 years.
[b] Mean time off medication among the 9 participants who had used it = 38.8 months.
[c] With the exception of Leanne, whom the SCID indicated was currently experiencing hypomania, "last episode type" is not based on a formal assessment measure. Rather, "last episode type" was ascribed based on participant self-descriptions of their most recent bipolar mood (e.g. type, severity and duration).
[d] Participants stated this reflected terminology in use at time of their diagnosis.

majority of participants stated they were pleased that research was being done on the topic of managing bipolar moods without medication, as they felt this was an important and under-researched area.

The model developed from the data is presented in Fig. 2, which depicts a sequential process beginning with the decision not to use medication, leading to choices about how to act in response to changing mood states. Throughout this, the concept of "Ideas About Myself and My Moods" influenced the choices participants made. This concept relates to how participants perceived themselves and their moods, and how their understanding of their moods affected their perception of themselves. For example, several participants described their elevated moods as a valued part of their personality rather than as a symptom of illness. This concept was also frequently influenced by how participants wished to be seen by others (e.g. as being helpful, competent at work, a good parent). Rather than outlining this concept separately, it is discussed with reference to key points where it influences other elements of the model.

3.1. Deciding whether to use medication

The initial decision whether to stop using medication entailed what Liam described as a "cost–benefit analysis". Participants cited side-effects as a major concern, describing distress resulting from problems including weight gain, tremors, loss of libido, and lithium toxicity. Hayley (who had never used medication) was concerned about side-effects because of others stories of the impacts medication had on them, and her own negative experiences with medication prescribed for other problems.

At this point the concept "Ideas About Myself and My Moods" is particularly influential. Participants frequently described side-effects changing their view about themselves in ways they found undesirable, for example having a sense of themselves as being hard working and productive, but feeling unable to achieve as much at work due to feelings of fatigue. Other participants described concerns about how others might perceive them due to side effects; for example, Liam described concerns that students he taught would see him as ineffective because of the impact of side-effects. Participants' cost–benefit analyses were also influenced by the perceived effectiveness of medication. For example, Lisa stated that when she used medication "I still had an episode", and concluded "what's the point in taking meds if you're still gonna have [an episode] probably?".

3.2. Searching for alternatives to medication

Having decided not to use medication, participants then searched for experiences and practical strategies that might help them learn how to live without medication. A wide range of strategies were identified at all stages of the model and these are listed in Table 2.

Participants talked about developing such ideas through therapy or through meeting others at support groups. Participants also tended to seek out experiences where they might learn ideas congruent with their existing "Ideas About Myself and My Moods". For example, Simon saw his bipolar moods as being largely precipitated by poor diet, and his choice to consult a nutritionist was guided by the idea that correct nutrition could reduce toxins in his body.

3.3. Trying to keep mood at a preferred level

Participants attempted to make changes in their lives to keep their mood in a desired state, intending to stave off any potential undesired mood changes (examples of these strategies and others are displayed in Table 2). These activities were sometimes seen to stabilise mood through exerting a positive overall effect on wellbeing, which was believed to subsequently have an impact on mood.

The extent to which participants consciously engaged in "Trying to Keep Mood at a Preferred Level" seemed to be determined by the extent to which moods were perceived as a problem according to their "Ideas About Myself and My Moods". For example Lisa, who rarely experienced low mood and perceived her high moods positively, stated: "I generally tend not to manage it that much because it's not that much of a problem".

One particular obstacle to implementing strategies at this point in the process was that they frequently required time, effort, and as Simon described it, "discipline". This meant it could be tempting to stray from these strategies in favour of more immediately rewarding behaviours, such as eating unhealthy foods or drinking alcohol with friends. Lack of finances was also identified as a barrier to being able to implement many of the strategies described in model.

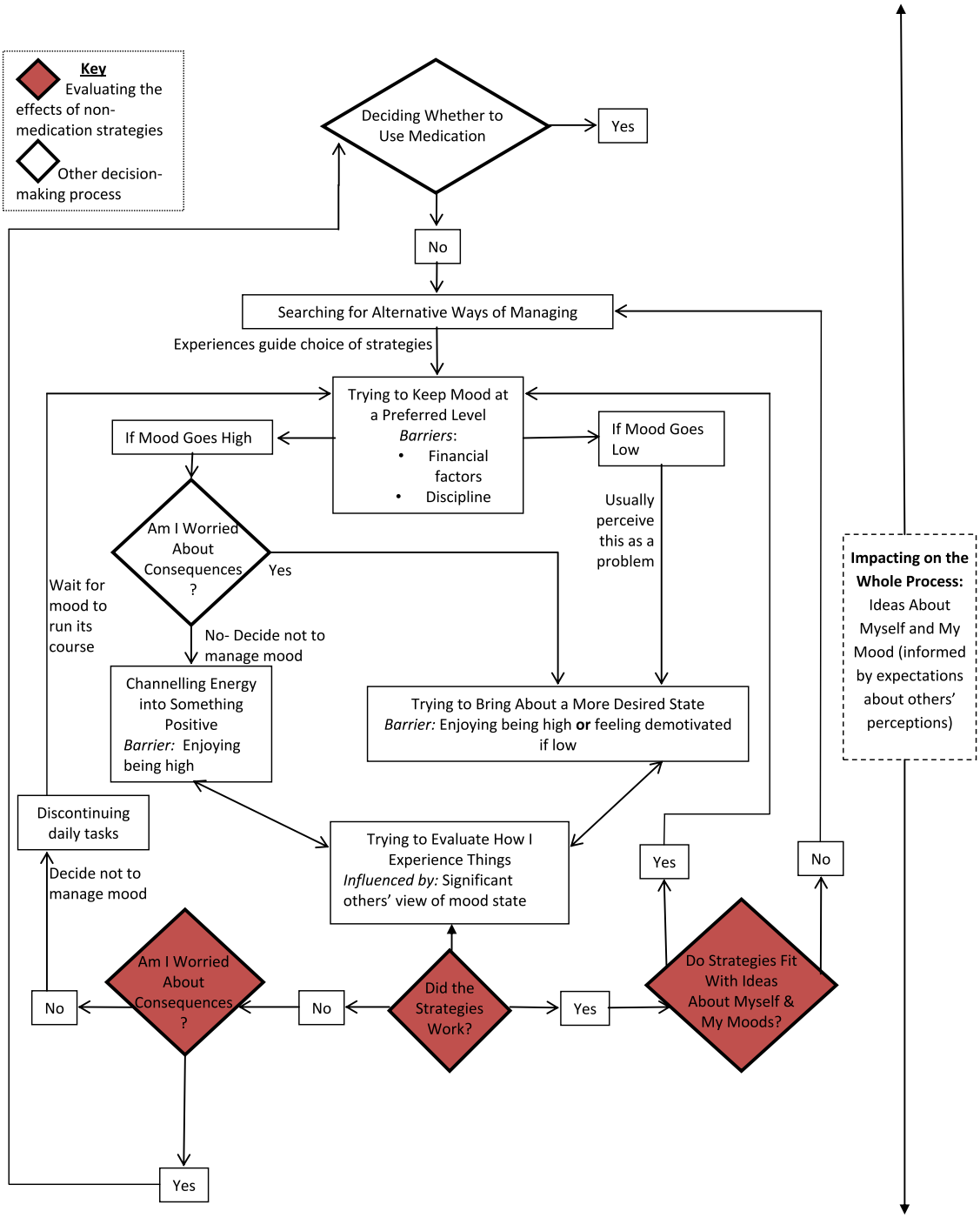

Fig. 2. Diagrammatic representation of model.

3.4. *Channelling energy into something positive*

Participants described trying to channel energy into something positive when they felt their mood was high, but did not feel sufficiently concerned about the consequences of this to change their mood. Participants were more likely to use this strategy when high moods were evaluated as having a positive effect, as part of "Ideas About Myself and My Moods". Participants stated that when high in mood they would actively choose to take advantage of this by increasing exercise (Nicole), productivity (Leanne, Hayley), or take advantage of their increased creativity by spending more time engaging in creative pursuits (Lisa, Nick). However, this course of action was identified by some (Lisa, Nick, Nicole) as potentially further elevating mood, leading to a risk that it could begin to have a destructive, rather than constructive, effect.

3.5. *Trying to bring about a more desired state*

When participants noticed their mood becoming higher or lower than desired, they subsequently acted with the intention of trying to bring about a more desired cognitive, emotional, or physiological state. Leanne described this as

> *…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*

Table 2
Examples of strategies used by participants at different stages of the model.

Stage of Model	Strategies used (and Who By)
Trying to keep mood at a preferred level	Doing more exercise (Kevin); Eating well (Kevin, Nicole, Simon); Being self-employed (Katy); Only having short contact with triggering family members (Hayley); Trying to avoid stress (Nick); Going to France at certain times of year (to mitigate changes in daylight) (Simon); Making time with partner (Katy)
Channelling energy into something positive	Focussing on a specific task or project (Liam); Making a to-do list and systematically working through it (Leanne); Spending more time on creative tasks and activities (Nick); Focus on being productive at work (Lisa); Archery (Hayley); Doing the garden (Hayley)
Trying to bring about a more desired state	Self-medicating with alcohol (Kevin; Liam); Pampering, make-up (Leanne); Changing perception of unpleasant thoughts (Nicole); Setting more work to do in the morning (Katy, Liam); Taking valerian root (Hayley); Taking vitamin E (Simon); Lighting scented oils (Leanne); Keeping usual bedtime routine (Katy); Going to a gallery (Andrew); Taking dog for walks (Nicole); Do a boring task (Lisa); Stopping and reflecting (Leanne); Spend time with someone soothing (Lisa)
Trying to evaluate how I experience things	Asking a friend's opinion about a situation (Liam); Using an online mood tracker (Katy); Compare my current mood to Winnie the Pooh characters (Leanne); Use an app to record my mood (Nick); Partner telling me when I'm too high (Andrew, Hayley, Leanne); Using meditation to observe feelings (Nicole)
Discontinuing daily tasks	Taking time off work (Nick); Letting myself stay high (Nick); Finding things to spend money on (Simon); Going to parties (Lisa); Going travelling with friends (Lisa)

calm you down, if you're paranoid anything that'll make you feel safe…

Participants described using a variety of stimuli to bring their mood down to the level, they desired when feeling too high, ranging from a hot bath through to the use of essential oils. Some participants cited that the effect of using these strategies when low was to tackle what Kevin and Nicole termed "negative thoughts", which tended to centre on negative evaluations of the self or recurring feelings of isolation. Other strategies ranged from practical activities that would alleviate negative feelings, such as pampering or getting a haircut (Leanne) or looking at lists of forthcoming positive activities (Nick), through to strategies directly challenging thoughts, learnt via techniques such as meditation or cognitive therapy (Nicole).

3.5.1. Barriers to implementing strategies

The enjoyment of being high in mood was described by participants as affecting their motivation to use strategies that might change this. For example, Nick stated that:

…there's a line where once it's crossed I'll just go with it and I'll want it to be higher, so I'll […] *then switch from being sensible, like let's calm it down a bit to* […] *I'll collect wood for my own bonfire.*

This was frequently reported by participants of whom "Ideas about Myself and My Moods" saw elevated mood as being positive and/or valued. Alternatively, feelings of low mood could alter participants' perceptions about themselves, such that they no longer wished to put strategies into practice. Katy described how her more negative views of herself when low might impact on her organising time with friends, as "I worry about whether other people want to spend time with me".

3.6. Trying to evaluate how I experience things

Throughout the process of managing without medication participants described efforts to evaluate their mood, such as when "Trying to Keep My Mood at a Preferred Level". Evaluating mood seemed to take on a particular significance at this point, with participants reporting attempts to determine whether bipolar moods were impacting on their motivation to implement strategies, and looking for indicators suggesting that moods were affecting their perception. At this stage, participants frequently looked to significant others to point out the occurrence of these indicators as Andrew stated: "my partner's a medical writer, so she's… very good at spotting if I'm going a bit funny". Feedback from others helped participants make a conscious choice to use strategies to alter their affective state. At this point participants either returned to the previous stage of the model and implemented strategies to change their mood, or they moved to the next step and evaluated whether strategies had exerted the desired effect.

3.7. Evaluating the effects of non-medication strategies

In much of the same way that participants described undertaking a cost–benefit analysis around whether or not to stop taking medication, they underwent a similar process regarding whether to carry on using specific non-medication strategies. As in the analysis relating to medication, participants evaluated whether strategies had achieved their aims, then whether the consequences of using a strategy cohered with their "Ideas About Myself and My Moods". For example, Kevin talked about self-medicating with alcohol:

… ultimately I don't think that I could carry on long term and do what I want to do with my life, simply being depressed and relying on alcohol to get by, because for me that's not what I wanna do.

If effective strategies were seen as congruent with participants' ideas about themselves and their moods, they were used again. However if they were seen as incongruent, participants began to search for further inspiration about how to manage without medication. At this stage of the model participants compared the consequences of their non-medication strategies with the consequences of using medication:

Since I'm off the medication I'm a much more stable person, I'm much calmer about everything, about the lows, about the highs, about normal life, everything is much more… I wanna say in control but it's not in control, but it just feels different to when I'm on the medication. (Nicole).

Participants were faced with a different choice if they evaluated strategies as unsuccessful and their mood was still higher or lower than they wanted. In these instances participants tended to attribute this to their mood being sometimes uncontrollable, rather than strategies being inadequate. At this point participants began to weigh up the possible consequences their mood might have on their life and that of others if left unaltered. If participants were worried about destructive consequences, they would return to the model's starting point of deciding whether or not to use medication. For example, Leanne stated "if I get close to […] I'm gonna lose my child, I'm not being a good mum, I'm dangerous to me cos I'm being dumb or to others then I'll take the medication". Notably, Leanne had stated that following a previous manic

episode her child had been taken into care. As Leanne's quote indicates, her decision-making process considered how the consequences of not using medication might impact significant others, and how this in turn might affect her views of herself. Leanne was the participant who seemed most willing to use medication again for short periods if she had to (to the extent she kept spare medication at home in case it was needed). This may have been due to her experience of finding short-term courses of olanzapine effective in managing more difficult periods of higher mood ("I know I can go to bed tonight and take olanzapine and tomorrow all of these symptoms will be gone"). It may be that her willingness to use medication was associated with her past experiences of negative consequences resulting from past mood episodes.

3.7.1. Discontinuing daily tasks

If strategies had not altered participants' moods and they were less worried about possible consequences, they described disengaging from daily tasks and taking "time out [to] just let myself get better" (Nick). This typically involved taking time off from work and other commitments, and waiting for the period of bipolar mood to run its course. Lisa described a point at which, if strategies had not worked, she felt her mood was no longer manageable and she would stop trying to influence it:

> *…once I've started sleeping 2 or 3 h a night or even 1 or none, it's too late for management strategies it really is* […] *I'm on it and I'm not going to back off, you know what I mean [laughs], even if they would work I have no desire whatsoever to do anything about it, I'm in it and I'm just gonna let it.*

Other participants stated that once their mood reached this point, they would need to turn to others for practical help. For example, Simon described an occasion where a friend found and recalled cheques Simon had written during a manic episode. Participants who allowed periods of elevated mood to reach this point tended to have "Ideas about Myself and My Moods" which involved high moods being seen positively. Once mood had returned to a more stable level, participants then re-engaged in attempts to manage their mood.

4. Discussion

This paper is the first to explore the processes by which people manage bipolar moods without medication. Participants described undertaking an ongoing evaluative process while managing their moods, relating to issues such as whether or not to stop using medication, whether current ways of managing cohered with their views of themselves and their moods, the effectiveness of strategies for managing, and whether they would have to use medication again at some point in the future. Furthermore, participants' intentions when implementing strategies varied across time depending on their evaluations of their mood state and its consequences.

4.1. Findings in the context of current literature

4.1.1. Literature on managing bipolar moods

The results of the current study fit well with findings from other studies that have investigated experiences of managing bipolar moods with medication. As in the qualitative studies by Mansell et al. (2010), Russell and Browne (2005) and Murray et al. (2011) , participants cited the influence of others at key times when managing their mood, most frequently through loved ones pointing out when mood states may be becoming a problem. Also congruent with these previous findings, central issues for participants included: the importance of making lifestyle changes in order to increase overall wellbeing; ongoing consideration of the pros and cons of medication; and ongoing consideration of the pros and cons of elevated mood states. Unlike the studies cited above, the current project enquired specifically about whether participants' intentions were followed through by action. Pursuing this line of enquiry in the present study highlighted important obstacles and challenges for those managing bipolar moods without medication.

4.1.2. Models of health behaviour and bipolar moods

Our findings are consistent with a number of underlying theoretical models that have been proposed to understand how people manage health problems (the Self Regulation model (SRM)) and specifically bipolar experiences (Integrated Cognitive Model The Self Regulation Model (SRM) of Leventhal et al. (1984), as applied to mental health by Lobban et al. (2003), suggests that people's ways of managing in response to a health difficulty are influenced by beliefs around personal identity, and about the nature, cause, and consequences of their difficulty. The model presented here suggests such beliefs were highly pertinent for this sample, with participants frequently considering whether behaviours would help them move towards realising ideas about who they wanted to be and how they might achieve their potential. Furthermore, the model fits with Horne and Weinmann (1999) Necessity Concerns Framework (NCF), which expands on the SRM by suggesting that decisions whether or not to use medication will be influenced by individual perceptions of its necessity and concerns about its impact. This study builds on this framework by suggesting that these beliefs may be equally pertinent to decisions about the use of a wide range of strategies, not just medication.

The ICM of Mansell et al. (2007) focusses on the meaning that individuals place on changes in mood, and how their subsequent attempts to control mood may inadvertently lead to increased feelings of depressed of elevated mood. Congruent with the ICM, the present study found that individual responses to mood fluctuations were influenced by beliefs about moods, the self, and relationships with others. The ICM suggests some individuals may benefit from relinquishing attempts to control their moods and focus instead on achieving goals that are not dependent on mood state. Some participants in the present study adopted a similar stance by deciding not to implement strategies to change their mood but instead focussing on specific goals that their mood helped them achieve. This suggests the ICM might be usefully applied to people who do not use medication for bipolar moods, particularly given its potential acceptability to people who see bipolar moods as holding positive aspects they would not want to eliminate by using medication.

4.2. Further clinical implications

Current guidance from NICE (2014) and the APA (Hirschfeld, 2005) emphasises the role of medication in managing bipolar moods, and it has been suggested that psychosocial interventions should focus on addressing beliefs about medication that may lead to decisions not to use it (Chapman and Horne, 2013). The findings of this study suggest that people who have chosen not to use medication may have already very carefully weighed up the costs and benefits, and a professional stance that emphasises the importance of adherence to medication may act as a barrier to such individuals engaging in services. Instead of focussing on medication adherence, services emphasising a broader range of approaches might engage people who have decided not to use medication. This may entail professionals taking a more collaborative stance that takes account of and supports individuals' decision-making processes, and accepting

that some individuals may make an informed, considered choice not to use medication.

4.3. Future research

Researchers could continue the lines of enquiry opened in this paper by investigating which factors might predict being able to manage well without medication. Researchers could also examine which demographic or mood-related features predict positive outcomes when managing bipolar moods without medication. This could help inform conversations between service users and professionals about whether to use medication, the possible consequences of not doing so, and what difficulties might occur.

4.4. Limitations

This paper does not present a model generalisable to all people who manage bipolar moods without medication. In line with a constructivist GT approach (Charmaz, 2006) the aim was instead to produce a model that represents how participants in this study constructed the processes involved in managing without medication, as a starting point in this under-researched area.

Some may question whether findings presented here are based on a group of individuals whose bipolar experiences are different from people who present at services requesting support. However, data on participants' mood experiences from the SCID show that all participants described a number of clinically significant past mood experiences. Furthermore, half of the sample reported that the impact of their mood experiences had at some point been severe enough to result in hospitalisation.

No standardised measures of current functioning were employed. However this may be inferred from information given by all participants, all but three of whom were in some form of education or employment. Of those who were not, two (Leanne and Nicole) expressed satisfaction that they were better able to participate in valued activities such as volunteering than when they took medication. This might therefore be considered a sample who were, on the whole, living satisfactorily without medication for their bipolar moods. As no participant's latest mood episode culminated in hospitalisation, all participants could be considered to be managing their moods without major crisis.

5. Conclusion

Existing research often suggests that non-adherence to medication among people diagnosed with BD is inherently problematic, and is the result of a lack of insight and/or inaccurate cognitions about medication. In contrast, the findings of this study suggest that the decision to stop using medication may be based on well-founded concerns about the effects (and side-effects) of medication, and may be the result of a deliberate evaluative process rather than a “lack of insight”. Furthermore, once this decision is made, participants engage in an ongoing decision-making process, evaluating the effects of strategies and deciding whether changes are necessary, given pre-conceived views of themselves, who they want to be, and beliefs about their moods.

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Conflict of interest

No conflict declared.

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