DOCTORAL PORTFOLIO IN
COUNSELLING PSYCHOLOGY

by

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for the
Practitioner Doctorate: Counselling Psychology
Award: D.Couns.Psych

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DECLARATION

The research dossier or any part thereof has not previously been presented in any form to the University or to any other body whether for the purposes of assessment, publication or for any other purpose (unless otherwise indicated). Save for any express acknowledgments, references and/or bibliographies cited in the work, I confirm that the intellectual content of the work is the result of my own efforts and of no other person.

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Finally, I would like to thank the staff at the self help group and all the partners who gave up their time to participate in the research and for having the desire and courage to speak about their experiences. I hope that this is the first step in breaking down the ‘brick walls’ they have faced.
DEDICATIONS

I would like to dedicate this portfolio to my family.

Firstly, my dad who was the inspiration for me training to become a psychologist and the main motivation for me choosing my research project. He has also read every single word in this portfolio several hundred times and possibly knows it better than I do!

Secondly, my sister for all the love, support and encouragement she has given me and ensuring that I kept a decent work/life balance!

Finally, my mum who has stood by my side through all the ups and downs and, as a result, however isolating and lonely this journey has been, I know I have not been alone. She has kept me grounded and focused. A truly amazing woman who does not realise her own strength.
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All work throughout this portfolio has been appropriately anonymised and all identifiable information removed, so no participant can be identified.
Preface: An Introduction to the Portfolio

This portfolio contains a selection of work completed for the Practitioner Doctorate in Counselling Psychology at the University of Wolverhampton. It contains three dossiers: Academic, Therapeutic Development and Research.

The Academic Dossier contains papers that were submitted for the following modules: ‘Life-span Approach’ and ‘Issues and Ethics’. The Therapeutic Development Dossier contains an essay exploring three years of placements (‘Supervised Practice’) and an essay reflecting on my professional development (‘Professional Issues’). Finally, the Research Dossier contains a literature review, a research report and critical appraisal.

Confidentiality of clients, research participants and their families have been protected throughout the portfolio. Individuals’ names and places have been changed and any potentially identifying information has been omitted or anonymised. Client studies, process reports and all raw data (including interview transcripts) are available in the Confidential Attachment which has been submitted separately and is not available to the public.

The work within this portfolio demonstrates my journey from a theory-led, orientation-specific therapist to a client-led, integrative therapist who is continually learning and growing. Within the preface I hope to apply Prochaska and DiClemente’s (1986) Stages of Change Theory to my own journey to help demonstrate this change (see Figure 1 below). This is a model I have increasingly
attempted to use to inform my therapeutic practice, along with Egan’s Skilled Helper Model (2002). The Stages of Change model provides a framework through which we can understand the different stages an individual goes through during the process of any change in attitudes, beliefs and behaviour. The notion of the stages demonstrates that for most a change in behaviour occurs gradually and over time. It must also be recognised that this is a dynamic process and that an individual can move between the stages at different rates and also return to earlier stages. When reflecting on my time completing the Doctorate, I feel that during the last three years I have changed in many areas of my life. My therapeutic stance, my way of interacting with clients and my understanding of working with different client groups have all gone through a process of change which I feel fits in with the Stages of Change model. The work throughout this portfolio will hopefully exhibit how changes have occurred and have helped me become the Counselling Psychologist I am today.

**Figure 1: Stages of Change (Prochaska and DiClemente, 1986).**
My career in psychology began as a Forensic Psychologist, conducting risk assessments and running a variety of groups. The main therapeutic stance throughout this role was Cognitive Behavioural Therapy (CBT). I attended various training days and workshops identifying how this theory could be best applied to an individual’s offending behaviour. I approached the Doctorate in Counselling Psychology as a specific, theory led CBT therapist. I was uncertain as to the benefit of exploring different theories as I believed that all problems could be applied to a CBT structure and that this approach would benefit all clients. On reflection I was perhaps coming to the course in the pre-contemplative stage, uncertain that any change was needed. I also feel I was approaching the course with a desire to become a Chartered Psychologist, rather than with a desire to grow and develop as a Psychologist. The Doctorate has taught a number of diverse therapeutic orientations and, whilst on placement, my supervisors, colleagues and fellow trainees have introduced me to further ways of working with clients. Coming to the course from a specific therapeutic stance I found this threatened and challenged my identity and I felt uneasy at the thought of ‘having’ to utilise different therapeutic approaches for individual pieces of coursework.

As I began to work with different theories, however, I believe I moved into the contemplative stage of change. I began to see that other ways of working may benefit clients. The focus on Rogers’ (1951) core conditions within our first year of training has had a particularly significant impact on my awareness of the way I work. Although I was already aware of the importance of the therapeutic relationship I was not conscious of how this developed and what skills were involved. I also did not realise how this relationship itself could be therapeutic and change could occur
without any “interventions” being used (such as homework, exposure etc). Within my practice I struggled with how to apply the core conditions in a natural way and to understand that these conditions were interventions in themselves. It was only after a discussion with my supervisor, in which he advised me to try and relax in therapy and just ‘be present’ to the client, that I realised how powerful these interventions were and that being empathic, genuine and warm was a part of who I was – if I just relaxed!

The importance of being present to individuals and the core conditions was also a feature of my research. Whilst reviewing the literature for this I came across numerous articles highlighting how carers of individuals with mental health problems wanted support from a professional whom they felt was warm, genuine and would try to understand the situation they were in. Unfortunately it would seem that not many carers for individuals with mental health problems have had the opportunity to access support from a professional. Being not only a Counselling Psychologist but also an integrative therapist gives me the skills to ‘be there’ for carers by employing the person centred core conditions and being warm, genuine and empathic in my interactions with all individuals involved in a client’s care. In the future I would like to continue looking at the support received by carers, in particular the support received from psychology.

Throughout my career to date I have always wanted to work with adults. Within initial assessments I have focused on past events and have often explored these when trying to understand present difficulties. However, I never gave much thought to how what happens within a certain life stage (for example adolescence) can impact upon how an individual develops throughout life. Completing the essay for the Lifespan
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Approach module (‘Who Am I? – Pregnancy in Adolescence and Identity Development’) opened my eyes to a different way of working with clients. When writing this essay I struggled to see how it applied to my practice as a Counselling Psychologist. However, I now recognise that I have worked with women in their 40s, 50s and 60s who have had children at a young age and that this may have impacted on how they formed their identity. In my practical work, I have now worked with clients looking at how their development through certain life stages may be contributing to the difficulties they are facing in the present. This is another example of how my therapeutic practice has changed over the last three years. I am also now more open to working with clients in a different way. Working with a lifespan perspective is still not a natural way of working for me. With regards to the Stages of Change, I feel I am still in the planning stage in that I am working at implementing this perspective into my repertoire of therapies.

The idea of making a mistake is another area where I feel change has occurred. When I started the Doctorate I did not like making mistakes and did not want to admit to them. I wanted to do things right and do them the right way. I was in the pre-contemplative stage in that I could not see a problem with this. I began to challenge this belief in my academic work when I decided to chose qualitative methodology for my research. I had never used or studied in depth this methodology and had never even heard of Interpretative Phenomenological Analysis (IPA). Prior to starting my analysis I read books, found previous articles that had used IPA and attended conferences to ensure I knew what I was doing. However, the more I read, heard and learnt the more aware I was becoming that there is no right or wrong way to do IPA and most experts encouraged you to find your ‘own way’ of conducting the analysis. This really challenged me as ‘my way’ would be different to another’s and then who
is to say what is right and wrong? IPA is also based on a double hermeneutic. This means that the analysis is based on my interpretation of the participants’ interpretation of their experience. My interpretation will be influenced by many things. My past experiences, my family values and my cultural background, for example, are unique to me. Engaging in the analysis process has therefore forced me to be more flexible in my approach. There is no ‘right way’ and I have to learn to be more comfortable and confident in ‘my way’.

In terms of my practical work, I have slowly become more comfortable with clients in acknowledging either when we have taken the wrong therapeutic path or when I do not know the answers. When I acknowledged this to clients, I was surprised by their responses, as clients often stated that they were relieved because if I made mistakes it was alright for them to make them. I now recognise that this is not a sign of weakness and owning up to your short comings can actually be a strength. Understanding my own beliefs and rules surrounding making a mistake has challenged my need to ‘get it right’ and not make mistakes. It has also encouraged me to be more flexible. When I started training I was rigid in the way I approached things, often not doing something unless it was done ‘by the book’. Now, coming to the end of my current training, I feel I am becoming more flexible in all areas of my life and this has allowed me to be less controlling and more genuine in my approaches. I am still actively working towards this element of my identity and do not feel I have reached the maintenance stage yet.

My journey to becoming an integrative therapist has not been smooth and I have moved through the Stages of Change many times. As I moved away from being an orientation-specific therapist I was uncertain as to what an integrative therapist was. I
was learning more and more theories and therapeutic approaches and applying them to my client work, when it seemed appropriate, in an almost haphazard fashion. I had no focus and as a result I was not only confused in my therapeutic work with clients but also in my identity as a therapist. On reflection it was as though I had lots of responsibility in providing safe and ethical interventions for my clients and becoming a competent practitioner, but I had no control. I was being taught numerous techniques and needed to apply these for different components of the course. These feelings of responsibility yet no control were also experienced by the participants within my research. It is also a struggle I think many of my clients face and it is almost a feeling of powerlessness.

I have dealt with this internal struggle through empowering myself. Yes, I need to learn different ways of working, but it is up to me how I integrate these into my practice. Part of this change from being an orientation-specific to integrative therapist has been about learning what works and what does not work for me. Therefore, instead of feeling powerless, I can view it as an opportunity to learn. This movement from powerlessness to empowerment is something that I now focus on with clients as well. When I have felt uncertain I now recognise that I have ‘lapsed’ into my old ways of working, which were rigid and CBT led. I have slowly worked my way back round the stages and ‘maintained’ my way of working. However, with each lapse I feel I have learnt something new about my way of working and the length of time in between the lapses is getting greater as I become more confident in being an integrative therapist. Understanding that we can learn from a lapse and that it can make us stronger has often been a turning point for clients.
In the Therapeutic Development Dossier (Professional Issues) I have focused on various ‘turning points’ within my own professional development. These turning points have had a significant impact and have either changed the way I viewed things or offered a moment of clarity perhaps when I was feeling overwhelmed or confused. Completing this assignment gave me an opportunity to reflect on my professional development and the journey I had made. Initially, when writing this, I assumed my main ‘turning points’ would reflect the largest and most difficult situations I have faced over the last three years, however, although these were inconvenient and difficult emotionally, they did not have an overwhelming impact on my professional development. Instead I found it was smaller and seemingly insignificant events that have made the biggest impact. For example, completing a drawing in personal therapy and discovering an article which highlighted the stages of a trainee’s development have contributed to my development as a therapist, the values and beliefs I hold and my way of working.

When looking back on my journey from an orientation-specific to integrative therapist, I see that I was just using various theories whenever they seemed appropriate with clients and there was, as mentioned earlier, no focus within these sessions. Although we set goals for therapy in the initial sessions, there was no plan as to how we would get there or how we would know when we had arrived. In terms of the Stages of Change I felt that I was in the contemplative stage. I knew that this was a problem as it did not feel like the best, or even most appropriate, way to be working, however I did not know what to do or how to address it. Eventually, in supervision, I raised my concerns and my supervisor discussed his understanding of integrative working. He suggested using a therapeutic model as a base in which all other theories can be placed into. The model he used was Egan’s Skilled Helper
Model which has three parts – exploration, understanding and action. By adopting this within my practice I felt that, not only did I have a focus and an understanding of how therapy could work, but I could also provide this to my clients. After successfully implementing this way of working I began to explore different models that I could use as a base. The Stages of Change model is another ‘base’ that I have started to use and I found this worked particularly well when I was working with individuals with eating disorders. I would explain the model, we would identify which stage the client was in and employ different theories and therapeutic techniques in order to help the client move through the stages to an appropriate point, addressing their behaviour. This model appears to be very positive for clients. It not only gives them direction, but it allows them to see visually that they can change.

Through the course of the Doctorate I have had the opportunity to work with a number of different clients experiencing a range of problems. The essays within the Therapeutic Development Dossier demonstrate the breadth of this work. During the last three years I have actively sought out placements and work that would give me the opportunity to broaden my experience. When I started the course I had only worked with individuals with an offending history and, although they may have experienced mental health problems, substance abuse or personality disorders, the main focus of any work was on the offending behaviour. Focusing on just the problem behaviour led me to be a ‘theory led’ therapist. I was taught theories as to why people offended and trained in various treatment manuals for individuals with offending behaviour (i.e. Life minus Violence and Sex Offender Treatment Programmes) and, as a result, I was not seeing individuals as unique. Everybody could be categorised and labelled and treated in a certain way, following a manual. Since commencing the Doctorate I have found myself moving away from this way of
working more and more. After receiving a referral for an individual experiencing depression in my first placement, I instantly searched for a manual that I could work through with the client. However, within the initial session I discovered that, although this individual was experiencing the symptoms of depression, it was the reasons for this that needed to be explored and a manual could not help us do this. This was my first step towards becoming a client led therapist and realising that although people may come with the same problems, the reasons for these problems may be very different. Engaging in personal therapy has also helped with this development. Every problem I brought, no matter how generic, my therapist would explore this with me and look at how it relates to my own personal beliefs, values and experiences. By doing this I felt understood, listened to and that my problems were being taken seriously.

This transition from a theory-led to a client-led therapist was part of the motivation behind writing an essay on the issue of confidentiality with suicidal clients for the Issues and Ethics module. Having worked as a Forensic Psychologist in Training in both prison settings and secure units I have worked with many individuals expressing suicidal ideation and engaging in suicide attempts. When these incidents occurred, individuals would either be put on suicide watch or put on ‘within line of sight’ observations, more support offered and perhaps their medication reviewed and increased. As a Counselling Psychologist in Training all my placements have been community based and therefore when I did encounter a suicidal client my way of working with this client was different to my previous experience. In this situation I wanted to do what was best for the client, however I was aware of organisational regulations and guidelines from the British Psychological Society and Health Professions Council that I also had to take into consideration. Within this situation I
felt a conflict between my growing identity as a client-led therapist and my responsibility as a psychologist. This led to my desire to understand more about the ethical implications of working with a suicidal individual in the community and in particular with relation to confidentiality. The essay for the Issues and Ethics module allowed me to explore how working with suicidal clients can impact on psychology trainees and also what guidelines are specifically put in place by the British Psychological Society and Health Professions Council and the impact these can have on clients. I am still learning and understanding how to find a balance between professional and organisational guidelines and the needs of the clients and I envisage that I will continue to learn as I go on with my journey as a Counselling Psychologist.

As my time on the Doctorate draws to an end I can see that I am once again entering the contemplative stage of the model. I feel that I have developed my identity as a Counselling Psychologist in Training and have moved from a theory led, orientation-specific therapist to an integrative client led therapist. However, as I embark on my career as a qualified Counselling Psychologist, I feel that I am once again thinking about my identity. It is perhaps naive to think that my identity will remain the same. My journey has taken me from a theory-led practitioner to a client-led practitioner, however recent Government initiatives, including the Improving Access to Psychological Therapies programme which specifically focuses on CBT, may make it difficult to find a balance between theory-led and client-led. When I first started the Doctorate I wanted to be qualified and felt that once that had happened I could relax, hang up my ‘training’ gloves and get on with my job. I now realise that actually I am only at the beginning of my training and the Doctorate has just been a platform to help me get to the first step! Within the Doctorate I have had to learn about certain theories in order to pass the course and meet the British Psychological Society and
Health Professions Council requirements. I now have more freedom to look at different areas (such as neuro-linguistic programming, solution focused therapy, interpersonal therapy) and expand on those that I have already learnt and found work for me. I am not yet at the stage where I am planning how to do these things or how they will fit into my identity, but I am contemplating that change will happen.
References:


Academic Dossier
Who am I? Pregnancy in Adolescence and Identity Development.

Adolescence is recognised as a period of development where young people move away from the dependence of childhood to the independence of adulthood. One of the main tasks of this life stage is the development of an identity. Similarly, the transition to motherhood is a developmental task also thought to be accompanied by a change in identity. Every year there are approximately 15 million births globally to girls between the ages of 15 and 19, with the United Kingdom currently having the highest adolescent birth rate in Western Europe (Whan, Nissen and Ahlberg, 2005). What happens when the task of becoming an adolescent and becoming a mother are mixed? Most of the research on adolescent mothers has focused on the negative impact they have on their children and on society. However, it is important to identify how young women cope with establishing their own identity and having to develop a maternal identity concurrently. This essay will explore how identity is developed in adolescence and during pregnancy and how young women unify the two. It will then look at how psychologists can best work with women experiencing pregnancy during adolescence.

Counselling psychologists work with people from all walks of life – different social classes, religions, cultures and, of course, different ages. Each individual who enters therapy brings with them their own unique and personal experiences. However, the age that they are indicates that there will be certain experiences and events that are common to most people of that age. By adopting a life span perspective, counselling psychologists can have some initial expectations of what the client may bring to therapy or their current experiences. These can then be either confirmed, refined or
rejected as therapy progresses (Sugarman, 2004). Different stages in life—childhood, adolescence, early adulthood, retirement—are characterised by concerns and tasks thought to be unique to that stage in life and, as a result, these will impact on the issues that clients bring to therapy. Erikson’s (1963) theory of psychosocial development is still one of the most well used lifespan models in the psychology field. The model identifies eight developmental stages which occur during the lifespan, beginning with infancy and ending with old age (Kroger, 2007). Each stage is characterised by specific psychosocial tasks which require resolution before an individual can move successfully onto the next stage. Forming an identity is thought to be a task which occurs in adolescence. Becoming a parent is thought to be a development task which occurs in adulthood, once an individual has formed an identity and developed intimate relationships. However, it is important to explore what happens to identity formation if these two developmental tasks occur at the same point in the lifespan.

Adolescence has been described as the phase of life between childhood and adulthood (Kipke, 1999), however it is only recently that this distinct period of time has been viewed as a discrete life stage. It was only with industrialisation that adolescence emerged as a separate part of the life span (SmithBattle, 2000). The adolescent years are thought to be characterised by a time of dramatic change biologically, cognitively, psychologically and socially (Trad, 1993). The speed of growth and change in adolescence is second only to that of infancy (Kipke, 1999). As a result of these changes it is thought that identity formation is an inevitable task of adolescence.

Identity has been described as a sense of self or a unique consistent character over a period of time (SmithBattle, 2005). Identity development is the fifth psychosocial
stage of human development as depicted by Erikson’s model of human development. This stage, entitled ‘identity versus role confusion’, states that if adolescents are not given the opportunity to explore new roles and cannot foresee a positive future, then they may remain confused about their identity.

The fifth psychosocial stage is characterised by several developmental tasks which adolescents must negotiate to achieve a positive identity. They must choose an occupation which is both socially acceptable and personally rewarding. A personal commitment to an ideological world view is made, be that religious or political ideology. During adolescence individuals also explore their sexual orientation, a task which can cause a great deal of confusion especially if their personal preference is in conflict with prevailing social and cultural views. Those who have successfully resolved the above mentioned developmental tasks are thought to have a high level of comfort with self, a sense of direction in life and confidence that significant others will support and value them (Graf, Mullis and Mullis, 2008). It is suggested that a coherent sense of identity is needed to be successful in one’s social, personal and occupational life. Hulbert and McDonald (1997) suggest that an individual has attained a positive role identity when they understand their present self in terms of their past achievement and can unite this with their future goals. If an adolescent struggles to form a positive identity then they may become confused when making decisions, may make rash decisions or refuse to face necessary choices (Sugarman, 2000). Consequently not achieving an identity or a positive identity is thought to halt or delay an adolescent’s development and limit their opportunity to continue through Erikson’s psychosocial stages.
Identity throughout adulthood is not thought to remain static once a positive identity has been achieved. Instead it is thought to be flexible in order to allow identity to be modified as individuals undergo different life experiences (Kroger, 2007). Erikson (1963) suggested that once a positive identity has been achieved by late adolescence, young adults will embark on the next psychosocial stages of intimacy followed by generativity. Although there are many ways of achieving generativity, it is mostly expressed through the experience of parenthood. The transition to parenthood is thought to overwhelmingly affect an individual’s self concept and identity. The transition requires parents to balance numerous roles, such as career, marriage and parenting, which can be difficult to manage concurrently (Kroger, 2007). For women the transition to motherhood is a major developmental task, with pregnancy producing physical changes to a woman’s body, changes in her relationships and interactions with others and also changes in her identity (Brubaker and Wright, 2006). Becoming a mother is thought to involve moving from a known, current reality to an unknown, new reality (Mercer and Ferketich, 1994). It is a period during which women experience psychological, physiological and social change, with many mothers feeling ill-prepared to deal with these changes (McVeigh and Smith, 2000). Research has tended to focus on the effect mothers have on their children, with mothers often being criticised for any difficulties their children may face (Vejar, Madison-Colmore and Ter Matt, 2006). However, more attention is now being given to the mother’s development throughout the pregnancy and, in particular, the changes to her identity.

Establishing a maternal identity is thought to be a complex, progressive process which begins during pregnancy (Mercer and Ferketich, 1994). Through pregnancy it is thought that women construct an ideal image of themselves as a mother and they
then incorporate this into their identity. McMahon (1995) argues that pregnant women go through a process of re-socialisation, and as a result they view themselves as new people. This transformation of the self primarily involves, ‘achieving a feminine identity as a loving, caring, responsible person’ (McMahon, 1995, p 130). When constructing a female identity, motherhood is no longer seen as the only resource to accomplish this, however, the role of nurturing others still remains dominant within the discourses of femininity (Choi, Henshaw, Baker and Tree 2005). The dominant societal view of women is that it is their primary responsibility to mother. However, whilst developing this maternal identity, women may also experience great loss as they realise that parts of their life are incompatible with motherhood and these are relinquished. They have to adjust to changes in feelings about their status as a woman and the loss of their former self as well as changes in their social relationships (Mauthner, 1999).

In recent years Feminist theorists have begun to look at where these views of the ‘ideal image of motherhood’ have come from in order to help women undergoing this change in identity. Researchers suggest that women’s expectations of motherhood are influenced by the dominant ideology which shows women as natural mothers, immediately able to take care of their babies and be selfless carers and nurturers (Woollett and Marshall, 2000). A study of pregnancy manuals supported this ideology by encouraging mothers to lay aside certain aspects of their own identity to promote the interests of their child (Choi et al, 2005). Due to this ideology it appears that being a mother and being a woman become intrinsically mixed and, therefore, to be a ‘good’ mother would also mean being a ‘good’ woman (Choi et al, 2005). The ideology is also used as a standard for women to measure themselves against to determine if they are ‘good’ or ‘bad’. As a result, women may be unwilling to seek
help or express any negative emotions either during pregnancy or after birth for the fear of being seen as a ‘bad mother’ (Choi et al, 2005). When faced with the reality of motherhood, many women have to accept that they cannot meet this ideal and this leads to dissatisfaction and a conflict in identity (Weaver and Ussher, 1997). When working with women who are in the process of establishing a maternal identity, psychologists may be working with these women to help them come to terms with this change in status and the parts of themselves that they feel no longer fit with this new identity. Alternatively, they may be working with women to help them find ways of responding to multiple roles, deal with changes in relationships and prioritise roles and activities (Sugarman, 2004).

As can be seen, forming an identity during the transition to motherhood can be unpredictable, stressful and challenging (McVeigh and Smith, 2000). However, when pregnancy occurs in adolescence it is thought that the challenges and stresses faced are exaggerated. Parenting can be problematic as the young person has not yet had the opportunity to complete the developmental tasks of adolescence (Erikson, 1963). Young women and men who become parents in adolescence have not had time to resolve the psychosocial stages of identity and intimacy and, therefore, they are at risk of their social and emotional development being delayed (Hurlbut and McDonald, 1997). Without the resolution of these stages it is thought an individual will not be able to cope with the tasks of parenthood. As a result, combining parenting and adolescence, which are both times of developmental crisis, may have negative consequences for not only the young person, but their child as well (Hanna, 2001).
There are many factors which influence how an adolescent mother develops her identity such as the dominant views of society and social support received. An important area of consideration for psychologists when working with adolescent mothers is levels of self esteem. Erikson (1963) suggests that a hallmark of an achieved identity is positive self esteem. In terms of mothering, positive self esteem is thought to enrich a woman’s capacity to mother and interact with her child (Mercer and Ferketich, 1994). Women who experience low self esteem are thought to have difficulty seeking social support and are more likely to experience symptoms of postpartum depression (McVeigh and Smith, 2000). Therefore, following Erikson’s theory, it is assumed that positive self esteem is a predictor of positive parenting and proficient parenting requires the mother to have a sense of her psychosocial identity (Hurlbut and McDonald, 1997).

For adolescent mothers the exposure to stigma and negative attitudes is thought to play a central role in developing their identity. The predominant view of adolescent mothers is that they are not good mothers and unable to take responsibility for their children. Adolescent mothers are thought to leave their children with family members or babysitters, are unable to look after their children both financially and emotionally and are not mature enough to care for a baby (Mylod, Whitman & Borkowski, 1997). However, rather than forming their identities by accepting this stereotype it appears young mothers try to create an identity in opposition to this negative view (Fessler, 2006). When developing their identity young mothers are not using Cooley and Mead’s concept of the looking glass self, in that we see ourselves as others see us (Fessler, 2006). In fact, young mothers are developing their identity to directly counter the way others see them. Young mothers, in trying to battle the negative stereotype, adopt characteristics they feel are attributes of a good mother.
These characteristics include mothers watching the children themselves, not going out too much and socialising and always putting their children first. The good mother identity appears to be something most adolescent mothers strive for, yet this can cause problems for them. Adolescent mothers may strive to fulfil an identity of maternal perfection which could lead them to set impossible targets for themselves. Difficulties may be encountered by young mothers as they realise that their goals for mothering, societies views of a good mother and what is realistically possible are incompatible (Fessler, 2006). Psychologists working with young women who hold such views could assist them in normalising the experience of becoming a mother. They may also help them develop a positive identity, despite the stigmatised societal view, by employing strategies from narrative theory. Psychologists could assist adolescents to develop a counter story which would help resist the dominant view of their experiences and identities. This may also assist in repairing any damage which has already occurred to their identity (Brubaker and Wright, 2006).

A strong social support network is thought to be essential for women of any age and can have a positive influence on their maternal identity development (Pond and Kemp, 1992). Adolescent mothers describe the support they received during their pregnancy as something they relied on to help them form a positive identity. Although initially their own mother’s reactions to the adolescent’s pregnancy may be negative, adolescents described these interactions as helping them to develop a positive identity characterised by maturity, responsibility and striving to become a good mother (Brubaker and Wright, 2006). Other influences on adolescent mother identity development include a loss of physical attractiveness. Adolescents placed great emphasis on the physical changes which occurred during pregnancy, how this affected their relationships and their identity development (Brubaker and Wright,
2006). The adolescents experienced changes to their bodies as disruptions to their identities and would avoid activities and interactions which would expose their new physique. Another sense of loss focused on innocence and respect. Brubaker and Wright (2006) reported that the adolescents’ narratives revealed that their sense of self had been damaged as others lost respect for them. The dominant societal view, which contends that girls should maintain sexual innocence, may constrain adolescent mothers’ ability to form a positive identity.

Psychologists working with adolescents work with a variety of issues including family separation, bullying and behavioural problems. As highlighted at the start of this essay, psychologists often work from a lifespan perspective which allows them to orient themselves with their clients lives and recognise the different issues and problems of specific stages in life (Sugarman, 2004). Although the main task of adolescence is identity development, when working with adolescent mothers psychologists may have to incorporate the additional identity transition of becoming a mother. One central belief that appears to inform clinical interventions with adolescent mothers is that deferring parenthood would improve the life chances of the adolescent. As a result, many interventions aim to arm adolescents with knowledge about life options, job training and sex education (SmithBattle, 2005). However, as most research suggests that an adolescent’s parenting is at risk unless she has achieved a positive role identity, clinical interventions could focus on facilitating young mothers’ opportunities to achieve this. These interventions could provide the skills and environment in which adolescents could achieve a role identity. This would allow adolescents to become more prepared for parenting by not only giving them the opportunity to develop a role identity, but also improving self esteem (Hurlbut and McDonald, 1997).
Often adolescents will view psychologists as an extension of their parents or as another authority figure they have to deal with (Sugarman, 2004). Adolescents may feel that there is not enough privacy for self disclosure or question the boundaries of confidentiality. Adolescents who are also mothers share the same concerns as their non-parenting counterparts, but also feel prejudged because they are young mothers (Hanna, 2001). Adolescent mothers have reported feeling patronised by health professionals and have chosen not to use these services rather than face such attitudes (Hanna, 2001). There are a number of ways in which psychologists could make the services they offer more appealing to adolescent mothers. Valuing the adolescent mother’s right to autonomy by paying attention to communication and relationship skills as well as parenting skills may increase the adolescent’s sense of worth. In turn, using this woman focused rather than child focused approach allows psychologists to focus on the development of confidence and assertiveness skills. In addition, as mentioned above, these services should serve to enhance the developmental tasks associated with adolescence, including a sense of belonging, feelings of self worth and the acquisition of skills (Hanna, 2001).

Finally, psychologists need to use caution when using the life span perspective and, in particular, Erikson’s model of psychosocial development to inform their practice when working with adolescent mothers. According to Erikson (1963) adolescence is supposed to provide a moratorium from adult responsibilities in which adolescents have the freedom to differ from their family, develop a career and change from concrete to formal ways of thinking. It is unlikely that adolescent mothers have had the opportunity to adequately resolve the stages needed prior to becoming a parent. Erikson’s model of development, however, is based on middle class ideals. It
assumes that adolescents have the opportunity and resources to experiment. For some, scarce educational, economic and employment opportunities means that they have little choice in life (Dalla and Gamble, 2000). Erikson’s model also assumes only one role can be developed at a time, yet more dynamic interpretations suggest that multiple roles may be developed simultaneously and that identity exploration does not cease once the parental role has been adopted. Identity development is recognised as a lifelong process, with each newly acquired role being successfully integrated into an individual’s self concept (Burke and Tully, 1977). The way in which maternal identity is developed in adolescents is likely to be effected by contextual factors. However, so far our understanding of contextual factors is limited as most research on adolescent mother development has focused on western samples. As a result, cultural variations in beliefs about the most appropriate age for childbearing have been neglected (Dalla and Gamble, 2000). Individual differences may also play a part in the extent to which adolescent mothers are at risk from adverse, developmental outcomes. There is a need for research to go beyond merely stating the positive and negative consequence of adolescent parenting towards an understanding of the individual differences that may assist adjustment to a potentially stressful event (Mylod et al, 1997).

In summary, most of the research on adolescent mothers currently focuses on the views of the western industrialised world. This world views adolescence as a distinct life stage which is associated with exploration of roles. This research not only fails to account for cultural differences, but individual differences as well. More research is needed so clinicians can be aware, when working with adolescent mothers, of the cultural differences. What clinicians deem a non-normative event may not be seen that way by the client. It is also important to understand the influence that pregnancy
during adolescence has on the lives of adolescent mothers and why some mothers make the transition more successfully. Although Erikson’s model of development may serve to explain why some adolescent mothers struggle with anxiety, depression and parenting skills, the model has its limitations and, as such, it should be used as a guide rather than assuming it applies to all adolescents.
References:


Working with Suicidal Clients: The Issue of Confidentiality

“Both psychotherapists and clients consider confidentiality an essential component to a successful therapeutic relationship. With this cornerstone securely in place, a client can feel free to address painful matters without fear of reprisal.”

(Spiegel, 1990, p. 636).

It is estimated that suicide accounts for approximately one million deaths globally each year and it is the tenth leading cause of death worldwide (Hawton and van Heeringen, 2009). Although statistics show that the annual number of suicides is decreasing, amongst certain groups, in particular young males, it is still rising. In England it is predicted that, on average, somebody takes their own life every two hours (Reeves 2004). As the field of Counselling Psychology grows and professionals begin to work in a greater variety of settings, their likelihood of encountering clients with suicidal ideation will increase. Kleespies, Penk and Forsyth (1993) reported that approximately ninety seven percent of psychology trainees, including those training in counselling psychology, had worked with a suicidal individual. Twenty nine percent of these trainees reported working with a client who had attempted suicide and eleven percent had worked with a client who had committed suicide. Working with suicidal clients is thought to be one of the most stressful clinical endeavours, with a large proportion of psychologists who experienced a client’s suicide having posttraumatic symptoms (Trimble, Jackson and Harvey, 2000). It appears that following a client’s suicide or attempted suicide psychologists experience a range of emotions including shock, sadness, anger, guilt and depression (Reeves and Mintz, 2001). When working with suicidal clients the
decision to break confidentiality is one of the main dilemmas faced by therapists (Litman, 1994). Confidentiality is regarded as one of the, if not the, most important aspects of a successful therapeutic relationship. This opinion is highlighted in the above Spiegel quote. This essay will first explore the issue of confidentiality, how psychologists work with this concept and the difficulties they face. It will then look further at how psychologists view confidentiality when working with both clients who are threatening suicide and those who have successfully taken their own lives and the processes involved when deciding whether or not to breach confidentiality.

In particular this essay will focus on the impact working with a suicidal client and the decision to break confidentiality has on trainee psychologists. From my own experience and having spoken to other trainee psychologists, this appears to be one of the biggest ethical dilemmas a trainee can face and one that invokes much fear.

Such strong feelings can be invoked when working with suicidal clients that many therapists may wish to avoid working with such clients (Coverdale and Roberts, 2007). A study in the 1990s which surveyed psychology training clinics discovered that a high percentage of the clinics had exclusion criteria and many did not provide services for suicidal clients (Bernstein, Feldberg and Brown, 1991). The anxiety experienced when working with a suicidal client can be invoked at any point in a psychologist’s career, yet for trainees the levels of stress experienced following a client’s suicide are thought to be as great if not greater than qualified professionals (Kleespies et al, 1993). Despite the significant impact suicide has on trainees there is relatively little training on suicide within professional training courses. Psychologists often questioned the adequacy of their training as preparation to deal with such situations (Trimble et al, 2000) and, in one survey, only fifty five percent of trainees reported having some training in suicide and the instruction was minimal (Kleespies
et al, 1993). Amongst trainee psychiatrists seventy-seven percent felt the impact of a clients’ suicide was ‘severe’ and sixty-two percent felt it had a major impact upon their development. However, rarely had any of these trainees had any training on how to handle suicide (Kaye and Soreff, 1991). Suicide is clearly an important issue and one which relevant training is needed for Counselling Psychologists as they find themselves working in more environments where clients may experience suicidal ideation. How psychologists combine working with suicidal clients with issues of confidentiality needs to be reviewed to assist not only those qualified, but also trainee psychologists who may be less experienced, less secure in their roles and more shocked by suicidal gestures and acts. Trainee psychologists may be more confused about their personal beliefs around suicide; they may not fully understand the ethical issues or professional policies surrounding suicidal clients and confidentiality and may not be familiar with the policies surrounding suicide of the organisation that they are working within (Kleespies et al, 1993).

Confidentiality is thought to be one of the most important elements in effective psychotherapy. It enables a relationship of trust to develop between the therapist and client (Jenkins, 1999) and, without confidentiality, clients cannot be expected to disclose embarrassing and sometimes potentially damaging information in the therapy setting (Younggren and Harris, 2008). Yet, despite its importance, confidentiality is a difficult concept to define. Confidentiality is closely tied to terms like privacy, secrecy, confidence and anonymity and these are often not clearly defined by the people using them (Venier, 1998). A common understanding of confidentiality is that whatever is said or implied will not be shared with others, unless the client has given authorisation (Rubanowitz, 1987). Protecting a client’s confidentiality is a primary obligation for psychologists, with many citing this as their most important
professional duty (Fisher, 2008). The importance of confidentiality to effective therapy was emphasised in America by the Supreme Court, which declared:

Effective psychotherapy, by contrast, depends upon an atmosphere of confidence and trust in which the patients are willing to make frank and complete disclosure of facts, emotions, memories and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counselling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment. (Jaffee v. Redmond, Younggren and Harris, 2008, p. 590).

In Britain today, psychologists are registered with the Health Professions Council (HPC) which produces ethical codes which psychologists must adhere to and provides guidance on confidentiality. The British Psychological Society (BPS) also provides codes and guidance, but psychologists can choose whether or not to be members. The HPC, which is for various health professionals, sets out fourteen duties to which professionals must adhere (HPC, 2009). These include various duties such as acting in the best interest of the client, keeping professional knowledge and skills up to date and keeping accurate records. One point in particular specifically applies to confidentiality. The HPC states that all professionals should respect the confidentiality of their clients and all information must be confidential and only used for the purpose it was provided for. The BPS sets out more in depth guidelines surrounding confidentiality which specifically applies to the various settings in which psychologists work (BPS, 2009). The BPS states that confidentiality needs to be discussed within the first session with clients and clients need to be made aware of
the limitations of confidentiality. When describing these limitations, psychologists need to draw the client’s attention to potentially conflicting legal obligations and the likelihood that information may be shared with colleagues in supervision. If psychologists feel there is a need to breach confidentiality the BPS states this should only happen under exceptional circumstances where psychologists have enough evidence to justify serious concern. For example, concern about a client’s safety, persons that might be endangered by the behaviour of the client or the welfare of a child or vulnerable adults. The BPS recommends that psychologists consult with colleagues before such disclosure takes place, if there is time to do this.

Research has been conducted assessing psychologists’ views on confidentiality and how they adhere to the guidelines. Confidentiality is held very highly by psychologists. Koocher and Keith-Spiegel (1998) noted that confidentiality has long been viewed as, “a cornerstone of the helping relationship” (p.115) and the American Psychological Association (APA) has stated, “confidentiality is a core value of our profession. It is, as they say, bred in our bones” (Behnke, 2005, p.76). Previously it was assumed that effective therapy could only take place if absolute confidentiality was assured. Without this it was thought that clients would avoid self disclosure (Nowell and Spruill, 1993). Today, some psychologists still hold the view that everything revealed within the therapeutic encounter should be absolutely confidential. This viewpoint leaves psychologists facing an ethical dilemma and there appears to be much confusion and anxiety surrounding confidentiality (Fisher, 2008). Confidentiality within the therapeutic relationship can never be absolute as certain limitations are placed on it by the law, professional bodies and organisational policies. As such, the psychologist’s own personal values may clash with legal and professional limitations.
Relatively little is known about how psychologists’ views on confidentiality effect their clinical work. The research that has been conducted on this issue has focused on a number of different professions and looked at a number of different ethical issues. One study revealed that eighty-seven percent of mental health professionals indicated that they would not report child abuse even though they were aware that it was mandatory to do so (Thelen, Rodriquez and Sprengelmeyer, 1994). Another showed that twenty nine percent of psychotherapists in North Dakota would not disclose information when a third party was in danger (Jagim, Wittman and Noll, 1978). Baird and Rupert (1987) found that only one psychologist in seven US states would never breach confidentiality with a dangerous client. This research shows the differing thinking among professionals concerning confidentiality. However, whether they would breach it or not, psychologists view confidentiality as one of the key elements of effective therapy. Research investigating clients’ views of confidentiality indicates that the public expect psychologists to maintain confidentiality as a general rule, however they also expect psychologists to break confidentiality if it’s in the best interest of the public (Rubanowitz, 1987). The general public expect psychologists to disclose information to the relevant parties when a client reports a murder (planned or confessed), suicide plans, child abuse, treason or major theft (Knowles and McMahon, 1995). However, this disclosure would only be appropriate if it was to the parents of young children and other mental health professionals. Disclosure should not occur to insurance companies, doctors, spouses, parents of teenagers or the courts (Knowles and McMahon, 1995). Overall, it appears that the general public would support conditional, discretionary confidentiality.
Those who support absolute confidentiality have sought to warn others about the risks of placing limitations on confidentiality. However, as professional bodies stress the need for conditional confidentiality, it is important that clients are made aware in advance of the conditions in which confidentiality may be breached. Many psychologists prefer to begin the therapeutic relationship by listening to the needs of the client. However it is only ethical to begin therapy without discussing conditions to confidentiality if confidentiality has no conditions (Fisher, 2008). When confidentiality is conditional, failure to notify clients means their right to enter into the relationship, make autonomous decisions and accept the conditions, is taken away. Some therapists have reported they fear explaining the limitations of confidentiality may disrupt the therapeutic relationship, discourage some people from seeking therapy or instil distrust in the therapist (Nowell and Spruill, 1993). As a result it appears that many psychologists are reluctant to initiate a conversation about confidentiality. Baird and Rupert (1987) found that only sixty one percent of psychologists discussed confidentiality and nineteen percent reported informing clients that everything would be kept confidential. In another study, eighty percent of psychologists reported considering it very important to inform clients of the limits to confidentiality, however, only sixty percent did so (Somberg, Stone and Claiborn, 1993).

However, does informing the client about the limits of confidentiality affect the therapeutic relationship or a client’s disclosure? Applebaum, Kapen, Walters, Lidz and Roth (1984) found that psychiatric patients believed disclosure of information about them without their consent would negatively affect the therapeutic relationship. Similarly, Woods and McNamara (1980) discovered that participants who were offered absolute confidentiality were more likely to disclose information than those
who were informed about limitations to confidentiality. However, Muehleman, Pickens and Robinson (1985) found that participants did not differ in their willingness to self disclose even if they had been given detailed information about the limits of confidentiality. Also, Nowell and Spruill (1995) discovered that a complete explanation of the limits of confidentiality may not prevent clients from disclosing information. The initial meeting between a client and therapist appears to be the ideal time, and maybe the only time, to inform clients of conditions to confidentiality and it is recommended by the BPS that this discussion take place in the first session. After this meeting it may be too late (Fisher, 2008).

As can be seen, despite the guidelines set out by the BPS and HPC, there are many different opinions amongst psychologists with regards to confidentiality, especially when it comes to informing clients about the limitations of confidentiality and when confidentiality should be breached. Because Counselling Psychologists are now more likely to work with a suicidal client, it is important to review how psychologists feel about breaching confidentiality with a suicidal client, what influences their decisions and what is their understanding about confidentiality once a client has successfully taken their own life. When a client threatens to take their own life it appears that psychologists are faced with a number of dilemmas. Firstly, should they break confidentiality or not, and secondly, have they, as the BPS guidelines state, enough evidence that this individual wishes to cause serious harm to themselves, to justify breaking confidentiality? Only occasionally do clients make explicit references to suicide. Often such thoughts are expressed in more abstract terms and it can be difficult to know how to respond to a client who has not explicitly stated that they wish to kill themselves (Reeves, 2004). Suicidal clients need to have the opportunity to explore their feelings and identify ways in which they can manage their distress.
(Reeves, 2004). When assessing suicide risk, therapists need to consider how likely it is that clients will end their own life. Simply expressing suicidal thought is generally insufficient to justify breaking confidentiality (Reeves, 2004). Therapists need to engage in vigilant risk assessment. Careful discussions about the client’s suicidal thoughts and how they might react to them will put the therapist in a better position to make a decision (Reeves, 2004). Disclosure of information to another person, say the individual’s general practitioner, in the absence of a strong belief that the client is at immediate risk of taking their own life, could lead to potential situation where the therapist can be sued by the client for breaching confidentiality (Bond, 2000). On the other hand, failure to disclose such information when there is a strong belief, could lead to the therapist being accused of failure to care for their client.

Deciding whether or not to disclose information regarding clients’ suicidal thoughts provokes much anxiety in psychologists. Research has shown that how a therapist responds to a suicidal client and their decision to break confidentiality is influenced by a number of factors. These include their own personal values, the threat of litigation and the organisational structure (Reeves and Mintz, 2001). Psychologists’ are is guided by the policies and principles of the professional bodies they are members of. In terms of guidance for psychologists working with suicidal clients and when to breach confidentiality, the codes supplied by the BPS and HPC do not refer specifically to this situation. Instead they provide general guidance on how to work with clients experiencing many different problems. However, when working with suicidal clients, psychologists do need to have these guidelines in mind. The HPC state that as professionals, psychologists are, ‘responsible for your professional conduct, any care or advice you provide and any failure to act’ (HPC, 2009). As mentioned previously the BPS state that confidentiality can be broken if the
psychologist feels they have sufficient evidence that a client is going to hurt themselves, yet consultation with another professional before confidentiality is breached is advised (BPS, 2009). The BPS states that the codes should be used when making decisions about the needs of the client; however it recognises that psychologists need to make decisions based on their own professional and ethical judgement. It appears from the codes as though the decision to breach confidentiality with a suicidal client comes down to the professional judgement of the psychologist working with them and the codes should be used as guidance.

The majority of studies investigating how psychologists respond to ethical dilemmas have focused on legal issues and the professional guidelines within which the psychologist operates. As a result, it is difficult to determine the extent to which psychologists rely on personal values. Research conducted by Thelen et al (1994) revealed that a psychologist’s own personal philosophy played a major role in their decisions. When faced with a suicidal client, psychologists have a choice between maintaining a policy of respect for the client’s autonomy and their right to make a choice and acting to preserve the client’s life (beneficence, Bond, 2000). Some would argue that psychologists have a duty of care to their clients and should always act in their best interest. However, when looking at suicide, this view is often in conflict with respecting the client’s autonomy. If the psychologist believes that preserving life is in the best interest of the client, this does not respect the client’s autonomy and their right to chose what is best for them. Another area which may be confusing for psychologists is when a client is terminally ill. For the client suicide may seem appropriate for them to end their suffering before the illness becomes worse (Bond, 2000). Psychologists who support this may feel they are respecting the client’s autonomy and it would be in the best interest of the client, however this may
clash with the view of professional bodies and organisations within which psychologists work. With regards to breaching confidentiality, if therapists held a strict opinion that they did not approve of suicide there appeared to be more clarity about the point at which confidentiality should be broken. Therapists struggled with this decision if their own personal philosophy believed people should have the choice with regards to suicide (Reeves and Mintz, 2001). The theoretical stance from which a psychologist is working may also influence their decision making process. For example, a therapist working from a person centred perspective may view the act of suicide as an act which the client has a right to choose and it is not up to the therapist to change this (Jenkins, 1997).

It appears that the organisation within which an individual works can be a powerful influence on how the therapist responds to suicidal threats. Reeves and Mintz (2001) found therapists reported that the organisations they worked for shaped their decisions about if, when, and how to break confidentiality when working with a client threatening suicide. It appears that organisations often produce policies and procedures for the therapist to follow should a client threaten suicide. Despite these policies and procedures often being in conflict with the therapists own personal values, therapists were highly aware of the effect a client suicide would have on the organisation and on their own reputation within the organisation (Reeves and Mintz, 2001). Therefore it appears as though the policies put in place to deal with suicidal clients by organisations significantly affect the decisions therapists make when breaking confidentiality.

Historically suicide was against the law and anyone who failed in their suicide attempt could be imprisoned. In the 18th Century someone who completed suicide
would then have their property confiscated by the state (Jobes and Berman, 1993).

The Suicide Act 1961 stopped attempted suicide and suicide from being criminal
offences and suicide is now viewed as a product of a mental disorder which requires
prevention and intervention. This responsibility frequently falls to the mental health
professionals involved in the individual’s care (Jobes and Berman, 1993). To try to
reduce the number of suicides the Government have introduced a number of policies.
The way in which suicide can be reduced is frequently being detailed in Government
documents with the National Suicide Prevention Strategy for England developing this
further (Reeves, 2004). The impact of these policies means that suicide prevention
and reduction becomes a priority for all therapists.

In the 1980s it was predicted that 1 in 6 completed suicides were patients engaging in
therapy and about fifty percent of all people who committed suicide had, at one point,
experienced psychotherapy (Berman, 1986). Malpractice related to suicide is thought
to be the sixth most frequent claim brought against psychologists, however it is the
second most costly. Not only can litigation of malpractice liability be financially
damaging, it can also be professionally and personally devastating (Jobes and
Berman, 1993). The fear of litigation is a central factor when deciding whether or not
to break confidentiality. Reeves and Mintz (2001) found that often therapists broke
confidentiality earlier than they felt they should in order to avoid litigation. A
psychologist’s decision to break confidentiality when a client threatens suicide
appears to be influenced not by their own personal philosophy, but by the pressure
put on them through external policies (organisational, professional and government)
to preserve life and through the fear of being sued. Research suggests that
organisational policies and procedures influence therapists the most during their
decision making process. Reeves and Mintz (2001) found that when faced with a
suicidal client therapists were not making the decision whether to breach confidentiality or not, but rather when to breach confidentiality and trigger the procedures put in place by the organisation. Therapists in this study experienced this influence in a negative way stating that they felt they were coerced into breaking confidentiality when this contradicted their personal philosophy (Reeves and Mintz, 2001). This impact of organisational policies on decision making may be confusing for trainee psychologists when these policies contradict the philosophy of the course they are attending. For example, counselling psychology trainees attending a course with a person centred philosophy may be learning that clients are autonomous beings yet the other policies which trainees must operate within state that psychologists should intervene and prevent acts such as suicide, thus taking away the client’s autonomy.

Another important issue to consider when discussing the issue of suicide and confidentiality is what happens if a client has succeeded in taking their own life. It has been shown that the decision to breach confidentiality when a client expresses suicidal thoughts produces a great deal of anxiety for psychologists, however, once suicide has been completed is there the same level of anxiety and does the ethic of confidentiality extend to the dead? There will be some individuals who do not care what happens to their disclosures once they die. However, there will undoubtedly be others who would not want or expect their disclosures to be revealed after their death. One case in particular has brought this issue into the public eye. Anne Sexton, a poet in the 1960’s, committed suicide in 1974. In the mid 1980’s Sexton’s psychiatrist, Martin Orne, released hours of therapy tapes to an author writing a biography on Sexton’s life (Burke, 1995). The release of these tapes triggered a negative reaction in the media with many psychiatrists claiming Orne had betrayed his client and that a
client’s right to confidentiality should survive death (Burke, 1995). This case raised concern amongst the public and amongst the psychology profession (Chodoff, 1992). Confidentiality, as has already been highlighted, is central to the client therapist relationship. Without confidentiality clients may lose their trust in psychologists and feel unable to disclose their inner most fears. It is important to inform clients of the limits of confidentiality, but should clients be informed that after their death records may be released for potential legal investigations? What effect would this information have on the therapeutic relationship? It appears as though there is no research exploring clients views on confidentiality of records after death and there is no mention of training courses for psychologists exploring such issue (Burke, 1995). Further research and clarity is needed regarding this issue to help inform not only psychologists currently working, but also future psychologists currently learning about confidentiality and its limitations.

Working with suicide is both a very real possibility for Counselling Psychologists and a very distressing situation. Therapists working with clients expressing suicidal ideation stated that they questioned their professional perspective when faced with this situation and questioned their competence and ability to practice safely (Reeves and Mintz, 2001). Trainee psychologists may not only question their competency when working with suicidal clients, but also how this will impact on their professional status and future (Coverdale and Roberts, 2007). As we can see, there are many influencing factors when deciding whether or not to breach confidentiality with a suicidal client and, although they are all important in protecting the client, perhaps the sheer number of influencing factors is adding to the distressing and confusing nature of working with suicide for trainees. A corollary then is that training programmes and supervisors must help prepare trainees in how best to work
with suicidal clients and inform them of the many different factors which may influence their decision of whether or not to break confidentiality (Coverdal and Roberts, 2007). Firstly, supervision is thought to be important for all professionals after a client has expressed suicidal ideation. Supervision can serve the dual purpose of reaffirming the specific intervention used with the client and also their professional and personal competence (Reeves and Mintz, 2001). Secondly, it is recommended that training programmes should provide a coherent training component, addressing both suicide and confidentiality, which is integrated within the counselling psychology philosophy (Westefeld, Range, Rogers, Maples, Bromley and Alcorn, 2000). Furthermore, in the event of a client succeeding in taking their life, supportive interventions with the trainee or professional may be needed.
References:


Counselling Psychology Practice

Introduction
Throughout the last three years I have been fortunate to have had three very different placements. I have worked with adults and adolescents and engaged with individuals experiencing low self esteem, eating disorders, sexual abuse, offending behaviour, post traumatic stress and dissociative disorder to name a few. These experiences have helped to shape and develop my identity as a Counselling Psychologist. They have provided me with valuable tools that will assist me in becoming an effective practitioner and have contributed to my ever changing sense of self. There were far too many significant experiences to include in this essay, however I have tried to include those that not only give the reader a sense of what I have done, but also how I have developed.

Placement One: Primary Care


My first placement was based in a Primary Care team. Clients were seen on site at Laureate House, which is based in the main hospital grounds.

Whilst on placement the theoretical focus at university was the Person Centred Approach (PCA, Rogers, 1951) and Cognitive Behavioural Therapy (CBT, Beck, 1976) and these heavily influenced the work I did with clients. Having already worked with CBT I instantly found this more appealing as I felt comfortable with the concepts. However, I had used CBT in a forensic setting, supervised by Forensic
Psychologists, and I discovered quickly that using CBT as a Counselling Psychologist in Primary Care was very different. Within the forensic setting everything was manualised, timed and rigid. I knew exactly what should be done and the point the client should be at by the end. When I received my first referral, a client with depression, I quickly set about searching for a manual that would give me guidance on what to do with a client in each session. However, what became apparent was that, yes, the client was depressed, but as a result of severe childhood sexual abuse and the recent loss of a child. I had to work with the client, not with the diagnosis. This was particularly challenging as I was working with Clinical Psychologists in Training and their training appeared to focus on how to use CBT for specific disorders. In peer supervision we would often discuss ways of working with clients and they would offer me their insights and examples of sessions I could conduct, however I felt strongly that I should stick to what the client brings and work with that. I know that my insights have had an impact on these trainees (who are now in their final year of training) and I have witnessed them take on board the idea of being client led.

The awareness of being client led has impacted on the way I produce formulations. Previously my formulations followed traditional CBT methods (Grant, Townend, Mills & Cockx, 2008), however this now feels too rigid. My supervisor introduced me to a way of formulating that was evolving and easier to complete with the client, thus giving them ownership of the formulation. Initially I felt precious over the formulation, it was my development, my creation and I did not want the client to change it. However I have discovered that this is part of my shadow (as described by Jung, cited in Page 1999). I wanted the control and I didn’t want to hand it over to
the client as I would feel lost. However, once I started to develop this with the client, I discovered that doing the formulation allowed clients to own their experiences. Whereas before they had just been words in their heads, now it was real.

In previous jobs I learnt the importance of note keeping. However, when I met Deborah\(^1\) and she expressed suicidal wishes and intent, I discovered just how essential it was to keep my notes up to date and everybody involved in her care informed of our progress. Previously, when working in Secure Units, if someone expressed suicidal ideation they would be placed on 1:1 support and maintained within eye sight at all times. Deborah was not under a section and I could not ‘make’ her do anything. I had to follow the procedure set by the service and I felt I was just left waiting to see if she would attend our next appointment or been successful in ending her life. In this situation I utilised both supervision and personal therapy to help me understand the ambiguity I was left feeling.

I have worked with clients experiencing a number of different psychological problems on this placement and learnt that I need to work differently with every client both practically and therapeutically. Practically I discovered that, because clients were having to come to see me, this could often cause a great deal of stress if they needed time off work or to find a child minder etc. Again, this was a new experience for me as I was used to working in a hospital or prison setting where the clients were always ‘just there’. I had to learn to be more flexible with my time and

\(^1\) The names of the clients have been changed for confidentiality and to ensure adherence to the British Psychological Society’s Code of Conduct and Ethical Practice (2006), specifically to comply with the codes Standards of Privacy and Confidentiality.
perhaps see clients first thing or last thing in the day, to try and alleviate some of this stress.

Therapeutically, I have learnt that what works for one individual will not necessarily work for another. Just because two clients experience low self esteem does not mean that conducting experiments will work for both. I have learnt to be more flexible in my approach. One book in particular has helped me do this. ‘The gift of therapy’ by Yalom (2001) has almost given me permission to interact with clients in a certain way (such as the use of touch) and discuss things that I may have felt should not be discussed in the therapy room. I feel this book has had a huge impact on my development as a therapist and has challenged many of the ideas I had about what should and should not be done in the therapy room.

As I commenced supervision on this placement I was at stage 1 of Hogan’s (1964) stages of therapist development. I was uncertain, insecure and felt dependent on my supervisor to tell me how to do things. Initially I had supervision twice a week for an hour and a half, however, as I grew this felt smothering and controlling. I was being overwhelmed by supervision and not given enough freedom to develop who I was as a therapist. I had previously had very negative experiences with supervisors and was afraid to approach this matter and was anxious that the reason we were having so much supervision was because my supervisor saw me as incompetent. When I did broach the subject my supervisor offered me reassurance and we worked out a supervision timetable that suited us both. Following this I feel supervision turned a corner and it became more about the process, rather than just describing the content of my sessions.
Placement Two: Eating Disorder Service (EDS)


This is an eating disorder specialist unit and, although it is run privately, referrals are received from and funded by the NHS.

At EDS I have had the opportunity to work with individual clients and groups. I have led a guided self help group which allowed me to adopt a supportive role rather than being an active facilitator with aims and objectives to meet in each session. This was a new role for me and I feel employing the person centred core conditions allowed me to get to know the individual members of the group on a deeper level and work with them there, which I have not experienced in group work before. I have also facilitated the Coping Skills Group which is much more focused on devising coping skills to deal with specific issues. In this group I feel I draw on my knowledge of CBT and motivational interviewing to help run the group smoothly. The Intensive Outpatient Programme was often a tense environment and I think having an understanding of dynamics, and in particular transference and counter transference, allowed me to manage the situation more effectively (Jacobs, 2004).

As the Government continue to make changes to the way funding is provided to the NHS, I have witnessed the anxiety caused in various NHS settings and conversely, how this is also an exciting time for privately run organisations. EDS are currently working on how to market themselves to a wider geographical area and on new ideas so that they can compete more with the well established NHS psychology services. This has given me the opportunity to witness how bids are put together and also be a
part of innovation groups, coming up with new ways of working with eating disorders and how to improve the service.

Working at the EDS has allowed me to make comparisons between working in the private sector and the NHS. EDS appears to be more outcome focused and there is a bigger push on completing outcome measures both before, during and after therapy and communicating these results to referrers. At the end of therapy clients are asked to complete Patient Experience Questionnaires and if there is any negative feedback this is raised. It feels as though this is designed to measure your success as a therapist and I have felt pressure whilst in therapy with clients, hoping that they give me good feedback. Feeding back the negative is a drawback I have noticed - managers are keen to point out what has gone wrong, however when things go well individuals are not offered any positives. This is something I would like to challenge as I continue in my career. It is important to look at what went wrong so we can learn and grow, however I also feel it is essential to look at when people are doing well so we can learn from this.

Until this placement I have only worked with adults, however at EDS I had the opportunity to work with adolescents. I found it difficult to pitch where I should be working with teenagers, sometimes feeling as though the work was too childish for them and other times too complex. I decided to combine a more visual way of working with the traditional talking therapies. Following the success of this I have since spread this way of working out to all clients and gauge when we start working whether this will be appropriate or not. When working with young clients with anorexia it was difficult for them to see the long term consequences of their current
actions on their bodies. I developed different worksheets that were designed to help clients think about their futures and what would happen if they continued abusing their bodies this way. I also found drawing on examples from the media and using magazines in sessions a useful way of bringing to the adolescent client’s the idea of body image and understanding the impact the media has on their own ideas.

Jessica was a 17 year old experiencing bulimic symptoms, self harming behaviour and low mood. She would often sit silently in sessions, crying and stated that she found it difficult to express herself and that she was a ‘freak with no friends’. I struggled with how to work with Jessica until at University we had a lecture on working with children and we experimented with drawing pictures. I knew Jessica enjoyed arts at school so in the next session I brought in paint, pencils and paper and asked Jessica if she could draw, write or create something that explained how she was feeling. The end result of this session was a poem. Jessica sat and sobbed loudly, stating that she had never known how to express herself before and that is why she self harmed. After this session there were no more incidents of self harm and instead Jessica became more creative in how she expressed herself and joined creative writing groups. This experience taught me that exploring how you feel does not just have to be done through talking. Although I engage in ‘talking therapy’, I feel there is a lot more I can learn and develop in my skills if I look to the arts (writing, painting etc). Since this point I have been lucky enough to work with a drama therapist and the benefits of this for my clients have been vast.

Before commencing this placement, I assumed that working with individuals experiencing anorexia, bulimia and binge eating disorder would require different
skills. However, although the presentation of each disorder is different, many of the themes underlying the eating disorder (the beliefs, personality characteristics etc) are similar. For example, I have worked with Jenny, a 43 year old single mother who has experienced anorexia for 24 years, and Caroline, a 31 year old business woman with binge eating disorder. Physically these women appear very different, however underlying this both women struggle with all or nothing thinking, perfectionism and low self esteem and much of the work we have done addressing these issues has been similar. One book in particular, Bulimia: A Guide to Recovery (Hall & Cohn, 1999) has been useful when working with clients experiencing an eating disorder. The book provides an account of a bulimia sufferer’s story. All my clients who have read this, whether they experience anorexia or bulimia, have found hearing someone else’s story useful.

EDS philosophical underpinning is CBT and therefore most of the work undertaken with clients should be CBT based unless there is a specific reason for not doing this. The service specifically employs Enhanced Cognitive Behavioural Therapy for Eating Disorders (Fairburn, 2008) and this states where a client should be up to at each session in therapy. When working with Sophie, a client with anorexia, I found that although in some respects we were where we ‘should’ be in terms of her new way of thinking, she still had not got a regular eating pattern and was feeling overwhelmed by the therapy. I was torn between the needs of the client and the service. This was my first experience of having the Service I was working for impacting on the therapy.
In terms of supervision, many supervision sessions were conducted over the telephone at EDS. Having the opportunity to reflect on this I do not feel that this was as helpful as face to face supervision. Within my other placements I feel I have gained a lot from witnessing how my supervisors interact with me and have had impromptu discussions which have resulted in my supervisors finding me a piece of research or an example of their client work, which cannot happen over the phone. In terms of Hogan’s stages of development, within this placement I have moved through stages 2 and 3. When I first started I felt I had shed my dependency and insecurity to a degree and was fluctuating between the need to be autonomous and the need for reassurance. I experienced frequent fluctuations in motivation, at some points thinking this was the right profession for me and at other times wondering what I was doing there, and also had periods of being extremely confident in my abilities as a therapist or being completely overwhelmed. I can see that I gradually moved into stage 3. This recognition came when I was no longer telephoning my supervisor over practically every issue. I was more confident in the decisions I was making in the therapeutic relationship and felt more able to take responsibility if things did not work. Within the supervisory relationship there was also a change. Rather than just taking I was able to offer my own ideas on how to work with different clients.

**Placement Three: Primary Care**

**September 2009 – April 2011**

This placement was based in a Primary Care team. Referrals were received for adults with mental health problems ranging from moderate to severe and enduring. Clients were seen in various GP practices.
Until I started this placement I have called myself an integrative therapist. I used elements of PCA and CBT to inform my practice and, as the course continued, any useful hints and tips from other approaches that have been mentioned (existential, gestalt, mindfulness etc). However, I did not have a base from which to use these approaches and often felt lost in sessions with clients, not understanding what I was using and what I would do next. During supervision my supervisor introduced me to the idea that an integrative therapist is not someone who just uses techniques from any approach. Instead it is having an underlying theory and using that as a guide, whilst pulling ideas from different theories, to assist the client. I have looked at various models since, such as the cycle of change (Miller & Rollnick, 2002), however the idea my supervisor suggested was a model developed by Egan (2002). This model is broken down into three stages: exploration, understanding and action and within each stage different theories and therapeutic skills are used. Having this knowledge and understanding has given me more confidence when working with clients. It has made the process of explaining therapy to clients easier and they have more control over the therapeutic process. Therapy is not something ‘done to’ clients, but something that they are ‘doing’.

Through this placement I feel the biggest lesson I have learnt is to be client led and the importance of fitting theory to the client. It has felt unnatural entering therapy without a specific plan of how I am going to work with an individual; however by using Egan’s model I feel I am more flexible. As long as I can identify which of the three stages I am at with a client, I can bring different theories and techniques to the table to best suit the client’s needs at that particular time. I worked with one client who was experiencing debilitating anxiety and held the belief, ‘I’m not normal’. We
adopted Egan’s model and started exploring where this belief, and the anxiety that accompanied it, came from. Following her formulation we explored early experiences, later experiences in life and also her views of herself, others and the world. Following this exploration, we had several in depth discussions trying to understand these experiences, what they meant to her when they occurred and whether the messages she received from them at the time still held true. I was amazed at the powerful impact exploring her experiences and trying to understand them had for the client. After many discussions she came to the conclusion that the messages she had internalised at the time were no longer true for her and she had developed different messages since which were much healthier. In terms of action, the main task was to start living according to her new adaptive messages rather than the old inhibiting messages.

During my placement, the NHS Trust started to make several changes to the way therapy was offered to individuals in this area. The first IAPT posts were filled and people were being referred more frequently to their services. As a result, the Psychology and CBT waiting list was being filled with individuals with more complex presentations. It was also made a requirement that IAPT measures were completed by all clients before each session. The introduction of IAPT appears to have placed a greater emphasis on outcomes and meeting monthly targets in terms of how many clients should be seen in a week and how quickly they should be discharged. The clinicians seeing clients for therapy appear to be under increasing pressure to achieve ‘results’ (in terms of the scores on the IAPT measures) and to see clients within eight to ten sessions, despite their presentation.
Luckily at the moment, as a trainee, I am not under the same pressures as my Supervisor and can see clients for longer than ten sessions. Most of the clients I have seen have presented with an extremely complex problem which cannot be discussed, challenged, let alone resolved in ten sessions. I feel it would be unfair, unjust and negligent to discharge some clients after ten sessions just because that is a service requirement. I have discussed this with my Supervisor on several occasions and can see the constant battle he has justifying to the service (and mainly people who do not work therapeutically with clients) why he is still seeing clients well after ten sessions. I envisage that this too will be a battle that I will face should I find a post in the NHS, however I feel strongly that I am treating an individual and we all have different needs and I do not think that any service, theory or clinician can say all individuals should be ready for discharge after ten weeks.

Within this placement I have worked with a variety of client problems. One client, Sandra, moved to England from abroad ten years ago and was experiencing depression and low self esteem. It became apparent early in our sessions that she struggled with English, however, after discussions with my Supervisor and Line Manager, it was felt that an interpreter was not needed. I had to adapt my way of working as Susan was struggling with the pace of the sessions and communicating her feelings. We developed a work book where I would write down everything discussed in the session. In this book we would set practical tasks for Susan to do during the week. To record what had happened during these tasks we devised different charts so Susan did not have to write much. The aim of doing this was to ensure Susan did not feel overwhelmed and that she felt she could engage despite the language barrier.
Within my first two placements I feel that supervision was somewhere where I could seek reassurance, check out my growing identity as a therapist and learn from my supervisors ‘how’ to do things. However, in my final placement I have also begun to learn what an effective supervisor is and how to achieve this. My supervisor has taught me that within supervision there is a need to find a balance between three things: learning, management and support. Hawkins & Shohet (2006) have commented that these things often do not sit comfortably next to one another and therefore many supervisors may concentrate on only one of the roles. I feel that having an awareness of the three roles and also the pitfalls, will aid me as I become a supervisor for other professionals. With regards to Hogan’s (1964) model of therapist development, I feel I am floating in-between stages 3 and 4. At times I feel I am secure in my own insecurities and have the autonomy to practice independently, which would mean I have reached stage 4, however I still feel that need for reassurance from my supervisor, despite denying that there is still some dependency there.

In terms of taking responsibility as a leading practitioner or manager of others, during this placement there have been first and second year trainees from different Counselling Psychology Doctorate Programmes and I have assisted my Supervisor with organising these placements and also offering group supervision, facilitated by myself. Initially the group supervision appeared to be about containing their anxieties and worries about working with clients and completing the Doctorate and I could identify that they were in the first stage of Hogan’s model. However, I now feel we have moved forward with this and our sessions are spent looking at case presentations.
and everybody giving ideas on how best to work with clients. This has given me tremendous experience as I feel I have been able to develop some skills needed as a Supervisor, including managing other’s anxieties and the effect they have on me and my own anxiety.

Conclusions

Finally, I wanted to think about the 5 main things I would take from my placements with me into my professional practice as a fully qualified Counselling Psychologist. I think they would be as follows:

1. The importance of being client led and matching theory to clients, not clients to theory.
2. The benefits of having the three steps of supervision (learning, management and support) and integrating the three.
3. The importance of keeping accurate and up to date clinical records.
4. The need to be flexible in my methods of communication. Sometimes we need to be creative in how information is communicated.
5. The knowledge that I will always be learning different ways of working with people and every one I meet will throw up a new challenge that I will learn from. I do not believe I can ever know everything and the day I think I do is the day I should retire!
References:


Reflective Essay: Professional Development

When first asked to write an essay on my professional development I did not know where to start. Do I chronologically run through the years, hoping to show development? Do I take each placement in turn and describe changes? I did not feel either of these would truly do justice or show the extent to which I have developed as a Counselling Psychologist over the last three years. Neither would they show that, alongside this professional development, there has been a personal change and growth and the person leaving the Doctorate is not the same person that started it. To reflect this development I will first look at what led me to the course and the person I was when I started. I will then identify various different turning points which have occurred throughout my training which have impacted on my development before finally reflecting on who I am now and contemplating what the future holds.

During my A-Levels and whilst choosing my undergraduate degree I wanted to be the next Cracker – the TV Forensic Psychologist who aided the police in solving crimes. The job sounded exciting, dangerous and action packed, however soon after I graduated and was employed in my first forensic assistant psychology post I realised this was not the case. Instead the majority of my time was spent compiling risk assessments and running various groups with individuals detained under the Mental Health Act (1983). Although this work was enjoyable there was still something missing and I sought employment working with individuals in the community. This led me to work for a company which conducted court reports on families where children were deemed to be at risk from their parents. Engaging with the families was fascinating and learning about their histories introduced me to some of the
difficulties families, and particularly parents, can face. Many of the parents I assessed had experienced abusive relationships, drug and alcohol problems or financial difficulties either in their past or current lives. Part of my role was to identify which areas they needed help with and devise treatment plans; however I could not implement these plans. This was extremely frustrating and led me to investigate what fields of psychology did focus on talking therapies. This investigation led me to Counselling Psychology and the Practitioner Doctorate course.

Another influence was my parents. When I was 15 my father had what Doctors referred to as a ‘nervous breakdown’ and was given early retirement. A couple of years later my mother had to retire to care for and support my father. Until that point mental illness was something that affected ‘other people’ and not something I could ever truly understand. However as I became more aware of what was happening at home I saw the struggles my father, as a service user, and my mother, as a carer, were having and started to think this was not only something I could understand but something I could get involved and help with. This experience has also influenced my research question for my Doctoral Thesis. I wanted to explore the experiences other spouses had when they were suddenly thrust into the role of caring for their loved one and uncover what I, as a Counselling Psychologist, could do to assist with this change. Whilst thinking about my reasons for undertaking the Doctorate I can see that I identify with Guggenbuhl-Craig’s (1971) ‘wounded helper’ theory. I have used my own experiences to form the foundations of my empathy with clients and their own wounds.
Reflecting back over the last three years, I can see that I am not the same person I was when I started the course. I started severely doubting my ability and my suitability to be on the course. I had no prior counselling experience and felt isolated from my peers as a result. To compensate for this lack of knowledge and skills I thought I needed to learn everything. I was very theory led, doing everything that each book I was reading told me to do. I was petrified of being myself or going with what the client brought to the room through the fear of ‘getting it wrong’. Although this fear is still with me to an extent, throughout the last three years I have learnt to be more relaxed and trust both the clients and myself within the therapeutic process. At the beginning I also felt that the future was clear for me. I would complete the Doctorate, get a job as a Counselling Psychologist and my training would be over. I have now realised however that being a Psychologist means that you are constantly training and the Doctorate and key turning points, which will be described below, are really only the beginning of a (hopefully) long and enlightening journey into the world of Counselling Psychology.

Turning Point One

In the various assistant and trainee roles I had before commencing the Doctorate I had had some negative experiences with supervision and supervisors. In one position supervision was seen as a luxury rather than a necessity. In another, supervision was about the supervisor’s agenda and highlighting the things they felt I was not doing correctly and was very critical. Needless to say these experiences left me confused as to what supervision actually was. My supervisors did not explore how I could best make use of supervision and this is only something I feel I have had the opportunity to look at later on in my training (see turning point eight). At the start of my first placement for the Doctorate I was both anxious and hopeful about supervision. My
supervisor was a Chartered Counselling Psychologist and for the first time the purpose of supervision was discussed with me. However three months into my placement I was only seeing one client a week and having two sessions of supervision a week, each an hour and a half long. I was feeling overwhelmed and smothered by supervision, yet scared to say anything. After all I was only a first year trainee and surely my supervisor knew best. If I said something would that result in me failing the course? Despite these questions and doubts I knew that I needed more clients to pass the course requirements and I also wanted the opportunity to put into practice the skills we were learning. When I finally spoke to my supervisor about this it was easily resolved. I realised I had engaged in several cognitive thinking errors. Firstly I had engaged in catastrophising and predicted that my supervisor’s response would be to either state I was incompetent and needed that much supervision or that he would fail me. I had also attempted to mind read my supervisor and made negative assumptions about the way he thought of me without having any evidence (Briers, 2009). I feel this incident changed our supervisory relationship for the better and, as a result, my case load increased and supervision decreased. I also learnt that I, like many of my clients, engaged in cognitive distortions and that expressing concerns and feelings does not have to result in a negative conclusion.

Turning Point Two

Whilst completing the course I have read many books on different types of therapy, therapeutic interventions and Counselling Psychology in general. However one book in particular has made a significant impact on my development as a professional. At the end of my first year I was introduced to Yalom’s (2001) book entitled ‘The Gift of Therapy.’ This book provides 88 ‘tips’ from Yalom that he has discovered over his work as a therapist. I felt this book gave me reassurance about certain things that
may or may not happen in the therapy room, reassurance which I have been unable to find from any other source. For example, Yalom speaks about the use of touch with clients and how it is acceptable to comfort a client if they are upset, but this needs to be discussed afterwards. The book also speaks about acknowledging your errors and I feel this tip has had a powerful impact on my work as a therapist. Acknowledging my mistakes or that I may not know the answer seems to give clients a sense that it is alright to make mistakes and as individuals we cannot possibly know everything. This has been a turning point in therapy with many clients feeling more in control and not being as harsh on themselves when they experience a lapse or set back in their recovery. It has been hard for me to acknowledge when I have made errors and I have utilised personal therapy and supervision to uncover why this might be. Jung’s (Stevens, 1994) theory of the shadow appears to offer an explanation and is discussed in Turning Point Three.

Turning Point Three

My discovery of Jung’s concept of the shadow occurred in a module focusing on psychodynamic principles and instantly struck a chord with me. Everyone is thought to have a shadow side. The forming of the shadow begins at an early age. As a child grows those favourable aspects of their personality, the behaviours, qualities, skills, feelings and desires that are valued by those with influence over them and the society they live in, are encouraged and they then tend to be integrated into the conscious experience. At the same time a child also develops a shadow side into which they place and repress those aspects of themselves that they learn are disliked or unacceptable to those who have influence upon them (Stevens, 1994). Bly (1988) chose to depict the shadow as a figure dragging a long bag behind them full of all the unwanted aspects of ourselves we encounter. It felt important to me that, if I had a
shadow side, I worked to uncover what was in it (a process called ‘realisation of the self’ by Jung) as this could impact on my work as a Counselling Psychologist. To begin with I started looking at what influenced me to become a Counselling Psychologist in addition to the reasons mentioned above. Page (1999) suggests that when starting out as a Counselling Psychologist, we might say a ‘calling’ or a desire to do work that feels worthwhile motivated us to undertake this profession. However as we develop in the profession, Page (1999) suggests that other, perhaps less acceptable, motivations may be uncovered. For me one of these hidden motivations was a desire to be a Doctor. This is something I have always wanted yet had never acknowledged as a reason for undertaking the Doctorate.

Once I started exploring my shadow in personal therapy I uncovered more things that were in my shadow side. My desire not to make mistakes maybe placed here because I believe making mistakes is a sign of weakness. I also have a desire to be independent and this maybe because ‘dependent’ is in my shadow. Not only have I found it useful to look at my shadow, but my clients appear to have benefitted from exploring their shadow as well. I hope to continue exploring my shadow throughout my professional life because new elements of my shadow may be created as I develop as a Counselling Psychologist. For example, certain parts of us (i.e. if we are mischievous, sarcastic, flirty) may not fit with the role of a Counselling Psychologist and therefore we may repress these parts into the shadows of our unconscious. However this does not mean it has to stay there. Once we recognise what has happened, we can bring this part of us back from the shadows and allow it to be part of us again (Page, 1999).
Turning Point Four

Throughout the Doctorate I have lived in a different area to where the course is taking place. On placements I have often been the only trainee Psychologist and always the only Counselling Psychologist. Therefore I have felt quite isolated. However, in my final year of training a local university started running a Doctorate programme. This meant that there were more trainees in the area and also on my placement. As I was in my final year of training, my supervisor asked me to speak to my fellow trainees and perhaps set up peer supervision in order to assist others just embarking on their training. I enjoyed sharing my experience and knowledge and help with any of the trainees’ concerns or worries. Whilst running peer supervision, my supervisor and myself have put together a package for future trainees coming onto placement to try and ease fears, provide information which may help them with clients and also the best way to keep track of client contact hours and record this. By engaging in these tasks I have realised that I would also like to supervise trainees one day and I have begun to think about what further training I will need in order to do this (see turning point eight).

Turning Point Five

During the Doctorate and on my placements I have learnt many different theories and ways of working with clients – CBT, person centred approach, schema therapy and motivational interviewing to name a few. By the third year, when working with clients I often found myself drawing from all these theories instead of focusing on one. In supervision I reflected on this, stating that I felt like a ‘haphazard therapist.’ My supervisor spoke to me about being an integrated therapist (Culley, 2004). I had always thought this meant using different theories when working with clients, such as using the person centred core conditions with some elements from CBT. However,
my supervisor explained that it is drawing from different theories, but having a base to work from. He introduced me to Egan’s (2002) Skilled Helper Model and explained that this has three stages, exploration, understanding and action. From this I could draw different theories into each stage of the model. Since introducing this with clients I can see how beneficial having a model is. I now feel like there is direction within our sessions and I am not blindly searching for interventions and wondering how everything fits together.

Being integrative in this sense has also allowed me to be client led. Balancing theory and what the client brought was something I found difficult at first and I often tried to make the client fit with the theory I was using. I then moved on to using which ever theory I felt fitted in that session, before finally discovering Egan’s model. Being client led rather than theory led has allowed me to be more present with the client rather than worrying about what intervention I was going to use next.

Turning Point Six

During the Doctorate it has been difficult to explain what has changed and how I have developed. I feel like I have gone through a series of stages to get to the point I am now and I have moved between being over-confident to under-confident, before finally arriving at the point I am now at. When I discovered Hogan’s paper I could not believe it. Although it was written in 1964, the stages it explained seemed to fit in exactly with my experience. Hogan describes how trainees move through four stages of development. These are described below:

1. In this stage the trainee is heavily influenced by a method and will try to apply everything they have learnt. Trainees are thought to be insecure and unaware
of their own motivations. They are also highly motivated but uninsightful of the impact they have on others.

2. This stage is characterised by a dependency-autonomy conflict. There is also a struggle with insight and the trainee varies between being over confident in his new skills and overwhelmed by the responsibility. There are also fluctuations in motivation.

3. In stage three there is an increase in professional self confidence and this may be accompanied by a denial of remaining dependency. There is a greater insight and more stable motivation.

4. In this stage there is personal autonomy which is adequate to independent practice, an awareness of the limitations of insight and an awareness of changing levels of motivation. (Hogan, 1964).

Within my first year I can see that I moved from stage one to two following the incident in turning point one. After speaking to my supervisor about my concerns I can now see that I was then in a battle between a desire to be autonomous and discovering what type of therapist I was. However I also felt concerned and worried about ‘getting it right’ and therefore wanted guidance from my supervisor and reassurance. Perhaps I was also in stage two during the incident described in turning point seven. My motivation to complete the course, attend placement and make any effort was constantly shifting and I was struggling to have any insight into why this was. I cannot identify precisely when I moved into stage three, however I became aware that I was denying any remaining dependency when I began supervising first year trainees. I think I did not want them to see any weaknesses, however just like my clients mentioned in turning point two, when I did acknowledge this my fellow
trainees all stated that they felt relieved, they were starting to question whether I was human or not!!!!

Movement into stage four has only really occurred over the past few months and I still fluctuate between this and stage three. I feel I have now found a balance between working from my own initiative and seeking help. I feel this has been reflected in all areas of my professional development. Throughout the Doctorate I have been fiercely independent, solving problems on my own or accessing external support. In the last few months I feel I have found more of a balance between my need to be independent and the need for support, especially in relation to completing my thesis. As a result of finding this balance I feel more confident, more supported and less isolated.

Turning Point Seven

The Doctorate specified that as a trainee I needed 30 hours personal therapy. Initially I was doubtful about engaging in this as I was unsure of how it would help me. However, not only have I be able to deal with some of my past difficulties and problems encountered on the course, it has also given me the experience of understanding exactly what it is like for a client when they come to see me. One particular moment from my personal therapy has helped me personally and also with how I work with individuals coming to therapy. When I was half way through the course I felt stuck. I could not motivate myself and was frustrated with every area of my life. In therapy I struggled to explain how I was feeling. In one session my supervisor gave me a piece of paper and a pen and asked me to express how I was feeling on the paper. After initially feeling uncomfortable, but with lots of encouragement from my therapist, I drew a woman sat crossed legged in front of a
wall. From this drawing I could explain that I felt like this was where I was in terms of my development. I currently had a brick wall in front of me and no way of getting over it. I was de-motivated and slumped on the ground. This led to a discussion about what would help me over the wall. These things included the support from my family and friends, my dreams and what being qualified would mean. Filling in each brick with one of these helpful things made me feel more positive and determined. The end result can be seen in Appendix 1.

Following this I realised that it is when my clients become stuck that I feel most frustrated, yet perhaps the reason they feel stuck is because they are struggling to express how they are feeling – just like I was. This made me think a lot about ‘talking therapies’ and whether they just had to be about talking. Although it felt strange at first, I started taking more materials to sessions and then, when a client was struggling or said they felt stuck, I would ask if they wanted to try and explain in a different way. This has been very successful and has led me to research different types of therapies, such as art therapy (Pearson & Wilson, 2009). Using more creative techniques with clients is something I have passed on to other trainees at my placement and they have also found this to be successful.

Turning Point Eight

I have recently attended a workshop at the British Psychological Societies offices in London entitled ‘Becoming an Effective Supervisor.’ I attended this course initially because I wanted to start my journey of becoming a supervisor once I qualify and although I feel I gained a lot from this, I feel it taught me most about being a supervisee. As mentioned in turning point one, the purpose of supervision and my role within this has never previously been explained. More recently supervisors have
discussed different methods of supervision; however, I have always felt more of a passive than active participant in this. On the workshop giving power to the supervisee was discussed. Supervision should be about what the supervisee needs to bring and they should set the agenda. As a trainee I feel over the last year I have utilised supervision more in this way. I have been setting the agenda with my supervisor adding things to this list. However I feel this has only happened since I have moved into stage 4 of Hogan’s (1964) model of development and I have become more comfortable with myself as a therapist. The workshop has highlighted the importance of explaining the purpose of supervision and the different roles (supervisor and supervisee) have within this. As I am about to embark on my journey as a qualified Counselling Psychologist with the potential to supervise others, I think exploring what supervision is and what a supervisee’s role is within that will become an essential element at the beginning of all my supervisory relationships, even when I am the trainee.

At the beginning of this essay I reflected on the person I was when I started the Doctorate. Having experienced all the turning points mentioned above, I do not feel that it is the same individual leaving as started. Now I am coming to the end of my Doctorate I find myself doing things that I would never have dreamed of doing at the outset. I am questioning theories and what is written in books. I have discovered that each individual is unique and sometimes they cannot be moulded into what a theory says. I now feel more confident in my abilities and, ironically, I feel this is partly because I feel more at ease with admitting my mistakes and lack of knowledge and also in seeking help. I always envisaged at the end of the course I would seek employment with the NHS. Although this is still something I would like to do, with all the recent Government changes and cuts that are currently occurring in the health
service, I have had to start thinking further afield. This has led me to look at private sector work in this country and also jobs in different countries. The dilemma of where to work reminds me of a poem by Robert Frost (see Appendix 2). I could take the worn path which is comfortable and safe by working in England, in a geographical area I know, with an approach I know. Or I could take the path less travelled and explore different theories, cultures and perhaps bring Psychology to a group of people previously neglected. At the moment I can feel myself edging towards the latter path.

So what does the future hold? As mentioned earlier, at the start of the Doctorate I believed that once I got to this point my future would be clearly marked out for me and my training would be over. How wrong I was! In terms of my professional development I feel I am leaving the course with more of a sense of what type of therapist I am and what personal philosophy I follow in that I am integrative in my approach and client led. However at the moment I think I am a generic therapist. I envisage that my journey will now be about learning about different types of theories to see which fit with my integrative approach.

My Doctoral research into the experiences of partners/spouses living with a loved one with bipolar disorder has made me aware of what an important role partners can play in caring for their loved one and assisting in their recovery. Despite this, partners often feel excluded by professionals and caring can have a negative impact on their relationships and mental health. Having run a group for families and friends of those experiencing eating problems on my placement, I have seen how important having a space to talk and gain information is for carers and the positive impact this can have on an individual’s experience. In the future I hope to be able to further explore what
support carers for an individual with a mental illness need and perhaps implement a group work programme to provide some of this support.

From having the opportunity to sit down and reflect on my professional journey, it is only now I can see the true extent of the change that has taken place over the past three years. The different experiences I have had throughout the course, on my placements and by interacting with my peers have all helped me to form an identity as a Counselling Psychologist. However, I do not feel this is a stable identity. Just as I have experienced over the last few years, I think there will be many changes to my professional identity as I encounter new theories, as new government initiatives come in and as I meet different people. Although the thought of a constantly changing identity alarmed me at first, I can now see that this is important to make sure I continue to engage in appropriate and ethical work with clients. Finishing the Doctorate and not being prepared to continue growing, exploring and learning would make me stagnant and I would be unable to fulfil the Health Professional Council (HPC) and British Psychological Societies (BPS) requirements. Therefore, as mentioned before, completing the Doctorate is not the end of my training or journey, it is only one step on the road.
References:


Appendix 1

Motivation
Friendship
Revenge
Steph
Choice
Desire
Freedom
Destiny
Success
Stronger
America!
Mum
Experience
Dreams
Money
Dad
Determination
Vicky
Chartered
Support
Potential
Joy
Love
Achievement
Career
Life
Family
Zoe
Opportunity
Future
Appendix 2

The Road Less Travelled

Two roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveller, long I stood
And looked down one as far as I could
To where it bent in the undergrowth;

Then took the other, as just as fair,
And having perhaps the better claim,
Because it was grassy and wanted wear;
Though as for that the passing there
Had worn them really about the same,

And both that morning equally lay
In leaves no step had trodden black.
Oh, I kept the first for another day!
Yet knowing how way leads on to way,
I doubted if I should ever come back.

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I--
I took the one less travelled by,
And that has made all the difference

...Robert Frost
Research
Dossier
‘IN IT TOGETHER’: THE EXPERIENCES OF PARTNERS LIVING WITH THEIR LOVED ONES WITH BIPOLAR DISORDER.

by

Alexandra Barnett
SEARCH STRATEGY

Electronic journal databases such as Medline, Psychinfo, PsycARTICLES, PsycBOOKS and Psychology and Behavioral Sciences Collection were searched. The following key words were used in searches: bipolar disorder; caregivers; coping styles; professional support; treatment and interventions; burden; mental illness; positive experiences; spousal caregivers; social support; Lazarus and Folkman; deinstitutionalisation; government policies; qualitative research; Interpretative Phenomenological Analysis (IPA). The OPAC catalogue at the university was also searched and the NHS Trust library where the researcher is currently on placement. Articles and information were obtained from electronic databases, from journals and books held at the university, the NHS Trust library and some articles were ordered from the British Library. The search engines Google and Google Scholar were also used to search for articles. The most up to date and current literature was searched for and, therefore, the most recent studies were included. Where current literature was not found, older studies had to be used. A literature plan was produced, which asked questions about what the current study wanted to explore. All studies were read and evaluated to assess whether they met these questions. Other criteria that was used when appraising the literature was how relevant the literature was to the current study, what methodology was used (this study tried to identify other qualitative studies) and how the literature contributed to the psychology field and current caregiver literature.
Literature Review
In It Together: The Experiences of Partners/Spouses Living with a Loved One with Bipolar Disorder.

What is bipolar disorder?

Bipolar disorder is a chronic, recurrent and life long illness (Baldassano, 2002) which is characterised by extreme swings in mood, from being very high (mania) to being very low (depression) (Miklowitz, 2007). As a result of these extreme swings the Diagnostic and Statistical Manual of Mental Disorders defines bipolar disorder as a mood disorder (4th edition, American Psychiatric Association, 1994). Episodes of depression are characterised by low mood, lack of energy, problems with concentration, feelings of hopelessness and loss of appetite (Peterson, Kerr & Johnson, 2004). The risk of suicidal ideation or suicide attempts is high for those individuals with bipolar disorder during depressive episodes with 30-40% of them experiencing these at some point in their lives (Chessick, Perlick, Miklowitz, Dickinson, Allen, Morris, Gonzalez, Maramgell, Causegrove & Ostacher, 2009). In contrast, during manic episodes individuals may experience increased energy, inflated self worth, grandiose ideas (which can lead to delusional beliefs), decreased need for sleep and irritability (Peterson et al, 2004). Episodes of mania can significantly disrupt an individual’s social and work life and lead to periods of hospitalisation (Dent, Close & Ryder, 2004). A hypo manic episode occurs when there is mood elevation, but without delusions or significant disruption to an individual’s work and social life. A mixed episode is when symptoms of both mania and depression occur at the same time (Dent et al, 2004). A diagnosis of bipolar disorder is made when both episodes of depression and manic, hypo manic or mixed episodes have occurred (American Psychiatric Association, 1994). The disorder, however, can often go
undetected as during a manic episode it may appear that the individual is capable of rational thinking (Peterson et al, 2004). To diagnose bipolar disorder a pattern of episodes must be identified and General Practitioners may deal with specific complaints rather than looking at longitudinal patterns (Peterson et al, 2004). A recent study revealed that 40% of clients discharged from one hospital with a diagnosis of bipolar disorder had entered hospital with a diagnosis of unipolar depression, revealing how frequently bipolar disorder is misdiagnosed (Ghaemi, Sachs, Chiou, Pandurangi, & Goodwin, 1999). The Depressive and Bipolar Support Alliance (Ogilvie, Morant & Goodwin, 2005) reported that, on average, it can take eight years and three medical physicians to make a correct diagnosis of bipolar disorder.

It has been estimated that by the year 2020 bipolar disorder will be the 6th leading cause of disability worldwide (Murray & Lopez, 1996). Angst and Gamma (2002) estimate that in the UK up to 1 million people are diagnosed with bipolar disorder and Morris (2008) has estimated that 1.5% of the population are affected. It is predicted that there is a lifetime prevalence rate ranging from 0.9% to 2.1% (Baldassano, 2004). Bipolar disorder is thought to lead to more lost quality of life than ischaemic heart disease and cerebrovascular disease (Ogilvie et al, 2005). If an individual diagnosed with bipolar disorder at 20 were to be left untreated, it is estimated that they would lose 12 years of good health and 14 years of their working life (Wyatt & Henter, 1995).

Bipolar disorder is a debilitating illness with more than 90% of people diagnosed experiencing recurrences of mania or depression during their life time (Miklowitz, 2007). Although bipolar disorder has frequently been thought of as an episodic
illness with long periods of wellness and a return to normal functioning between episodes, recent research has suggested that individuals remain either intermittently or persistently unwell during the course of their illness (Judd, Akiska, Schettler, Endicott, Maser & Soloman, 2003). Over a ten year period one study estimated that a bipolar sufferer will experience five episodes of hospitalisation (Soloman, Keitner, Miller, Shea & Keller, 1995). In a review of the research, Huxley & Baldessarini (2007) found that as few as 33% of individuals diagnosed with bipolar disorder had achieved a pre-morbid level of functioning.

For those affected by bipolar disorder, it can be a significant source of distress, disability and premature mortality through suicide (Zergaw, Hailemariam, Alem & Kebede, 2008). It can affect every area of life. The National Depressive and Manic Depressive Association (NDMDA) reported that between 57% and 73% of bipolar patients were either divorced or experiencing marital difficulties (Lish, Dime-Meenan, Whybrow, Price & Hirschfeld, 1994). In terms of employment, individuals diagnosed often need to take days off work, may struggle concentrating, or may not be able to continue working at all (Baldassano, 2004). The NDMDA survey found that 37% of its members were unemployed at the time of the survey (Lish et al, 1994) and another study found that only 43% of individuals had jobs six months after discharge from hospital and just 21% were functioning at an expected level (Dion, Tohen, Anthony & Watemaux, 1988). Individuals may find the cyclical nature of bipolar disorder significantly impairs their ability to function in both social and work environments. However, problems with functioning can persist despite the resolution of the symptoms during manic and depressive episodes, with 75% of individuals also experiencing functional disabilities between episodes (Rea, Miklowitz, Thompson, Goldstein, Hwang & Mintz, 2003).
Information regarding the age of onset for bipolar disorder is unclear within the literature, with one study stating the average age of onset is close to 19 years (Burke, Burke, Regier & Rea, 1990) and another 28 years (Goodwin & Jamison, 1990). A reason for this discrepancy may be that it takes a long time to diagnose bipolar disorder. Clinical research suggests that it can take between five to ten years to diagnose as the disorder can take this long to manifest itself. In the early stages of the disorder an individual’s behaviour may be mistaken for other things before it is recognised and diagnosed as bipolar disorder (Peterson et al, 2004). Bipolar disorder is thought to typically develop in early adulthood, during the prime of a person’s life, when they are establishing a career and family. It can affect any ethnic or socioeconomic group and men and women equally (Lam, Jones, Hayward & Bright, 2005).

**Shifts in care**

Mental illness is very common. The Department of Health (1999) has predicted at any one time around one in six working age adults will experience a mental illness, most often anxiety or depression. Initially individuals diagnosed with a severe and enduring mental illness, such as bipolar disorder, were admitted into mental health institutions (Goosens, Van Wijngaarden, Knoppert Van Der Klein & Van Achterberg, 2008). A process of deinstitutionalisation over the last 50 years has resulted in a marked shift in the provision of care for such individuals (Baronet, 1999) with many now living at home, in the community, being cared for by their families (Eakes, 1995). In 1992 the General Household Survey (Office of Population Census and Surveys, 1992) predicted that there were more than 7 million people in the United Kingdom caring for a sick or ill relative. The 2001 population Census in England
(ONS, 2002) revealed that of these 7 million, approximately 1.5 million were caring for an individual with a mental illness. As more and more families become the main provider of care for their ill relative they are responsible for a substantial amount of their care often with little or no understanding of the illness (Magliano, 2008). As family members take over this role it may be that they develop more of an understanding of how the illness effects their relative in all situations and perhaps this is something professionals or ‘experts’ can learn form when treating individuals with a mental illness. However, further research is needed to explore family members knowledge and to understand how this can impact on the way professionals treat individuals.

Family members and friends caring for a loved one with a mental illness are often referred to as a caregiver or carer. A caregiver is defined as, ‘the usually unpaid, non-professionals, such as family and friends, who have a significant input to the care and support of those affected by severe psychiatric illness’ (Ogilvie et al, 2005, p. 26). The concept of an informal carer is relatively new with Bytheway and Johnson (1998) arguing that 40 years ago the term ‘carer’ did not exist in the English language. People who would now be identified as carers would not have viewed themselves in that way. Bytheway and Johnson (1998) suggest;

“We can think of the concept of ‘carer’ as a social construction, a category created by the interplay between individual experience and various interest groups – policy makers, researchers and pressure groups” (p.241).

As a result the concept of carer is now a social identity recognised in policy and law (Bytheway & Johnson, 1998).
As deinstitutionalisation occurred there was an increase in research exploring the effect that family and carers’ attitudes and behaviour had on the individual with a mental illness. The main assumption was that families could cause an individual’s illness through their own behaviours (Dore & Romans, 2001), focusing, in particular, on whether or not a family displays high expressed emotion (high levels of criticism, hostility and/or emotional over involvement) (Miklowitz, 2007). Studies have revealed that individuals with bipolar disorder who return home from hospital to high expressed emotion families are two to three times more likely to relapse in the following nine months than those who return home to low expressed emotion families (Barrowclough & Hooley, 2003). Further research exploring what characteristics high expressed emotion families show which may contribute to relapse need to be identified. Professionals could then incorporate these into skills training work assisting family members with coping for their loved ones.

Recognition of the impact caring for a relative with a mental illness can have on an informal caregiver has been highlighted in recent government policies. These have identified meeting the practical, health and emotional needs of carers of an individual with a mental illness as a high priority. Standard 6 of the National Service Framework for Mental Health (Department of Health, 1999) requires professionals to assess the needs of every carer caring for an individual receiving care under the care programme approach (CPA, Wilkinson & McAndrew, 2008). This assessment should cover caring, physical and mental health needs. The National Strategy for Carers (Department of Health, 1999b), the Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act (2000) are further recognition of the important role carers play in the community (Arksey, 2003). Since these policies
have been put in place there does not appear to have been research exploring how effective these have been in assisting caregivers. Research exploring how these policies help carers with care giving tasks, how they affect carers own mental health and what further support carers get as a result of being assessed all needs to be explored.

There is a paucity of literature regarding care-giving for individuals with bipolar disorder and many of the findings from the research with schizophrenia and dementia caregivers have been generalised to bipolar disorder (Ogilvie et al, 2005). Bipolar disorder is episodic and cyclical in nature and therefore the impact this has on caregivers and how they cope with the illness may be very different to other mental illnesses. In addition there is also a particularly high risk of suicide associated with bipolar disorder which will impact on caregivers (Hill, Shepherd & Hardy, 1998). It is therefore important to look at the experiences of caregivers for loved ones with bipolar disorder independently from other mental illnesses to explore both the positive and negative impact and how caregivers experience this.

**Impact of Caring**

Family members frequently find themselves responsible for the day to day tasks of caring for a loved one with a mental illness (Brady, Goldman & Wandersman, 1994). The research on generic mental illness informal care-giving has reported a considerable adversity associated with the care-giving role (Maskill, Crowe, Luty & Joyce, 2010). The task of caring for someone, whose behaviour may sometimes be unpredictable and challenging, places great demands on the caregiver (Heller, Roccoforte, Hsieh, Cook & Pickett, 1997). The stress of caring can impact upon all areas of the carer’s life: relationships, work, leisure activities and children (Baronet,
1999) and can impact negatively on the carer’s physical and mental wellbeing. Carers are susceptible to weight gain/loss, psychosomatic complaints, poor sleep and depression and anxiety (Barrow & Harrison, 2005, Perlick, Hohenstein, Clarkin, Kaczynski & Rosenheck 2005). The stress of care-giving has led Lefley (1997) to claim that family caregivers represent, ‘a stressed and potentially at risk population whose quantitative problems may equal or even outweigh those of the persons around whom they revolve’ (p.443).

The cost of providing care can be considerable for family members. It can impact on financial security and stability, coping, achievement of personal goals, mental health and relationships (Jeon & Madjar, 1998). To date, most research on caring has focused upon the level of burden experienced by carers. Burden is considered to be a significant consequence of caring for someone with a mental illness. Platt (1985) defined burden as, ‘the presence of problems, difficulties or adverse events which affect the life (lives) of the psychiatric patient’s significant other, e.g. members of the household and/or the family.’ Two types of burden have been identified, objective and subjective burden (Hoenig & Hamilton, 1966). Objective burden is concerned with the actual symptoms and behaviour of the ill individual and the consequences that these have for the caregiver (Cuijpers & Stam, 2000). Disruption of leisure activities, household routines and careers and strained family relations are all examples of objective burden. Subjective burden concerns the psychological consequences of the illness on the caregiver, i.e. subjective distress, burnout and reduced mental health (Van Der Voort, Goossens, & Van Der Bijl, 2007).

Research from the schizophrenia, dementia and unipolar depression domains have revealed that burden upon informal caregivers is common and has significant impact
on many areas of life (Mueser, Webb, Pfeiffer, Gladis & Levinson, 1996). In Fadden, Bebbington and Kuipers’ (1987) study burden was found to arise from three main areas. Practical issues, such as loss of income and social life, coping with problem behaviours, such as withdrawal, and their own psychological adjustment. Another study found that caregiver burden is significantly associated with caregivers’ perception and beliefs about the specific illness (Ogilvie et al, 2005). Studies have revealed that objective burden is positively associated with caregiver psychological distress (Coyne, Kessler, Tal, Turnball, Wortman & Greden, 1987) and subjective burden positively associated with depressive symptomology in caregivers (Song, Biegel & Milligan, 1997).

There is a paucity of research on the burden experienced by caregivers of an individual diagnosed with bipolar disorder and any work which has been done is largely confined to US healthcare settings and the Netherlands (Perlick et al, 2004, 2005 and 2007, Goosens et al, 2008). Unfortunately many policies and treatment programmes set up for caregivers, including those of individuals with bipolar disorder, have used research from other disorders and generalised this to bipolar disorder (Ogilvie et al, 2005). This is not only unhelpful, but information may also be inaccurate. The literature on unipolar depression, for example, is unlikely to accurately capture the full impact bipolar disorder has on caregivers. It misses out the impact of manic episodes and the difficulties caregivers can face when an ill individual looses insight of their illness (Ogilvie et al, 2005). The research which has explored experiences of caregivers of persons with bipolar disorder has revealed that severe levels of burden were reported by over 50% of 266 caregivers and moderate or severe levels of burden were reported by over 90% of the caregivers interviewed and
that burden was experienced in many different areas of life (Perlick, Clarkin, Sirey, Raue, Greenfield, Struening, & Rosenheck, 1999).

It is important to look at the characteristics of bipolar disorder which may lead to increased levels of subjective and objective burden for caregivers. Reinares, Vieta, Colom, Martinez-Aran, Torrent, Comes, Goikolea, Benabarre, Daban & Sanchez-Moreno (2006) found that the most burdensome behaviours for caregivers were hyperactivity, irritability, misery and withdrawal. Other studies have identified aggressive and violent behaviour, suicidal ideation, impulsive spending and depressed mood as symptoms creating the biggest burden (Dore & Romans, 2001, Targum, Dibble, Davenport, & Gershon, 1981). A history of rapid cycling (having a high number of episodes during a short period of time) is related to higher levels of subjective burden for caregivers (Reinares et al, 2006). Chakrabarti, Kulhara & Verma (1992) found that objective burden was significantly higher for caregivers of individuals diagnosed with bipolar disorder than for those with unipolar depression. Poor social and occupational functioning in the ill individual and the caregiver being responsible for dispensing medication (Chakrabarti et al, 1992) were found to cause significant subjective burden for caregivers of bipolar disorder. However, it may be difficult to generalise from this study to the western world as it was conducted in India and there are many socio cultural differences. Ogilvie et al (2005) suggest that caregivers may experience more burden during manic episodes, however so far research has found that caregivers find depressive symptoms to impose greater burden (Perlick et al, 1999, Post, 2005). Ogilvie et al (2005) suggest this may be because there is a lack of adequate tools to measure burden within the fluctuating episodes of bipolar disorder. A valid measure needs to be produced to assess how much burden individual caregivers experience during the manic and depressive
episodes. This may then be helpful when informing government policies for professionals trying to identify the most beneficial way of assisting carers alleviate levels of burden experienced.

In terms of caregivers own physical and mental health, research has revealed that people living with someone with bipolar disorder report poorer physical health and utilise health services far more than the general population (Gallagher & Mechanic, 1996). A study conducted by Perlick et al (2005) found that service utilisation rates for mental health and primary care services of caregivers of an individual with bipolar disorder were considerably higher than the general population. Caregivers were also found to have elevated rates of depression. Reinares, et al (2006) discovered that nearly 70% of caregivers were distressed by the way their own emotional health had been affected by care-giving activities. One of the few qualitative studies conducted with spouses/partners of individuals with bipolar disorder discovered that caregivers experience a range of physical and psychological health complaints as a result of caring for someone with bipolar disorder. These include tension, tiredness, fatigue, muscular pain and insomnia (Tranvag & Kristoffersen, 2008). More studies are needed to explore both the physical and psychological effects caring for a partner with bipolar disorder has on the well partner.

Bipolar disorder can lead to a loss of career prospects and financial independence for the individual diagnosed and this can increase the burden felt by the informal caregiver (Van Der Voort et al, 2007). Twenty seven percent of caregivers in Dore & Romans (2001) study had experienced a reduction in income since the onset of illness and partners in particular were more likely to experience a reduction in income compared to other caregivers. Caregivers often have to manage their loved ones
finances during an episode of illness and this financial support can continue once the individual is well. Forty six percent of caregivers found coping with financial affairs a significant source of stress (Dore & Romans, 2001).

Burden has been shown to occur as a result of the breakdown in the relationship between caregiver and the individual they care for (Dore & Romans, 2001). In Dore and Romans (2001) study 90% of caregivers questioned found that during episodes of illness the individual they cared for became distant and was difficult to get close to. This caused severe distress in 64% of caregivers. This finding has been confirmed by Van Der Voort, Goosens & Van Der Bijl’s (2009) qualitative study, which found that the main burden experienced by partners of individuals with bipolar disorder was not being able to get close and share important aspects of their daily lives with their partner often leaving them feeling alone. During episodes of illness caregivers have reported that the relationship between themselves and the ill individual is more tense and there are more arguments than at other times (Tranvag & Kristoffersen, 2008). Nearly half of caregivers in Dore and Romans (2001) study reported that these arguments had sometimes escalated into violence and that partners were more likely to be exposed to violence than parent caregivers. Many caregivers who are also partners/spouses have reported problems within their marriage. Seventy seven percent of partners in Dore and Romans (2001) study revealed there were sexual problems within the marriage, with two out of the thirteen partners stating that they were aware their partner had been involved in an extramarital relationship when manic. Only one study could be found which discussed divorce rates amongst couples where one partner was diagnosed with bipolar disorder. Mayo’s study, from 1979, reported that the divorce rate was higher amongst where one partner had bipolar disorder when compared to the general population. As this study was
conducted 30 years ago more up to date research regarding divorce rates for couples where one partner has bipolar disorder is needed.

Not only are caregiver’s relationships with the person they are caring for affected by burden, the caregiver’s relationships with others, both family and friends, can also suffer. Research has shown that once an individual has been diagnosed with bipolar disorder, the caregiver’s social network can reduce as friends and other family members struggle to deal with the illness and with what to say to the caregiver (Dore & Romans, 2001, Tranvag & Kristoffersen, 2008, Fadden et al, 1987). This can increase the burden felt by caregivers as there is less support and a lack of confidants to speak to. The impact this has on the caregivers own mental health and their ability to cope with the care giving tasks needs further exploration.

Care-giving is not necessarily just a burden. There can also be positive aspects and benefits such as feelings of love, pride and gratification (Baronet, 1999, Rose, 1996). Veltman, Cameron and Stewart (2002) explored both the positive and negative experiences of individuals providing care to relatives with chronic mental illness. All caregivers experienced a range of positive and negative experiences; however the majority all believed that care-giving had made them stronger, more understanding, patient and appreciative of the time spent with their families (Veltman et al 2002). Almost all families can identify strengths that they have developed as a result of coping with their loved one’s mental illness (Greenberg, Seltzer & Judge, 2000). Chen & Greenberg (2004) discovered that family caregivers for individuals experiencing schizophrenia could identify new insights about their lives, personal strengths and greater intimacy with others as a consequence of their experience of care-giving.
Maskill et al (2010) have explored both the negative and positive experiences of caregivers of bipolar disorder. Their research revealed that caregivers experienced an array of emotions ranging from harmful to rewarding. Participants in this study described the caring experience as providing an opportunity for self growth and greater empathy for those facing a similar situation, as well as increasing feelings of love and compassion towards the care recipient (Maskill et al, 2010). Further research is needed to aid understanding, inform professional interventions and to explore the positive experiences carers may have from caring for a loved one with bipolar disorder.

**How do Caregivers Cope?**

Due to the extensive burdens identified in the literature it is important to understand the coping experiences of caregivers. Cuijpers and Stam (2000) suggest that burden and coping are strongly related and that levels of burden may affect the way an individual copes or the way an individual copes may affect the levels of burden experienced. Coping has been defined as, ‘constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person’ (Lazarus & Folkman, 1984, p.141). The mental health and caregiver literature has shown increased interest in coping styles as information on family coping can be useful in understanding how people adapt to difficult situations. It is therefore important to understand the coping style or styles caregivers adopt and to assess how beneficial these are, not just for the patient but for the caregiver themselves.
Most studies assessing how caregivers cope with bipolar disorder have used Lazarus & Folkman’s (1984) model of coping as a theoretical framework. Despite the methodological differences between studies assessing caregiver coping, common patterns were found. All studies found that caregivers used a mixture of coping styles to deal with a patient’s illness. The studies by Chadda Singh & Ganguly, (2007) and Chakrabarti & Gill (2002) revealed that caregivers were more likely to use problem-focused strategies, such as positive communication and seeking information. Shorter duration of illness was associated with strategies such as collusion, coercion and seeking spiritual help. Chakrabarti & Gill (2002) found that high economic status was positively correlated with caregivers seeking information. Higher level of burden was negatively correlated with positive communication and being unaware of the illness was positively correlated with caregivers talking less with friends. The study also found that collusion was linked with less social support. Nehra, Chakrabarti, Kulhara & Sharma (2005) found that caregivers of people with bipolar disorder and schizophrenia used a mixture of adaptive and non-adaptive coping strategies. They also found that female caregivers of bipolar used problem-focused strategies more than male caregivers. Goosens et al (2008) study compared male and female caregivers of bipolar patients to males and females in the general population. They found male caregivers more likely to use avoidance coping styles than males in the general population, and female caregivers sought less social support in dealing with problems than females in the general population.

Within the coping literature it is suggested that, ‘coping thoughts and actions differ according to which situational demands are being attended to at any one time’ (Lazarus & Folkman, 1984, p.174). The coping response is thought to be best understood if the context in which the response is used is narrowly defined. Of the
four studies reviewed, none of them instructed respondents to report on their current coping or specified a specific stressor for caregivers to focus on when reporting on coping. Considering the cyclic nature of bipolar disorder, assessing the coping strategies caregivers employ during the specific episodes (mania and depression), may be of interest. In order to get an in-depth understanding of caregiver coping with bipolar disorder, future research should focus on how caregivers cope with episodes of depression and mania. Goosens et al (2008) report that many of the participants in their study stated that their results would have been different had they participated when the patient was either acutely manic or depressive.

**Interventions**

Without informal carers the cost of providing care within the community would be much higher and some individuals with serious mental illnesses would not be able to live independently (Lelliott, Beevor, Hogman, Hyslop, Lathlean & Ward, 2003). Brown and Birtwistle (1998) found that individuals who experience a mental illness use services less if they are living with carers, however carers suffered ongoing distress associated with this role. It was therefore recommended that mental health services, ‘for moral and practical reasons should do as much as possible to support carers’ (p.143). The literature indicates that carers of an individual with a mental health problem largely report negative experiences in relation to health professional support, with studies revealing caregivers felt excluded, stressed and unsupported by staff (Rose, Mallinson & Walton-Moss, 2004, O'Brien & Cole, 2004).

Due to the nature of involvement carers have with their loved one experiencing a mental illness, it is essential to explore not only carers’ experiences with mental health services providing care for their loved ones, but also their experiences with
what support, if any, is offered to them on an individual level. The Government has
recognised the important role carers play in caring for individuals with a severe
mental health problem and stated that all individuals providing care should have their
needs assessed on at least an annual basis (Department of Health, 1999). However a
survey conducted by Rethink (2003) revealed that only one in five carers received a
carer’s assessment and only 28% of these had received a care plan. It is unclear how
beneficial these care plans were for carers and how they addressed their needs.

In terms of carers for loved ones experiencing bipolar disorder, most available studies
have explored carers’ experiences of services provided for their loved ones and, on
the whole, these experiences have been largely negative. Maskill et al (2010)
discovered carers were disappointed with services and these were not what they had
expected. It was felt that there were limited services available for their loved ones
and within those services that were available staff did not fully understand the
symptoms of bipolar disorder. Tranvag and Kristoffersen’s (2008) study found
similar results. Partners of individuals with bipolar disorder felt that professionals
lacked care and were unsupportive. Participants stated that when their partner was
discharged from a service the responsibility for their care fell on the caregiver’s
shoulders often without a follow up from health professionals. One identified study
has attempted to explore carers experiences of support. Many of the participants in
Van Der Voort et al’s (2009) study did not have access to any professional support
and when it was available it was clearly directed at the care recipient. However, most
of the participants in this study described a desire for professional support and wanted
it to serve two purposes. Firstly they wanted support to reduce burden and diminish
loneliness. Secondly, participants wanted support to help them cope better with care-
giving tasks. Many of these participants seemed unaware of support available and
stated that searching for support could often be another source of burden. The studies mentioned above were not conducted in the United Kingdom and no research has been found exploring partners/spouses experiences of care for themselves from professionals within this country. The research conducted in this study will provide a starting point for future research exploring partners experiences of support addressing their needs when caring for their partner diagnosed with bipolar disorder.

When looking at what support would be helpful for carers, Muscroft and Bowl (2000) discovered that family members living with a depressed loved one valued having an opportunity to talk and saw it as essential, however a narrow range of outlets was described. Caregivers were found not to be in contact with professions that could facilitate talking (i.e. counselling, psychology). This was due to a lack of knowledge about what counselling was and how to access it, fears about confidentiality being broken, a sense of shame and anger about this service not being provided by the NHS (Muscroft & Bowl, 2000).

In terms of Counselling Psychology it is important to look specifically at individual caregivers’ experiences of psychology, what impact this has had and what they would have liked from psychology in hindsight and in the future. There needs to be an exploration of not just what psychological support caregivers would have liked for their ill relative, but also for themselves. The few studies which have looked at bipolar disorder caregivers’ needs for professional support have referred to professional support as a generic group and has not broken this down to look at the individual professions (i.e. Community Psychiatric Nurses, Psychiatrist, Psychologists etc). Hill et al (1998) is an exception. Participants in this study were asked to rate the perceived usefulness of professionals involved in the care of the
individual with bipolar disorder. This revealed carers had little experience with psychology and they were rated as only moderately helpful. However, Hill et al (1998) put psychologists and psychotherapists in the same category and members of the focus groups stated that they did not know the difference between them and this confusion may account for some of the low scores. Within this study carers felt they were the ‘forgotten sufferer’ and wanted more counselling which would include educational material, learning personal coping strategies and looking at their own mental health. Further work is needed to explore how psychologists can have a positive input in a caregiver’s life, not just by educating caregivers on bipolar disorder but by giving caregivers the opportunity to discuss the impact their loved ones’ mental illness, and the tasks of care-giving, have had on their lives.

Research on the experiences of caregivers has tended to focus on caregivers of individuals with schizophrenia and dementia and neglected those caring for individuals with bipolar disorder. Of the research which has been conducted this has not focused specifically on partners/spouses. Therefore little is known about how these experiences impact on the partner’s inner world. The research which has focused on bipolar caregivers’ experience has tended to focus on the negative aspects, in particular the levels of burden experienced. The majority of these studies have utilised quantitative methods of enquiry and it is only recently that qualitative methods have been employed to enquire about caregivers experiences. Qualitative methods have not allowed participants to explore and describe things in depth. Those qualitative studies which have been done (Maskill et al, 2010, Tranvag & Kristoffersen, 2008, Van Der Voort et al 2009) have not been conducted in the UK and therefore there is a lack of knowledge about the experiences of partners/spouses of individuals with bipolar disorder, how they cope and what support there is
available for them in this country. The current study will therefore use qualitative methods to explore both the negative and positive experiences of partners/spouses caring for a loved one with bipolar disorder. It also aims to explore how partners cope with caring for their partner with bipolar disorder specifically trying to identify if there is a difference between how they cope with the manic and depressive episodes of the illness. This gap in the research has been highlighted by previous reviews (Ogilvie et al, 2005), however this has not yet been researched. Recommendations regarding how the issues raised within this study can be addressed by future research are included within the research report.
Research Report
ABSTRACT

The aims of this study were to explore partners’ experiences of living with a loved one with bipolar disorder and how they coped with these experiences. Another aim was to explore whether these individuals felt that Counselling Psychologists could play a role with care-giving tasks and their own psychological needs.

Five individuals, who were currently living with, or had been living with, a partner with bipolar disorder, volunteered and participated in a semi-structured interview. These interviews were transcribed and analysed using Interpretative Phenomenological Analysis (IPA) as described by Smith, Flowers and Larkin (2009). A table of super-ordinate and sub-ordinate themes was created as a result of this analysis.

Partners’ experiences are characterised by various phases which partners could move around and between. This was referred to as the ‘cycle of changing illness awareness’. This theme adds to the existing literature. As partners moved around and between these phases they experienced different emotions, employed different coping strategies and had experiences of being ‘in it together’ interchangeably with being ‘isolated and alone’.

This research concludes that partners’ experiences of caring for a loved one with bipolar disorder do not follow a linear, predictable path and as a result, professionals working with caregivers need to be aware of which phases of the ‘cycle of changing illness awareness’ partners are in when offering interventions. The analysis also suggests that partners cope differently when their loved one is manic and depressed. However, further exploration is still needed.
INTRODUCTION

Bipolar disorder is a chronic and severe mental illness which is characterised by manic episodes alternating with depressive episodes (American Psychiatric Association, 2000). In the majority of instances individuals also experience residual symptoms in between episodes. Up to 75% of individuals diagnosed with bipolar disorder also experience functional disabilities between episodes which can lead to diminished career prospects, decreased social functioning and financial dependence (Rea et al, 2003).

The deinstitutionalisation movement over the last 50 years has meant more family members are now providing informal care to their loved ones (Baronet, 2003). The effects of the family's attitudes on the course of the illness have been well documented (Mino, Shimodera, Inoue, Fujita, Tanaka & Kanazawa, 2001, Yan, Hammen, Cohen, Daley & Henry, 2004). This is now complemented by a growing recognition of the negative implications of providing care to a loved one with bipolar disorder can have on families. In a systematic review Van Der Voort et al (2007) found that caregivers for those with bipolar disorder frequently experienced severe burden including disruption to career, leisure time and household activities, reduced mental health and social support and strained family relations. Recent studies have shown that caregiver’s burden may influence the clinical outcome of bipolar disorder (Perlick et al, 2004) and 89% of family caregivers of individuals with bipolar disorder (n = 500) experience burden (Perlick et al, 2007). Despite the considerable adversity found that is linked with being a caregiver, research has discovered some rewards and benefits associated with caring for someone with a mental illness. These rewards can include increased love towards the care recipient, greater empathy towards others in

It is important to understand how caregivers cope with tackling burden as this can affect not only the caregivers day to day functioning, but also has a bearing on the course of their loved one’s illness (Nehra et al, 2005). Studies of coping in caregivers have mainly focused on caregivers of people diagnosed with schizophrenia. Two patterns of coping have been identified (Budd, Oles & Hughes, 1998): Problem focused strategies to cope include measures such as problem solving, seeking information and using positive methods of communication (Lazarus & Folkman, 1984). Emotion focused strategies, on the other hand, involve approaches such as avoidance and resignation (Lazarus & Folkman, 1984). Research concerning the coping patterns of caregivers of individuals with bipolar disorder has been relatively neglected. However, it has been predicted that as levels of burden and disability in bipolar disorder are similar to schizophrenia then the coping styles adopted by caregivers may be similar (Ogilvie et al, 2005). When looking at bipolar disorder it is important to remember the different episodes, i.e. mania and depression, and identify whether caregivers cope with these episodes differently. Goosens et al (2008) discovered that caregivers reported they would have responded differently to questions about methods of coping had their loved one been either manic or depressed at the time. This highlights the need for research to explore the coping methods employed by caregivers of an individual with bipolar disorder and this may, in turn, inform health professionals when working either with the caregiver to provide support for their loved one or directly with the caregiver.
Little research has been found on the need for professional support for carers of individuals with bipolar disorder, however suggestions can be drawn from the research regarding the needs of carers for individuals with mental health problems in general (Rose, 1998). This research suggests that carers need support for themselves in terms of coping with their own physical and psychological problems that have occurred as a result of the care-giving role, and also more involvement in the treatment and care of their loved one (Rose, 1998, Hill et al, 1998). It appears that there is a need to first understand caregivers’ needs and wants from professional support and secondly to assess their experiences of what support has been offered and what is currently available to carers of individuals with bipolar disorder. Once this has occurred appropriate, acceptable and practical interventions can be developed and professionals can be trained in a way which will support both the ill partner and their caregiver.

**Why partners?**

Within the care-giving literature the family is often regarded as an homogeneous group, who all share the same experiences and cope in the same way (Heru, 2000). However, there is now increasing awareness that the needs and experiences of family members may be different depending upon their relationship with the ill individual (Tranvag & Kristoffersen, 2008). In the schizophrenia caregiver literature it appears that the majority of participants are parents (Hill et al, 1998). It is suggested, however, that the experiences and needs of partners/spouses may be different from other family members (Lam, Donaldson, Brown & Malliaris, 2005). As bipolar disorder is thought to be diagnosed more at an age when individuals are settling down with partners and children, it may be that many caregivers for individuals with
bipolar disorder are partners. Therefore it is important to look at their experiences, needs and concerns separately from other family members.

Most of the research to date which focuses on partners of individuals diagnosed with bipolar disorder has focused on the effect they have on their partner’s illness. Studies have focused on the well partner’s high levels of expressed emotion and negative affective style and the impact this has on the recovery of their ill partner (Miklowitz, 2004). This research has revealed that the risk of a relapse is doubled in couples where there are high levels of expressed emotions. Janowsky, Leff & Epstein (1970) reported that spouses often believed that their partner’s behaviour during manic episodes was spiteful and within their control, whereas their ill partner often felt victimised and blamed for things beyond their control. Marital disharmony has been suggested as an indicator of the presence of bipolar disorder in one of the partners, as well as an indicator of relapse (Harris, Pistrang & Barker, 2006). As a result of this research there has been an increase in interventions being developed which use spouses/caregivers as ‘agents of change’ (Charlesworth, 2001). This means interventions target caregivers’ skills and how they appraise the person they care for, instead of targeting the caregiver’s own needs and concerns (Ogilvie et al, 2005).

Research has revealed that many spouses/partners would not have married or had children with their partner with bipolar disorder if they had known the disorder could be genetic and hereditary (Targum, et al, 1981). The first episode of illness may be particularly difficult for spouses as they may find it difficult to understand what is happening, feel they have lost the individual that they married yet also feel hope that their spouse will get better (Tranvag & Kristoffersen, 2008). Spouses with children
may have concerns surrounding their partner’s ability to look after children should they become unwell and those planning on starting a family may have concerns over the heredity of the illness (Henker, 1985). Financial difficulties (when depressed the partner may disregard bills or be unable to work, when manic an individual can spend vast amounts of money without thinking about the consequences, Henker, 1985), alcohol and drug abuse (Targum et al, 1981), domestic problems (Lam et al, 2005) and fears of a recurrence of the illness are just a few of the issues facing partners of an individual diagnosed with bipolar disorder (Tranvag & Kristofferesen, 2008).

Most previous research has focused on the burdensome and negative aspects of the care-giving role for spouses and has excluded any positive aspects (Veltman et al, 2002).

This research will add to the literature about bipolar disorder caregivers and in particular partners who care for their partner diagnosed with bipolar disorder. Exploring partners’ experiences of living with and providing care to a partner diagnosed with bipolar disorder is important because little is known about how these experiences impact on the partner’s internal world. The aim of the current study was to explore the experiences of partners living with their partner diagnosed with bipolar disorder and how they cope with these experiences. A further research question explored partners’ experiences, if any, with professional support both for their unwell partner and for themselves.
METHOD

Methodological Rationale
Existing research into partners’/spouses’ experiences of living with a partner diagnosed with bipolar disorder have mostly used quantitative methods to test researchers’ hypotheses. For example, they have assessed levels of burden experienced, different coping methods, marital and sexual satisfaction and levels of expressed emotions shown by family members to name a few (Lam et al, 2005, Van Der Voort et al, 2007, Perlick et al 2007). However, although this research tells us that levels of burden are high amongst caregivers and that coping styles are often maladaptive, it does not explain why these levels are high, it does not allow individuals the chance to express any positive experiences they may have, and it does not give individuals the opportunity to state what could be done to help them. Quantitative research tests out existing theory and neglects the phase of discovery (Hayes, 1998). Therefore the present research employs qualitative research in the form of Interpretative Phenomenological Analysis (IPA) to enable a fuller exploration of partners’ and spouses’ experiences of living with a loved one with Bipolar Disorder.

Qualitative Research
Some qualitative methodologies differ from quantitative methods in that they attempt to collect and analyse the accounts people give regarding their own experiences, rather than predicting outcomes. If these accounts and experiences are to be understood, then researchers need to engage in how the world is perceived through the eyes of the participants and from their own perspective (Denzin & Lincoln, 2000). The aim of qualitative research is to highlight and understand the meanings
individuals give to social interactions and circumstances, with the objective being to understand the phenomenon rather than explain it (McLeod, 2003). Willig (2001) suggests qualitative researchers aim to understand “what it is like” to experience particular situations and how individuals manage these situations. Qualitative research, then, is based within the broad hermeneutic tradition (Messer, Sass and Woolfolk, 1998).

McLeod (2003) argues that qualitative research gives people a ‘voice’ that allows their experiences to be documented. A desire to hear their voice and clarify the meaning individuals give to specific social interactions is why a qualitative researcher selects participants based on their theoretical significance rather than using randomised or stratified sampling techniques which are common in quantitative research (Yin, 1994).

Qualitative approaches are generally engaged in exploring, describing and interpreting the personal and social experiences of the individuals involved in the study (Smith, Flowers & Larkin 2009). The Literature Review for the present study has identified a gap in the existing knowledge base about how partners/spouses experience living with their loved one when they have a diagnosis of bipolar disorder. Qualitative approaches are the most suitable method to explore this phenomenon and to begin filling this gap.

**Introduction to Interpretative Phenomenological Analysis (IPA)**

Qualitative research is not a homogeneous domain (Lyons & Coyle, 2007). There are many different research approaches and methods based on differing philosophical assumptions. The main aims of the present research was to gain a greater
understanding of partners’/spouses’ experiences of living with a loved one with bipolar disorder, in order to understand their needs, how they cope and to inform service development. IPA was postulated as the most appropriate method to meet these aims.

IPA has developed over the last decade into a distinctive psychological approach to research and one that has been supported by a growing number of psychological studies, particularly in health psychology (Smith et al., 2009). The aim of IPA is to explore individual experiences and how individuals make sense of their own personal world (Smith & Eatough, 2007). Its objective is to represent the experiences that people have as they encounter, engage and live through different situations. It can be said that IPA turns away from objects in the world and focuses its attentions towards the participant’s perception of those objects instead (Smith et al., 2009).

IPA’s epistemological position is essentially phenomenological, in that it is concerned with an individual’s personal account of a situation or event. IPA also highlights that the researcher has an active role in the research process. A researcher’s own conceptions can complicate the understanding of the participant’s experience; however it is also needed in order for sense to be made of the other person’s world (Smith & Osborn, 2008). Therefore in IPA there is a two stage interpretation process occurring, a double hermeneutic. The participants are trying to make sense of their world, whilst the researcher is trying to make sense of the participants trying to make sense of their world (Smith & Osborn, 2008).

IPA is characterised by having three defining features: it is idiographic, inductive and interrogative (Smith, 2004). It is idiographic in that each participant’s interview is
analysed and individual tables of themes are constructed. Only at the end of this process are all the interviews integrated to create a master table of themes. It is inductive in that, unlike quantitative research, the study makes no hypotheses. A loose rationale gives the study flexibility and allows unpredicted themes to emerge. Finally, the themes that emerge are related to existing theoretical knowledge allowing the process to be interrogative.

IPA was chosen above other methods for several reasons. Previous studies exploring family members’ experiences of caring for a loved one with a serious mental illness have employed a variety of different qualitative methods including grounded theory, content analysis and IPA (Perkins, Winn, Murray, Murphy & Schmidt, 2004, Rose et al, 2004, Wynaden, 2007). Grounded theory is based on the symbolic interactionist school of thought and its goal is the construction of a theory that provides understanding and explanation of identified key categories (Wynaden, 2007). Grounded theory requires researchers to continue sampling until saturation point is reached and no new themes or categories emerge (Strauss & Corbin, 1990).

Another reason IPA was chosen above grounded theory was because of the emphasis IPA places on the researcher’s role in the construction of the analysis (Smith, 2004). IPA assumes that researchers will bring their own experiences to an analysis and emphasises the importance of the reflexive process to make this explicit. This was an important consideration as the researcher has a personal experience of living with a parent experiencing bipolar disorder and watching them being cared for within the spousal relationship. Although this prior experience may aid interpretation, it may also be a potential source of bias which will be highlighted within the study.
A strength of IPA is that it is essentially participant centred, and the open-ended questions in the semi-structured interviews allows the participants to explore and describe things that cannot be discovered through questionnaires alone. However, it is limited in that it relies on the individual participant’s ability to accurately verbalise their thoughts and emotions (Willig, 2001). A situation or event may be described differently by people depending upon external factors or internal influences, such as personality characteristics (Gergen, 1999). Despite these limitations, it is thought that IPA would be a particularly useful tool for this study when exploring people’s experiences of living with loved ones with bipolar disorder as the strengths of the method suit the aims of the research.

**Ethical Approval**

This study was approved by the Ethics Committee of the University of Wolverhampton, School of Applied Sciences. A copy of this ethical approval was sent to all the Self Help Organisations (Appendix 1) following which approval was given verbally from one of the Self Help Organisation. Please refer to Appendix 2 for a copy of the Res20.

**Researcher**

I have a close family member experiencing Bipolar Disorder and this was my personal rationale for choosing to look at this specific disorder and a reason for my desire to explore the experiences of partners and spouses living with bipolar disorder.

I am currently a Counselling Psychologist in Training at the University of Wolverhampton on the Doctorate Programme. Whilst undertaking this programme and research, work placements have been completed at two NHS trusts working with
adult mental health and adults with severe and enduring mental health problems, and a private organisation with a focus on eating disorders. Having spent the majority of my working life involved with adults experiencing mental health problems, I began to consider the family members of those individuals and their experiences of living with someone with mental health problems.

Whilst at the eating disorder placement I was encouraged to consider the whole family/social network involved with the client and regular sessions were set up (with the client’s permission) with their significant others. These appeared to be of great benefit to both client and their family, with both stating they gained a greater understanding into each other’s feelings and had more empathy as a result. This, in turn, appeared to benefit the client’s recovery.

**Participants**

In qualitative research, participants are selected on the basis of their theoretical significance (Strauss & Corbin, 1990) rather than using randomised or stratified sampling. In IPA participants are selected purposively because they offer access to the participant’s perspective of the phenomenon being studied (Smith et al, 2009). IPA studies therefore try to find a fairly homogenous group for whom the research question will be meaningful (Smith et al, 2009). As the topic being researched in this subject is quite rare (partners/spouses experiences caring for their partner with bipolar disorder) this defined the boundaries for the sample that was sought. By conducting this type of sampling this study will report in detail on a particular group of people caring for loved ones with bipolar disorder and does not claim to say something about all people (i.e. parents, children) who care for a loved one with bipolar disorder.
Smith and Eatough (2007) suggest that the priority in IPA is to do justice to each participant’s experience and that detailed case by case analysis can take time. Within IPA research sample sizes tend to be small and although there is no right or wrong answer to how big a sample should be, Smith and Osborn (2008) recommend that for individuals conducting time limited work, five or six participants is a reasonable size. The target sample size for this study was between five and seven participants.

Participants were all partners/spouses or ex-partners/spouses of individuals who had been diagnosed with experiencing bipolar disorder. Participants had to meet the two inclusion criteria. Firstly, their current or ex partner/spouse had to have bipolar disorder and secondly, they had to be living with or have lived with their partner/spouse. Throughout the report the term spouse/partner/caregiver and interviewee will be used interchangeably to describe the participants and unwell partner, ill partner, loved one and partner with bipolar disorder to describe their partner diagnosed with bipolar disorder.

Various self-help organisations who worked with individuals experiencing bipolar disorder, in the North West of England, were identified. These organisations were then contacted via letter (Appendix 3) and the managers asked if they could help identify individuals who met the inclusion criteria and who would be willing to participate in the research.

Six individuals (four women/ two men), who appeared to meet the inclusion criteria, stated that they were happy to be contacted regarding the study. Three individuals were currently accessing support at a self help organisation, one individual worked for a self help organisation and two individuals made contact via word of mouth
through another participant. Upon initial contact it became apparent that one individual did not currently reside with their partner and had not lived with them in the past. As they did not meet the inclusion criteria this person was not interviewed. The other five participants all agreed to participate in face to face interviews. Details of the participants in the current study are shown in Table 1 below (all participants and their families have been given pseudonyms and these will be used to refer to participants throughout the research report).

Table 1: Participant Characteristics

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Marital Status</th>
<th>Length of Relationship (years)</th>
<th>Length of Partner/Spouse Diagnosis</th>
<th>Partners Age</th>
<th>Diagnosis before/after start of relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sue</td>
<td>38</td>
<td>Cohabitating</td>
<td>7</td>
<td>40</td>
<td>63</td>
<td>Before</td>
</tr>
<tr>
<td>Debbie</td>
<td>62</td>
<td>Divorced</td>
<td>31</td>
<td>43</td>
<td>64</td>
<td>After</td>
</tr>
<tr>
<td>Katherine</td>
<td>61</td>
<td>Married</td>
<td>30</td>
<td>11</td>
<td>58</td>
<td>After</td>
</tr>
<tr>
<td>Alan</td>
<td>45</td>
<td>Married</td>
<td>12</td>
<td>25</td>
<td>42</td>
<td>Before</td>
</tr>
<tr>
<td>Jack</td>
<td>52</td>
<td>Married</td>
<td>30</td>
<td>15</td>
<td>49</td>
<td>After</td>
</tr>
</tbody>
</table>

Interview Schedule

A semi-structured interview schedule was developed (Appendix 4). The questions were developed following a critical reflection of the existing literature and discussions within supervision (see Appendix 5 for Supervision Log).

The objective of the schedule was to gain an in-depth account of partners/spouses experiences of living with an individual experiencing bipolar disorder, how they coped with both the manic and depressive episodes and their experience of professional support, in particular any input from a psychologist or psychological service for both their partner and themselves. After the first interview, the schedule was amended slightly to ensure that participants understood the questions were about
their experience not their partner/spouse. On some occasions participants answered questions in their other answers and therefore they were not asked to repeat this information again. Interviews were adapted according to the responsiveness of the interviewees and questions were rephrased or repeated where it was felt necessary. This, in turn, helped to individualise each interview.

Each interview was conducted individually and analysis did not begin until after all the interviews had been completed and transcribed. The interviews varied in length depending upon what the participant had to say. Interviews lasted between 30 minutes and 1 hour 30 minutes. Each interview was followed by a debriefing session and participants were given a debriefing information sheet (Appendix 6). Interviews were analysed using IPA.

**Procedure**

Potential participants were sent an information sheet outlining the nature and rationale of the current research (Appendix 7) and a confirmation sheet (Appendix 8), which individuals were asked to complete to indicate their willingness to participate in the research. Contact details provided on the confirmation sheet were used to contact potential participants to first assess whether they met the inclusion criteria and then, if the inclusion criteria was met, set up an interview. Interviews were arranged to be conducted at a mutually convenient time and at their local self help organisation. All rooms were suitable for the interview purpose and were private to ensure confidentiality.

At the time of the interview, I introduced myself, discussed the rationale behind the research and explained the procedure the interviews would take. A consent form
(Appendix 9) was given to each participant to sign. In this confidentiality, anonymity and rights to withdraw were explained. Participants were advised that all transcripts would be anonymised and pseudonyms would be used and all transcripts would be stored securely. After any questions had been answered or areas of uncertainty discussed, consent forms were signed and the audio recording device (an Olympus Digital Voice Recorder WS-321M) was activated.

During the interview the interviewer tried to maintain a balance between following the interview schedule and giving participants the time and space to articulate their experiences in their own way. Following the interviews a debriefing session was offered to discuss any positive or negative feelings arising from the interview. Participants were provided with a debriefing sheet (Appendix 6) which contained the researcher’s contact information, should participants have any further queries, and details of other self-help organisations in their area which may be able to offer further support if required. These measures were taken to ensure that participants were supported and their welfare taken into consideration. This was important as the individuals interviewed could be identified as a potentially vulnerable group.

Throughout this process the researcher was supervised by two Chartered Psychologists and had opportunities to raise any concerns or issues in a confidential setting. Support was also offered via personal therapy which was utilised throughout the research process.

**Analytic Strategy**

All interviews were transcribed and given line numbers (see Confidential Attachment for copies of transcripts and Appendix 10 for the Transcription Protocol). Any
information which could have potentially identified the participant and their family was removed and participants were allocated pseudonyms. Each transcript was analysed using IPA following the suggested guidelines in Smith et al (2009). In this study each participant’s account was examined separately with no reference to the other interviews. Each script was read and re-read and initial notes on any thoughts, feelings or questions made in a research diary. Exploratory notes were then made on the right hand side of each transcript. These notes reflected the categories described by Smith et al (2009). Descriptive notes were made in blue ink, linguistic notes in red ink and conceptual notes in black ink. When making exploratory notes the transcript was read from start to finish and from finish to start (backwards), so the researcher could truly immerse themselves in the narrative.

When this process was complete exploratory notes and the participants’ accounts were reviewed and emergent themes were extracted and recorded on the left hand side of the transcript. These were re-examined and clusters of themes were identified and arranged into subordinate themes and these were recorded in individual tables with supporting quotations from the interviews. Individual tables were used to write memo’s (Appendix 11) which define themes and describe and convey the individual’s experience. The next part of the process involved laying out all the individual tables of themes on a large surface so that patterns across the cases could be identified using different coloured pens. From the individual table of themes common patterns in themes were identified. These were drawn together and originally ten master themes were identified. Using the individual tables of themes and memo’s it was identified that some of these themes could be collapsed into one. New super-ordinate and subordinate theme names were written on pieces of paper and placed on a large surface area. Again using coloured pens, the themes from individual tables which felt
suitable to place in these new themes were written underneath the new heading. This process can be seen in Appendix 13. Themes were combined to create a master table of themes and a diagrammatic representation of themes. Throughout this process I frequently spoke to my supervisors to gain second opinions on the creation of new themes. These are reported in the analysis section. Throughout the research process a reflexive journal, where personal perceptions of the interview process were documented, has been maintained by the researcher.
FINDINGS

Individual tables of themes and memos (see Appendix 11) that were created from the transcripts were analysed. From this analysis a Master Table of super-ordinate and sub-ordinate themes (see Table 2) was developed.

Five super-ordinate themes were identified:

1. Changing Illness Awareness
2. In It Together
3. Isolated and Alone
4. Coping Ability
5. Emotional Change

The super-ordinate and sub-ordinate themes were incorporated into a diagram (see Figure 1, pg 130).
Table 2: Master Table of Super-ordinate and Sub-ordinate Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Quotes from Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changing Illness Awareness</strong></td>
<td></td>
</tr>
<tr>
<td>1. Sudden decline in health</td>
<td>‘He could be alright one day and then suddenly bad the next’ (Katherine, 43-44)</td>
</tr>
<tr>
<td>2. Lack of understanding</td>
<td>‘There was something wrong and nobody could tell me what was wrong’ (Jack, 44-45)</td>
</tr>
<tr>
<td>3. Persistent threat</td>
<td>‘Always on the edge of cracking up again’ (Debbie, 57-58)</td>
</tr>
<tr>
<td>4. Growing illness awareness</td>
<td>‘I understand more of what it is like’ (Katherine, 295)</td>
</tr>
<tr>
<td>5. Fear of the unknown</td>
<td>‘What’s the outcome of all this, you know, I have fears as a carer’ (Jack, 715-716)</td>
</tr>
<tr>
<td>6. Acceptance/resignation</td>
<td>‘The grass is greener on the other side, but a lot of the time it’s not’ (Alan, 597-599)</td>
</tr>
<tr>
<td><strong>In It Together</strong></td>
<td></td>
</tr>
<tr>
<td>1. Impact on relationships</td>
<td>‘They understand enough and they do support me’ (Sue, 400-401)</td>
</tr>
<tr>
<td>2. Duty of care</td>
<td>‘In sickness and in health’ (Jack, 1118)</td>
</tr>
<tr>
<td>3. Positive professional support</td>
<td>‘The support I had from the doctor, my doctor was very good’ (Katherine 584)</td>
</tr>
<tr>
<td><strong>Isolated and Alone</strong></td>
<td></td>
</tr>
<tr>
<td>1. Implications for self</td>
<td>‘When somebody’s anxious it’s infectious’ (Sue, 336)</td>
</tr>
<tr>
<td>2. Distance from others</td>
<td>‘I feel that some of my friends were quite negative’ (Alan, 383-384)</td>
</tr>
<tr>
<td>3. Lack of professional support</td>
<td>‘They don’t know how to treat the illness. It’s not like a cut’ (Jack, 317-318)</td>
</tr>
<tr>
<td>4. Impact of illness</td>
<td>‘What a waste of life. He just exists really’ (Debbie, 311-312)</td>
</tr>
<tr>
<td>5. Responsibility/control</td>
<td>‘You feel a big huge sort of responsibility, he’s very dependent on me for everything’</td>
</tr>
<tr>
<td></td>
<td>(Katherine, 222-223)</td>
</tr>
<tr>
<td><strong>Coping Ability</strong></td>
<td></td>
</tr>
<tr>
<td>1. Active behavioural</td>
<td>‘It’s about knowing the illness, but mainly knowing how it affects him and his personality’ (Sue, 284-286)</td>
</tr>
<tr>
<td>2. Active cognitive</td>
<td>‘You’ve got to remain positive’ (Alan, 292)</td>
</tr>
<tr>
<td>3. Avoidance</td>
<td>‘I cannot go home, I cannot face going back’ (Debbie, 538-539)</td>
</tr>
<tr>
<td>4. Self effacement v self fulfilment</td>
<td>‘Human nature sometimes, in a way, means you have to look after yourself’ (Debbie, 596-597)</td>
</tr>
<tr>
<td><strong>Emotional Change</strong></td>
<td></td>
</tr>
<tr>
<td>1. Positive emotions</td>
<td>‘I do think that I do help you know, in her recovery’ (Alan, 590-591)</td>
</tr>
<tr>
<td>2. Negative emotions</td>
<td>‘It sort of makes you feel really upset. It sort, it can make you feel angry’ (Alan, 218-219)</td>
</tr>
</tbody>
</table>
**Figure 1: Interrelationship between Super-ordinate Themes**

**Changing Illness Awareness**

- **Suddenly Decline/Initial Hope**
  - Acceptance Resignation
  - Fear of the Unknown
- **Lack of Understanding**
  - Persistent Threat
- **Growing Awareness**

**IN IT TOGETHER**
1. In it together
2. Impact on relationships
3. Duty of care
4. Positive Professional support

**ISOLATED & ALONE**
1. Implications for self
2. Distance from others
3. Lack of professional support
4. Impact of illness
5. Responsibility/Control

**COPING ABILITY**
1. Active Behavioural
2. Active Cognitive
3. Avoidance
4. Self effacement v Self fulfilment

**EMOTIONAL CHANGE**
1. Negative emotions
2. Positive emotions
Each super-ordinate theme, and the resultant sub-ordinate themes, was analysed using evidence drawn from the transcripts to explore what experiences partners living with a loved one with bipolar disorder may have had and how these have changed.

**Changing Illness Awareness**

This super-ordinate theme suggested that partners went through a process of change as they became more aware of the illness and the impact this had on their ill partners. All interviewees appeared to experience a change in their awareness over time. Within the interviews there were specific phases that partners living with their partner experiencing bipolar disorder went through; however instead of this being a smooth progression through the phases, participants appear to move back and forth and between the phases. The movement between phases is effected by new developments and challenges with the illness, the treatment being received, the partners view of self and any illness related behaviours the unwell partner may engage in to name a few. As a result of this movement this super-ordinate theme and its sub-ordinate themes are depicted in a cycle in Figure 1.

The route through the phases is not linear for caregivers and events may occur which can move them around the cycle. The sub-ordinate themes which make up this cycle are sudden decline/initial hope, lack of understanding, persistent threat, growing illness awareness, fear of the unknown, acceptance/resignation.

1. **Sudden decline/initial hope**

The couples in this study met at different stages of the onset of the illness. For Debbie, Katherine and Jack, they had been married for several years before the onset of the illness, however both Sue and Alan’s partners had already been diagnosed
before the commencement of the relationship. Nevertheless, regardless of the stage
the couple were at in their relationship, the discovery that their partner experienced a
mental illness had an impact on the interviewees due to what seemed to be a sudden
decline in their partners’ health. Katherine explained that this change in her
husband’s health almost seemed to occur overnight:

“The first I knew of it was one day when he came home from work very upset and
broke down but couldn’t really tell me what it was. I didn’t, I had no inclination, no
idea that he was under any pressure or anything until this happened so it was very, it
was just a shock really that he could be alright one day and then suddenly bad the
next day” (lines 38-43).

This sense of shock conveyed by Katherine in the above passage was compounded by
her husband’s inability to explain what was happening and the ambiguity of diagnosis
provided by the doctor:

“He was diagnosed, diagnosed as being (pause) when he went to the doctors he must
have been diagnosed as being under pressure and stress” (lines 54-56).

It was months before Katherine’s husband was diagnosed with having bipolar
disorder:

“He was sent to see a psychiatrist at the hospital, the local hospital and he went to
see him and they described, they said he was manic depressive yes” (lines 62-65).
Even though some of the interviewees knew that their partner experienced bipolar disorder before they commenced with the relationship, the first episode of illness they witnessed was still a shock. Alan reported that he had just started going out with his future wife when she relapsed. His wife’s relapse appeared to occur quickly:

“About 3 days later she phoned me up and said that she was actually in hospital. She’d actually had a relapse” (lines 53-55).

This sudden decline in his wife’s health was upsetting for Alan:

“You can’t even imagine to see someone that are so happy and then to have a relapse and go into hospital. It’s quite shocking to see” (lines 60-62).

Reflecting on his wife’s illness, Jack revealed that although at the time this change from well to ill appeared to happen quickly, he can see that there was a build up to his wife’s breakdown:

“Julie um...had a breakdown in 1995 which was done through family stress; it was brought on by a death in the family. We didn’t realise before the breakdown that she’d had some illness that she was up and down a lot previous to the breakdown” (lines 18-22).

Despite the sudden decline in health of their partners many interviewees stated that after the initial period of illness they were hopeful that their ill partner would get better and return to normal functioning. Debbie, who is now divorced from her
husband, reported that she was hopeful at the beginning of their relationship and her ex-husband’s illness that things would improve:

“You think that love will find a way and everything’s going to be wonderful” (lines 89-91).

After his first experience of his wife relapsing, Alan felt that he did not want to end the relationship and he adopted an optimistic attitude that things would be okay in the end:

“I knew that we could work things out” (lines 76-77).

Sudden decline and initial hope appears to be the first phase of an evolving cycle of changing illness awareness for many interviewees. The rapid decline in health shocked partners and evoked feelings of confusion. However there was hope amongst some partners that this was a ‘one-off’ and that things would work out.

### 2. Lack of understanding

Following the sudden decline in health, partners began to realise that something was seriously wrong due to the way their ill partner was acting and behaving.

“She was so high with the hallucinations and voices and everything and she couldn’t cope with life and everything” (Jack, lines 170-172).

“He just use to sit for hours and not, not talk to me or be in a sort of world of his own” (Katherine, 97-98).
Partners were unprepared for these behavioural changes and did not understand what was happening. For Katherine this lack of understanding came from her husband’s inability to explain what was happening and because she had no prior knowledge or experience with mental health problems:

“At first I didn’t understand what was happening because he couldn’t talk to me. He didn’t tell me anything much about it...he just used to close up if I asked, um, clam...he wouldn’t say anything about what was wrong” (lines 82-85).

“I’ve never experienced or known anybody with depression before, let alone manic depression, it all, everything’s new to you and you don’t know, you don’t really, it’s hard to understand. It’s hard to be with somebody who’s got depression to know what they’re going through” (lines 166-170).

Not having any prior experience of mental health problems within their family meant that partners had nothing to compare this new experience too and, therefore, struggled to understand and comprehend what was happening when their partner was first taken ill:

“’I’d never experienced anything like that with my family’ (Debbie, lines 150-151).

For Jack his lack of understanding was perpetuated by the ambiguity that surrounded his wife’s illness and receiving a diagnosis. The behaviours his wife was engaging in (hearing voices, screaming, shouting – lines 31-32) during the first episode of illness
led Jack to believe there was something underlying, however he felt that professionals involved in his wife’s care could not tell him what was wrong:

“There was something wrong and nobody could tell me what was wrong” (lines 44-45).

Jack wanted to increase his understanding about his wife’s illness. However, his attempts to get information were often hindered:

“When she was actually diagnosed in the hospital that was the hardest thing to get information. Again everything was told to the patient. Nothing was told to the partner or carer whose going to be her carer” (lines 141-145).

The language used by Debbie to describe what happened during her ex-husband’s first episode of illness highlights a lack of understanding. Debbie reported that her ex-husband had a ‘sort of’ nervous breakdown (line 43). The uncertainty in this statement may be as a result of ambiguity surrounding a diagnosis at the beginning of her ex-husband’s illness:

“He kind of cracked up after his father died very suddenly. Um...his mother’s always been very possessive (pause), very possessive with him and she suffered from what she called her nerves as well so I’m wondering if there’s maybe something in the genes a bit” (lines 48-52).

The above passage from Debbie shows her questioning the illness and trying to decide if it is a genetic disorder. Debbie’s way of explaining what happened to her ex-
husband (cracked up, nervous breakdown) may reflect the ambiguity in diagnosis from professionals or reflect a colloquial way of describing mental illness and bipolar disorder.

Alan recognised that when he first met his future wife he had no idea what bipolar disorder was:

“Didn’t have a clue” (line 45).

This lack of understanding induced a need in Alan to go out and research not only what bipolar disorder was, but also how it impacts differently on individuals:

“It makes you want to research, you know, the whole thing about bipolar” (lines 170-171).

At the beginning of their relationship Sue recognised that, because she did not understand the illness, she worried a great deal about the impact the illness had on her partner:

“Because I didn’t understand the illness quite as much as I do now. I was worried about how ill he was and I couldn’t see him” (lines 202-205).

Sue identifies that due to this lack of understanding she would often imagine the worst case scenario:
“I suppose I panicked that…if you’re not with somebody you think the worst and I suppose…um…I worried about not being in touch because I thought, I imagined him being really, really unwell” (lines 205-209).

All partners experienced a lack of understanding about bipolar disorder and the effect it has on their ill partner. However a lack of understanding not only occurs during the initial episode of illness, but can occur if there is a change in the illness behaviour. For example, Jack felt that he understood his wife’s pattern of behaviours when she experienced a manic episode. However on one occasion she spent money instead of engaging in the expected pattern of behaviours:

“She’s flirtatious and every episode has been, except for one, has been flirtatious. There’s only been one when she’s spent money” (lines 1278-1280).

As the illness progresses it may change and there does not appear to be a clear trajectory of illness behaviours or episodes in relation to bipolar disorder.

3. Persistent threat

The unpredictable nature of bipolar disorder was something that most partners experienced over the course of their loved ones illness. As the illness progressed and partners became more aware of the nature of bipolar disorder, it appears as though there was a realisation that the first period of illness was not a one off. In the statement below, Alan sums up the repetitive nature of his wife’s illness:
“You knew at some stage Stacey would get ill again and it would like, you know, keep repeating itself and there was always a good chance that she would end up at the hospital” (lines 118-121).

Whilst partners highlighted the episodic nature of bipolar disorder, they also recognised that in between the mood swings their ill partner could be stable for a time. However it is unclear whether partners felt their loved ones ever returned to ‘normal’ levels of functioning again. The fear that their ill partner could relapse at any point was never far from their minds. Debbie expresses this view:

“He was always very much on the edge of cracking up again, but he did get a really good sales job at one point and he was an absolutely brilliant salesman when he was well” (lines 57-60).

“There were periods of quite a few years between the crack ups when he functioned really well” (lines 84-86).

The realisation that the first period of illness was not a one-off caused Debbie a great deal of worry as the relationship continued:

“I think really I got a lot more worried about it further along the line in our marriage when I began to think he wasn’t ever going to get better” (lines 172-175).

Jack described his frustration and anger at his discovery that his wife will always experience bipolar disorder. He explained that this detail had never been explained to him by professionals and it was something that he had to uncover by himself:
“And you know the illness is not going to disappear overnight. There is no cure for the illness....I knew that, nobody’s ever told me that” (lines 705-707).

“Cause nobody’s ever turned round to me and said well in another 10 years she’ll be cured, it’s only a 10 year illness or a 20 year illness” (lines 712-714).

Due to the persistent threat of the illness and the difficulty in predicating when an ill partner will experience an episode, Jack reported that caring for his wife impacts on every moment of his life:

“It has an impact on all our life from morning to night and from night to morning” (lines 308-309).

Katherine described the difficulty of living with an individual whose behaviour was often unpredictable due to the nature of the illness. She reported that it was like:

“Walking on eggshells” (line 143).

This terminology was also used by Jack:

“I have to be careful with what I say as well, ‘cause if I say things it could set the illness off so I’m always treading on eggshells” (lines 767-769).

This was because Katherine was not sure how her husband would react to what had been said or different situations:
“You never knew how he was going to react to what you said and things like that....um....sometimes he’d be alright but other times he’d storm out of the room and bang on the door and go off” (lines 143-146).

“It’s the unpredictability of the moods, mood swings and that kind of thing, even now you just don’t know how he’s going to react to things, different situations” (lines 384-386).

It appears that partners view bipolar disorder as a persistent and unpredictable illness, which can evoke many negative feelings including anger, frustration, fear and worry. The awareness that their ill partner may experience a relapse in their mental health is never far from the partner’s mind and this seems to impact on the way interviewees may interact within the relationship.

4. Growing illness awareness

As the relationship continued and the illness progressed partners’ became more aware of bipolar disorder, the impact it has on their ill partner and their behaviours. Some gained this awareness through researching the disorder, some over time through personal experience and others through speaking to people, either professional, loved ones or others who had experienced a similar situation. Jack explained how he acquired a greater knowledge through all of the above methods:

“I’m a self motivated person, at first I went into everything, I read all the books. We didn’t have the internet then like we do these days. Um...I, I banged on people’s doors, I wanted to know everything that I could know about bipolar manic depressive
disorder. I got in touch with societies that deal with these things. I got all the leaflets and all the bumph so I read it all so I could understand what the basic knowledge is” (lines 437-444).

As the partners illness awareness grew it appeared that their emotions also changed. For Katherine, with greater awareness and understanding came more empathy for what her husband was experiencing. She recognised that in the beginning, when she perhaps lacked understanding, Katherine felt sorry for her husband, however this turned to anger when she felt she was being pushed away. Currently Katherine is more accepting of her husband and the impact his illness has on him and his behaviours. This pattern is demonstrated in the following extracts:

“It’s a lot better now and I understand more of what it is like and what he went through and you feel sorry. I felt very sorry for him and the way he’s been and what he’s had to go through or his feelings and that and I still feel like that for him” (lines 293-297).

“In the beginning, in the beginning I, I was sad and sorry for him and I tried to understand what was going on and I tried talking to him, but I was just pushed away really so then you go through a phase of being angry and um....and then thinking well if that's the way you’re going to be, just ignoring them in a way” (lines 471-476).

“That goes and eventually you learn just to accept it and you know, you know that it’s going to be alright in the end” (lines 478-480).
Alan views understanding as one of the most important elements of being in a relationship with someone with bipolar disorder:

"I think you've got to understand what that person's going through. I think that, um, it's just like, you know, it makes...I think the big thing, you know, is it makes you want to research, you know, the whole thing about bipolar" (lines 167-171).

Similarly to Katherine, the greater the awareness and understanding Alan had, the easier it was for him to accept the illness and the impact it had on his wife:

"I think the biggest thing for me is that I understand it more and I think if you do understand it, it can become more.....you can actually accept it a lot more" (lines 245-248).

Partners’ awareness appears to be evolving and growing. As partners experiencing bipolar disorder engage in new behaviours, their well partners’ awareness of the illness changes and with it the emotions they experience. This is highlighted by the cyclical nature of the super-ordinate theme Changing Illness Awareness.

5. Fear of the unknown

As a result of the nature of bipolar disorder there appears to be a fear of what will come next, how their ill partner’s behaviour will be in the future and what impact this will have on them and their lifestyle. In this study it appears that fear of the unknown falls into two categories. There is the fear of what long term effects having bipolar disorder will have on an individual and a fear that, because of the illness, their dreams and goals for the future are different.
Jack explained that, although he was aware of the illness and had conducted extensive research into the topic, he was still worried and concerned about the future. His main fears revolved around the long term outcome of having the illness, the long term effects of taking medication and his evolving role as a carer for his wife:

“Nobody’s ever told me that in 20 years time this illness could make her 10 times worse than she is now because of the severity and medication she’s on, because medication does, over a long period of time, have an effect in you. Um...and I see progressive, slow but progressive, changes in the way Julie is in the way her mind works. Not physically, the mind. Um...and my biggest fear is that she’ll end up with Alzheimer’s because its, Alzheimer’s is a mind disease, as is a mental illness, bipolar is a mind...but no one will ever say...there’s no outcome. Nobody’s ever studied the long term effect of all this” (lines 723-733).

“You’re not telling me over the last 50 years people haven’t had bipolar, there haven’t done any studies on it, have they? And people haven’t come out with 30 years of somebody with this illness they’re going to end up 10 times worse than they are on an average day basis, not high and low but they will progress slowly, they’ll slow down, their mind will not function as quick that they’ll need more help and there’s nothing to prepare me for that” (lines 740-747).

Throughout the interview, Jack reveals that there has been limited information on what to expect from his role of being a caregiver. From his research into bipolar disorder, Jack had found no information on what signs a caregiver should look out for as an illness progresses or how to cope and deal with changes that may occur:
“There is nothing there to say in the next 10-15 years what’s going to happen. Watch out for these signs, watch out for other things creeping in now because the longer you have an illness, other things are gonna start going in. But nobody tells you, do they” (lines 751-755).

Debbie explained that from her husband’s first breakdown there was probably always an underlying fear about the long term impact having bipolar disorder would have:

“There was probably an underlying, underlying worry for me as it was the unknown really” (lines 149-150).

In terms of their future, Debbie stated that she did not really think about the implications of her ex-husband’s illness until they had children together. After this Debbie became more concerned about their future together:

“Um it was only later on, after we’d had the children really that I started to feel really worried about our future as a family” (lines 180-182).

For Katherine this fear of the unknown was focused on the impact her husband having bipolar disorder had on their future relationship and dreams as a couple. Katherine reported that her husband had become socially isolated since being diagnosed with bipolar disorder and she worried about what this meant for their future:

“In the future I know what my husband would want, but I don’t want it and it worries me this. I, I want to be in contact with people and see people. And eventually if any
of my daughters have children I’d want to see them and he’s just not bothered, he’d go and live somewhere isolated, out of the way and I just wonder what will happen in the future” (lines 358-364).

There is a great deal of anticipation for Katherine about the future and this often causes her to feel upset:

“I do get upset um wondering, worrying, anxious about what, what we’ll do in the future” (lines 373-374).

Uncertainty about the future of the relationship, unanswered questions about the illness and the long term impact it will have on individuals seem to cause a great deal of anxiety amongst the interviewees. Although it has been identified that bipolar disorder does not follow a smooth course and individuals can experience a number of different symptoms, partners need to be made aware of any commonalities that have been identified and informed of how the illness may or may not progress. It would seem that any answers rather than no answers would be beneficial for partners.

6. Acceptance/resignation

All partners interviewed had a number of years experience of being with and living with a partner experiencing bipolar disorder. Over this time partners have gained a greater insight into bipolar disorder and its impact on their ill partner. This has gradually allowed them to accept or become resigned to the fact that their partner has a mental illness. Over the course of the illness partners appear to have had time to re-evaluate some of the experiences that caused them most concern. As Sue demonstrates below, she now feels she has a more realistic view of the illness and the
impact it has on her partner. Whereas at first she may have been anxious about certain behaviours, she now understands how they will manifest and impact:

“I’ve got a more realistic view of it now and I might think, ‘oh no’ but at the same time I know we’ll get through it and it wears off. It’s not a major thing” (lines 237-240).

Katherine acknowledges that it has been a long journey to acceptance, indicated by the word ‘eventually’ in the following two extracts. However she has now adapted to this new way of life and has learnt new ways of being so the relationship works:

“I’ve learnt to accept that eventually he does come out of it and I don’t necessarily ignore it but I just carry on, try to carry on as normal” (lines 459-461).

“Eventually it comes, it comes back, he comes round so I’ve just learnt to live with that I think” (lines 478-480).

Alan appeared to engage in a process of normalising his wife’s illness and comparing this to others in order to accept the situation. Alan explains that there are possibly things that he cannot do because of his wife’s illness, however he does not know if he would be able to do them anyway if the situation were different. Therefore, he tries to focus on the positive things that his wife having bipolar disorder brings to their relationship:

“I think that people do think the grass is greener on the other side, but a lot of the time it’s not. You do think you know if I wasn’t going out with Stacey I could do this, I
could do that, I could do this and it’s not always the case and I think you know, when you’re in a situation and you are married to someone with bipolar and they are witty and they are funny and you know they’re not going to go off with someone else (pause) hopefully. It does even though sometimes it’s hard and it’s frustrating. I wouldn’t change it for the world” (lines 597-607).

As Jacks awareness of the illness developed and the periods of time in between episodes of his wife’s illness increased, he was able to put things into perspective and reflect on the relationship. He reported that his daughter frequently asks why he has stayed with his wife:

“Because I love somebody and when she’s well she’s got the same kind of love as I have and that’s what I like about it. When she’s on par she loves me as much as I love her and she would never hurt me if she couldn’t help it through her illness, she would not hurt a hair on my head” (lines 1374-1378).

For the four partners discussed above they have all accepted their partner is affected by bipolar disorder and they want to stay in the relationship. For Debbie, however, acceptance came in the form of accepting that she could not stay in the relationship. After much deliberation Debbie decided to separate from her husband:

“I thought probably it was best if we did split up” (lines 71-72).

Acceptance does not appear to be a permanent state or feeling. Just as with the cycle of change, something can happen within the relationship to disrupt these feelings on some level. A relapse, their partners engagement in a new behaviour or even a
change in medication or professional help can take the partner back to another point in the cycle. In all the partners interviewed their ill partner was currently stable and had not experienced a relapse for some time. This may explain why all partners currently appear to be in the acceptance stage of the cycle of changing illness awareness. If partners were interviewed whilst their ill partner was experiencing a relapse they may be in a different stage.

In It Together

Previous research exploring the experiences of partner’s living with a loved one with bipolar disorder have discovered that although partners live with their loved one they often feel alone, isolated and excluded (Van Der Voort et al, 2009, Tranvag & Kristoffersen, 2008). However, within this present research partner’s often gave a sense that they were ‘in it together’ with their ill partner. This sense of togetherness was highlighted by a number of subordinate themes, including impact on relationships and duty of care.

Within this study some partners felt that although it was not them experiencing bipolar disorder, the impact the illness had was just as significant for them as it was for their ill partner. Jack explained that he felt that his wife’s bipolar disorder affected both him and his wife:

“So really its two people, this illness. It’s not just one person, it effects both people a lot” (lines 1059-1061).
Jack felt strongly that the bipolar disorder was something both his wife and he lived with and because of this he should have a say in a number of things, including how the illness is treated:

“It’s an illness we both live with” (line 1580).

“It’s my life as well and I do want a say in it” (lines 86-87).

It appears as though Sue feels she and her ill partner are a team when it comes to dealing with and coping with his illness:

“I do think that he’ll have periods of being unwell and periods of being agitated and stressed and we’ve coped with them and we will again and it’s, it’s fine, we deal with it” (lines 231-234).

1. Impact on relationships

In terms of relationships it appears as though well partners relationships with family, friends and their ill partner have changed over the course of the illness. The creation of new friendship groups which consist of other individuals either experiencing mental health problems or caring for someone with mental health problems, feeling closer to their loved one and receiving support from family are different ways in which caring for their loved one impacts on relationships and can make partners feel like they are in it together. Friendship groups changing and being offered support are perhaps signs that the illness has just as much of an impact on the well partner.
Alan created new friendships with individuals who were more understanding and positive about his relationship with his wife:

“I thought I needed to make that break to move on from them and find new friends who were more understanding” (lines 387-389).

Jack reported that many of his friends are now those who either have a mental illness or care for someone who has. This new social network are more understanding and supportive and Jack does not have to explain his wife’s behaviours, which could cause Jack an enormous amount of stress:

“It’s very, really close friends that understand the illness then that you go out with” (lines 297-298).

Other partners have received support from family members and friends, which has perhaps given them recognition that they too are affected by the illness. Sue acknowledged that she receives support from her parents with regards to her partner’s illness:

“I have my parents who I say don’t understand completely cause they don’t live with it and so you can’t, but they understand enough and they do support me” (Sue, lines 398-341).

Debbie and Katherine appear to have experienced support from friends which they have found helpful:
“There was one friend who I did talk to cause she’d experienced exactly what I was going through and that was very helpful and I could talk to her and she knew what it was like, but...oh and the one person I did speak to about more or less right from the start was a cousin who lives a long way away who I don’t see very often who didn’t know the situation so I could talk to her. So I did talk to her” (Katherine, lines 422-428).

“I think I would have gone completely out of my tree (laughs), you know, had I not got my girlfriends to meet some times (laughs)” (Debbie, lines 270-272).

An individual’s mental illness can not only have an effect on a persons’ wider social network, but also on the relationship of those closest to them. Since her husband’s diagnosis of bipolar disorder, Katherine feels that they have become closer in their relationship:

“In some ways we’ve become a lot closer” (line 552).

It appears that the support received from family and friends and changes in social relationships can help partners feel more included and it is a recognition that the illness has just as much impact on them as it does their ill partner.

2. Duty of care

Within this study it was found that some of the partners viewed caring for their loved one as part of their spousal duty. This duty can be shown in a number of ways, be it practically caring for their loved one or moving house in order to improve their partner’s mental health. Debbie stated that although she thinks these values are old
fashioned now, at the time she married her ex-husband it was forever and therefore she had to continue with the marriage:

“It’s a bit old fashioned now I suppose, but when you get married you think it’s for good. You know in sickness and in health so you know you just think you have to keep going” (lines 115-118).

Debbie explained that as a wife she had certain duties:

“I should be able to make him right, you know, you’re supposed to love him, you should look after him, nurture him and make him better” (Debbie, lines 587-590).

Jack also refers to his wedding vows when discussing caring for his wife:

“I always believe in the words I said when I got married. For better or worse, for richer or poorer, in sickness and health. Um and them are the cornerstones of my life” (lines 1116-1119).

As a result, it appears Jack feels it is his duty to care for his wife in sickness and in health. In an attempt to care for her husband and improve his mental health, Katherine and her husband moved to a house with a bigger garden so he could spend time in the garden:

“The reason we moved to the house was because er my husband had had a breakdown and we wanted to get away from where we were living and he enjoys
gardening and because of the large garden we bought the house really” (lines 20-24).

Some partners within this study appear to see caring for their ill partner and doing whatever is necessary to help improve their mental health, as their duty as a spouse/partner.

3. Positive professional support

Partners within this study expressed that they had received positive support in some situations, however in general their experience with professional support was negative. For most partners, positive support was received from one individual rather than a team. Alan received a great deal of support over the years from the Community Psychiatric Nurse involved in his wife’s care:

“She’s had a Community Psychiatric Nurse who just seems to know everything and know everyone” (lines 617-619).

Knowing that this support is there and readily available has made a big difference to how Alan feels and the way he copes:

“It’s just knowing that there is professional people there and the support that Stacey does have has made a big difference” (lines 631-633).

Receiving positive support from one person involved in their loved ones care appears to have made a difference to partners. They expressed feelings of gratitude and felt respected for their role in caring for their ill partner. Both Jack and Katherine had
positive experiences with their Doctors at their GP surgeries. For Jack he felt that the Doctor understood not only his role within caring for his wife, but also how this impacted upon him:

“So every time I go about myself the last question they’ll say to me, ‘how’s Julie?’ Now that's good doctors that” (lines 1567-1569).

Katherine felt the support she received from her Doctor was very helpful:

“The support I had from the doctor, my doctor was very good when I went to see her. She was very good and she helped me a lot” (lines 583-585).

Being able to speak to her GP was very important to Katherine:

“She was somebody I could talk to and I felt that she understood what was happening” (lines 588-589).

Maskill et al (2010) also found that participants had positive experiences with individual members of staff and that this had a positive effect on treatment outcomes.

**Isolated and Alone**

The feeling of isolation and being alone is a complicated phenomenon and can occur in numerous aspects of the well partners’ life. Most of the partners interviewed had experienced some sense of isolation or exclusion as the following extracts show:

“He just didn’t want me to see him like that” (Sue, line 211).
“I did feel very isolated” (Debbie, line 401).

“You can’t shout or tell people what goes on behind closed doors” (Jack, lines 531-532).

“I’ve been on my own a lot of the time with it” (Katherine, lines 432-433).

Five sub-ordinate themes were identified that seemed to contribute to feelings of isolation and aloneness within the partners of individuals experiencing bipolar disorder.

1. Implications for self

Implications for self has been included as a sub theme for ‘alone and isolated’ as it is something that only the well partner will experience and maybe an experience that only others who have been in similar positions can truly understand. Therefore the well partner is thought to be ‘alone’ in this experience. Caring for a partner with bipolar appears to affect an individual in a number of ways. It appears to impact on the well partner’s mental health and also on their perception of themselves throughout the caring process.

All partners interviewed expressed that their mental health had been affected in some way either since their partner became ill or since they started the relationship. Sue acknowledged the effect living with her partner had on her mental health by joking that when he is anxious it is infectious:
“When somebody’s anxious it’s infectious and to be around that can be really, it can be overwhelming sometimes and that’s the only way it affects me negatively. I think, I’m starting to catch this (laughs) and I’m going to end up as bad as you” (lines 336-340).

Debbie also used humour as a way of recognising the impact on her own mental health. When discussing her social life Debbie felt her mental health would have been negatively affected if she had given up seeing her friends:

“I think I would have gone completely out of my tree” (lines 270-271).

Jack recognised that the responsibility of caring for his wife puts a great deal of pressure on him and this could impact negatively on his mental health:

“I do feel sometimes the pressure put on me; it could bring me down sometimes” (lines 87-88).

For some partners the effect of caring on their mental health meant that they actually had to seek help themselves. After a visit to her GP, Katherine was sent for counselling:

“I went to the doctor eventually because it got so bad and she sent me for counselling” (lines 116-117).
Debbie also sought professional help for herself, however she was wary of the stigma attached to having mental health problems and therefore accessed help independently from her doctors:

“I went to the centre and got put in touch with a lady who was a counsellor and I did have some counselling sessions and (pause) I used to cry most of the time through them, but it felt wonderful to have someone there to bounce my feelings off. But, you know, I had to pay for it, but it was all off my medical record” (lines 210-215).

At the start of his relationship with his wife, Alan found caring for her very stressful and had to take time off work as a result:

“It was so stressful and I did actually go on the sick for six months” (lines 196-198).

In terms of how they viewed themselves, some of the partners expressed that they had often felt that they were to blame for their partner’s ill health:

“Sometimes you were thinking it was your fault” (Katherine, line 153).

Debbie felt that she perhaps contributed to her ex-husband’s illness because she was not as sympathetic as she could have been:

“Maybe there were times when I wasn’t as sympathetic as I should have been” (lines 728-730).
However, Debbie acknowledges that she could not fully understand what her ex-husband was experiencing as she had not experienced bipolar disorder herself and that she was exhausted from the caring role:

“I mean until you have proper full blown depression and mania yourself you really don’t know what it is like” (lines 726-728).

“I was just wound down with it” (line 730).

Jack expressed that he could not give up the caring role and all that went with it because if he did and something happened he would feel he was to blame:

“I think if I didn’t worry and something happened who would I blame? Myself again, ‘cause there’s nobody else out there to help” (lines 902-904).

These feeling of self blame could lead to increased feelings of guilt which could further isolate partners thus increasing their feelings of being alone, which can further impact on the caring partner’s mental health.

2. Distance from others

Social networks and the couple’s relationship may be negatively affected in a number of different ways. Partners may experience negative attitudes from their family and friends which may ultimately result in a change of social circle to or further isolation. The relationship between the couple may also become strained due to the illness and well partners may feel alone as they cannot speak to their ill partner.
Negative attitudes from friends and family were often experienced by partners. Debbie think that this negative attitude arises due to a lack of understanding amongst others:

“A lot of people still think with mental health problems it’s ‘oh tell him to snap out of it’” (lines 348-349).

Because of some of his friends’ negative attitudes towards his relationship with his wife, Alan felt he needed to make a decision to leave these friendships behind:

“I feel that some of my friends were quite negative. So as times gone on me and Stacey was getting closer, but some of my friends were just drifting apart” (lines 383-387).

Alan feels that this negative attitude towards his relationship stems from a lack of understanding about mental health problems:

“People don’t understand it so really they think, well they don’t really want to get involved cause they don’t know what to say, they don’t know how to handle it” (lines 372-375).

Jack has found that his social network has completely changed since his wife’s first period of illness.

“You don’t go out with total strangers some times because you don’t know what the outcomes gonna be, how are they gonna react to you if you say something to you go
out and she’s on a bit of a high or she goes out and she’s depressed and how they’d take it and I have to explain that well you have to excuse us cause she has an illness” (299-304).

Instead of experiencing a change in social network, Debbie and Katherine both experienced a distancing from friendships. Debbie recognised that by the time she and her husband split up they did not have many mutual friends:

“By the time we split up we didn’t really have any other couples to go out with because he didn’t want to go out” (lines 374-376).

As the illness progressed Katherine’s husband became more withdrawn from others and Katherine felt this not only isolated him but her also:

“He didn’t want to go out, he didn’t want to see anybody...um....he became, we became sort of really in a way very isolated” (lines 209-211).

Partners also experienced a distance between themselves and their ill partner. Debbie felt because the focus was always on her ex-husband’s illness she was often excluded:

“Not feeling, having any feeling for my emotional needs at all everything was focused on his illness” (lines 189-191).

This led to Debbie feeling alone emotionally in the relationship:

“So I felt very lonely really, emotionally” (line 195).
Katherine also experienced a distancing from her partner:

“If I did say anything to him he was very dismissive or he didn’t want to know” (lines 139-140).

These feelings of distance have had a negative impact on both Debbie and Katherine leading to feelings of loneliness and helplessness:

“You just felt helpless” (Katherine, line 140).

The experience of living with a partner experiencing bipolar disorder can have a negative impact on the couple’s social network and their relationship. Lack of understanding may distance others from the couple and may result in a change in the social network to individuals in similar positions. There may also be a distancing between the couple, leading the well partner to feel alone and helpless.

3. Lack of professional support

The present study revealed negative experiences with professionals had been had by nearly all of the interviewees and these have been broken down into three categories.

1. Partners experienced a general lack of support from professionals and when support was offered this was often inappropriate to their needs. 2. Often approaches adopted by professionals were aimed only at the ill partner and thus systems were individualised excluding the well partner. 3. Finally there seemed to be a need from partners for their experiences and care-giving efforts to be validated by professionals.
These negative experiences all contributed to the feelings of isolation experienced by partners.

The systems put in place to support the ill partner were seen as individualised by those interviewed. Well partners often felt excluded from the treatment process by professionals and seemed to regard the idea of patient confidentiality as a means of keeping them in the dark. Jack feels as a carer he should have the right to all the information available regarding his wife’s care:

“You can only go so far and that's as far as a carer can go. After that it’s patient confidentiality and that's a big stumbling block, patient confidentiality. Because once you as a carer, your exempt from seeing certain things or saying certain things. Or doing certain things because it’s patient confidentiality and I, I feel that we should have the right to have every information that's going. Have the right to see things, to be involved in things and we, we're not” (lines 641-649).

Jack described this idea of patient confidentiality as ‘coming against brick wall’ (line 649), which, as a carer, he cannot get over. Debbie described patient confidentiality as the shutters coming down suggesting that she is then shut out from any involvement in her husband’s care:

“The shutters went down. ‘Oh no confidentiality, we can’t discuss it’” (lines 140-141).

Partners also felt that any treatment should also take into consideration their needs and concerns. After all as Debbie pointed out:
“No man is an island” (lines 735-736).

Jack explained how he felt the partner’s/carer’s perspective needs to be taken more into consideration by professionals, moving away from the individualised approach to a more collaborative way of working:

“That's what we should have more of. People coming up to you as a carer and saying how’s it going? Is there anything that's not right before its gone wrong? Is there anything we can do to help you? Is there anything you need?” (lines 1588-1592).

At the moment Jack feels he is constantly coming up against this brick wall which is the individualised approach:

“That's one of the biggest problems that I’ve always found is that when it comes to me speaking to people I can’t speak to people. I find it very hard for authorities to let a carer speak for somebody” (lines 209-212).

As different health care professionals became involved in their ill partners care, partners often felt excluded from this process. The support being provided by the health care system was sometimes viewed by partners as inappropriate. Whilst reflecting on his wife’s past hospitalisations, Jack compared the treatment of his wife’s mental illness by health professionals to the treatment of a physical ailment, such as a cut or a broken arm implying that this is how individuals with a mental illness are treated:
“Because as usual they don’t know how to treat the illness. It’s not like a cut, it’s not like a broken arm, put plaster on it” (lines 317-319).

Hospitalisation can often be the end result for individuals with bipolar disorder if episodes of the illness cannot be managed in the community. However Jack views the hospital as the wrong environment for his wife:

“Putting her in hospital is, is the hard thing to do. It’s the wrong environment. If I could have everybody who’s got an illness put into respite for the first point of contact I would do. If I could set up 100 places in a town and just have people taken away from society, put in a place where they’re free and feel comfortable and feel secure and let them self medicate and bring them down and realise that they’ve been ill before they end up in hospital, because when they’re in hospital they’re looked after but they’re neglected” (lines 389-398).

Jack felt that discharging his wife back into his untrained care when she has not fully recovered is inappropriate:

“We’re not trained. We get no training whatsoever as a carer about how to look after somebody” (lines 428-230).

This experience was also identified by Alan:

“If there’s no beds you can’t just walk in and say I want a bed. There’s got to be beds there available to have. So what they’ll do is they’ll just send you home and then
you’ve got to wait for a bed to come up, which can be, which can be a bit of a nightmare” (lines 679-684).

Due to the individual approach to treatment adopted by health professionals, partners felt there was a lack of involvement and lack of support offered to them. This lack of support was highlighted by partners in the following extracts:

“Um (pause) somebody to really listen to me and believe what/how...my side of how he was behaving” (Debbie, lines 697-698).

“you feel so let down ‘cause if I go to somewhere and say I need this, ‘Oh we don’t know anything about it...where do....what you on about,’” (Jack, lines 633-635).

“No formal support at all” (Debbie, lines 139-140).

However, when support has been offered to partners on many occasions this has been viewed as inappropriate to their needs. Katherine went to see her GP as she was struggling with anxiety and feeling low in mood whilst looking after her husband. Her GP prescribed Katherine anti-depressant medication and also referred her to see a counsellor:

“She did try to give me tablets and anti depressants and things but I didn’t, I couldn’t take them in the end” (lines 586-588).

Katherine felt the counsellor she was referred to was inappropriate:
"The counsellor I wasn’t very happy with. I was at first, she was alright but then as I said once she started to try and delve too deep into maybe what was causing this depression...... My husbands...um....it upsets me too much and I just didn’t want to know so I stopped seeing her” (lines 589-595).

It would appear that within the sessions the counsellor focused upon her husband’s illness and not on the experiences and feelings Katherine was currently having. Instead of being client led and working with what Katherine brought to therapy, the counsellor perhaps had her own agenda, influenced by her own expectations, and this actually caused Katherine more distress.

Debbie viewed her interactions with most professionals involved in her ex-husband’s care as unhelpful and inappropriate. She reflected on one occasion where she asked to speak to her ex-husband’s clinical psychologist and was shocked by the response she got:

“I did go and see his clinical psychologist and, I know I probably shouldn’t say this, I know she wrote a letter afterwards that said I was a bit of a worrier which I found very insulting” (lines 455-458).

Debbie felt that the psychologist could not empathise with or comprehend the position she was in as her ex-husband’s wife and carer:

“I just thought if you were in my position you would worry” (lines 460-461).
This negative experience left Debbie questioning the efficiency of the healthcare professions involved in her ex-husband’s care:

“I thought well I don’t know how you got a job” (line 749).

Partners wanted their experiences acknowledged by professionals and to have an opportunity to discuss these experiences. Partners felt as though they could offer something to professionals in terms of their knowledge of what their ill partner was like on a day to day basis. Despite this, the spouses/partners in this study often felt that their experiences were disregarded or they were not believed by professionals. Debbie stated:

“There wasn’t anybody there to see what he was like, I was the observer, but nobody really wanted to listen to me” (lines 706-708).

Not being listened to by professionals had a negative impact on Debbie:

“It was like you didn’t count” (line 711).

As a result, Debbie never felt welcomed by professionals and she described her position as a carer as being on the sidelines:

“I felt like I was on the sidelines. I didn’t always go cause I just didn’t feel welcome really” (lines 772-773).
Jack also experienced the feeling that his opinions as a carer were not listened to by professionals:

“You are only there as an observer. You can only say so much and then they’ll say I’m not speaking to you” (lines 1543-1545).

Instead of receiving validation from professionals that they were coping and doing well caring for their ill partners, some partners were blamed by professionals and accused of making their partner’s illness worse. Debbie experienced this when she attended a psychiatry appointment with her ex-husband:

“He used to ask me to go with him so I could explain how he was and she didn’t really want to listen and one time she said, ‘well your far worse today now you’ve got your wife with you’” (lines 758-761).

Although Debbie said this comment laughing, it feels as though this laughter is a way of dealing with the pain caused by what was said. Similarly Alan was informed by staff at the hospital where his wife had been admitted that they felt he was actually making his wife worse by visiting her everyday:

“They do actually say when I was going to see Stacey every single day it was actually making her worse” (lines 432-434).

Instead of feeling listened too many of the partners felt like they were banging their heads against brick walls whilst trying to speak to professionals. Jack stated:
“Don’t forget, it’s that brick wall. You come up against it again” (lines 1542-1543).

Debbie also experienced this sense of banging her head against a brick wall when trying to make herself heard and her views and opinions understood by professionals:

“It was like banging my head against a brick wall at the time. Nobody really seemed to want to listen. I don’t know whether they thought I was making it up or what, I didn’t feel believed anyway” (lines 778-781).

Sue was the only partner interviewed that had no experience of professional support either for her ill partner or herself. This may be related to the fact that Sue’s partner had been experiencing bipolar disorder for a long time before their relationship started and as Sue highlighted:

“He’s had about 40 years experience of dealing with it so he’s actually quite good at it. He’s a bit of an expert at keeping himself well” (lines 39-41).

4. Impact of illness

When an individual diagnosed with bipolar disorder experiences depression they may withdraw from social activities and from engaging with family and friends. When they are manic individuals may be hyperactive and engage in reckless behaviours (Dent et al, 2004). The impact bipolar disorder has on the ill partner and their behaviours may leave their partners feeling confused, anxious and hurt by their behaviours, questioning the impact of the illness on their partner and experiencing a sense of loss for how they have changed.
Some of the behaviours ill partners engage in can cause a significant amount of distress for their partner and make them feel isolated not only from their ill partner but their family. Jack explained that when his wife was manic she would become flirtatious with other men and this had resulted in her having several extra-marital affairs over the years. This behaviour had a big impact on Jack:

“That does have a big effect on me. It has a big effect on our relationship” (lines 259-260).

When his wife does experience a manic episode Jack feels he is the one she ‘turns on’ and tries to shut out from her life:

“The first person she goes against is me” (line 855).

Katherine found her husband’s behaviours very worrying as he would often just walk out of the house and Katherine would not know where he had gone or when he would be back:

“If something was said that upset him he’d just suddenly disappear and walk out of the house and you wouldn’t know where he’d gone or how long he was going to be. It was very worrying and upsetting” (lines 148-151).

Partners questioned the impact of the illness on their partners’ behaviours and the amount of control they had over their actions. Reflecting upon her relationship with her ex-husband, Debbie reported that she felt her ex-husband portrayed an image of
himself as somebody who struggled to go out, yet on several occasions he had been
able to leave the house:

“He’d been in a bank! This is him who couldn’t go out! Been in the bank and got
cash and got the neighbour to take him” (lines 485-487).

“He’d managed to get himself to Morrison’s on a Saturday to shop for salmon,
because he had to cause I wasn’t doing it for him, so I think he lent on me an awful
lot” (lines 508-511).

As a result Debbie felt cheated by her ex-husbands behaviours and that he was
relying on her too much throughout their marriage:

“I felt a bit cheated really. I thought why couldn’t you do that before” (lines 513-
514).

It seems as though Debbie is now questioning whether the illness had as much of an
impact on her ex-husband as she first thought. Jack, on the other hand, believes that
the illness his wife has is responsible for her behaviours. Jack’s wife had several
extra-marital affairs when she was manic. This has caused Jack a lot of distress over
the years, however he feels strongly that his wife does not mean to cause him so
much upset:

“She would never hurt me if she couldn’t help it through her illness” (line 1377).
Another impact of the illness was that some partners felt their loved ones were not the same as they were when they first met. Katherine described how she experienced a sense of loss when her husband was diagnosed with bipolar disorder and her realisation that he had not been able to work up until retirement age:

“I feel very sad in a way for my husband because of what he’s missed and I think he was very young when he had to finish work and I think he’s, he’s upset that he’s missed out on 10 years of his teaching life” (lines 315-318).

This sense of loss can be isolating for partners. Katherine reflected back on her relationship with her husband and stated that he was once more outgoing:

“Has altered a lot compared to what he used to be, he used to be quite gregarious and friendly and go to the football with his friends and things” (lines 319-321).

Now she feels as though she is:

“Living with somebody but they’re not really there” (lines 245-246).

Although she and her partner are no longer together, Debbie also experienced a sense of loss as she feels her ex-husband is no longer living just existing:

“What a waste of a life, he just exists really. You know he hasn’t got a proper life at all” (lines 311-313).
The present study suggests that bipolar disorder has a direct impact on individuals’ behaviours and these can leave their partners feeling alone. Partners may find themselves fearful of what their ill partners may do when unwell or questioning the actual impact the disorder has on them.

5. Responsibility/Control

Within the interviews the majority of partners described that they had all the responsibility for ensuring that their ill partner was cared for, taking their medication and keeping well, however they had no control over what their ill partner did, how they behaved and how they were treated by professionals (i.e. what medication they were on). As a result, partners felt an overwhelming sense of responsibility on the one hand and powerlessness on the other. Many of the partners described a sense of powerlessness when discussing their partner’s illness. Alan felt that his wife’s illness controlled how they lived their lives:

“*You’ve always got to be thinking, you’ve always got to be planning ahead all the time. ‘Cause it’s not...even though when she’s well and she’s taking her medication and everything’s going, you know, good and she’s doing stuff with her friends, it’s always there. It never goes away, even though she’s well, it’s always at the back of your mind. It’s something that..... You never go through a day where you don’t think about it. It’s just always there*” (lines 155-164).

Alan also recognises that his wife needs to take medication and as a result, their life can revolve around making sure she is taking it:
“The thing can revolve around the medication and making sure that she’s taking it” (lines 140-141).

Jack recognises that his wife’s illness has shaped not only his life but his family’s life:

“The illness has nurtured us, because we have to learn the illness. Not just me, like I say my daughter has to learn the illness and Julie has to learn the illness and that illness then nurtures us into how to live our life” (lines 518-522).

As the illness has ‘nurtured’ Jack it means he leads a very different life to others:

“I mean everybody says we all lead a normal life but we don’t lead a normal life in a sense because our life is different to your life, or next door neighbours life. It may seem that we get up in a morning, go to work, come home and go to bed, but they don’t see what goes on behind closed doors” (lines 526-530).

Due to the impact the bipolar disorder has on her husband’s behaviours, Katherine feels this has resulted in her husband controlling how they live their life:

“In a way he’s very controlling” (line 308).

“The way that we live because of how, how he is still” (line 310).
Many spouses found that they had to take responsibility for most day to day tasks. Debbie found that she was solely responsible for looking after the finances when her ex-husband was unwell:

“Looking after the household finances, which wasn’t easy” (lines 323-324).

It appears Katherine felt responsible for her husband in every area following his diagnosis. As a result she became responsible for most things within the house:

“I feel then you feel a big huge sort of responsibility, he’s very dependent on me for everything. That’s another thing he’s given up everything to do in the house is my responsibility the bills, the cars, looking after things and that. He doesn’t seem to be able to cope with the responsibility of anything like that” (lines 221-225).

For Jack being his wife’s carer is a huge responsibility and is more than just simply looking after someone:

“I’m the first point of contact or I’m the first person who gets in contact with anybody. So you can see, from my point of view, that being a carer is a lot more responsibility than just looking after somebody” (lines 109-112).

As the ‘first point of contact’, Jack feels he has to take full responsibility for his wife:

“I take everything on board, I take everything, I take all the responsibility of Julie’s well being” (lines 114-115).
A consequence of having this responsibility is that Jack feels he is more to blame for when things go wrong. With regards to medication, it appears Jack feels that if he encourages his wife to change medication and it does not work that this is his responsibility:

“How do I cope with that saying yes or no, cause at the end of the day it will be a yes or no again from me and my responsibility. Cause if it doesn’t work who gets blamed? Not the doctor, it would be me cause I’ve said yes to it” (lines 1049-1052).

Coping Ability

Within this study partners used a range of different coping strategies. It would appear that the range of coping styles is constantly changing and this may be connected to the where a partner is in the cycle of illness awareness, however further exploration is required on this matter.

1. Active behavioural

Partners within this study used coping strategies classified as active behavioural at various stages throughout their partner’s illness. Two main forms of active behavioural coping were found amongst partners in this study, seeking support and talking and information seeking. Alan found that talking was one of the best ways of coping with his wife’s illness and he would often talk with his manager at work:

“I was, um, talking to my manager I was going in seeing her and she said if you ever need any help, you know, you know where I am. So I was always going to her into her office and we’d shut the door and we’d just talk” (lines 402-407).
Sue found speaking to her manager at work, who also shared a similar experience, useful and reassuring:

“The manager who has a daughter who has bipolar and she knows what I mean if I talk to her” (lines 396-397).

Having someone to speak to who had also had a similar experience was also important to Katherine and had a positive impact on her ability to cope with her husband’s illness:

“Once I started talking to my friend who was experiencing it was a lot better” (lines 611-612).

Debbie, reflecting on her relationship with her ex-husband, felt that had she had someone to speak to and talk about what was happening when she was still with her ex-husband it would have helped:

“It’s been quite nice to have someone to listen” (lines 793-794).

“If you’d had come and asked me then I’d have probably got a lot out of it” (lines 800-801).

Alongside seeking support and talking, partners identified information seeking as another way of coping with their partner’s illness. This way of coping perhaps links with the sub theme growing illness awareness in the cycle of changing illness awareness. Partner’s cope with the illness by seeking information about it, this in
turn increases their understanding of the illness and helps them to move through the phases in the cycle. Jack felt that without having an understanding of his wife’s illness it would be difficult for him to cope:

“If she’s got an illness I need to know cause if I don’t know I can’t cope with it and if I can’t cope with it I can’t live with somebody through an illness” (lines 151-153).

Similarly, Alan felt that without an understanding of his wife’s illness he would not be able to cope. Alan felt that he needed to use his own resources and research the illness to increase his ability to cope:

“I think the big thing, you know, is it makes you want to research, you know, the whole thing about bipolar, cause then it helps you to cope with, you know the illness as well” (lines 169-172).

Information seeking appeared to not only involve researching what bipolar disorder was but also how the illness impacted upon their ill partner. For Sue the latter is more important in helping her cope:

“It’s about knowing the illness, but mainly knowing how it affects him and his personality” (lines 284-286).

The active behavioural coping styles adopted by partners in this research could be described as pro-active attempts to improve their ability to cope with their partner’s illness. It appears that having someone to talk to, especially someone with a shared
experience, and increasing understanding about the illness through actively seeking information all increase partner’s ability to cope.

2. Active cognitive

Coping styles identified by partners which fall into the category of active cognitive coping include remaining positive and accepting their partner’s illness and the situation they are in. Remaining positive is one way that Alan copes with his wife’s illness:

“I think that you’ve got to remain positive” (lines 291-292).

When discussing coping styles, partner’s explained that they cope with the depressive episodes of their partner’s illness by learning to accept that this is part of the illness and things will get better. Acceptance falls into the active cognitive coping style. Katherine has learnt to accept that the depressive episodes are just part of her husband’s illness and he will be alright again:

“When he’s depressed I’ve just...um...when he becomes very quiet and doesn’t want to talk to anybody and will just sit and I’ve learnt to accept that eventually he does come out of it” (lines 457-459).

Katherine felt that as a result of this acceptance she had learnt to live with her husband’s depression:

“I’ve just learnt to live with that I think” (lines 467-468).
Accepting that his life has changed and mental illness is now a part of his daily life has helped Jack to cope. Jack appeared to feel that coping with his wife’s illness had become such an integral part of his daily life that he was not sure he would be able to cope if he was taken out of this situation:

“And if lots of people say to me, how do you cope with it? Well you just do, it’s an existence, its life, that's how your life is” (lines 506-508).

“It’s our daily life, it’s my daily life, it’s my daughter’s daily life, its Julie’s daily life. If you took us out of that environment and put us into a different environment we probably wouldn’t be able to cope” (lines 511-514).

Using active cognitive coping styles did not appear to be as popular amongst partners as using active behavioural coping styles. Although Katherine revealed that acceptance is a way of coping with the depressive episodes of her husband’s illness, further exploration is needed to discover how other partners cope with this part of bipolar disorder.

3. Avoidance

Most partners revealed that they utilised some form of avoidance strategy to cope with their partner’s illness. The partners within this study employed different methods of avoidance to cope, some avoided thinking about their partner’s illness, others would avoid being with their ill partner and sometimes partners may avoid speaking about their partner’s illness either to family or friends.
Both Katherine and Alan found that they sometimes coped by trying to take their mind off their partner’s illness and avoid thinking about it. Katherine found that she avoided thinking about her husband’s illness and in particular the impact it may have on their future:

“I don’t really want to think about it” (line 369-370).

For Alan he copes by trying to take his mind of his wife’s illness:

“I think to just try to take your mind off the whole thing” (lines 420-421).

Some partners coped by avoiding their partner when they were unwell. Debbie reflected on one occasion when she felt she could not return to her house and her ex-husband so stayed the night in a hotel rather than going home:

“When it got to time to finish work I just thought ‘I cannot go home, I cannot face going back to that house and going back to all these problems.’ So I went and stayed in a hotel over night” (lines 538-541).

Sue felt that sometimes living with her partner can be overwhelming. As a result, she often feels that one way of coping with this is to ‘get out’ of the situation:

“I need to go out” (line 341).

Partners may feel the need to keep things that happen within the relationship hidden through fear or shame, or they may decided that their partner’s mental health is not a
topic they wish to discuss with others. Throughout the interviews partners gave the
distinct impression that at some behaviours or aspects of their partner’s illness they
could not share with others. When Jack’s wife was experiencing manic symptoms, he
would keep this to himself as he felt others would not understand:

“They don’t understand 100% but... ’cause you keep a lot of it away. When things are
high what goes on you keep to yourself. You don’t explain what’s happened. That’s
another thing you can’t tell anybody what’s happened. I can’t go up to somebody and
say well she’s been seeing somebody again because they’ll say why do you put up
with it” (lines 1419-1425).

Sue on the other hand, explained that she chose to keep details of her partners’ mental
health private and not share things with her friends as she felt this was ‘none of their
business’:

“It’s not a secret, but I just don’t spend my time with my friends talking about his
mental health. It’s not...... (Laughing) or mine! It’s just not something that comes
up” (lines 351-355).

However, she did identify that one of the reasons for this is because people will not
completely understand:

“I don’t think anybody else, unless they’re in there, really understands what it’s like
and how overwhelming that can be” (lines 341-344).
In terms of her work colleagues, Katherine’s husband was also her boss and therefore she did not wish to discuss what was happening at home as she felt this would be disloyal to her husband:

“I couldn’t talk to my friends at school, my colleagues at school because I felt as if I was being disloyal, because he was the head of the school where I worked and if I talked to people who I worked with...it wasn’t fair” (lines 102-105).

As a result Katherine felt as though there was no one there for her:

“I just felt as though I didn’t have anybody” (line 112).

When looking at the different episodes of bipolar disorder, it seems that partners have used avoidance coping strategies to cope with their partner’s manic episodes more than the other coping styles. Many of the partners do not feel as though they cope very well with their partner’s manic episodes and are often in dread of these occurring:

“I dread the highs. I dread what's gonna come” (Jack, lines 1251-1252).

“I don’t think I do” (Katherine, line 487).

Manic episodes appear to be the most difficult element partner’s find to cope with:

“Overdrawn the mortgage account and I think that’s the hardest bit to cope with” (Alan, lines 492-493).
This finding that partners struggle to cope with manic episodes may offer support to Ogilvie et al’s (2005) thoughts that manic episodes have a negative impact on caregivers and their relationships with the individual they are caring for.

4. Self effacement versus self fulfilment

It appears that whilst learning to cope with their partner’s illness, the partners in this study struggled to find a balance between self effacement and self fulfilment. Self effacement implies that you consider another individual more important than yourself (Van Der Voort et al, 2009). Katherine appears to have put her husband’s needs ahead of her own since he first became ill:

“You feel as though you don’t go out if you get invited out you don’t go cause you feel guilty leaving them” (lines 249-251).

“I give in because I don’t want to upset him” (lines 354-355).

Katherine did not just put her husband’s needs before her own, but also took into consideration others feelings when she made decisions about who to speak to about her concerns and worries about her husband. Katherine felt that she could not speak to her husband’s family as she did not want to cause them any distress:

“I couldn’t talk to his parents, his mother because it would worry her and she’d be upset” (lines 110-112).
For Alan it seems that he struggled between putting his wife’s needs before his own and putting his needs first. At the beginning of his relationship when his wife first became ill Alan reflected that he was committing all his time to his wife:

“I was there every single day, seeing Stacey and I wasn’t going out” (lines 423-424).

However, he later comments that he was not going to stop doing the things that he enjoyed:

“So even when I did find out Stacey did get ill that really didn’t hold me back from doing what I wanted to do” (lines 296-298).

It appears that Debbie eventually came to the conclusion that she needed to engage in self fulfilment behaviours and put herself first:

“Human nature sometimes, in a way, means you have to look after yourself sometimes, haven’t you? You can’t always bend the way in the person that you’re living with” (lines 596-599).

Although Jack has stayed with his wife, he too appears to have come to the same conclusion as Debbie, that he needs to put himself first. As a result, Jack has made a conscious effort to engage in activities just for him, away from his home life and feelings of responsibility for his wife:

“It’s mine, it’s for me and if I haven’t got these things what would I have” (lines 933-934).
There appears to be a pattern in partners experiences with most, at the start of their partner’s illness, putting the needs of their loved ones first before eventually finding a balance with self fulfilment. For Debbie it appears the only way to find that balance was to leave the relationship.

**Emotional Change**

This super-ordinate theme suggested that partner’s emotional reaction to their ill partner changes as the illness progresses and as partners struggle to find a balance between in it together and isolated and alone. A repeated shift between these two super-ordinate themes, as well as changing coping styles, results in a mixture of positive and negative emotions experienced by partners. All partners identified that they experienced a range of emotional responses in relation to their partner and their mental illness and these changed over the course of the illness.

1. **Negative emotions**

Most partners interviewed for this study identified experiencing negative emotions at some point during their partners’ illness. These negative emotions, however, were not permanent and changed with the episodic nature of the illness and as the illness progressed.

When their partners were depressed, spouses/partners experienced feelings of fear, particularly in relation to their partner’s behaviour. Most partners expressed a fear that their partner would commit suicide at some point. Alan reported that his wife would often disappear for hours and he would be fearful that she would not return:
“I think at first I thought when she was going away maybe she wasn’t going to come back again. She was actually going to go away and commit suicide. That is actually the first thing that you do actually think about” (lines 258-262).

This fear of suicide appears to be constantly with Alan:

“Lots of things are going through your head and every second that they don’t come back it just makes you worse” (lines 271-273).

Debbie also experienced similar feelings of fear surrounding her ex-husband’s behaviour when he was depressed as he had once engaged in suicidal behaviour:

“He did take an overdose once (pauses) I can’t remember if he did it more than once, but he certainly did it once and that was really frightening” (lines 603-605).

Similarly to Alan, thoughts of suicide were never far from Debbie’s mind:

“There were times when I used to get home from work and think I’ll find him hanging in the garage and I’m not saying that flippantly, I really believed that he might have done it at some point” (lines 609-612).

Partners felt, however, that as the illness progressed and they understood it better and how it affected their partner, this fear and worry eased. As Sue became more familiar with her partner’s illness and understood how it affected him, she experienced a decline in her feelings of worry:
“I don’t need to worry about the bipolar at all now. It’s not a worry. I know he’s never going to get to the stage where... I think it’s very unlikely he’ll ever be hospitalised because he’s so good at looking after himself” (lines 227-231).

With regards to manic episodes it appears that partners experienced a lot of worry surrounding the behaviours their partners engaged in. Debbie explained that she was often worried about the financial impact her husband’s behaviour would have on the family when he was manic:

“He used to spend money to cheer himself up, which was really worrying as I could envisage big financial worries” (lines 184-186).

Alan explained that his wife would also spend money when she was manic and on one occasion this was as much as £3000. Initially Alan felt very angry about this:

“It sort, it can make you feel angry” (line 219).

Alan reported that he felt this way as he did not understand why his wife was doing the things she was doing and this could be very distressing for him:

“And its, its, it's just sort of like the whole thing it just upsets you a lot” (lines 237-238).

During settled periods Jack reported that he did not worry about his wife, however he did experience worry during a manic episode due to his wife’s behaviour:
“When she starts to go high do I worry. Um...and...that’s when I start thinking, ‘what’s she up to,’ when she’s out, what’s going on, is she going where she said she’s going?” (lines 895-897).

This feeling of worry was constantly with Jack during these periods and he felt that this was almost his responsibility as he asked:

“Who else is going to worry?” (line 899).

Partners felt that the behaviour their partner’s engaged in during manic episodes was something they would never get use to. Jack reported that he dreaded the thought of his wife having another manic episode and that had not changed in the 15 years since she was first diagnosed:

“I dread the highs. I dread what's gonna come” (lines 1251-1252).

This feeling of dread about the behaviours partners engaged in when manic, was also experienced by Katherine. These negative emotions experienced during these times has not changed for Katherine over the course of the illness:

“I don’t know what I do then. I just, I want to run away. I don’t know cause I’m frightened then. I get very frightened” (lines 487-489).

For some partners, there was often a range of negative emotions experienced. Katherine explained how her emotions would quickly change between anger and
guilt. She stated that she would often feel angry at her husband for not doing anything to help himself, however she would then feel guilty for feeling this way:

“You feel as though they’re not helping themselves so then you get angry, but then you feel guilty because that person is obviously suffering and it is really, it’s really hard to be sympathetic all the time” (lines 174-177).

Katherine identified that her emotions did change over the course of the illness and as her relationship with her husband continued:

“You go through a phase of being angry and um....and then thinking well if that’s the way you’re going to be, just ignoring them in a way” (lines 474-476).

Alan expressed how he could often feel upset and angry with regards to his wife’s illness:

“It sort of makes you feel really upset. It sort, it can make you feel angry” (lines 218-219).

He explained that he would often feel this way as he did not understand why his wife was engaging in certain behaviours and actually thought that she may be doing some of these things on purpose:

“Frustrated. Yeah angry I suppose at, you know, I think that, you know, if you don’t understand the illness your thinking that the things their doing, they’re doing it on purpose” (lines 221-224).
Previous research exploring the negative emotions associated with the care-giving role has focused on generic mental illness and has therefore not identified different emotions associated with the different episodes related to bipolar disorder. Partners in this study identified that during a manic episode there is a great deal of worry with regards to the behaviours their loved one may engage in, such as spending excessive amounts of money or engaging in extra marital affairs. However, when an individual is depressed, partners are fearful that their partner may commit suicide.

2. Positive Emotions

Many of the partners interviewed were surprised to be asked about positive or rewarding experiences related to care-giving:

“Oh that’s a hard one. Rewarding?” (Katherine, line 565).

Alan and Frank both reported feeling a sense of pride in the role they play in caring for their wives:

“I do think that I do help you know, in her recovery” (Alan, lines 590-591).

“I feel proud then. I feel as though I’ve achieved something” (Jack, lines 1575-1576).

As partners became more aware of the illness there appears to be a shift towards experiencing more positive feelings. Katherine reported that both she and her partner were now more open about their feelings:
“I think we do talk more openly about things and our feelings” (lines 554-555).

Sue acknowledges that by being with her partner she thinks she has more confidence to engage in activities. She thinks this is because he is more confident and outgoing:

“It’s like if we go places he’ll do things that I would never dream of daring to do and yet it pushes me a bit I think” (lines 518-520).

As a result, Sue feels as though she does things she would previously never have done:

“We once went to a party and I would never ever have gone to the VIP area or...but we kind of ended up there by accident and then once we were in there he can kind of carry it off really well and I kind of went along with it as well and you just (laughing)...it yeah, it allows me to do things that I probably wouldn’t have done” (lines 526-532).

For Debbie, she recognises that following her divorce from her husband she has much more of an appreciation for her life now:

“I think as well I’ve got more of an appreciation for how my life is now” (lines 567-568).

However, she also acknowledges that she feels the experience of living with an individual with bipolar disorder has made her a more tolerant person and this has helped her with her job:
“It’s probably made me a more tolerant person” (line 560).

“I think working at the doctors gives me more of an insight as well. I summarise medical records and sometimes I can read about other people and think yeah, I know how you feel” (lines 562-565).
DISCUSSION

This research had two aims. Firstly to gain an understanding about partners’/spouses’ experiences, both positive and negative, of living with an individual with bipolar disorder and to understand how partners cope with this experience. Finally, to establish how Counselling Psychologists can assist partners with the care-giving tasks and also their own psychological needs. Previously many of the findings from the generic caregiver literature have been applied to bipolar disorder caregivers (Ogilvie et al, 2005). Previous research tends to views caregivers as an homogenous group and does not distinguish between parental, sibling and spousal caregivers. Within the present study it was thought that, although many care-giving experiences for individuals with a mental illness would be the same for bipolar caregivers, due to the cyclical nature of bipolar disorder there would be some unique experiences. Also, as bipolar disorder is thought to develop typically in early adulthood, at an age when individuals are establishing a career and a family (Lam et al, 2005), partners may, therefore, provide the majority of care for these individuals. From the standpoint of a Counselling Psychologist, having an awareness and understanding of these unique experiences would provide information the Counselling Psychologist could use when working with caregivers and their partners, both individually and together.

This discussion examines the emergent themes shown in figure 1 (page 130), in relation to the existing literature and research. Implications for treatment of both individuals experiencing bipolar disorder and their partners and in particular the role of counselling psychology within this treatment will follow. Finally, limitations of the present study and suggestions for future research will be discussed.
Changing Illness Awareness

Explorations of the experiences of individuals living with a mental illness have revealed that there are underlying patterns and commonalities in these experiences. In his investigation with 20 individuals diagnosed with clinical depression, Karp (1994) argued that depression follows a discernible career path which is characterised by key stages that each requires a re-definition of self. Although there is a variation in the timing of the events, all participants in Karp’s study described these stages and explained a change which occurred with each stage. It appears that mental illness follows a clear trajectory and research is beginning to explore whether there is a parallel path for caregivers’ experiences. Karp & Tanarugsachock (2000) identified four moments within the care-giving career that will impact on the caregivers’ experience. Before diagnosis caregivers are confused by the behaviours of their family member. Diagnosis clarifies the situation for caregivers and there may be feelings of hope. The realisation that this illness may never go away can result in changing emotions for the caregivers from initial hope to perhaps grief that the family member will never achieve the dreams the family held for them. Acceptance that they can do nothing to change things follows for caregivers which result in feelings of relief. This career path appears to be linear in nature.

Within this study it was found that from the day their partner first became ill partners embarked on a cyclical care-giving path. A path characterised by frequent movement around the cycle and in between the phases. This movement occurs as the partner experiencing a mental illness suffers relapses and engages in different illness related behaviours. This changing awareness seemed to shape all other experiences related to the illness, depending upon whereabouts the partner was in this cycle of change. As partners move through the phases they experience a movement between feeling as
though they and their unwell partner were ‘in it together’ to a sense of being ‘isolated and alone’. The coping styles employed also change as they move through the cycle. The movement between these three super-ordinate themes and between the phases of changing illness awareness are accompanied by various emotional changes, from positive to negative, which is another super ordinate theme.

The way caregivers move through the different phases as their awareness of bipolar disorder changes is reflective of the stages of change outlined in Prochaska & DiClemente (1982) Transtheoretical Model of Change. In this model changes in behaviour occur as an individual progresses through a number of stages (Miller & Rollnick, 1991). Each stage involves varied and specific tasks. However clients may move back and forth between stages and a lapse in the changed behaviour can result in a client re-entering the cycle again, either at the beginning or at some later stage. The cycle of changing illness awareness was found to consist of six phases. The first phase, sudden decline/initial hope, occurred when their unwell partner became ill either for the first time or for the first time within their relationship. Partners were shocked by the suddenness of the decline in their unwell partner’s mental health, however on some levels remained hopeful that they would return to premorbid levels of functioning. This sense of hope at the beginning of the illness has been identified by other studies exploring the care-giving experience, including Tranvag & Kristoffersen (2008) and Karp & Tanarugsachock (2000).

A general lack of understanding appears to follow soon after partners overcome the shock of their partner’s decline in health (‘I didn’t understand what was happening’ Katherine, line 82). This subordinate theme is similar to a theme uncovered by Tranvag & Kristoffersen (2008) – ‘fear and the incomprehensible’, in which partners
of individuals with bipolar disorder felt unable to understand their new chaotic life situation. It has been shown that family members caring for an individual with an illness (mental or physical) need certain information to help them provide effective support (Fruin, 1998) and recent government initiatives to provide information, support and care have been set up. Unfortunately in many of the partners’ cases the information that they wanted and needed was not available (“the hardest thing to get information” Jack, line 142-143).

Partners became aware that this illness was a persistent threat as they recognised that this decline in health was not a one off and developed a growing understanding that there was a risk of future episodes. Bipolar disorder is characterised by extreme swings in mood from manic episodes to periods of depression. The course of bipolar disorder is not smooth and an individual may experience many relapses during their lifetime (Lam et al, 2005). This realisation led partners to take on more responsibility and adopt a more watchful attitude towards their ill partner (“I have to be careful with what I say as well, cause if I say things it could set the illness off so I’m always treading on eggshells” Jack, lines 767-769). This theme is also recognised in Tranvag & Kristoffersen’s (2008) study and they identified that the increased levels of burden experienced as a result of constantly being watchful for signs of relapse eventually takes its toll on partners and they experience their own mental health problems. The experience of their own mental health problems was also identified by partners within this study and these may well occur during this stage, however further exploration is needed to make this connection.

To counteract this lack of understanding and to aid themselves in watching for triggers, partners sought information to try and develop their knowledge about bipolar
disorder. As a result, many partners experienced a shift in emotions and often felt more empathic towards their unwell partner the more they understood. This shift in emotions as individuals become more aware of the illness was also discovered by Maskill et al (2010). It appears that partners continually come back to ‘growing illness awareness’ as there are changes in their partners illness, changes in medication or different life stages are met. As Jack describes, no-one had told him what his wife’s illness will be like in the future, therefore his exploration and growing awareness of the illness will never stop. This constant change could perhaps maintain an empathic connection through stimulating exploration and understanding.

The final two themes in the cycle of changing illness awareness are fear of the unknown and acceptance/resignation. The fear of the unknown was mentioned by several of the participants in terms of what the future held for them. Some partners appeared to cope with this by avoiding thinking about it (“I don’t really want to think about it” Katherine, line 369-370). This is reflected in Tranvag and Kristoffersen’s (2008) study where they found that spouses of individuals diagnosed with bipolar disorder felt their life situation had become frightening, incomprehensible and unpredictable. In terms of acceptance/resignation, this appeared to happen over the course of their partner’s illness. This was also found in Van Der Voort et al’s (2009) study as partners were seen to resign themselves to the situation they found themselves in, which they felt was an active choice and step towards self-fulfilment. Similarly Karp & Tanarugsachock (2000) found that a recognition of the permanent nature of the illness led partners to accept their unwell partners’ condition. However, just as with the other phases in the cycle of changing illness awareness, it appears partners move in and out of these phases as different situations arise.
In It Together

The theme ‘in it together’ has been briefly touched upon in other studies with bipolar caregivers, however the full extent of this theme or the impact it can have on the caregiver has not been fully explored. A sense of togetherness was identified in Van Der Voort et al’s (2009) study in which the theme ‘alone together’ was elicited. This theme postulated that although partners felt emotionally alone and excluded, they were living with their partner who was diagnosed with bipolar disorder. Similarly in Maskill et al’s (2010) study they found that participants felt closer to their loved ones and more compassionate since adopting the caregiver role. The theme within this study suggests that ‘well’ partners viewed themselves and their ‘ill’ partner as a team in that they dealt with the illness, and the problems caused as a result of this, together: “It’s an illness we both live with” (Jack, line 1580).

As a result of being ‘in it together’ partners seem more accepting of certain things and view these in a positive light. For example both Jack and Alan experienced a change in their social circle following the onset of their wives’ illness. Instead of being resentful of this change, both appear to accept this as a beneficial change that helps with the care-giving role. Some of the partners viewed caring for their unwell partner as part of their role and responsibility of being in that relationship. Within the generic caregiver literature for mental and physical illness many caregivers who were spouses appeared to view caring for their partner as their duty (McLaughlin, Hasson, Kernohan, Waldron, McLaughlin, Cochrane & Chambers, 2011). Two partners mention the vows they took when they got married, ‘in sickness and in health’, and even though one partner is no longer with her husband, both felt that when they got married it was ‘for good’ and they needed to follow these vows.
Similar to other studies exploring the experiences of caregivers with professional support, this study discovered for the most part these experiences were negative (Van Der Voort et al 2009, Maskill et al 2010, Tranvag & Kristoffersen, 2008). However, caregivers did have some positive experiences with individual mental health professionals. Positive interactions with carers for individuals with mental health problems from health professionals is thought to improve carer’s resilience in coping with the specific challenges they face and increase their sense of control in caregiving situations (Chen & Greenberg, 2004). An opportunity to share their worries with someone who they felt understood was valuable to caregivers (“I felt that she understood what was happening” Katherine, lines 588-589). This opportunity to share their problems allowed partners to feel recognised and valued, a need which all individuals require to be met in order to feel accepted and improve self esteem. Esteem needs are the fourth level of Maslow’s (1970) hierarchy of needs prior to self actualisation. Without this recognition or acceptance partners could experience low self esteem and have a negative perception of themselves (this is further discussed in ‘Isolated and Alone’).

The sub-themes within this super ordinate theme demonstrate the different ways in which partners feel they are part of a team with their unwell partner in dealing with any issues which arise. This may also have implications for how professionals, including Counselling Psychologists, work with individuals diagnosed with bipolar disorder and their partners.
Isolated and Alone

Feelings of isolation, exclusion and aloneness have been identified within the care-giving literature as a consequence of the care-giving role (Van Der Voort et al, 2009). Previous research has indicated that family members of an individual experiencing a serious mental illness feel distant from the individual who is ill due to illness symptoms and because of a sense of loss, contrasting the present with the person before their illness occurred (Dore & Romans, 2001). Family members may feel excluded from their unwell partner’s care by health professionals and may feel that their own needs and concerns are not considered, thus further isolating them from the process (Wilkinson & McAndrew, 2008). They may also feel isolated from their social network, either because of a lack of understanding amongst family and friends or because they feel the need to hide certain aspects of their unwell partners mental illness from others (Fadden et al, 1987).

All partners within this study reported feeling alone and isolated at some point whilst caring for their unwell partner. The negative impact caring for an unwell partner has on the caregiver’s own physical and mental health has been well documented. Caregivers who report higher levels of strain also report experiencing poorer levels of general health (Gallagher & Mechanic, 1996) as well as more sleep problems and more visits to primary care (Perlick et al, 2005, Perlick et al, 2007). All partners reported that their own mental health had been affected and sometimes they felt to blame for their unwell partner’s illness. These feelings of guilt and blame have been identified as subjective burden within the literature (Dore & Romans, 2001) and can lead to further feelings of isolation.
Often partners felt that their relationship with others, including their ill partner had changed. For example, in terms of their social network many partners found that their friendship group changed to include more individuals either experiencing a mental illness or caring for someone with a mental illness. Partners relationship with their ill unwell partner often changed, with partners sometimes expressing that they felt closer to their unwell partner since they adopted a caring role and at other times feeling more distant from their unwell partner and isolated. For individuals diagnosed with a mental illness the emotional, social and practical support offered by their family has been shown to be an important factor in the recovery process (Topor, Borg, Mezzina, Sells, Marin & Davidson, 2006). This is especially important as social networks, such as friendships, may break down (MacDonald, Hayes & Baglioni, 2000). To the researcher’s knowledge there has been little research conducted exploring the impact on a couple’s social network should one partner be diagnosed with bipolar disorder or on the well partner’s social network. Research exploring the experiences of partners with a depressed spouse (Fadden et al, 1987) discovered that the couple’s social network may be negatively affected as people cease to get in touch. This experience was identified by many of the partners interviewed in the present study. The relationship between the couple can also be negatively affected with the divorce rate for individuals with bipolar disorder being distinctively higher than the general public (Dore & Romans, 2001).

Friendships may have changed as a result of their unwell partners illness and partners sometimes felt their families could be unsupportive due to a lack of awareness about what was happening. As a result, communication with others may be limited and communication within the home may also have changed with partners feeling they are no longer able to share their thoughts and feelings with their partner. As well as
not being able to share emotions with the unwell partner, partners also experienced a sense of loss of who their partner was ("Living with somebody but they’re not really there” Katherine, lines 245-246). Studies exploring family member’s experiences of care-giving for generic mental health problems have revealed that feelings of loss are often a central experience amongst families (Jones, 2004). The bereavement process families engage in is complicated as the person they have lost is still present, but very much altered. Families may experience a sense of loss because their loved one has become a different person and will not reach the goals that were once held for them. Bruce and Schultz (2002) have called this kind of loss ‘non-finite’ as it is renewed when different life stages are reached.

Not having their needs validated by professionals and feeling that there was a lack of adequate support available both for them and their partner, appears to have increased feelings of loneliness and isolation amongst carers. Working with families and carers living with an individual with a serious mental illness is increasingly being seen as an important issue for health professionals (Oppong-Tutu, 1997). However, research exploring caregivers’ experience of working with professionals who care for their loved ones repeatedly suggests that the relationship between professionals and families is poor (Creer, 1975).

A lack of professional support is a common finding amongst caregivers for loved ones with bipolar disorder (Tranvag & Kristoffersen, 2008, Van Der Voort et al, 2009, Maskill et al, 2010). Partners within this study not only experienced a lack of support from professionals, but when support was available, for both themselves and their unwell partner, it was seen as a negative experience and deemed inappropriate. Jack, for example, felt that hospitals can no longer deal with the demand for beds and,
as a result, patients are often discharged from hospital before they are fully recovered. Within the modern healthcare system there has been a reduction in the number of psychiatric hospital beds and inpatient stays are encouraged to be as short as possible (Wilkinson & McAndrew, 2008). This may be putting more pressure on partners to care for their partner diagnosed with bipolar disorder when they are unwell.

Another finding within this study was that partners often felt services were individualised in that they only catered for the ill individual and disregarded their support network, including partners. A reason for professionals reluctance to involve partners in treatment may stem from some of the models of mental illness which have previously informed practice. Early family therapy models often blamed families for causing mental health problems and, although the influence of these ideas have faded, research still needs to be done on the influence of families on mental illness and mental illness on families (Miklowitz, 2004). Previous research has revealed that patient confidentiality is used as a means of withholding information and not involving caregivers in their loved ones care (“Oh no confidentiality, we can’t discuss it” Debbie, lines 140-141). A Rethink survey (1999) discovered that confidentiality was used by mental health professionals as a reason to withhold information from carers.

This finding of feeling ignored by professionals (“It was like banging my head against a brick wall “ Debbie, line 778) has been replicated in other studies identifying caregiver involvement within acute psychiatric hospitals (Wilkinson & McAndrew, 2008, Clarke, 2006). Sommer, Williams, Ciarocco and Baumeister (2001) have identified that continually being ignored can lead to an individual experiencing low self esteem. Recognition from others is thought to be something
which all individuals aim for in order to feel accepted and self valued. Another way of recognising carers and reducing feelings of isolation may be for mental health professionals to discuss with them their experiences of caring. Warne and McAndrew (2007) suggested that mental health professions should speak to carers as they can learn from their lived experiences as a way of understanding how to work with the individual experiencing mental health problems.

Previous research exploring caregiver’s experiences of caring for an individual with bipolar disorder have found that caregivers view this role as lifelong commitment (Maskill et al, 2010). The partners in this study appeared to agree and with this commitment came a great deal of responsibility and pressure. However, despite this level of responsibility, partners often felt powerless about what happened to their partner with bipolar disorder in terms of treatment or how they behaved. Powerlessness refers to a lack of control and this psychological concept has been frequently related to the care-giving experience (Millberg, Strang & Jakobsson, 2004). A lack of control is a core feature of Seligman’s (1975) learned helplessness theory and its relationship with depression. Further research has found that a feeling of powerlessness amongst carers increases their risk of suffering from an illness themselves, including depression (Harris, 2001). Within this study, all partners reported that living with their ill partner had a negative impact on their mental health. This link, however, requires further exploration.

**Coping Ability**

Throughout the cycle of changing illness awareness partners appear to use different coping methods at different phases. Using a range of coping strategies has been shown to be common in individuals when perceived levels of stress are higher
Previous research from the generic caregiver literature has revealed that carers use two main coping styles (Chadda et al, 2007, Chakrabarti & Gill, 2002). Problem-focused coping strategies include defining the problem, weighing up alternatives and generating alternative solutions. These strategies are thought to be more constructive and therefore more adaptive. In contrast, emotion-focused coping strategies are seen as less adaptive. These are directed at lessening the emotional distress and include avoidance, distancing, resignation and minimising (Lazarus & Folkman, 1984). Carers experiencing high levels of stress and burden are thought to employ more emotion focused coping strategies (Magliano et al, 2000).

Lazarus and Folkman’s (1984) transactional model suggests that the negative effects of stress on an individual’s health are mediated by the person’s coping style, the way they appraise a situation and the resources that they have available to them to cope with the stressor. Coping can be defined as a behavioural, affective or cognitive effort made by the individual to counteract the impact of stress (Zeidner & Endler, 1996). Coping has been further classified as a combination of efforts including avoidance, active behavioural and active cognitive components. An avoidance coping style includes strategies such as trying to ignore the problem, keeping fears and worries to oneself and using legal or illegal drugs. Active behavioural coping styles relates to external behaviours such as problem solving or talking and seeking professionals’ help. Finally, active cognitive coping styles involve internal processes such as positive reassessment and acceptance (Kartalova-O’Doherty & Doherty, 2008, Boschi, Adams, Bromet, Lavelle, Everett & Galambos, 2000). Another coping style found within this study mirrors the findings from Van Der Voort et al (2009). Similarly to partners in that study, it appears the partners were searching for a balance.
between self effacement (putting the needs of others first) and self fulfilment (putting one’s own needs first).

Partners in this study were found to engage in four main coping styles – active behavioural, active cognitive, avoidance and self-effacement versus self fulfilment. These appeared to be used interchangeably or concurrently throughout the cycle of illness awareness. For example, during ‘lack of understanding’ in the cycle, partners appear to engage in both active behavioural coping styles, such as seeking information (“it makes you want to research”, Alan, line 170), and self-effacement versus self fulfilment (“I couldn’t talk to his parents, his mother because it would worry her and she’d be upset” Katherine, lines 110-112). During the ‘acceptance/resignation’ phases, partners may be attempting to manage their appraisals of the stressor perhaps by trying to see the positive side of the situation and drawing on past experiences of a similar situation (Billings & Moos, 1981). This would be an example of an active cognitive coping style.

When working with individuals with a mental illness, assessing their partner’s coping style and helping them to cope in a more adaptive way, may be advantageous to both partners. However, this research did not assess which style partners used the most and it is therefore unclear whether partners adopt adaptive coping styles or maladaptive styles the most. The Carers Assessment is a government initiative which states that all those caring for an individual under the Care Programme Approach (CPA) should have their caring, physical and mental health needs assessed (Wilkinson & McAndrew, 2008). This assessment could be developed further to include an assessment of how carer’s cope with the caring role and this, in turn, could
be used to help inform professionals working with both the individual with mental health problems and their family in assisting them to cope more effectively.

Throughout the current literature, how caregivers’ cope with bipolar disorder has not looked individually at the different episodes (mania and depression) that contribute to this disorder. Within this study some partners did make distinctions between the way they cope when their unwell partners are manic or depressed. When depressed some partners employ an active cognitive coping style in that they have learnt to accept that depression is part of the illness (“And if lots of people say to me, how do you cope with it? Well you just do, it’s an existence, its life, that's how your life is” Jack, lines 506-508). However, some partners appear to adopt an avoidant style of coping when their partner is manic. It seems that partners find this the most challenging aspect of bipolar disorder to cope with and one partner claimed they did not feel they coped at all with these episodes (“I don’t think I do” Katherine, line 487). To the researcher’s knowledge this is the first study to identify carers’ different styles of coping with manic and depressive episodes.

**Emotional Change**

Exploration of emotions involved in the role of care-giving now recognises that carers can experience both positive and negative feelings connected to this role (Baronet, 1999, Rose, 1996). Work with caregivers in general has revealed that carers experience a range of emotions including fear, guilt, worry, love and pride over the course of their loved one’s illness (Veltman et al, 2002). Research specifically exploring caregivers of bipolar disorder has also found a range of emotions are experienced. Maskill et al (2010) discovered that carers often felt more appreciative
of life and empathetic towards others as a result of the caring role, however they also identified that carers could feel frustrated and hopeless.

Similar to Veltman et al’s (2002) study, partners within this research were often surprised to be asked about positive and rewarding experiences ("Rewarding?" Katherine, line 565). However, most partners did express positive feelings in relation to their partners since the commencement of their illness and the care-giving tasks. It appears as though partners experience a range of emotions within each stage of the cycle of changing illness awareness. For example, during the sudden decline/initial hope stage, partners experience both shock and upset ("It’s quite shocking to see" Alan, line 62) and a sense of hope that things will be ok ("I knew that we could work things out" Alan, lines 76-77).

For professionals working with carers it is important to remember that carers experience both positive and negative experiences. It has been argued that in the past some mental health professionals’ attempts to be supportive of families may have inadvertently reinforced the idea that they are victims of a tragedy (Hatfield, 1997). Veltman et al (2002) have suggested that mental health professionals need to help caregivers identify the positive aspects of their relationship with their mentally ill loved one and, as a result, carers may focus less on the negative aspects and focus more on their sense of accomplishment and satisfaction with the role. However, when looking at emotions it is important to acknowledge the person’s own sense of the situation to ensure their feelings and experiences are validated.
Implications for Counselling Psychologists and Service Development

There has been a recent surge in attention being paid to carers in legislation and policy (Henderson, 2002, Wilkinson & McAndrew, 2008). Numerous Government initiatives have been set up to help the plight of informal carers of family members and loved ones with various mental health problems. Despite this, research exploring caregivers’ needs and wants still reveal these are not being addressed and their experiences with professionals are repeatedly described as negative (Van Der Voort et al 2009, Maskill et al, 2010).

Growing illness awareness was found to be part of the cycle of changing illness awareness and researching and uncovering information about their partner’s illness was a method partners used to cope. Many of the partners in this study explained that this information was not offered to them by professionals and most of their knowledge has been developed through their own means. The impact for partners of having to research the disorder themselves needs to be further explored. For some, to have to find this information through their own means, could be a potential source of further burden or for others a sense of empowerment.

Psycho-educational programmes have been found to contribute to a greater knowledge, new problem solving skills and reduce the risk of new episodes for the ill family member (Miklowitz, 2004). Education on the nature of bipolar disorder, its treatment, prognosis and medication may all contribute to this growing illness awareness. Services may benefit from producing information for carers that they can read at home containing the above mentioned information, or develop programmes specifically for carers. However, groups and educational material cannot cover all aspects of the carers needs and may be too universal. Carers need to
be given time to work through their thought processes in a more individualised setting.

Partners in this study often felt excluded by professionals involved in their partner’s care and felt that the health system was individualised and did not recognise their role in caring for their loved one. Only one partner within this study had experience with psychological services. This partner’s husband was seeing a psychologist as part of his treatment and her experience with this health professional was very negative as she felt criticised and judged. Other research has found that carers have a desire to have a more positive collaborative relationship with mental health staff (Maskill et al, 2010). Van Der Voort et al (2007) found that carers desired to have a professional with whom they had a good rapport. They believed that a professional who was easy to talk to, was non-judgemental and non-critical, could see the uniqueness of both carer and patient and someone who is honest would help to facilitate this relationship. As Counselling Psychologists we are perhaps in a good position to offer this relationship by employing Rogers’ (1951) core conditions of empathy, congruence and unconditional positive regard. These conditions are often a core feature in counselling skills training courses and are a central feature in the development of the therapeutic relationship.

When working with carers caution must be taken with what interventions are used and how these are implemented. When working with individuals diagnosed with a mental health problem, many professionals assume that their partner is their carer (Henderson, 2001). This identity may be something carers aspire to. It may also be an identity both they and their ill partner reject. As a result, professionals need to be aware of how an individual providing care to their ill loved one views themselves and
tailor support accordingly. For example, a partner who does not view themselves as a carer may not feel attending a carers’ group is appropriate, but may still need support in their role.

Within this study partners described that medical professionals adopted an individualised approach which often left them feeling excluded from their partner’s care. The theme ‘in it together’ reveals that couples see themselves as a team that works together and both are equally affected by the effects of the illness. As Counselling Psychologists we need to be careful that interventions devised for carers do not become too individualised and thus exclude the individual experiencing mental health problems. There needs to be consideration of the impact individual approaches have on the partner’s relationship. Perhaps there needs to be a migration away from interventions which seek to make one partner the ‘expert’ at providing care to the other to interventions which see the relationship as the central focus and a basis from which change can occur (Henderson, 2001).

**Limitations & Suggestions for Future Research**

A relatively homogenous sample of participants were selected for this research (Willig, 2001). Purposive sampling was employed to select partners who were living or had lived with a partner with a diagnosis of bipolar disorder. Three out of the five participants were recruited via a self help organisation for individuals with bipolar disorder and their carers. The other two participants were informed of the study by one of the participants. This limits the transferability of the results. It could be argued that the majority of the partners were motivated to enhance their understanding and access more support by the nature of being a member of a self help
Another limitation is that all participants are white and appear to be living comfortably. The findings should, therefore, be understood as limited to this context.

At the time of the study the partners diagnosed with bipolar disorder were all stable and had not experienced a relapse for a number of months. Had partners been interviewed either during an episode or just after an episode of depression or mania their responses to questions may have been different. Goosens et al (2008) discovered that participants in their study felt their responses to questions would have been very different had they been interviewed when the patient was either manic or depressed.

One of the criteria for inclusion in the study was that one partner had to have a diagnosis of bipolar disorder. It was the partners who specified whether a diagnosis of bipolar was present not the researcher, therefore the information may not have been always correct. To make this study more robust partners with a diagnosis could be assessed prior to their partners being interviewed. However, as the research was about experiences and the majority of partners interviewed were accessing support from a bipolar disorder self help group, this may not be necessary. Another alternative may be to access partners whose loved ones are currently in or have just been discharged from in patient units. This would resolve the problem of diagnosis, however partners may be in the process of caring for their partner during a relapse in their mental health and this may cause undue distress.

This study adds to the current literature which states that caregivers for an individual with a mental illness are more likely to suffer from mental health problems themselves (Barrow & Harrison, 2005, Perlick et al, 2005). All partners within this
study had experienced some problems with their own mental health whilst caring for their loved one. To assess this impact more fully, further research could use a valid measure to gauge partner’s current mental health. This information may then inform professionals either currently working with carers or devising service developments for carers in the future. Psycho-educational packages designed to assist carers with care-giving tasks may also need to include material which advocates looking after ones own mental health and provide information on how to do this and also the benefits of doing this for both carer and patient.

Previous research has employed different scales to assess caregivers methods of coping (Ways of Coping Checklist – Hindi Adaption, Nehra et al, 2005, Family Coping Questionnaire, Chakrabarti & Gill, 2002, and the Utrecht Coping List, Goosens et al, 2008). These scales are generic and do not specifically focus on the episodic nature of bipolar disorder. Within this study it was found that caregivers often employ different coping styles to cope with depressive and manic episodes of their partner’s illness. Future research may develop a coping scale to specifically focus on the different episodes within bipolar disorder. Alternatively, researchers may instruct participants to focus on a manic or depressive episode when responding to questions about coping styles to establish any differences. This information would again help to inform professionals when devising programmes for carers that look at identifying and building more adaptive coping skills.

It would be interesting to explore the experiences of both the partner diagnosed with bipolar disorder and the partner caring for them of the professional support available to them to establish if there are any common patterns within this experience. The majority of studies which have explored generic caregivers’ experiences have
revealed there is a general lack of support experienced (Van Der Voort et al, 2009, Maskill et al 2010, Tranvag & Kristoffersen, 2008). Lack of support by both professionals and social networks was found in this study to increase feelings of isolation amongst caregivers and could potentially lead to increased feelings of burden which have been identified by other studies (Van Der Voort et al, 2009). Perlick et al (2007) found an association between caregiver burden and more frequent patient relapses, hospitalisations and psychiatric symptoms. Therefore further research into what support would best benefit caregivers may also have an impact on patient recovery and reduce the amount of support they need. In terms of the partner with bipolar disorder it may be interesting to explore their experiences of professional support alongside their carer. This information could then be used to further inform service development and create a more holistic service rather than an individualised one.

The current study provides a rich account of five partners’ experience of living with or having lived with an individual diagnosed with bipolar disorder, however further research needs to be carried out with partners from different socio-economic, cultural and ethnic backgrounds. Ogilvie at al (2005) suggest the caregiver’s beliefs are shaped by cultural as opposed to medical models of illness. For example, the impact of caring is likely to be different if the patient is a husband or wife in relationships that value traditional gender roles. Professionals need to be aware of these differences when offering support to individuals or groups of informal caregivers.

In addition to exploring caregivers’ experiences from different socio-economic, cultural and ethnic backgrounds, there is also a need to explore and compare different care-giving relationships and the impact this may have on their experiences. The
The majority of research to date has labelled caregivers as a generic group and has not specifically looked at parental, spousal or sibling caregivers (Maskill et al, 2010). However, Dore & Romans (2001) identified that there are differences in the experiences of parental and spousal caregivers. For example partners were more likely to be exposed to violence than parents and partners were more likely to experience a significant reduction in income compared to other caregivers (Dore & Romans, 2001).

Another limitation of this study revolves around the use of language to describe both the well partner and the partner diagnosed with bipolar disorder. In Upton and Reed’s (2006) study of partners caring for their partner with dementia, they found that partners did not want to be referred to as carers as they did not view themselves in this way despite providing care for their loved one. Similarly, Henderson (2001) argues that some partners may reject the carer role as defined by society and professionals and instead view the change in their relationship in a different light. Within this study the term partner, spouse, carer and caregiver has been used interchangeably to describe the partner without a diagnosis of bipolar disorder. In the future research should perhaps assess how partners view the carer identity and whether they feel they fall into this category. If they do not fit this identity how do they view the changes in their relationship and how would they describe their role. I feel this would put partners more at the heart of the research.

**Summary and Conclusion**

The findings from this study have identified that the partners’ experiences of offering care to their loved one with bipolar disorder does not follow a linear, predictable path. All partners described a process in which their awareness of their loved one’s illness
changed, however this appeared to follow a cyclical path. Partners could move around, back and forth or between depending upon the course of their loved one’s illness. As partners move around this cycle they employ different coping strategies, experience different emotions and have experiences of being ‘in it together’ interchangeably with feeling ‘isolated and alone’.

The theme ‘in it together’ adds to the existing literature. Some partners within this study described feeling as though they and their unwell partner were a team, who coped with and dealt with the bipolar disorder together. This may have implications for how Counselling Psychologists work with individuals diagnosed with bipolar disorder. A move away from individualised approaches to a more systemic way of working involving the partner in treatment may produce better outcomes for both partners. This approach, however, needs to be explored further with both partners’ thoughts and concerns being taken into consideration.

Within the theme ‘coping ability’, how partners cope with the episodic nature of the bipolar disorder was explored. It was discovered that some partners use different coping strategies to cope with the manic and depressive episodes. This is the first study, to the researcher’s knowledge, that explores how carers cope with the episodic nature of bipolar disorder, therefore further exploration is needed before this information is used to help inform service development. However, professionals could perhaps be aware of this when working with carers living with bipolar disorder in helping them cope more adaptively. Recommendations for how coping styles can be assessed more readily with partners/carers have been discussed within the discussion.
The majority of partners’ experiences with professionals were negative. Experience with psychology was limited and viewed as unhelpful. Counselling Psychologists could perhaps support partners by utilising a collaborative approach which demonstrates an understanding of both the positive and negative experiences associated with the caring role. Exploration of the caring role and what this means to both the individual with bipolar disorder and the carer needs to be assessed so that both people can be assisted in an appropriate manner to cope with the impact of this serious mental health problem.

In summary, the model presented here is a tentative one that appears to capture important experiences had by the partners within this study. This model could be used to sensitise practitioners, including Counselling Psychologists, to the complexity of the experiences of caring for someone with bipolar disorder as their partner/spouse.
Critical Appraisal
CRITICAL APPRAISAL

When I was first asked to produce ideas about what I could base my research on I instantly started thinking about what work I was doing in my placements and how I could further this. I also spent time trawling through different university lecturers’ profiles reading about their research interests hoping that one would also appeal to me. I thought that if my research was based either on something to do with my placement or a lecturer’s interest, I would firstly receive more support and help and secondly I could feed off their enthusiasm for the topic in order to find motivation. Having already completed a Masters I was aware of how difficult it is to remain motivated throughout the research process. However, nothing really appealed to me and as more of my colleagues got ideas and identified potential supervisors I became more and more panicked. Around this time I started personal therapy and in one session, whilst describing my sense of panic at not being able to choose a research topic and my fear of being left behind, my therapist asked me why I decided to do the course. At first I was stunned. I couldn’t understand what this had to do with a choice of research and then I realised that my motivation to do the course could also be what I based my research on – my parents.

My father was diagnosed with bipolar disorder when I was 17 years old and I have witnessed the struggles both he and my mother have gone through over the past 11 years. However, despite all the difficulties, they have coped and appear to be happier than ever. When I started to explore other people’s experiences of living with and caring for someone with bipolar disorder I was shocked, firstly by how this research focused only on the negative impact of living with someone with bipolar, and secondly by the lack of research exploring partner’s experiences. The research that
there was focused on levels of burden (Ogilvie et al, 2005) experienced by those offering care and, although this is important, I felt there was more to carers’ experiences.

By focusing on partners’/spouses’ experiences of living with their loved one diagnosed with bipolar disorder I realised I could also link this to my work on placement. Whilst working at an eating disorder service I was encouraged to think about how working with family members may help in a client’s recovery. Even just providing psycho-educational material to loved ones appears to have had a positive impact on a client’s progress in therapy. Therefore I feel this research could be clinically useful and influence my own practice working with adults of working age, many with complex mental health problems such as bipolar disorder, even if I do not publish it. Due to my prior experience it may be possible that my preformed expectations and ideas may subconsciously influence the IPA analysis and I have tried to maintain an awareness of this throughout the study.

Deciding where from and how to recruit partners/spouses proved challenging. I was aware of the Manic Depressive Fellowship (a self help organisation) and some of the literature I had found had previously recruited from their mailing list. With this information I began a ‘Google’ search, identifying different self help organisations in the North West that specialised in offering support to carers for individuals experiencing bipolar disorder. I originally contacted three organisations, however two informed me that they never worked with partners, and they were only ever contacted by parents. I found this fact in itself interesting. Why did partners not contact services as often as parents? Were services more accessible to parents? Did partners have less opportunity to learn about services? I felt these questions were
outside the scope of this research, however they are important to look at if services are to be designed that assist all carers not only with their care-giving tasks but also with their own mental health needs. Eventually, one of the organisations did put me in touch with three partners who were either living with or had lived with a partner with bipolar disorder. The two other partners were friends of one of the partners who accessed the group.

Many of the partners interviewed for this study expressed their gratitude at finally being able to give ‘their side of the story’. I gained a sense from partners that although they felt they were important in their partner’s recovery and helping them maintain a balance, they regarded themselves as a ‘silent observer’. From the interviews I often felt that this was just the first small step in the journey of exploring partners’ experiences of living with bipolar disorder and as a Counselling Psychologist there is much more we can do for this particular group. As a carer it felt as though partners did not really fit into any service and, with all the changes that are happening in the health care service, I feel the plight of carers needs to be raised and for these to be included in the new reforms.

The sense that this was partners first real opportunity to speak about their experiences also influenced how I wrote my research. One of the ways partners coped was by speaking to someone with the same experience. They found this both useful and reassuring. Therefore this research could potentially have the same effect for other partners who perhaps do not have the opportunity to speak to others in a similar situation. I therefore wanted to write my research report in a style that could be understood by the people the research was aimed at – the partners of individuals with bipolar disorder. I was anxious about doing this, however I feel I have managed to
find a balance between including psychological theory and making this accessible to individuals without an in-depth psychological knowledge.

Having read a great deal of literature on caregivers and discovering that the majority of this focused on the negative implications of this role, I thought caregivers would relish the opportunity to be able to share the positive experiences they have encountered. However, just as Veltman et al (2002) had discovered, partners were surprised by questions asking about the positive and rewarding aspects of caring. This is perhaps an indication of how the role of care-giving is seen within society. Is this role seen in such a negative light, as a hassle, as a burden, that individuals in that role feel there cannot possibly be any positives? This point in particular has made me think about future research and how perhaps the definition of carer and the connotation of what that means to the wider society needs to be assessed and, perhaps, an effort made by professionals and the government to change this view.

I decided to choose a qualitative methodology initially because I had experienced burn out from using quantitative methods. Having previously done undergraduate and master’s projects and various audits which all involved statistics I felt ready for a change. My interest in qualitative methodology grew further as I explored the literature on generic caregiver’s experiences. Most of this employed quantitative methods and I felt frustrated as I read the research as I sensed there was more behind the answers given to questions and I wanted to uncover what those answers were. I was unsure of which qualitative methodology to use, however after attending a two day workshop at Aston University on interpretative phenomenological analysis I felt inspired to give this methodology a go!
Throughout the course my desire to ‘get it right’ has been highlighted at various points. It is something I have since worked on in personal therapy and, as a result, I feel I have challenged many of my perfectionist beliefs. However throughout the interview process and resulting analysis I could feel this desire once again rearing its head. Through reading the available literature I felt I had created an interview schedule that would give participants the opportunity to talk about their experiences whilst eliciting new information about how they coped and their experience with professionals. Perhaps naively I thought that the interviews would run smoothly with each question being answered in turn. However after my first interview I discovered that this was not the case. After explaining the rationale of the study, participants often gave answers to several questions in one response and it often felt as though this was the only opportunity they had ever had to discuss their experiences. It felt wrong to intervene with my agenda and stop participants when they were actually answering all my questions without having been asked! Although this was initially uncomfortable I remembered that the aim of IPA is to explore individual experiences and how individuals make sense of their own personal world (Smith and Eatough, 2007). I felt that this was happening even if it was not following my interview schedule exactly.

I found the process of completing IPA was not a linear route, but was characterised by different phases which I moved between. In this way I felt this mirrored the process partners went through in the study as they entered the cycle of changing illness awareness. Before I began my analysis I found every book I could on IPA to see if there was a right way of doing this. I started following the guidelines set out in Smith et al (2009), but I found I was deviating from these guidelines on several occasions. To ease some of my tension of employing a new methodology I wanted to
be thorough in my approach, I therefore read through each transcript making initial notes before reading it again and making exploratory notes. When it came to analysing themes, my supervisor suggested using a colour coded key to link themes together. This appealed to my creative side and made the work seem more engaging. Although I was not doing the analysis ‘by the book’ I felt I was developing my own style of IPA. I was reassured by Smith et al (2009) who state that there is no clear right or wrong way to conduct IPA and that researchers are encouraged to be innovative in the ways they approach the analysis.

Eliciting themes and drawing up a table of super-ordinate themes was another area of the analysis I found very difficult. I was conscious that many of the participants felt that systems needed to be changed, however as partners/carers they did not have the voice to do that. I therefore wanted to do justice to their interviews and include everything I could. However, in doing this I was producing a great number of themes and the thought of interpreting them all was overwhelming. In supervision I looked at perhaps collapsing some of the themes into each other. I found this a difficult process, however since producing the Figure (see page 130) to go alongside my super-ordinate themes I can see that this process has not restricted what the partners said.

IPA suggests that there is a double hermeneutic involved in the analysis process, where participants are making sense of their world and the researcher is making sense of the participants making sense of their world. Recently there appears to have been a move towards suggesting there is in fact a triple hermeneutic in which the researcher is trying to make sense of their own world in relation to the participants world, whilst engaging in the double hermeneutic already mentioned above. As a researcher I
already have previous experience of living with someone with bipolar disorder. I was, therefore, engaging in this third hermeneutic throughout the whole research process. However, I was not aware of this until I reflected back on the process. My experience was the motivation for doing the research and will have undoubtedly have impacted on how I interpreted the transcripts of my participants. For example, when eliciting themes I was looking for positive experiences as well as negative ones. This may well have been because I was aware that my mother had many positive experiences as well as negative ones whilst living with my father and I was intrigued to see if others had a similar experience.

I spent time questioning whether it was a benefit to my research that I had this prior experience that may influence me in some way. Having given this a great deal of thought and spoken to others about this I feel that the benefits of having this experience outweigh the negatives. The biggest struggle I faced when completing a masters project was lack of motivation and loss of interest. I struggled to get ‘personally’ involved in the project and relate it to my practice. With this thesis I felt passionately about it. I wanted to do something to help people like my mum and dad who I felt had been neglected in research and in policies. Therefore, I had the motivation to continue with the work even though even through ‘dark days’, when I felt like giving up I knew that this work was important and that carried me through. I also could see the relevance to my practice and how important it was to think about the individuals external support network when working therapeutically with them. In terms of my insight into the disorder and problems partners may be facing, I felt this allowed me to ask questions during the interviews that perhaps wouldn’t have been asked without this experience. A negative of having this experience may have been that I was searching for my participants to have had similar experiences to my
parents, however I feel through supervision and personal therapy I managed this and was able to look at the interview transcripts and manage any bias.

Interviewing partners also had an emotional impact on me. Firstly I struggled with the transition from therapist to researcher. Many of the participants spoke emotionally about the difficulties and experiences they have had in caring for their loved one and also highlighted just how little support they have actually received. As a therapist I would have started to devise a treatment programme for these individuals and look into where they could access more support. However I was there as a researcher and therefore unable to offer the support I feel these individuals needed and wanted. Secondly, I found it hard on occasions listening to, and then subsequently reading, about some of the partners’ difficulties. I think this was because I was beginning to realise just what my parents had been through as I recognised many of the events that had happened in the participant’s lives had happened in my own. I also felt as though I was seeing some of these things through new eyes and not just as a therapist, but also as an adult. It is eleven years since my father first became ill and I am now a young adult with my own career, relationships and finances and I can appreciate more of the difficulties my parents faced around this time. Personal therapy has supported me tremendously through this process; however I also feel I have spent more time with my family and think we are closer now than ever.

I can see that my research has already started to impact on my therapeutic work. Within initial assessments I always ensure I take time to find out what social support individuals have and in subsequent sessions ask if clients would like some
information to take home to their families that may help explain any difficulties they are facing. My clinical/placement supervisor and I have spent time researching and producing information leaflets for this purpose. So far the results from doing this seem positive and I hope to continue this work further as a qualified Counselling Psychologist.
References


Baronet, A.M. (2003). The impact of family relations on caregivers’ positive and negative appraisal of their caretaking activities. Family Relations, 52 (2), 137-142.


Appendices
Appendices

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Appendix 1: University of Wolverhampton Letter Confirming Ethical Approval

Date: 5th March 2010

Re: The Experiences of Individuals Caring for Loved Ones with a Diagnosis of Bipolar Disorder: How They Cope and the Implications for Counselling Psychology.

Dear Sir/Madam,

I hereby confirm that the School of Applied Sciences Ethics Committee, at the University of Wolverhampton, has granted approval to Alexandra Barnett to conduct the study entitled ‘The Experiences of Individuals Caring for Loved Ones with a diagnosis of Bipolar Disorder: How They Cope and the Implications for Counselling Psychology’.

Yours faithfully,

[Signature]

Dr Neil Morris
Chair of the School of Applied Sciences Ethics Committee.
Appendix 2: University of Wolverhampton RES 20b Form

RES 20B
(October 2003)

School of Applied Sciences
Behavioural Sciences Ethics Committee:
Submission of project for approval

- This form must be word processed – no handwritten forms can be considered
- ALL sections of this form must be completed
- No project may commence without authorisation from the School Ethics Committee

CATEGORY B PROJECTS:

There is identifiable risk to the participant’s wellbeing, such as:

- significant physical intervention or physical stress.
- use of research materials which may bring about a degree of psychological stress or upset.
- use of instruments or tests involving sensitive issues.
- participants are recruited from vulnerable populations, such as those with a recognised clinical or psychological or similar condition. Vulnerability is partly determined in relation to the methods and content of the research project as well as an a priori assessment.

All Category B projects are assessed first at subcommittee level and once approved are forwarded to the School Ethics Committee for individual consideration. Undergraduates are not permitted to carry out Category B projects.

<table>
<thead>
<tr>
<th>Title of Project:</th>
<th>The Experiences of Individuals Caring for Loved Ones with a Diagnosis of Bipolar Disorder: How They Cope and Implications for Counselling Psychology.</th>
</tr>
</thead>
</table>
| Name of Supervisor: Dr Niall Galbraith 
(For all student projects) Dr Yvette Lewis |
| Name of Investigator(s): Alexandra Barnett |
| Level of Research: Practitioner Doctorate Counselling Psychology 
(Module code, MPhil/PhD, Staff) |
| Qualifications/Expertise of the investigator relevant to the submission: 2 years experience working as a trainee forensic psychologist with individuals suffering from a range of mental illnesses, and 1 year on a trainee counselling psychology placement at a Primary Care Psychology Team. |
| Participants: Five to seven participants will be recruited to participate in this study from various self help groups for people both experiencing and living with bipolar disorder around the North West of England. Participants will be spouses or partners living with a loved one with a diagnosis of bipolar disorder. |
Please attach the following and tick the box provided to confirm that each has been included:

<table>
<thead>
<tr>
<th>Item</th>
<th>Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale for and expected outcomes of the study</td>
<td>✓</td>
</tr>
<tr>
<td>Details of method: materials, design and procedure</td>
<td>✓</td>
</tr>
<tr>
<td>Information sheet* and informed consent form for participants</td>
<td>✓</td>
</tr>
<tr>
<td>*to include appropriate safeguards for confidentiality and anonymity</td>
<td>✓</td>
</tr>
<tr>
<td>Details of how information will be held and disposed of</td>
<td>✓</td>
</tr>
<tr>
<td>Details of if/how results will be fed back to participants</td>
<td>✓</td>
</tr>
<tr>
<td>Letters requesting, or granting, consent from any collaborating institutions</td>
<td>✓</td>
</tr>
<tr>
<td>Letters requesting, or granting, consent from head teacher or parents or equivalent, if participants are under the age of 16</td>
<td>N/a</td>
</tr>
</tbody>
</table>

Is ethical approval required from any external body? YES (delete as appropriate)
If yes, which Committee?

Board of trustees at charity.

NB. Where another ethics committee is involved, the research cannot be carried out until approval has been granted by both the School committee and the external committee.

Signed: ___________________________________________ Date: ____________
(Investigator)

Signed: ___________________________________________ Date: ____________
(Supervisor)

Except in the case of staff research, all correspondence will be conducted through the supervisor.

FOR USE BY THE SCHOOL ETHICS COMMITTEE

Divisional Approval
Granted: ___________________________________________ Date: ____________
(Chair of Behav Sci Ethics Committee)

School Approval
Granted: ___________________________________________ Date: ______________
Appendix 3: Letter Contacting Self Help Organisations

Dear Sir/Madam,

I am a Counselling Psychologist in Training currently undertaking my Doctorate at the University of Wolverhampton. As part of my research I am interested in the views and experiences of partners/spouses who currently care for and live with a loved one with a diagnosis of bipolar disorder.

It is estimated that up to one million people living within the United Kingdom have a diagnosis of bipolar disorder and the majority of these individuals are cared for in the community by their families. To date there has been a vast amount of research identifying the effects family attitudes and styles of coping can have on the recovery of an individual with a bipolar disorder diagnosis. However, little research has looked at the effects caring for an individual with a diagnosis of bipolar disorder can have on their families.

I am currently recruiting partners or spouses who live or have lived with a loved one with a diagnosis of bipolar disorder to talk about their views and experiences. The interviews will be conducted individually and at mutually convenient times and they are expected to last an hour.

I would appreciate it if you would allow me to attend meetings so I can ask for the help of your members. Please note that participation is completely voluntary and all information will be kept confidential.

I have enclosed a copy of the sheets that all participants are given before they decide to take part, which I hope you find useful.

Thank you very much for your attention.

Looking forward to hearing from you.

Kind regards,

Alexandra Barnett
Counselling Psychologist in Training
Appendix 4: Semi-Structured Interview Schedule

**OK SO I HAVE SET THIS RECORDING SO COULD YOU CONFIRM FOR THE RECORDING THAT YOU ARE HAPPY FOR THIS INTERVIEW TO TAKE PLACE.**

1. Could you please give me a brief biography of yourself – for example, I’d like you to talk about your family, your employment history etc?

   **PROMPTS:** Do you have any children? Grandchildren?

   How long have you been with your partner?

   Are you married?

   Who lives with you?

   What job did/do you do?

2. Could I now ask you to please give some background information on your partner, in particular focusing on their bipolar illness? For example, when were they first diagnosed, how old were they etc.

   **PROMPTS:** How old are they? How old were they when diagnosed?

   Length of illness since diagnosis

   Number of hospitalisations

   Were you aware of their illness before starting the relationship?

   What is their education history?

3. I would now like to take you back to the beginning, when you first found out about your partner’s mental illness. I would like to know about how this impacted on you, your lifestyle and your relationship with your partner?

   **PROMPTS:** What was your relationship like before? How did it change?

   How did you feel when you initially heard?

   What concerns did you have?

   Did you have to change your lifestyle at all? – hobbies, social activities, work?

4. I know it can be difficult to discuss emotions, but I was wondering if you could tell me a bit more about your emotional reaction when you first found out about the illness, how these emotions may have changed over time and what may have initiated these changes?
PROMPTS: How did your emotions change through the course of the illness?

What led to these changes?

How do you feel now?

5. I’d like to ask you a bit more about the personal impact your partners illness has had on you over the course of their illness. How has this affected your own personal life goals and hopes for the future?

PROMPTS: Are there things you feel you’ve not done because of your partner’s illness?

Would you have still had a relationship with your partner had you known about their illness when you met?

Have future plans changed either positively or negatively?

How is your own mental health?

6. Could you tell me now about other relationships you may have with friends or family members and how these may have changed over the course of your partner’s illness?

PROMPTS: Do you feel supported by other family members?

How involved are family members in helping you provide care?

If relationships have broken down, why do you think that is?

Do you feel you have enough support?

7. I would like to ask you now about how you have coped over time with your partner’s illness. I am particularly interested in how you cope during the manic and depressive episodes of the illness and if you feel this has changed?

PROMPTS: How do you cope during times when your partner is depressed?

How do you cope during times when your partner is manic?

Do you feel the way you have coped has changed over the course of your partner’s illness?

Do you think you’ve coped well with the changes that have occurred?
8. I’d like to now look at the role of caring for another person with bipolar disorder. Could you tell me about the most difficult aspect of caring for your partner?

PROMPTS: Could you tell me about the positive aspects of care-giving?
Could you tell me about the negative aspects of care-giving?
What have been some of your most rewarding experiences of caring for your partner?
Would you give up this role of caring for your partner if the opportunity presented itself?

9. We’ve previously looked at social support, I wonder if we could now explore what experiences you have had, if any, with health professionals. How did you experience the support offered and what, in hindsight, would you have liked?

PROMPTS: What support was offered to you?
Were you provided with enough information about your partner’s diagnosis and the treatment available?
Looking back what support would you have liked to have received? What difference would this have made?
In the future what support would you like and what impact do you envisage this will have on your life?
At any point was psychology involved in your partner’s care? How did you experience this?

10. Finally, I would like to ask you about the future. What are your plans and your hopes for the future now?

11. Is there anything else you would like to add? Is there anything you would like to say but do not feel you have had the opportunity?

THANK YOU VERY MUCH.
## Appendix 5: Supervision Log

<table>
<thead>
<tr>
<th>Date</th>
<th>Present</th>
<th>Length</th>
<th>Agenda</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>30/09/2009</td>
<td>Niall, Yvette, Alex</td>
<td>30 minutes</td>
<td>Research Proposal, Expectations, Self Help Groups</td>
<td>Research proposal submitted to RHIS.</td>
</tr>
<tr>
<td>28/10/2009</td>
<td>Niall, Alex</td>
<td>15 minutes</td>
<td>BSEC Ethics Form</td>
<td>Discussed Amendments, Set deadline for submission</td>
</tr>
<tr>
<td>15/12/2009</td>
<td>Niall, Alex</td>
<td>15 minutes</td>
<td>Progress report, SEC Ethics</td>
<td>Looked at information that needed to be included on the progress report and when this should be completed by. Niall to find decision from SEC committee.</td>
</tr>
<tr>
<td>02/03/2010</td>
<td>Niall, Yvette, Alex</td>
<td>45 minutes</td>
<td>Progress, Ghant Chart</td>
<td>Discussed where I am at now I have ethical approval. Niall is to get a letter from Neil Morris stating that I have ethical approval so this can be sent to the Self Help Groups. Discussed current lack of motivation and what I can do to improve this. Looked at plans for the next 6 months on Ghant chart.</td>
</tr>
<tr>
<td>04/05/2010</td>
<td>Niall, Alex, Yvette</td>
<td>45 minutes</td>
<td>Plan, Literature Review, IPA Group</td>
<td>Discussed the IPA workshop and ideas from that. Suggested that starting literature review now maybe too soon. Discussed critical review – important when assessing methodology to look at what this does not enable you to do as well as what it does enable you to do. Both Y &amp; N need to sign supervision log and this goes in the portfolio.</td>
</tr>
<tr>
<td>06/07/2010</td>
<td>Alex, Yvette</td>
<td>60 minutes</td>
<td>APA refs, Interviews</td>
<td>When reading through transcripts write all impressions down. Look for theoretical links (why you think that) do each interview at a time. Look for differences and similarities. Look for content and process- what do they mean? What are they getting at? For critical review think about</td>
</tr>
<tr>
<td>Date</td>
<td>Name</td>
<td>Duration</td>
<td>Notes</td>
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<tr>
<td>28/10/2010</td>
<td>Alex, Yvette, Niall</td>
<td>60 minutes</td>
<td>Review of where up to so far. Answered list of questions that I have produced over last few months. 1. Can we please set up our next supervisions in advance. 2. Is there no interim progress report this year? On one piece of information it says that the progress report needs to be done end of semester 1 another piece it says semester 2? 3. If it is an Annual Progress Review at the end of semester 2 I noticed that it now says you have to do a poster or presentation depending upon what you did the previous year. As I haven't done either before can I choose and who does this need to be presented too? 4. I was wondering if you had a copy of my progress report from year 2, semester 1? I emailed it when it snowed and never received a final copy of this. I am aware that I need this for my portfolio in May. 5. I have now done 5 interviews (I have the possibility of a 6th one but I am just waiting to hear back from them). I was wondering what I do with my audio interviews now I have transcribed them? I did put in my consent form that only I would hear these. 6. Finally I was wondering if there were any guidelines on how to set out your thesis/what needed to be included etc. So far I have had a look at several past theses to get an idea, however these do seem to be different.</td>
<td></td>
</tr>
<tr>
<td>09/10/2010</td>
<td>Alex, Yvette, Niall</td>
<td>90 minutes</td>
<td>Update on Progress Externers 3 Transcripts – Exploratory Notes, Themes Where Now? Discussed where I was up to so far and the progress I have made since last meeting in terms of analysis. Decided that I would send a draft version of my method section by Christmas to Yvette</td>
<td></td>
</tr>
</tbody>
</table>
Discussed my confusion over what exploratory comments and emergent themes should look like. In some examples they are sentences and in others one word. I feel that just using one word does not do justice to the person’s experience and therefore would prefer to go into more depth to capture that experience.

Looked through three transcripts that have already explored and drawn themes from. Discussed interview style and the depth of information gained from these. Discussed individual ideas about themes, how these can be developed further.

Discussed my fear of not knowing enough theoretical knowledge to tie into the themes. Talked about creating theoretical memos to try and link theory into the themes through this.

I want to keep the research at a level where the people it is aimed at will understand it. It is aimed at caregivers with no knowledge of psychology, but to give them a voice. Spent time discussing how I will achieve this.

09/12/2010
Alex Yvette Niall
60 Minutes
External examiner Transcripts Themes Next Steps

Will send first draft of method section by Christmas.

Felt that making comments on transcripts that were just one word did not really do justice to the words of the participants.

Need to keep reflecting whilst compiling themes who the research is for and why I am doing it. This will allow me to
<table>
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<tr>
<th>Date</th>
<th>Participants</th>
<th>Duration</th>
<th>Topic</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>20/01/2011</td>
<td>Alex, Niall</td>
<td>45 Minutes</td>
<td>Emerging themes Method Section</td>
<td>Reviewed Interim Report and Ghant chart to look at the next steps which need to be taken. Looked at the themes that appear to be emerging after completing all the analysis on the transcripts. Main themes so far appear to be ‘changing illness awareness’ and ‘professional and social support’. Discussed how these fit with the current literature. Went through method section and feedback. Looked at making changes and where could get the information from to do this. Once changes have been made will email this back to Niall and Yvette to double check.</td>
</tr>
<tr>
<td>10/03/2011</td>
<td>Alex, Yvette, Niall</td>
<td>60 Minutes</td>
<td>External &amp; Internal Examiner Feedback on memo’s Analysis</td>
<td>Currently have 10 super-ordinate themes. Discussed if these could perhaps be collapsed together and still do justice to what the participants are saying. Went through 10 super-ordinate themes and looked at what the subordinate themes are in each. Discussed theory that can be attached to each. External supervisor has agreed and supervisory team have agreed an internal examiner. Yvette and Niall discussed what will happen next in terms of getting these approved. Need to look more into themes from today’s meeting and email Yvette and Niall any further</td>
</tr>
<tr>
<td>Date</td>
<td>Participants</td>
<td>Duration</td>
<td>Notes</td>
<td></td>
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</tr>
<tr>
<td>14/04/2011</td>
<td>Alex, Yvette</td>
<td>45 minutes</td>
<td>Feedback on work. Journal articles Analysis&lt;br&gt;Received feedback on work submitted so far. Literature Review, Research Report Introduction and Method section given a few alterations to be made. Discussed what had left to do (analysis, discussion, critical appraisal, appendix, references). When these could be checked etc. Discussed model of research, how this fits in with current literature etc. Discussed the different types of journals could look to get research published in. Feel strongly that would like people who the research is based on see the work.</td>
<td></td>
</tr>
<tr>
<td>11/05/2011</td>
<td>Alex, Yvette</td>
<td>30 minutes</td>
<td>Editing Final Drafts Handing in&lt;br&gt;Discussed general information about how the portfolio should be set out, whether it should be compiled in a specific text, justified, double spaced etc. A final draft will be sent in to Yvette and Niall by the 27th May. Then a full final copy will be handed in either the 7th, 8th or 10th June.</td>
<td></td>
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</table>
Appendix 6: Debriefing Information Sheet

Debriefing Document

Many thanks for participating in the interview; your views are greatly appreciated.

This is a research project designed to look at the experiences of partners/spouses living with a loved one with a diagnosis of bipolar disorder. The study looks at individual experiences, how people cope and their experiences of support they have received, in particular from Psychologists.

Please remember that although some of the information from this research may be published, your confidentiality will be secured and you will not be identifiable. The tape from the interview will be kept in a locked cabinet and given a number which is known only to the researcher. Following transcription the tapes will be destroyed. Any identifiable information or names will be removed from the transcripts to protect your identity. You also have the right to withdraw from the research at any point and with no consequences.

A general summary of the findings of the study can be obtained by sending an email to the researcher on the below email address from autumn 2011. Unfortunately no individual feedback can be given.

Following the debriefing, if you require any more help please find below the numbers and web addresses of some organisations in your area which may be able to help with any issues that may arise.

Samaritans: 08457 90 90 90 (24hrs), Email: jo@samaritans.org
Mood Swings: 0845 123 60 50 (open between 10am and 4pm Monday to Friday)
Manic Depression Fellowship: 0808 802 1983 (24hrs), www.mdf.org.uk
Making Space: Wigan & Bolton 01942 491555, Manchester 0161 905 2053
MHIST: 01204 527200

Thank you once again for your participation.
Alexandra Barnett  alexandra.barnett@wlv.ac.uk
Psychology Department
Wolverhampton University
Wulfruna Street
Wolverhampton
WV1 1SB
Appendix 7: Information Sheet

Dear Partner/Spouse,

The Experiences of Individuals Caring for Loved Ones with a diagnosis of Bipolar Disorder.

I am a Counselling Psychologist in Training undertaking the above research under the supervision of the University of Wolverhampton. You are being invited to participate in the research study. Please take some time to read the information below before deciding if you wish to participate. Thank you for reading this.

What is the purpose of the study?
The purpose of this research is to find out about partners/spouses experiences of living with and caring for a loved one with a diagnosis of bipolar disorder and how they cope with these experiences.

Why have I been chosen?
As you are currently living with either a partner or spouse who has a diagnosis of bipolar disorder, your experiences, thoughts and feelings are important. Therefore your willingness to participate in this research is greatly appreciated.

What would happen if I took part?
You will be invited to take part in a tape recorded interview lasting approximately one hour. If you agree to take part I will arrange a date for you to attend an interview which will be arranged at a convenient time for you. You will be asked to sign a consent form which will allow the researcher to use the material from the interview.
Your participation in the interview is for research purposes only and will not in any way be therapeutic. It will not in any way affect any support or treatment you are currently receiving or support or treatment you may receive in the future.

Will the interview material be kept confidential?
Some of the information may be published, however, your confidentiality will be secured and you will not be identifiable. The tape will be kept in a locked cabinet and given a number which is known only to the researcher. Following transcription the tapes will be destroyed. Any identifiable information or names will be removed from the transcripts to protect your identity. As a member of the British Psychological Society I am bound to work in accordance with the Society’s guidelines and code of ethics. A copy of these guidelines can be found on the British Psychological Society’s website.

Do I have to take part?
You are under no obligation to take part in this research study. If you do decide to participate you will be asked to sign a consent form. You also have the right to withdraw from the research at any point and with no consequences.

If you are willing to participate please return the confirmation sheet with a telephone contact number in the stamped addressed envelope provided. Upon receipt I will contact you to arrange an appointment suitable to yourself for the interview to take place.

Thank you very much

Alexandra Barnett
Counselling Psychologist in Training.
Appendix 8: Confirmation Sheet

Title of Research

The Experiences of Individuals Caring for Loved Ones with a diagnosis of Bipolar Disorder: How They Cope and the Implications for Counselling Psychology.

Researcher

Alexandra Barnett, under the supervision of Dr Niall Galbraith and Dr Yvette Lewis.

Contact Email

Alexandra.Barnett@wlv.ac.uk

I would like to participate in the research mentioned above. I understand that any information given will be kept confidential and that I am free to withdraw from the study at any time.

I agree to the researcher contacting me on the number given below to arrange a convenient date and time for the interview to take place.

Signed........................................................................................................
Name..........................................................................................................
Telephone Number..................................................................................
Appendix 9: Consent Form

Title of Research: The Experiences of Individuals Caring for Loved Ones with Bipolar Disorder

Researcher: Alexandra Barnett

I......................................................................................................................... hereby give consent to participate in the above mentioned research study. The aim of the research has been fully explained to me.

I understand that:

☐ I will be interviewed for approximately an hour on my experiences of living with a loved one with a diagnosis of bipolar disorder and how I have coped with these experiences.

☐ The interview will be tape recorded.

☐ Confidentiality will be maintained and any identifiable information or names will be removed from the transcripts.

☐ Tapes and transcripts will be stored securely and anonymised, and following transcription tapes will be destroyed.

☐ I can withdraw at any time from the study.

☐ I have been made aware that the researcher works in accordance with the British Psychological Society’s guidelines and code of ethics and I can obtain a copy of these from the British Psychological Societies website.

☐ I understand that upon completion of the study, in autumn 2011, I can receive a brief summary of the general findings by emailing the researcher; however no individual results can be given out.

Participant
Name:.........................................................................................................................

Signature:..............................................................................................................
Appendix 10: Transcription Protocol

1. I listened to the interview again before beginning transcription to familiarise myself with the narrative and fully immerse myself in the data.

2. I transcribed each of the tapes myself. I listened to a short section of the interview and transcribed by hand.

3. Once I had transcribed the full interview I would listen to the interview again whilst reading through the transcript to ensure an accurate copy had been made.

4. The transcription includes pauses, interruptions, repetition of words and incomplete sentences.

5. Pauses are indicated by a series of full stops (for example ‘...’).

6. Non verbal communication (for example sighing, crying or hand gestures) are included in brackets.

7. Each line is numbered on the transcript and speakers are denoted by the participants words being in normal text and the interviewers words in italics.

8. All identifiable information has been removed from the transcripts and participants and their families given pseudonyms.
Appendix 11: Memo’s and Individual Tables of Themes

Memo 1: Katherine

Katherine is a 61 year old, retired lady. She lives at home with her husband whom she has been married to for 30 years. They have two children together and they have both now left the family home. Katherine’s husband has experienced bipolar disorder for the past 11 years.

Changing Illness Awareness

Throughout the progression of her husband’s illness there has been a change in Katherine’s understanding of what the illness is, how it affects her husband and the degree to which she accepts it is now part of her life. When her husband first became ill this was a shock to Katherine as it appeared to happen suddenly: “It was just a shock really that he could be alright one day and then suddenly bad the next” (42-43).

Alongside this shock was a lack of understanding as to what was happening because her husband could not tell her: “At first I didn’t understand what was happening because he couldn’t talk to me. He didn’t tell me anything much about it” (82-84). Also there was a lack of understanding because Katherine had never encountered this type of mental illness before: “I’ve never experienced or known anybody with depression before, let alone manic depression, at all. Everything’s new to you and you don’t know; you don’t really, it’s hard to understand. It’s hard to be with someone who’s got depression to know what they’re going through” (166-170). However, gradually Katherine did learn more about the illness and her understanding grew: “It’s a lot better now and I understand more of what it is like and what he went
“In It Together” (293-295). Although it appears that this growing awareness has helped Katherine, it has also made her more aware of the unpredictable nature of bipolar disorder: “I still get anxious about certain things and it’s the um...unpredictable nature or his unpredictable nature” (274-276). As Katherine’s awareness of the illness has developed, it appears her husband’s understanding and awareness of how the illness impacts on him has changed: “I suppose when he, he knows when he’s been in a depressed state he knows. I think he realises how much it hurts me and I know he doesn’t want to hurt me” (567-569) and this has allowed Katherine to come to the conclusion that he does not engage in these behaviours to purposively hurt her.

Finally there appears to have been an acceptance of the illness, the impact it has had on her husband, the impact it has had on life and her decision to stay with her husband, although she does question her reasons for staying in the marriage: “I chose to stay. I’ve stayed and stuck by him. Maybe I was too frightened to walk out and leave” (517-518) and: “you learn just to accept it and you know, you know that it’s going to be alright in the end” (478-479).

**Implications for Self**

Caring for someone with a mental illness is thought to have an impact on the carers own mental health. Katherine recognises the impact caring for her husband had on her own mental health: “In the end it got to me and I went to the....Doctor eventually because it got so bad and she sent me for counselling” (113-117). The experience of caring has also had a negative impact on Katherine’s self perception (“It’s my fault I suppose I’m not strong enough” 353-354) and it appears she often blamed herself for her husband’s illness: “sometimes you were thinking it was your fault” (153)
A sense of isolation runs through Katherine’s interview. She appears to have been isolated from her husband: “That was one of the worst things...being lonely, living with somebody but they’re not really there” (245-246), from other people as her husband did not want to socialise: “he didn’t want to go out, he didn’t want to see anybody” (209-210) and isolated from family: “I’ve been on my own a lot of the time with it” (432-433). There have also been a number of personal sacrifices Katherine has had to make as a result of her husband’s illness: “we’ve missed out on a lot of things that I would have liked” (331-332). In particular Katherine feels like she sacrificed spending time with her family: “he wasn’t very keen on having anybody else around like my parents, we didn’t really see his parents as they lived a long way away and I feel as though I resent that because I feel as though um I missed out seeing my family” (339-343).

Throughout her husband’s illness, Katherine appears to have struggled with finding a balance between self-effacement (putting others needs first) and self-fulfilment (putting herself first) and it seems like she often engages in the former. Katherine has often put her husband’s needs first because she wants to make his life easier and comfortable: “he’s just not comfortable and so I give in” (353). However, Katherine would like her needs to be put first: “I wish in a way that somebody...that he was the one that looked after me many a time” (532-533).

Control/Responsibility

It appears as though Katherine’s responsibility has increased since her husband first became ill. She is now responsible solely for the running of the home, the finances and her husband’s well being: “you feel a big huge sort of responsibility; he’s very dependent on me for everything” (221-222). Katherine continues to describe how her
level of responsibility has changed: “he’s given up everything to do in the house is my responsibility, the bills, the cars, looking after things like that. He doesn’t seem to be able to cope with the responsibility of anything like that. He wouldn’t answer the telephone or if anyone came to the door he wouldn’t go” (222-226). Despite this increase in responsibility, Katherine does not feel she has much of any control. She attributes that the illness controls her daily life: “begin to realise that the things that might upset him and depress him and you veer away from these. So in a way he’s very controlling” (306-308). She recognises the control the illness has: “to the way that we live” (310). The responsibility and dependency her husband now has on her is identified by Katherine as one of the most difficult aspects of living with someone with bipolar disorder: “the most difficult aspect um...it’s...the responsibility for everything and the dependency he as on me I think at the moment” (528-530).

Professional Support

In terms of professional support, Katherine has experienced mix support from professionals. Katherine has had very positive experiences with her own doctor. Within this relationship she has felt supported and listened to: “the support I had from the doctor, my doctor was very good when I went to see her. She was very good and she helped me a lot” (583-585) and: “she was somebody I could talk to and I felt that she understood what was happening” (588-589). However, the support she received from a counsellor she was referred to was not only unhelpful but perhaps inappropriate: “The counsellor I wasn’t very happy with. I was at first, she was alright but then as I said once she started to try and delve too deep into maybe what was causing this depression” (589-592). As a result of this negative experience Katherine stopped seeing the counsellor: “it upsets me too much and I just didn’t want to know so I stopped seeing her” (594-594).
It would seem that the support received by Katherine’s husband was very individualised and she was often excluded from this process: “I felt very excluded that it upset me in a way because I felt as though he was opening up to her where as he wasn’t to me. And she was finding out, learning and I worried about what he was saying to her” (625-629).

Need for Validation

Katherine identified a need for reassurance from the professionals involved in her husband’s care that he was going to be alright: “If I’d gone and if she’s reassured, if she said to me a bit more about how she thought he was” (200-202) and the need for her experiences to be validated and normalised by others in a similar position to herself: “if there was a support group or something that I could have gone to and just listened or heard what other people were going through, how other people reacted to the illness and how they were affected by it” (615-618).

There was also a need for validation from Katherine’s husband that she was helping and doing the right thing: “I wanted to help him, but he, he, it was hard. You don’t know what to say to him. If I did say anything to him he was very dismissive or he didn’t want to know” (137-140) however because Katherine did not get this validation she often felt helpless: “you just feel helpless that you can’t do anything to help them or you don’t know what to say to them” (140-142).

Coping with the Illness

With regards to the episodic nature of bipolar disorder, Katherine appears to have coped differently when her husband is depressed and when he is experiencing manic
symptoms. With regards to the depressive episodes, the way Katherine has coped appears to have changed over time, as is highlighted by the following passage: “When he’s depressed I’ve just...um...when he becomes quiet and doesn’t want to talk to anybody and will just sit and I’ve learnt to accept that eventually he does come out of it” (457-459) and: “In the beginning I, I was sad and sorry for him and I tried to understand what was going on and I tried talking to him, but I was just pushed away really so then you go through a phase of bring angry and um...and then thinking well if that's the way you're going to be, just ignoring them in a way”

In terms of coping with the manic symptoms of bipolar disorder, Katherine does not feel she copes: “I don’t think I do, I don’t know what I do then” (487). The coping skills that she does employ appear to be more emotion focused, a form of coping aimed at lessening the emotional distress: “I want to run away. I don’t know cause I’m frightened then. I get very frightened and have sometimes gone out of the house and left him on his own and hope that by the time I get back he’ll have calmed down” (487-491). Katherine appears to be hoping for the best, in terms of he will calm down by the time she gets back, and also avoidance: “I don’t really want to think about it” (369-370).

Other ways that Katherine appears to cope with her husband’s illness is just to go with things and let them happen: “I give in because I don’t want to upset him” (354-355) and having social support has aided her ability to cope. Discovering a friend had gone through a similar experience gave Katherine someone to share her experiences with: “Once I started talking to my friend who was experiencing it was a lot better” (611-612).
Implication for Relationships

Katherine’s husband’s illness not only seemed to have an impact on her relationship with him, but an impact also on her friendships. In the beginning Katherine didn’t feel as though she could speak to anyone about what was happening: “I didn’t feel as though I could talk to any of my friends about it. I felt I didn’t feel as though I could because I didn’t want them to know what was happening” (395-398). Not wanting her friends to know what was happening may be linked to her feelings of self blame, her own lack of understanding as to what was happening or even a sense of shame about her husband experiencing a mental illness. Katherine also felt unable to speak to her friends at work as her husband was the head teacher at the school she worked in and she worried she was being disloyal to him: “he was their boss they worked for him so that was being disloyal to him” (420-422).

With time, however Katherine feels she is more able to talk with her friends about her husband’s illness and, as a result, she feels more supported: “as the years have gone on and other friends...I’ve been able to talk to friends and tell them that they do know the situation now and I can talk to them so when things happen I can go see them and I feel as though I’ve got, I feel as though somebody is there” (398-402).

In terms of family relationships, Katherine acknowledges some of the support she has received from her husband’s family, however she feels as though she has been on her own a lot: “I feel as though I’ve been on my own a lot of the time with it” (432-433) and almost as though she has had to protect his family (in particular his parents) from certain aspects of his illness: “his parents now know what he’s like although I still don’t tell them everything” (402-404). Similarly, with Katherine’s sister in law, she recognises that she has been supportive but she doesn’t know completely what has
happened: “my sister in law’s been very good but she doesn’t know a lot of what’s gone on” (433-435). In a way, it appears as though the illness has isolated Katherine (not through choice) and her husband (through choice or the illness?) from others: “he became, we became sort of very isolated” (210-211).

**Emotions**

Katherine’s emotions with regards to her husband’s illness appear to have changed over time. Initially, when her husband first became ill, Katherine was upset and worried: “I was very upset um...and anxious” (237-238) and trod carefully around her husband: “you very sort of caring and careful to start off with” (239). As the illness progress she became more frustrated and angry: “you become more angry that it’s happening and angry at them because you don’t understand what they’re going through” (241-243) and often experienced guilt: “you feel guilty going out and leaving them” (254). Katherine recognises that her feelings have changed a lot over the course of her partners’ illness and that now she feels very sorry for her husband: “I felt very sorry for him and the way he’s been and what he’s had to go through or his feelings and that and I still feel like that for him” (295-297).

**Illness Effect on Partner**

Both the depressive and manic episodes of bipolar disorder can have an impact on the behaviours of the individual experiencing it. Katherine noticed that her husband often engaged in unpredictable behaviours when unwell: “He’d just suddenly disappear and walk out of the house and you wouldn’t know where he’d gone” (148-150). There is also a sense of loss over the person her husband was: “he has altered a lot compared to what he used to be, he used to be quite gregarious and friendly and
go to the football with his friends and things but now he doesn’t. He’s changed a lot and it's sad” (319-322)
### Client 1 (Katherine): Table of Themes from IPA Semi-Structured Interview

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<tr>
<th>Master theme titles</th>
<th>Sub-theme</th>
<th>Transcript key words</th>
<th>Indicator line</th>
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<td>Sudden decline in health/initial hope</td>
<td>‘It was just a shock really that he could be alright one day and then suddenly bad the next’&lt;br&gt;‘I didn’t understand what was happening’&lt;br&gt;‘I understand more of what it is like’&lt;br&gt;‘It’s the unpredictability of the moods’&lt;br&gt;‘I know what my husband would want, but I don’t want it and it worries me this’</td>
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<tr>
<td></td>
<td>Lack of understanding</td>
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<td></td>
<td>Growing illness awareness</td>
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<td></td>
<td>Fear of unknown</td>
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<td>Implications for self</td>
<td>Effect on own mental health</td>
<td>‘I was sent for counselling’&lt;br&gt;‘I’ve been on my own a lot of the time with it’&lt;br&gt;‘I give in because I don’t want to upset him’&lt;br&gt;‘I resent him at times...what I’ve missed out on’&lt;br&gt;‘Sometimes you were thinking it was your fault’&lt;br&gt;‘You feel like saying to them snap out of it’</td>
<td>113&lt;br&gt;432-433&lt;br&gt;354-355&lt;br&gt;332-333&lt;br&gt;153&lt;br&gt;172</td>
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<tr>
<td>Control/responsibility</td>
<td>Carer no power/illness controlling</td>
<td>‘In a way he’s very controlling’&lt;br&gt;‘You feel a big huge sort of responsibility, he’s very dependent on me for everything’</td>
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<td>Professional support</td>
<td>Positive support from professionals</td>
<td>‘My doctor was very good when I went to see her’&lt;br&gt;‘The counsellor I wasn’t very happy with’&lt;br&gt;‘I know my husband’s told the counsellor lots of things that he’s never told me’</td>
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<td>Individualism of medical approaches/psychology</td>
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**Client 1 (Katherine): Table of Themes from IPA Semi-Structured Interview (Cont.)**

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<td><strong>Need for validation</strong></td>
<td>Need for validation from professionals</td>
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<td>Give in</td>
<td>‘I give in because I don’t want to upset him’</td>
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<td>‘I don’t really want to think about it’</td>
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<td>Mania most difficult</td>
<td>‘I don’t think I do’</td>
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<td></td>
<td>Social support/Shared experience</td>
<td>‘I started talking to my friend who was experiencing it’</td>
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<td><strong>Implications for</strong></td>
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<td>relationships</td>
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<td>‘He became, we became sort of very isolated’</td>
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<td></td>
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<td></td>
<td>Partner’s awareness</td>
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Memo 2: Debbie

Debbie is a 62 year old woman who is employed part time as a Doctor’s receptionist. She is currently single and divorced. She was married for 31 years to her husband who was diagnosed with bipolar disorder at the start of their marriage. She has two children who have both left the family home.

Implications for Self

Throughout her relationship with her husband, Debbie often felt excluded by the professionals involved in her husband’s care: “the shutters went down” (140-141). Within the relationship itself Debbie also felt isolated. Family holidays were often in a caravan: “with caravans you can be isolated” (396) and by the end of the marriage Debbie felt they were: “isolated socially” (379-380) because: “he just couldn’t face people” (394). It appears that one of the reasons for this social isolation was because either societies or Debbie’s values meant that women could not go out in the evening without their husbands (“you can’t really go out in an evening without your husband” 242-243). Therefore it seems that Debbie’s social life was restricted because: “he didn’t like to go out, he couldn’t face mixing with people” (238-239).

Throughout her experience of caring for her husband, Debbie developed a negative self concept: “I’m his wife, I should be able to make him right, you know, your suppose to love him and you should look after him, nurture him and make him better and I couldn’t” (587-590). The word ‘should’ in the above statement indicates perhaps a societal view of a wife’s role in taking care of their husband. At times Debbie felt responsible for making the illness worse: “I began to think during his illness possibly I was making his depression worse” (70-71).
Whilst in the marriage it seems Debbie was engaging in self-effacement, putting the needs of others first, in this case her husband. She would often be careful with what she said: “he used to fly off the handle if you said anything” (186-187). However it seems as though eventually Debbie got to a point where she felt she had to start looking after herself: “but human nature sometimes, in a way, means you have to look after yourself sometimes, haven’t you? You can’t always bend the way in the person that your living with” (596-599). In the end Debbie decided that she had to put her own needs first which ultimately meant leaving the marriage. Since doing this it appears that Debbie has: “more of an appreciation for life” (567-568).

Debbie comments that she feels had she stayed in the relationship this would have had a negative impact on her own mental health and that her divorce was: “for my own sanity really” (366-367). Although she said this laughing, I felt there was a serious undercurrent beneath that comment. Similarly when she was talking about what would happen if she did not have her friends around: “I think I would have gone completely out of my tree, you know, had I not got my girlfriends to meet sometimes” (270-272).

**Control/Responsibility**

It would seem that throughout the relationship Debbie has had to take on board the majority of responsibility, not just for ensuring her partner stays well, but also the financial responsibility and the responsibility for looking after and raising their children. “Looking after the household finances, which wasn’t easy once he was on sick pay” (323-324) and “I could just imagine that eventually we’d get into so much debt that we’d probably have to sell the house” (449-451). Despite this responsibility, it would appear that Debbie had no power or control over what her
husband spent ("he wouldn’t discuss it and kept saying it was his money" 448-449) or over his treatment ("I was the observer but nobody really wanted to listen to me” 707-708). When looking at responsibility, there is a sense that Debbie felt she had no other choice but to take responsibility for her husband and stay in the relationship: “You know it’s just the way life went then and it’s a bit old fashioned now I suppose, but when you get married you think it’s for good. You know in sickness and in health so you know you just think you have to keep going” (115-118).

**Professional Support**

It seems that throughout her relationship with her husband, Debbie’s experience with professional support is quite negative. Many times Debbie felt like she was a forgotten party in her husband’s illness: “no man is an island...you’ve got to think about how you behave is affecting the people around you however ill you really are” (735-737) and when she did go and see professionals with her husband she did not feel welcome: “I felt like I was on the sidelines. I didn’t always go cause I just didn’t feel welcome really” (772-773). When Debbie finally did manage to speak to professionals, she often felt she was being blamed for her husband’s behaviour. One psychiatrist stated that he husband was much worse when Debbie was with him (“one time she said well your far worse today now you’ve got your wife’s with you” 759-760) and after seeing her husband’s clinical psychologist, Debbie was informed she had written a letter stating that Debbie was: “a bit of a worrier” (457-458). It also seems that the access available to professionals was only for her husband and Debbie was not a part of that, despite the large role she played in caring for her husband: “it was like you didn’t count” (711). Debbie often felt worried that she did not know what her husband was saying to different professionals: “I mean he might say my wife shouts at me all the time and I don’t know what he said to them…” (721-723),
because of this Debbie stated that she often felt: “tried and convicted” (595) in her absence.

Despite these negative experiences, there have been one or two professional people who Debbie has recognised as supporting her in some way. These individuals appear to have offered support even if it was not their place to do so ("there was only the OT and it was just more of an off the cuff remark from her" 637-638) and this care and compassion was very much appreciated by Debbie ("it felt wonderful to have someone there to bounce my feelings off" 213-214). Debbie stated that she would have liked to have accessed professional support where she felt listened to and believed ("somebody to really listen to me and believe what/how...my side of how he was behaving" 697-698).

**Need for Validation**

Within the relationship Debbie felt that her husband did not recognise or acknowledge the impact the illness had on her: “not having any, not feeling, not having any feeling for my emotional needs at all” (189-190). I sense that Debbie still feels the difficulties she faced throughout their marriage have not been acknowledged by her husband: “I think I got a raw deal out of it all” (528-529). Validation from professionals is also very important to Debbie, even if this has come retrospectively. Debbie spoke to one of the GP’s that her husband used to see about the divorce: “he said well you look after yourself now and I thought he probably understands more what I was going through” (519-520). This recognition from the GP gave Debbie permission to accept she had done all she could: “I would have been living with that guilt thinking I could have done more (pause) I don’t think I could really with hindsight” (514-516). However, this experience with the GP appears to be the
exception for Debbie. Her experience with other professionals recognising her needs was much more negative: “It was like banging my head against a brick wall at the time. Nobody really seemed to want to listen. I don’t know whether they thought I was making it up or what, I didn’t feel believed anyway” (778-781).

Coping with the Illness
Throughout her relationship Debbie’s main ways of coping appear to have been avoidance of the situation and escaping (either literally or figuratively through a book or activity). “Things that would take me out of myself, like I always liked reading. If I could get immersed in a really good book then that would take the pressure off for a while” (419-422). Debbie also spent some time working as a town councillor and this also gave her the opportunity to ‘escape’ for a time: “it got me away from my other problems for a while” (433). In terms of avoidance of the relationship, Debbie recalled one day after work when she felt she couldn’t go home: “I cannot go home; I cannot face going back to that house and going back to all these problems. So I went and stayed in a hotel over night” (538-541). Debbie stated that she feels had she received more support, both professionally and socially, she may have been able to cope differently with the situation: “I think if I’d have had a better support system I would have coped better” (717-718). It would seem that Debbie is engaging in a form of coping aimed at lessening emotional distress (emotion focused coping).

Implications for Relationships
Living with a partner diagnosed with bipolar disorder appears to not only impact on the relationship between carer and patient, but also on the carers’ relationship with others outside the home (i.e. family and friends). In terms of the relationship between Debbie and her husband there is a sense that this is a one sided relationship and that
Debbie was unable to share with her husband the usual decision making and planning that is important in maintaining a relationship: “I was saying we ought to be putting some into a better account with some interest so we can keep it for the bad times, but he just wouldn’t do it and he just kept spending” (443-446).

As Debbie grew more aware of the illness and learnt about its unpredictable nature she began to worry more about the future and saw this as quite uncertain: “you don’t expect that he’ll keep on having what people call nervous breakdowns every few years, you know. I would have never thought that” (111-113). There is also a sense of grief and loss regarding who her partner was and how the illness changed him over time: “if I drop in and see him I feel really sad when I come away and think what a waste of a life, he just exists really. You know he hasn’t got a proper life at all” (310-314).

With regards to support from family, Debbie feels that she has had no support from her family or her husband’s family. She puts this down to people still not really understanding mental health problems: “people still think with mental health problems it’s oh tell him to snap out of it” (348-349). It was only after the relationship ended that Debbie felt she got any support or recognition from others: “after I sort of told people we were splitting up. People then turned round and said I don’t know how you’ve coped with it for all these years” (351-354) and she got some support from her brother at this point. In terms of her parents, both Debbie’s parents had passed away at the point of the divorce, however Debbie feels her mother would be upset at the thought of her getting a divorce: “I think my mother would have been quite upset about us getting divorced, but I hope she’s understood why I did it” (365-367). In terms of support offered from friends Debbie recognises that she had some
good support from friends: “I did have some good friends and they were supportive and that meant for a lot” (401-402).

**Changing Illness Awareness**

Throughout the relationship there has been a change in what Debbie understands about the illness and how she feels about it. In the beginning, when her husband first became ill, there was a sense that this was a one off: “I didn’t expect it to keep carrying on” (157) and an optimism that things would get better: “you know looking forward to the future, the wedding and everything, everything was fine around then” (178-179). However, as her understanding of the illness grew she began to realise that there was always the threat he would experience the depression or mania again: “he was always very much on the edge of cracking up again” (57-58). After the relationship ended there was a belief that they were both better off apart and this was confirmed by her two sons: “after the split they both said that they thought we were both a lot better for the separation” (296-297).

**Changing Emotions**

Debbie’s emotions regarding her relationship and the bipolar disorder, appear to have changed over time. In the beginning, when her husband first became unwell, she was very optimistic and hopeful for his recovery: “in the beginning there was optimism there” (175-176) and: “you think that love will find a way and everything’s going to be wonderful don’t you?” (89-91). However, as the illness progressed and Debbie became more aware that the illness was still there, she began to get increasingly worried: “I got a lot more worried about it further along the line in our marriage when I began to think he wasn’t ever going to get better” (172-175). Initially after the divorce Debbie expressed feelings of guilt with regards to taking her children
away from their home: “I feel really bad that you’ve lost your home” (580). Despite these changing emotions, throughout the relationship Debbie felt the need to control her emotions and not express these to her husband: “trying to keep my mouth shut when I wanted to really let fly” (553-554) and: “self restraint at times was very difficult” (556).

Retrospectively looking at her experiences Debbie feels that she is now a more tolerant person now: “It’s probably made me a more tolerant person” (560) and has allowed her to be more empathetic with others: “I summarise medical records and sometimes I can read about other people and think yeah I know how you feel” (563-564).

**Impact of Specific Illness Behaviours**

Bipolar disorder is characterised by extreme swings in mood, from being very high (mania) to being very low (depression). When depressed an individual may experience feelings of hopelessness and the risk of suicide is high. The fear of suicide (“this might sound dramatic, but there were times when I use to get home from work and think I’ll find him hanging in the garage” 608-611) had a big impact on how Debbie experienced her relationship: “you always hold back on having a big blazing argument and clearing the air because you’re worried that they might go off and do something stupid” (606-608).

Throughout the relationship Debbie often found herself questioning her husband’s behaviours and the impact these had on his life. During the relationship: “the way he portrayed himself when he was at home was that he couldn’t go out and face anybody” (475-477), however there were occasions within the relationship where her
husband did go out: “he’d been in the bank! This is him who couldn’t go out” (485-486) and as a result Debbie felt she had been: “cheated really” (513). Looking back at the relationship Debbie felt that perhaps, some of the time, her husband was putting on an act: “Um (pause) well almost like he was putting it on a bit really” (517-518), “to draw attention to himself or my nerves are shot and I can’t do anything you’ll have to do it for me” (520-521). There appears to be strong resentment in what Debbie is saying, however she is quick to state that she does believe he is ill, perhaps this is through fear of being judged within the interview.
Client 2 (Debbie): Table of Themes from IPA Semi-Structured Interview

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Memo 3: Sue

Sue is a 38 year old, degree educated, woman. She has been with her partner, who has been diagnosed with bipolar disorder, for the past seven years.

Coping

How an individual copes is thought to involve constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands. Throughout the interview Sue’s way of coping with her partner’s illness appears to be constantly changing as their relationship continues and she learns more about her partner and how the bipolar disorder affects him. Sue reflected that on some occasions living with her partner when he is anxious can be: “overwhelming” (343) and she needs to: “go out” (341).

It would seem that over the course of the relationship Sue has resigned herself to the fact that her partner engages in certain behaviours due to the bipolar disorder and she cannot change this (such as making grand plans and staying up very late). As a result Sue has learnt to: “tune out and do my thing” (423) and: “just try stay calm and say yes, and I know it won’t actually happen” (424-425).

Reflecting back on the relationship, Sue acknowledges that one of the reasons the illness is: “not a big problem for us” (473-474) and she can cope with it, is because of her partners awareness of the illness and his attempts to manage this (“he’s aware of it and he tries to manage it” 474-475). She recognises that if he were not aware of the illness, did not look after himself or take medication she would find this much more difficult to deal with: ‘I would just be in a permanent panic’ (477-478), and: “I couldn’t cope to be with somebody like that” (478-479). The social support Sue has
received from family, friends and, in particular, her manager at work, has also helped Sue feel like she can cope with her partner’s illness: “the manager who has a daughter who has bipolar and she knows what I mean if I talk to her” (396-397).

Although support from her partner and others is clearly important in helping Sue to cope with the impact her partner’s illness has on her daily life, it appears that her ability to understand the illness and the impact this has on her partner is most beneficial in helping her cope. At the beginning of their relationship Sue: “didn’t understand how the bipolar affected him. I didn’t understand how unwell he got or how well he managed it” (262-265) and she, therefore, found this very distressing and worried things would go: “worse and worse and worse” (267). However as she got to know her partner, she learnt his triggers (“I know what’s going to trigger him being upset or distressed” 276-277) and how the illness impacted on him (“I now understand that he always comes back down” 268-269). Sue acknowledges that she now has a greater awareness and understanding about the illness and the affect this has on her partner (“I understand the illness better, but I understand how it affects him” 244-245) and this makes it: “a lot less worrying” (246-247).

**Implications for Self**

Sue comments that there have been times throughout her relationship, particularly at the start of the relationship, where she has felt excluded from her partner’s life: “I was aware that we couldn’t see each other at times” (83-84). Sue also comments on a particular period where her partner was depressed and she was: “In the dark all the time” (418-419). I wondered whether “in the dark” had a double meaning for Sue – she was in the dark both literally (as he was in bed with the lights turned off), but also figuratively as Sue states her partner also had the flu during this period of depression,
however she questions whether this was his way of admitting he was not well without having to acknowledge the depression (442-445).

Living with someone with a mental illness can have an impact on the carer’s own mental health. Sue acknowledges that sometimes when her partner is feeling anxious this can feel: “infectious” (336) and she begins to think: “I’m starting to catch this” (339-340), as if mental illness is contagious. She also recognises that if her partner experienced prolong periods of depression she thinks this would have: “really got me down” (451).

Within the interview, Sue reveals that she thinks there have been positive implications for herself through having a relationship with someone experiencing bipolar disorder, although she finds it difficult to separate what is the bipolar disorder and what is her partner’s personality. Sue stated that her partner comes across as a: “bubbly, kind of gregarious, charismatic person” (510) and that she can: “feed a bit of confidence off that” (511-512) and that: “he’ll do things I would never dream of daring to do and yet it pushes me a bit I think” (519-520). The “I think” perhaps indicated that Sue is still unsure about whether or not this is related to him or down to herself.

**Changing Illness Awareness**

As the relationship has progressed it seems that Sue’s understanding and awareness of the illness has changed and grown. In the beginning of the relationship there was a naivety about the impact the bipolar disorder would have on her or the relationship: “I thought it would be easier than it was” (110), “If he gets low he takes anti-depressants, if he gets high he takes anti-psychotics. That sounds quite sensible and
easy to manage” (115-117). However as the relationship progressed, Sue began to realise that this was not an: “exact science” (118) and when her partner became agitated and stressed it could be difficult to manage. Sue’s growing illness awareness has run parallel with the relationship and she now has a much greater understanding of the disorder and the things that go with this including medication (“There’s the medication as well and I now know what effect that has, sleepiness and all that kind of thing” 282-284).

Alongside the growing awareness of the illness, it appears there has also been a growing acceptance of the different behaviours and situation that can occur as a result of having a partner with a diagnosis of bipolar disorder. Sue acknowledges this change in acceptance: “at first I said, ‘Oh my god’ he’s up at 3 o’clock in the morning making lasagne what can I do? Now I just think well let him just get on with it” (426-429) and: “so it’s just learning to accept that there are some things that you can’t change and you don’t really need to” (431-433). Alongside this growing acceptance it seems that Sue has started to normalise a lot of the behaviours which at first she found: “unusual”(487) and: “weird” (489). “There’s no symptoms he can tell me that I find particularly shocking or distressing. I can normalise it” (145-147).

**In it Together**

Whilst conducting the interview with Sue and after reading through the transcripts, I got a feeling there was a sense of camaraderie between Sue and her partner and that they were ‘in it together’ in terms of both the relationship and the illness. It seemed as though, as a couple, they understood the illness and its effect on their relationship in a way that others wouldn’t understand: “it doesn’t seem as weird to me” (139-140) and: “it might freak people out if they saw it from the outside, but for us it’s, it’s quite
Unlike others who have taken part in the study, Sue did not feel an overwhelming sense of responsibility for her partner. In fact she felt that the responsibility was shared between them: “he looks after me probably as much as I look after him” (537-538).

**Support**

In terms of support Sue speaks mostly about the support she receives from family and friends and not professional support. This may be because of the length of time her partner has been experiencing bipolar disorder before their relationship started and his ability to manage the illness without the input from professionals. In terms of support from friends and family, Sue reported that although she felt she did get support from them, in particular her parents, they could never fully support her or understand as they did not experience it everyday; “Nobody’s ever been unsupportive, people have always been supportive, but, but they don’t really get it ‘cause they don’t live with it. Nobody really understands” (320-322). There is a sense of isolation in Sue’s words from family and friends due to this lack of understanding: “because they don’t live with him and they don’t see as much of him as I do I don’t think they fully realise what it’s like’ (333-335). It seems that, although Sue feels supported, this support has limitations attached to it because of her family and friend’s lack of understanding.

Studies have found that caregivers of someone with a mental health problem often experience stigma from friends, relatives and the general public. From Sue’s accounts it would appear that she has also experienced similar negative attitudes from her friends. Sue recounts a friend’s reaction when she first started working in the mental health field: “I remember my best friend saying to me, ‘don’t do that you’ll get stabbed to death by a schizophrenic’” (105-107) and when she started seeing her
partner Sue reported that she does not talk to friends about his mental health: “I don’t even talk to friends about the bipolar” (323-324). Sue gives the reason that they would not understand, however I wonder if this negative attitude she has experienced may also play a part in her avoiding discussing issues with friends.

**Illness Effect on Partner**

Sue’s partner had been diagnosed with bipolar disorder for about 30 years before the relationship started. This seems to have a big effect on the way the illness currently affects her partner and also how it impacts on their relationship: “he’s had about 40 years experience of dealing with it so he’s actually quite good at it. He’s a bit of an expert at keeping himself well’ (39-41). Sue does recognise that things might have been different had he become unwell during the relationship: “perhaps if we’d been together when he was a lot younger it might have been harder for both of us” (43-44).

In terms of the impact the bipolar disorder has on her partner, Sue struggles to imagine her partner without the bipolar disorder: “he wouldn’t be the person he is without it” (383-384). If she was offered a button to remove the bipolar Sue did not think she would: “I think it might change his personality and part of what attracted me to him was the kind of the charismatic thing and I like that” (386-389). It seems that for Sue her partner’s personality and the bipolar disorder are inextricably linked and she is unclear things are related to the bipolar disorder or because that is the person he is: “the two things are wrapped up together” (505-506).
Implications on Lifestyle

Similar to the bipolar disorder and her partner’s personality being linked, Sue struggles to identify whether the changes in her lifestyle are because of being in a relationship or being in a relationship with someone experiencing bipolar disorder: “if you become a couple your lifestyle changes anyway so I don’t know what’s bipolar and what’s just being part of a couple” (166-168). Sue recognises several changes since she started seeing her partner, however she does not think these things are because of the bipolar disorder (“I don’t think that its necessarily to do with the bipolar disorder” 175-176). She does, however, note that some things have changed in her life and that is directly linked to the bipolar disorder and the effect this has on her partner. “I’m a bit of a planner and I like to plan holidays and theatre trips and do that and we’ll go there but he likes, he doesn’t like to plan things in advance cause he doesn’t know how his mood is going to be” (180-183).

Emotions

Similarly to her illness awareness, Sue’s emotions have changed over the course of the relationship with her partner. In the beginning of the relationship there was a period where she was not in contact with her partner for a period of two weeks in which she feared the worst: “I panicked that...if you’re not with somebody you think the worst” (205-206). However it seems that that feeling of worry has changed over time: “I don’t need to worry about the bipolar now at all” (227-228) and she now feels she has a more realistic view of both the illness and its effect on her partner: “I’ve got a more realistic view of it now and I might think ‘oh no’ but at the same time I know we’ll get through it and it wears off. It’s not a major thing” (337-240).
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Memo 4: Alan

Alan is a 45 year old male who currently works as a Community Support Worker. Alan has been married to his wife, who has been diagnosed with Bipolar Disorder, for 12 years. They have a four year old son together.

Implications for Self

Caring for his wife has had an impact on Alan’s own mental health: “it was stressful and I did actually go onto the sick for six months” (196-198). Alan related that feelings of helplessness when his wife was in hospital had a big impact on his own frame of mind and mental health: “if you do have someone you do love in hospital and I think the hardest bit is knowing that there’s nothing you can do and obviously that is going to make you feel depressed as well” (317-321). He also recognised the act of caring can be exhausting: “It just sort of like, you know, makes you feel really exhausted, you know, all the time” (275-276) and: “It just gets you tired and exhausted” (279-280).

In terms of self-effacement versus self-fulfilment, Alan started the relationship mainly engaging in acts of self-effacement: “I was there every single day, seeing Stacey and I wasn’t going out” (423-424), however as the relationship developed he learnt the importance of putting his own needs first and finding a balance: “I think you need to take time for yourself” (426-427).

Despite the effect caring for his wife has had on Alan’s life, he states that this role has had no impact on his own long term personal goals: “you just got to get on with your life” (292-293) and: “even when I did find out Stacey did get ill that really didn’t hold me back from doing what I wanted to do” (296-298). Alan also found the role
of caring for his wife a rewarding experience: “I think (pause) the biggest one is just knowing that she’s getting better. And I do think that I do help you know, in her recovery” (589-591) and “I think, you know, when you’re in a situation and you are married to someone with bipolar and they are witty and they are funny and you know they’re not going to go off with someone else (pause) hopefully. It does even though sometimes it’s hard and it’s frustrating. I wouldn’t change it for the world” (601-607).

**Control/Responsibility**

As a carer Alan has taken on a lot of responsibility with regards to Stacey’s care. He has taken on responsibility for ensuring Stacey continues to take her medication and trying different methods of keeping her well: “you’ve got to make sure that Stacey keeps taking her medication” (134-135) and: “I think it’s also making her aware of what she’s eating and making sure that she’s getting plenty of fluids because they say that, you know, people with bipolar they’ve got to look after themselves, you know regarding food ‘cause obviously that does, you know, help your mental health” (141-147). However, despite this level of responsibility for Stacey’s care, at times Alan feels like he has little control, especially when Stacey is high: “Stacey had actually just gone out and just spent thousands of pounds. Money that we didn’t even have” (489-491), “They’re just so high that they do not understand what they’re doing” (494-495). It seems as though Alan has little control over Stacey spending this money, yet it is his responsibility to, somehow, get this money back and pull them out of debt: “I could work loads of overtime” (499-500) and: “I actually had to go round and borrow £1000 off my mum and dad” (508-509).
**Professional Support**

Alan has experienced mixed support from the professionals involved in Stacey’s care and the support received appears to have been dependent upon the area they were living in: “cause we use to live in the North, she didn’t get any support at all. Um but since she’s come to the South um, she’s had a Community Psychiatric Nurse who just seems to know everything and everyone” (615-619). Since moving to the South there appears to have been a lot of positive interaction with professional organisations: “if her CPN feels she needs to see a psychiatrist all he needs to do is phone him up and he can actually get an earlier appointment. I think that has been the biggest help” (664-666). For Alan knowing that the support is there and that there are professional people to help his wife should she become ill has made a difference to how he copes with the illness: “And it’s just knowing that there is professional people there and the support that Stacey does have has made a big difference” (631-633).

However, not all experience with professional support has been positive and he recognises that there are limitations to the support that is available: “There’s got to be beds there available to have. So what they’ll do is they’ll just send you home and then you’ve got to wait for a bed to come up which can be, which can be a bit of a nightmare” (680-684). Here Alan is discussing the fact that if Stacey is unwell she may have to wait for a bed to become available on a Psychiatric Ward. If there is not a bed available then she has to wait at home, perhaps with only Alan there to care for her which is why he states it can be a bit of a: “nightmare” (684). There have been times when Alan has found the information or advice given by professionals was unhelpful. When his wife was in hospital he was told that going to see her everyday
was actually: “making her worse” (434), however Alan has questioned this advice stating: “I’m not sure that this is for everyone” (435-436).

**Implications on Lifestyle**

There is a recognition from Alan that being married to someone experiencing bipolar disorder can have an impact on his life style: “it does, it can, it does completely change your life” (126-127), however, perhaps the swap from “it does” to “it can” implies that Alan is unsure whether he wants to acknowledge this impact as later on in the interview, when questioned how living with Stacey has affected his life goals, Alan stated: “Um...to be honest...it hasn’t” (287). Despite this uncertainty, Alan does suggest ways in which his life has been changed due to being married to an individual with bipolar disorder: “you’ve got to be more understanding and you’ve got to be more patient” (130-132) and: “you’ve always got to be thinking, you’ve always got to be planning ahead all the time” (155-157).

Another way in which being married to an individual experiencing bipolar disorder can impact on Alan’s life is through the stigma that can be attached to mental illness. Alan feels like there is: “a lot of bad press about people with bipolar, that they’re going to go round stabbing everyone and stuff like that” (734-736) and when his wife has been ill he feels people do not understand: “when Stacey has been ill you do get people looking and you know stuff, what’s wrong with her and stuff like that” (723-725).

**Coping with the Illness**

In terms of coping with the episodic symptoms of the bipolar disorder, Alan finds coping with the manic symptoms the hardest: “Stacey had actually gone out and just
spent thousands of pounds. Money that we didn’t even have. It was even to the case where she had actually overdrawn the mortgage account and I think that’s the hardest bit to cope with, you know, the money side of things when they’re just so high that they do not understand what they’re doing” (498-495).

Within the interview Alan states that the best way of coping with his wife’s illness is to stay positive (“you’ve got to remain positive” 292) and understand the illness: “I think you’ve got to understand what that person’s going through. I think that, um, it’s just like, you know it makes...I think the big thing, you know, is it makes you want to research, you know, the whole thing about bipolar, cause then it helps you to cope with, you know, the illness as well” (167-172). Having someone to talk to and share his experiences with appears to be another way Alan has coped with his wife’s illness. At work he reports having a strong relationship with his manager and he feels this is a valuable outlet for him: “where I’m working now you know my manager is absolutely brilliant” (400-401) and: “I just sort of went into work and had a chat with my manager and I just done it that way” (411-413). In addition to this relationship at work, being in touch with self help organisations has also proved beneficial in helping Alan cope with the responsibility of being a carer: “they basically send you on breaks, you know, away from the environment that, you know, might want to go away for the weekend” (640-642).

At times Alan also finds one way of coping with the situation is to ‘get out’ of the situation for a while: “just getting out, going to the gym, going out for walks, um, going out with your friends. Not sort of to talk about Stacey, just to get out” (417-420).
Implications for Relationships

With regards to Alan’s relationship with his family and friends, there appears to have been a change over time in his family and friend’s attitudes towards the relationship and in his friendship groups. Initially it would appear that Alan’s family were very negative about his relationship with Stacey: “my mum, um, use to be a psychiatric nurse so she’d actually worked with people with bipolar, but she wasn’t happy, about things” (79-81): “she just thought, you know, that I wouldn’t be able to cope” (83-84). Alan also felt that some of his friends were negative about his relationship with Stacey and as a result many of these friendships have broken down: “I think that there is friends that I did have that I don’t see any more, just basically because like, you know, I got closer to Stacey and I feel that some of my friends were quite negative” (381-384). Alan felt that he needed friends who were more understanding (388-389) and he now feels that he has much closer friendship (“I’ve got a lot closer friends now than I ever had, even though I’ve not known some of these as long as my old friends” 392-394).

In terms of his relationship with his family, Alan does feel that they have become more understanding about the relationship and accepting, especially since the birth of his son, however he still feels they are sceptical about the relationship and question whether he should have married Stacey: “I think there’s still that thing that they think I shouldn’t be going out with her. But I think the thing, I think they’re more understanding now than ever since we’ve had Tom” (356-259).

Changing Illness Awareness

Throughout the relationship there has been a change in Alan’s understanding of bipolar disorder and his acceptance of the illness. Initially discovering the illness was
a shock to Alan. His wife had explained to him that she experienced bipolar disorder at the start of the relationship (“she did actually tell me then, you know, once I’d asked her out cause she thought it would be unfair if she didn’t tell me” 38-40), however she relapsed soon after this: “I err...actually went to visit her in hospital and it was just a complete shock” (57-58). Despite this shock there was hope that the relationship could work: “I knew that we could work things out” (76-77). Also during the initial stages of the relationship there was a lack of understanding of what bipolar disorder was. When asked if he was aware of what bipolar was when he started the relationship with Stacey, Alan replied: “Didn’t have a clue” (45). However as the relationship continued, Alan started to research the illness. He felt it was important to not just understand what bipolar was, but how it was caused and what affects it could have on Stacey: “what causes it and how it affects people and how it affects them. I think you’ve got to look at the whole picture” (178-180).

From this growing understanding and awareness Alan appeared to be more accepting of the illness and its unpredictable nature: “when you’re in a situation and you are married to someone with bipolar and they are witty and they are funny and you know they’re not going to go off with someone else (pause) hopefully. It does even though sometimes it’s hard and it’s frustrating. I wouldn’t change it for the world” (602-607). He seems to have a renewed hope in that, although he knows there is always the chance Stacey will become ill again, he is positive that she will recover and have periods where she is well (“And you just got to keep on sort of thinking that at least when she goes into hospital she will come out and she will get well again” 121-124).
Emotions

Emotionally there was a change as Alan grew more aware of the illness, understood it and how it affected Stacey. In the beginning he was upset and angry: “emotionally it, it sort of makes you feel really upset. It sort, it can make you feel angry” (218-219). However as Alan’s awareness has grown so have his feelings about the illness. He now feels more positive and can find enjoyment in the illness: “they’re witty and they’re very, very fast you know the one liners and stuff like that is unbelievable” (576-578).

Illness Effect on Partner

Alan identified several ways in which he felt the bipolar disorder impacted on his wife. He described that it had a big impact on her behaviour. One way the disorder impacted on his wife’s behaviour is that it can make her very disorganised when she is unwell: “when she’s well she’s great, in fact she’ll do all her finances and that sort of thing, but like when she’s getting ill or she’s not too good they’re very, very disorganised and they sort of flit from one job to the next” (549-553). Alan also felt that the bipolar disorder can make many of his wife’s behaviours very unpredictable: “they just sort of disappear for hours on end and you haven’t got a clue, you know, where they are” (251-253) and: “at first I thought when she was going away maybe she wasn’t going to come back again. She was actually going to go away and commit suicide” (258-261).

A dramatic change appears to occur from when his wife is well and when she starts to experience symptoms of the bipolar disorder: “there the opposite to what they’re actually like when their ill” (66-67) and: “very, very witty really funny. And then to sort of see her when she wasn’t well, completely different person altogether” (71-73).
When his wife becomes ill, Alan feels that she lacks awareness and insight into her illness: “they’re, you know, completely, you know, high and they don’t have the same concept as, you know like, you know, me and you” (227-229) and: “Like when Stacey got ill she spent £3000. And to her it was nothing. She didn’t sort of see the concepts” (233-236).
### Client 4 (Alan): Table of Themes from IPA Semi-Structured Interview

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Memo 5: Jack

Jack is a 54 year old, employed man. He lives at home with his wife and daughter. He has one son who does not live at home. Jack has been married for 30 years and his wife has been diagnosed with bipolar disorder for the past 15 years.

Changing Illness Awareness

When his wife first became ill, there appeared to be a great deal of confusion surrounding her behaviours: “she was seeing things...um...people, hearing voices, screaming and shouting and really upset about things and I, um, felt there was something underlying” (lines 30-33). This confusion, combined with an ambiguity surrounding her diagnosis, left Jack feeling that he did not understand what was happening and nobody could explain it to him: “There was something wrong and nobody could tell me what was wrong” (lines 44-45).

As a result of this lack of explanation, Jack initially started to ask professionals questions to try and uncover what was wrong with his wife, however he found that the majority of the information was told to his wife and he was not taken into consideration: “When she was actually diagnosed in the hospital that was the hardest thing to get information. Again everything was told to the patient. Nothing was told to the partner or carer whose going to be her carer” (lines 141-145). Therefore, over the years, Jack has sought information himself from different sources: “I’m a self motivated person, at first I went into everything, I read all the books. We didn’t have the internet then like we do these days. Um...I, I banged on people’s doors, I wanted to know everything that I could know about bipolar manic depressive disorder. I got in touch with societies that deal with these things. I got all the leaflets and all the
bumph so I read it all so I could understand what the basic knowledge” (lines 437-444).

As Jack’s understanding of his wife’s illness grew, he became more aware of the persistent nature of the illness and also more fearful of the future because he did not know what was going to happen: “nobody’s ever told me that in 20 years time this illness could make her 10 times worse than she is now because of the severity and medication she’s on” (lines 723-726). Jack appears to be angry at the lack of information on the course of his wife’s illness in the future and feels unprepared for what is to come: “There is nothing to prepare me for what’s to come in the next 10 years. I’ve had to go through 15 years and get to this stage, but there is nothing there to say in the next 10-15 years what’s going to happen. Watch out for these signs, watch out for other things creeping in now because the longer you have an illness, other things are gonna start going in. But nobody tells you” (lines 749-755).

Despite this anger Jack appears to have accepted that his wife’s illness is a part of his life and something that he has adapted to (“It’s my life” lines 1132). He recognises that his wife’s illness has become part of his life too and that if this was taken away from him he would not know what to do: “if it was took away from us tomorrow what would that do to me, because I’ve had completely change my life to cope with this illness” (lines 1135-1137).

Implications for Self

Jack acknowledges that living with and caring for his wife who experiences bipolar disorder does have a negative impact on his own mental health: “It could bring me down sometimes” (line 88) and he finds the process of caring exhausting: “Its energy
sapping being a carer” (line 493). It appears that the sense of responsibility Jack feels for his wife can impact on his perception of himself. It would seem that if anything went wrong in terms of his wife’s mental health Jack would blame himself: “Who would I blame? Myself again” (lines 903-904). This may have a negative impact on Jack’s self perception.

It appears that Jack often felt alone with his wife’s illness: “You can’t shout or tell people what goes on behind closed doors” (lines 531-532) and this has been exacerbated by feelings of exclusion by professionals from his wife’s care: “I had to argue till I was blue in the face to go to all the meetings” (lines 145-146). This sense of isolation was also experienced with Jack in his relationships with others. He felt as though others, outside of his relationship with his wife, did not and could not understand what was happening and as though he was alone: “Everybody has distanced themselves from us” (line 1405).

Within the marriage and his role not just as husband, but also carer, Jack managed to find a balance between caring for his wife and putting his needs first. He stated that he would always care for his wife, whether she had an illness or not, as he sees that as his responsibility as a husband (“I take all the responsibility of Julie’s well being, which I would do as a husband any way” lines 114-116). However, over the years, Jack has engaged in more and more activities which he feels are ‘for him’. Jack gives the impression that without these activities that are just for him, he would struggle with his caring role: “It’s mine, it’s for me and if I haven’t got these things what would I have” (lines 933-934).
Control/Responsibility

Initially when talking about his wife’s illness, Jack reports that he feels he has been given all the control over the illness as he had the final say in whether his wife was sectioned or not: “I feel like I’m controlling somebody’s life” (line 79). However, over the course of the interview Jack acknowledges that actually his wife’s illness has controlled not just him, but his family and the way they live their life: “the illness has nurtured us, because we have to learn the illness. Not just me, like I say my daughter has to learn the illness and Julie has to learn the illness and that illness then nurtures us into how to live our life” (lines 518-522).

Jack has taken on a great deal of responsibility in caring for his wife over the course of her illness. He reported that because of the medication his wife is taking, this often makes it hard for her to get up in the morning and remember to keep appointments. As a result, he sees it as his role to ensure she keeps appointments, takes her medication and gets up in the morning: “I’m never away when I’m at work you know I’ve got to ring her to get her up in the morning because it’s hard for her to get up after medication” (lines 979-981). One reason Jack has taken on board so much responsibility for his wife’s well being is that he feels it is his duty to care for her. Jack refers back to his marriage vows within the interview and claims that these are the cornerstones for how he has led his life and what has helped him keep going: “For better for worse, for richer for poorer, in sickness and health” (lines 1117-1118).

Professional Support

Throughout his wife’s illness Jack’s experience with professional support has been mixed. On the one hand he has received positive support from his General
Practitioner, who he feels, by asking him about his wife’s illness, has recognised the role he plays in keeping his wife well. This has left Jack feeling proud of the work that he has done and what he has achieved (“I feel proud then because they’re asking me how her illness is” lines 1571-1572).

On the other hand, however, Jack has some negative experiences with professionals involved in his wife’s care. Jack has felt that throughout his wife’s illness he has been in a battle with professionals, trying to gain access to meetings regarding his wife, support for himself and his family and also support for his wife when she is unwell. Jack reported that he felt he has had to ‘bang on people’s doors’ (line 440) in order to achieve the above, however he still feels that a lot of the time professionals only aim their support at his wife and he is limited in what he can do as a carer: “If I ring up the crisis team and say I feel Julie is not well, well Julie needs to speak to me, Julie needs to ring us” (lines 214-215).

In terms of the support that has been available throughout his wife’s illness, Jack has often appeared to question the appropriateness of this care. He feels that sometimes professionals do not know how to treat mental health problems and uses a comparison to a physical health problem to explain this: “as usual they don’t know how to treat the illness. It’s not like a cut, it’s not like a broken arm, put plaster on it” (lines 317-319) and “Because it’s something to do with the mind to get the right balance you have to try different tablets” (lines 321-322).

**Need for Validation**

Receiving validation and recognition from professionals for his role in caring for his wife is very important to Jack. As mentioned earlier, when he is asked by
professionals about his opinion on his wife’s mental health, he feels proud and as though he is being recognised. However, there do appear to have been occasions when Jack’s opinion has been dismissed by professionals (“You can only say so much and then they’ll say I’m not speaking to you I’m asking Julie” lines 1544-1545). Jack reports that he is sometimes regarded as only an observer of what happens: “You are only there as an observer” lines 1543-1544.

Coping with the Illness

Throughout the course of his wife’s illness Jack’s way of coping appears to have changed. His main way of coping, however, does appear to be trying to develop a greater understanding of the illness and also learning to accept that it is part of his life and he cannot change things. In terms of developing his understanding, Jack feels that this is very important in enabling him to cope effectively with his wife’s illness. Without an understanding he does not think he would be able to cope: “If she’s got an illness I need to know ‘cause if I don’t know I can’t cope” (lines 151-152). With regards to accepting his wife’s illness and the impact this has on his life, it seems as though this has been a gradual process, but now Jack acknowledges that this is just how his life is: “It’s an existence, it’s life, it’s how your life is” (line 508).

Jack has also engaged in avoidance coping styles throughout the course of his wife’s illness. This appears to be particularly applicable when his wife is experiencing a manic episode. It appears that Jack does not know how to cope with this and the behaviours his wife engages in and he dreads manic episodes occurring: “I dread the highs. I dread what's gonna come” (lines 1251-1252).
Implications for Relationships

Since his wife became ill Jack has recognised that his social network has changed. As mentioned earlier he feels that a lot of people have distanced themselves from Jack and his wife and the people that he now goes out with socially are not the same as they were: “it effects a lot of our friends, a lot of our friends are now people who have actually got bipolar or manic depressive illnesses” (lines 281-283). Jack feels that he has had to pick friends now that understand his wife’s illness: “it effects your social life as well and a lot of times when you go out it’s very, really close friends that understand the illness then that you go out with. You don’t go out with total strangers some times because you don’t know what the outcomes gonna be” (lines 296-300).

Jack also recognises the impact his wife’s illness has had on his own relationship with his wife. Jack reported that when his wife is ill he is the first person she will turn against (“It does have a big impact on our relationship because the first person she goes against is me” lines 854-855). Jack reports that he feels this has a negative impact on his own mental health: “It drags me down. It saps my energy” (lines 858-859). As a result of some of his wife’s behaviours Jack feels he is unable to share with others what is actually happening. This may be because he feels people will not understand or may even judge him. This need to keep things hidden appears to be especially true when his wife is manic: “When things are high what goes on you keep to yourself” (lines 1420-1421).

Despite this Jack does feel as though he is a part of his wife’s illness and that it is something that affects them both. Within the interview Jack refers to his wife’s diagnosis of bipolar disorder as an ‘illness of two people’ (lines 1059-1060).
Emotions

Jack recognised that his emotional response to his wife’s illness has changed over time. During his wife’s first period of illness it appears this was a very worrying time for Jack as he did not understand what was happening. However, over the years he has learnt which behaviours are linked to his wife’s illness and has learnt to accept many of these. Jack reported that it is only now when his wife is manic that he worries: “Only when she gets high do I start to worry” (line 895).

Illness Effect on Partner

As a consequence of his wife’s illness she has to take daily medication. Jack has reported that the effects of taking medication are often negative for his wife. On one occasion she reported that the medication she was taking made her mind feel like cotton wool (“This medication made her feel like cotton wool” line 346). It appears as though Jack feels his wife is still developing her awareness about the illness: “She doesn’t realise how depressed she is or how high she is” (lines 243-244). When taking her medication, for example, Jack reported that she would take it for a while then when she started feeling better would stop taking it as she no longer felt she needed it: “they tried a different medication that worked for a short period of time, so they got the drug rate right and then again she got well ‘Oh I don’t need to take my tablets.’ So that ended with another period of hospitalisation” (lines 351-355).

Over the course of his wife’s illness Jack has learnt the behaviours that occur as a direct result of his wife’s illness. For example, when his wife is experiencing a manic episode she can become flirtatious (“When she gets high she gets very flirtatious” line 257). However he feels that she does not do this deliberately and he is certain
that she would never hurt him intentionally: “She would never hurt me if she couldn’t help it through her illness she would not hurt a hair on my head” (lines 1377-1378).

**Implications on Lifestyle**

In terms of the impact his wife’s illness has on his life and lifestyle, Jack reports that this has a massive impact on him. He feels that it effects everything he does: “it governs how I lead my life. Um...I have to be very aware of what I say, what I do and how I do it. I have to be very aware of what I say because if I say the wrong thing if I say the wrong thing it can set somebody off.....the things I say ‘cause I have to be careful with what I say as well, ‘cause if I say things it could set the illness off so I’m always treading on eggshells. The actions that I have, it feels as though I do things that can upset the balance by putting too much pressure in certain areas or if I’ve not got things in place where through a day I’ve done this, I’ve done that and everything’s set out in a, um, pattern so you can get through the day and if the balance gets upset because you haven’t done it that has an impact on me. Um....so I find that on my side of it that I’ve got to lead two different lives” (lines 763 – 777).
### Client 5 (Jack): Table of Themes from IPA Semi-Structured Interview

<table>
<thead>
<tr>
<th>Master theme titles</th>
<th>Sub-theme</th>
<th>Transcript key words</th>
<th>Indicator line</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changing illness awareness</strong></td>
<td>Lack of understanding</td>
<td>‘There was something wrong and nobody could tell me what was wrong’</td>
<td>44–45</td>
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<tr>
<td></td>
<td>Growing illness awareness</td>
<td>‘I have an insight into what kind of illness it is’</td>
<td>1283</td>
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<td></td>
<td>Persistent threat</td>
<td>‘The illness will still be here’</td>
<td>813</td>
</tr>
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<td></td>
<td>Fear of unknown</td>
<td>‘What’s the outcome of all this, you know, I have fears as a carer’</td>
<td>715–716</td>
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<td></td>
<td>Acceptance/Renewed Hope</td>
<td>‘She’s been a lot better in the last 2...2 to 3 years than she has been for a long time’</td>
<td>484–485</td>
</tr>
<tr>
<td><strong>Implications for self</strong></td>
<td>Effect on own mental health</td>
<td>‘It could bring me down sometimes’</td>
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</tr>
<tr>
<td></td>
<td>Sense of isolation/exclusion</td>
<td>‘You can’t shout or tell people what goes on behind closed doors’</td>
<td>531–532</td>
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<td></td>
<td>Self effacement vs. self fulfilment</td>
<td>‘It’s mine, it’s for me and if I haven’t got these things what would I have’</td>
<td>933–934</td>
</tr>
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<td></td>
<td>Exhausting being the carer</td>
<td>‘Its energy sapping being a carer’</td>
<td>493</td>
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<td></td>
<td>Self blame and negative self perception</td>
<td>‘Who would I blame? Myself again’</td>
<td>903–904</td>
</tr>
<tr>
<td><strong>Control/responsibility</strong></td>
<td>Illness controlling</td>
<td>‘The illness has nurtured us’</td>
<td>518–519</td>
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<td></td>
<td>Carer’s responsibility</td>
<td>‘I take all the responsibility for Julie’s well being’</td>
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<tr>
<td></td>
<td>Duty of care</td>
<td>‘For better for worse, for richer for poorer, in sickness and health’</td>
<td>1117–1118</td>
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Client 5 (Jack): Table of Themes from IPA Semi-Structured Interview (Cont.)

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<th>Transcript key words</th>
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<tr>
<td>Professional support</td>
<td>Positive support from professionals</td>
<td>‘I feel proud then because they’re asking me how her illness is’</td>
<td>1571-1572</td>
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<tr>
<td></td>
<td>Lack of support and inappropriate professional support</td>
<td>‘They don’t know how to treat the illness. It’s not like a cut’</td>
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<tr>
<td></td>
<td>Individualism of medical approaches</td>
<td>‘If I ring up the crisis team and say I feel Julie is not well, well Julie needs to speak to me, Julie needs to ring us’</td>
<td>214-215</td>
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<tr>
<td></td>
<td>Fight the system</td>
<td>‘I banged on people’s doors’</td>
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<td>Need for validation</td>
<td>Need for validation from professionals</td>
<td>‘You can only say so much and then they’ll say I’m not speaking to you I’m asking Julie’</td>
<td>1544-1545</td>
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<tr>
<td>Coping with the illness</td>
<td>Acceptance</td>
<td>‘It’s an existence, it’s life, it’s how your life is’</td>
<td>508</td>
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<tr>
<td></td>
<td>Greater Understanding</td>
<td>‘If she’s got an illness I need to know ‘cause if I don’t know I can’t cope’</td>
<td>151-152</td>
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<tr>
<td></td>
<td>Avoidance</td>
<td>‘I don’t open up very often. I’m a very closed person’</td>
<td>1454-1455</td>
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<tr>
<td></td>
<td>Mania most difficult</td>
<td>‘I dread the highs. I dread what’s gonna come’</td>
<td>1251-1252</td>
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<td>Implications for relationships</td>
<td>Relationship with friends and family</td>
<td>‘Everybody has distanced themselves from us’</td>
<td>1405</td>
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<td></td>
<td>Impact on own relationship</td>
<td>‘It does have a big impact on our relationship because the first person she goes against is me’</td>
<td>854-855</td>
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<tr>
<td></td>
<td>In it together</td>
<td>‘It’s an illness we both live with’</td>
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<tr>
<td></td>
<td>Unable to share</td>
<td>‘When things are high what goes on you keep to yourself’</td>
<td>1420-1421</td>
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### Client 5 (Jack): Table of Themes from IPA Semi-Structured Interview

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</tr>
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<td><strong>Emotions</strong></td>
<td>Emotional change</td>
<td>‘Only when she gets high do I start to worry’</td>
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<tr>
<td><strong>Illness effect on partner</strong></td>
<td>Impact of illness on behaviour</td>
<td>‘When she gets high she gets very flirtatious’</td>
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<tr>
<td></td>
<td>Effects of medication</td>
<td>‘This medication made her feel like cotton wool’</td>
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<td></td>
<td>Questioning the illness impact</td>
<td>‘She would never hurt me if she couldn’t help it through her illness’</td>
<td>1377-1378</td>
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<td></td>
<td>Partners awareness</td>
<td>‘She would not hurt a hair on my head’</td>
<td>243-244</td>
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<tr>
<td></td>
<td></td>
<td>‘She doesn’t realise how depressed she is or how high she is’</td>
<td></td>
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<tr>
<td><strong>Implications on lifestyle</strong></td>
<td>Lifestyle changes related to illness</td>
<td>‘It governs how I lead my life’</td>
<td>763-764</td>
</tr>
</tbody>
</table>
Appendix 12: Themes from Individual Tables.

1. **Debbie**

   Implications for self
   Changing illness awareness
   Control/responsibility
   Need for validation
   Professional support
   Coping with the illness
   Implications for relationships
   Emotions
   Illness effect on partner

2. **Katherine**

   Changing illness awareness
   Implications for self
   Control/responsibility
   Professional support
   Need for validation
   Coping with the illness
   Implications for relationships
   Emotions
   Illness effect on partner
3. Sue

Coping with the illness
Implications for self
Changing illness awareness
Control/responsibility
Implications for relationships
Illness effect on partner
Implications on lifestyle
Emotions

4. Alan

Implications for self
Control/responsibility
Professional support
Implications on lifestyle
Coping with the illness
Implications for relationships
Changing illness awareness
Emotions
Illness effect on partner

5. Jack

Changing illness awareness
Implications for self
Control/responsibility
Professional support
Coping with the illness

Need for validation

Implications for relationships

Emotions

Illness effect on partner

Implications on lifestyle
Appendix 13: Super-ordinate Themes Integrated from Clients’ Tables of Themes

Changing Illness Awareness

1. Sudden Decline in Health
   Sudden decline in health/initial hope.

2. Lack of Understanding
   Lack of understanding.

3. Persistent Threat
   Persistent threat.

4. Growing Illness Awareness
   Growing illness awareness, normalise behaviour.

5. Fear of the Unknown
   Fear of the unknown.

6. Acceptance/Resignation
   Acceptance/renewed hope.

In It Together

1. Impact on Relationships
No impact on personal goals, in it together, relationship with family and friends.

2. **Duty of Care**

Caring – a rewarding experience, duty of care for partner, shared responsibility.

3. **Positive Professional Support**

Positive support from professionals.

**Isolated and Alone**

1. **Implications for self**

Effect on own mental health, exhausting being the carer, sense of isolation/exclusion, greater freedom now alone, self blame and negative self perception, need for self restraint, personal sacrifice.

2. **Distance from others**

Stigma attached to bipolar disorder, impact of others attitudes, need for validation from partner, one sided relationship.

3. **Lack of Professional Support**

Lack of support and inappropriate help from professionals, individualism of medical approaches, need for validation from professionals, fight the system.

4. **Impact of Illness**
Lifestyle changes related to the illness, impact of illness on behaviour, impact on personality, partner’s awareness, questioning the illness impact, grief at loss of who they were, effects of medication, length of illness impacts on relationship.

5. **Responsibility/Control**

   Carer no power/illness controlling, Carer’s responsibility.

**Coping Ability**

1. **Active Behavioural**

   Shared experience, greater understanding, support.

2. **Active Cognitive**

   Remain positive, acceptance, coping with depression changes over time.

3. **Avoidance**

   Avoidance, mania most difficult, unable to share, give in.

4. **Self Efficacy versus Self Fulfilment**

   Self efficacy versus self fulfilment.
Emotional Change

1. Positive Emotions

   Emotional change.

2. Negative Emotions

   Emotional change.
Appendix 14: Copy of Notes for Contributors

Psychology and Psychotherapy: Theory, Research and Practice

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