INTEGRATING COUNSELLING AND PSYCHIATRY
IN THE TREATMENT OF MENTAL ILLNESS: AN INSIDE PERSPECTIVE

by

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Abstract

This autoethnographical study addresses the lack of qualitative research in the field of research in mental illness, specifically bipolar disorder. Historically, the narrative of the individuals who experience incapacitating emotional and psychological distress have not been recognized for their power to instruct and inform about psychiatric conditions and psychotherapeutic treatment.

The purpose of this study is to present a first person account of the lived experience of treatment for mental illness, specifically bipolar disorder, in order to highlight alternative frameworks for conceptualising and treating people who have been diagnosed with a mental illness. Using narratives based on my own personal experience, I intend to show ways in which postmodern treatment approaches that incorporate client centred personal counselling along side the effective use of pharmacotherapy can transform patients into active and empowered participants in their own recovery process.
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Introduction

Societal understanding of the nature of abnormal behaviour has evolved significantly over the past two thousand years. At different times throughout history, depending on the culture, various myths and misconceptions have defined societal attitudes towards individuals exhibiting abnormal behaviour. Some of these myths and misconceptions include beliefs that suffering individuals were being punished by God for their sins; were possessed by demons; or were witches to be burned at the stake. Fortunately, our understanding of abnormal behaviour has evolved to the point that individuals who display emotional and psychological distress are understood to require treatment rather than punishment.

The shift to understanding abnormal behaviour in the context of brain disease came in early nineteenth century as medicine was transforming from an art into a science and has led to the evolution of a classification system of disorders that enables practitioners to diagnose and treat abnormal behaviours. Exploring abnormal behaviour in the context of brain disease has also led to the discovery of drugs beneficial in treating individuals experiencing emotional or psychological distress.

This is not to say that modern Western societal understanding of abnormal behaviour is complete or that treatment of abnormal behaviour is wholly successful or uncontroversial. Though much research has been conducted on the subject, the exact nature of the underlying causes of mental illness remains unclear. Scientific understanding of the precise reasons for the efficacy of the drugs involved in treating mental illness is limited. The psychiatric diagnostic system used to assess and diagnose patients, called the Diagnostic and Statistical Manual or DSM for short, is based on an atheoretical model and does not look at or try to account for underlying causes of disorder.

Despite receiving treatment in the psychiatric system, many individuals suffering
emotional or psychological distress remain chronically disabled. In addition, the diagnosis itself may have negative consequences to the individuals self esteem and sense of personal agency in their wellness process. The societal stigma and discrimination remains.

Considerable research is being done on mental illness; however, this research is almost exclusively quantitative research that explores the subject from the theoretical perspective of mental illness as brain disease. This abundance of quantitative nomothetic research focuses exclusively on patterns and statistics with a scarcity of ideographic research from the perspective of the individual living with the disorder. This approach has its detractors among postmodern theorists and clinicians. These researchers and practitioners argue that reality is not singular and generalizeable across people, cultures and historical periods, but rather, reality for each individual is experienced uniquely. The self is not viewed as a stable, essential, knowable point of departure or destination but becomes instead an elusive process.

A focal point of this research is to address the lack of qualitative research in the field of research in mental illness. An important aspect within the tradition of qualitative research is the personal narrative; however, historically, the narratives of individuals who experience incapacitating emotional and psychological distress have been silenced and discounted despite their power to instruct and inform about psychiatric conditions and psychotherapeutic treatment. This circumstance is reiterated by Hiersteiner in her work Viewing a Mental Health Service Maze From the Inside Out: Women Clients Share Their Stories:

The sharing of these stories is a critical step to validate clients or patients as experts on their own lives. The personal testimonial is necessary to counterforce the socially constructed silence and stigma of mental illness. Restoring the client or patients to the expert author position on his/her own lived experience is a cornerstone of constructivist clinical practice and is an important element that is most often missing from the treatment
of mental illness in the psychiatric medical model context (p. 89).

The purpose of this study is to present a first person account of the lived experience of treatment for mental illness, specifically bipolar disorder, in order to highlight possible alternative frameworks for conceptualising and treating people who have been placed in categories described by the Diagnostic and Statistical Manual (APA, 1994). This is a significant piece of research because the vast majority of the research literature focuses on diagnosis and treatment and does not capture the lived reality of the individual who is actively construing the self and others while shaping her or his interpersonal world. Research and treatment in the field focus almost exclusively on biological pathology within the person. The role of personal experience, the societal expectations and norms and individual meaning making in causing and guiding the recovery process for mental illness is virtually unexplored. By providing an account from my experience as a patient in the psychiatric system, as a client within the counselling framework as a therapist and as an academic researcher, I hope to enhance the reader's understanding and awareness of the issues involved in treating "mental illness" and the need for continued examination and evolution of our conceptualisation of psychological disorder.

In this study I intend to show ways in which postmodern treatment approaches that incorporate personal counseling along side the effective use of pharmacotherapy can transform patients into active and empowered participants in their own recovery process. The purpose of this study is also to share from personal experience how current psychiatric treatment within the medical model, both inpatient and outpatient, can be in fact harmful (iatrogenic) to the patient’s recovery process.

The rationale for this study is that modern psychiatric practice emphasizes symptom reduction relying predominantly on drug therapy and underemphasizes the therapeutic nature of the patient's meaning making and self-learning in the recovery process. As well, not enough
research has been conducted to distinguish the phenomenology of distress of the patient that is a result of the disorder from the treatment process itself. This study presents a unique perspective: an autoethnographic perspective from inside the experience of mental illness, to allow the reader to enter into the experience as told firsthand by the individual living the experience, while also attempting to step away from the experience in order to draw some conclusions about how this personal experience may reflect upon the broader topic of conceptualization and treatment of mental illness, generally.

As I describe the experience of treatment I have received, differentiating the ways that were helpful from those that were harmful to me, I’m hoping that it might become apparent to the reader that mental illness, as a concept in the North American context, dominated by the DSM nosology and an essentialist biologically based understanding of disorder, needs to be re-examined from the perspective of the client. The research question I am presenting is what is the lived of experience of the treatment for Bipolar disorder and how does this lived experience differ when treatment incorporates insight oriented constructivist personal counselling.
Chapter 1

Literature Review

The purpose of this literature review is to provide an overview of the concept of mental illness, as it has developed and changed over time. I want to draw attention to the myths and misconceptions about people suffering from mental illness that have existed through history. I will provide a selection of the most up to date research literature on Bipolar Disorder (APA, 1994, DSM-IV). I will also provide information from a postmodern perspective that critiques traditional discourses of disorder. In doing so, I want to encourage you, the reader, to re-examine your current thinking about mental illness. I want to draw attention to the gaps in the traditional research literature that have occurred as a result of the omission of an insider perspective, the perspective of the person living with mental illness, told from the first person perspective.

This literature review will provide a historical overview of abnormal behaviour, including the myths and misconceptions that have defined societal attitudes towards individuals exhibiting abnormal behaviour. In the context of the historical review, this literature review will sketch a general outline of the birth of modern theoretical models of mental illness, and will provide some of the central critiques of each model.

This review will summarize the concept of abnormal behaviour as applied by modern day professionals and will describe the evolution of the Diagnostic and Statistical Manual model (APA, 1994). The review will define Bipolar Disorder, from the perspective of the DSM model and will summarize some of the recent studies in the field of bipolar illness. The review will also present an overview of the postmodern critiques of the traditional discourse of disorder as represented by the medical model and the DSM nosology.

A Historical Overview of Mental Illness

Clearly, the conceptualisation of abnormal behaviour is dependent upon prevailing
societal norms. Any discussion of experiences living with mental illness needs to be situated in the historical context within which it occurs. To understand the present day societal and medical perceptions of mental illness, it is helpful to examine the concept of abnormal behaviour as it has evolved over time.

To begin to examine the history of mental illness, it is helpful to understand the changes and shifts in popular thinking regarding abnormal behaviour that have occurred throughout the course of history. Different cultures have had various cultural standards in judging abnormal behaviour shaped by the prevailing world view at the time. The Western mental health system, as I have experienced it and as I am going to write about, is most directly influenced by Western European tradition. I acknowledge that this historical overview has a Euro-centric focus, which I hope does not indicate a lack of respect of other world views and traditions.

The Ancient world.

Throughout the course of history, the natural and supernatural have alternated as most prominent explanations for abnormal behaviour; however, only during the last century has brain disease become the dominant theory of mental illness within Western society. As far back as the Babylonians, abnormal behaviour was explained in terms of supernatural or divine causes (Nevid, Rathus & Greene, 1994). During the seventh century B.C., Chinese physicians believed an imbalance between primary natural forces, the ying and yang, was responsible for physical and mental illness (Wilson, O'Leary, & Nathan, 1992). Most ancient societies- including Babylonia, China and Egypt, as well as other centers of civilization- basically accepted the view that supernatural, not natural forces, caused abnormal behaviour (Wilson et al., 1992).

The ancient Greeks held a naturalistic view of the cause of disease. Empedocles, who lived from 490 b.c. to 430 b.c., originated the idea that the four basic elements (earth, fire, water, and air) were reflected inside the body in the four humours of blood, phlegm, yellow bile and
black bile. The balance of these humours were thought to be responsible for health and illness in the individual (Whybrow, Akiskal & McKinney, 1984). Supernatural influences were still thought to play a major role in the explanation of mood disorders, with melancholics (those displaying symptoms we now classify as depressive) believed to be born under the sign of Saturn and dominated by black bile, secreted by the spleen (Whybrow et al., 1984).

Galen, a Greek physician, who lived from 130-201 A.D., contributed important insights into the psychological causes of abnormality. He used the scientific method to continue searching for explanations of abnormal behaviour in his patients, when there was no direct evidence of physical illness (Rosenham & Seligman, 1995).

The Middle ages.

The influence of the Greek views persisted into the Roman times; however, following the fall of the Roman Empire, the efforts to discover natural causes of abnormal behaviour declined. Religion was very dominant in Europe during the Middle Ages, and therefore, abnormal behaviour was explained in supernatural terms: "troubled persons" were seen as being punished for some sin or as being possessed by the devil (Wilson et al., 1992). The treatment of choice was exorcism, where exorcists were employed to drive the evil spirits from the bodies of their intended victims (Nevid et al., 1994). The methods used to drive out the evil spirit were often cruel, the ill person might be "shouted at, deprived of food, flogged, or tortured in some other way" (Wilson, 1992, p.13). The belief that mental distress is a result of possession is a belief that still exists in society today. Though rare, exorcisms still occur today (Rosenhan & Seligman, 1995).
In the later Middle Ages, Pope Innocent VII in 1484 issued a papal decree encouraging the persecution of witches (Wilson et al., 1992). Sudden and inexplicable behaviour in an otherwise healthy person could lead to suspicion of witchcraft and, as a result, there were instances of people suffering from a mental disorder being put to death by painful means, on the suspicion of being witches (Rosenhan & Seligman, 1995; Wilson et al., 1992). Generally, though, the witchhunts appeared to be aimed at convenient political targets or unpopular neighbours, and were not a movement to persecute the insane (Wilson et al., 1992; Rosenhan & Seligman, 1995).

The Renaissance.

The witchhunting craze reached its peak between the 15th and 17th century; however, by the late 17th century and the 18th century, society at large began to move towards reason and science to explain human behaviour (Nevid et al., 1994). Over time, the understanding of mental illness changed, fuelled by Rene Descartes. He held beliefs that every question could be analysed by breaking the belief down into as many parts as possible. The mind and body were thought to be separate and autonomous entities.

By the early nineteenth century, several theorists were searching for a link between madness and the body, particularly the brain. As this shift to transform medicine from an art to a science was occurring, a German scientist, named Emil Kraeplin, became renowned in the field of classifying mental disorders (Barondes, 1998). Kraeplin (as cited in Barondes, 1998, p.29) believed that mental patients suffered from brain disease and he was the first to categorize patients who exhibited a similar series of symptoms as suffering from manic-depressive insanity: "Manic depressive insanity includes on the one hand the whole domain of periodic and circular insanity", lumping together those different mood disorders that included manic states and a state
of depression as well. Kraepelin and other notable psychiatrists, like Bleuler and Griesinger, arrived at the hypothesis that madness "took the form of a finite number of disease entities, each with its own distinct cause and cerebral pathology, together with distinctive psychological symptoms and outcome" (Kiesler, 1999, p.20).

Theories of Mental Disorder

**Modern theories.**

Although Kraepelin and others were interested in the link between the brain and these disorders, the biomedical model was gradually eclipsed by other developments, including Freudian psychoanalysis. Freud held to the belief that unconscious forces were the causes of behaviour and that these forces were a result of instinctual drives and early experiences (Szasz, 1974). Freud believed in the concept of an unconscious, teeming with unacknowledgable forbidden desires, and that dreams were the link to the hidden contents of the unconscious (Dolnick, 1998). Freud espoused the view that dreams were the connection between the normal mind and the disturbed one and were the key to understanding all phenomena of neurosis and psychosis (Dolnick, 1998). Freud's view on manic depression was that people with the illness suffered melancholic symptoms because the super-ego was being overly severe with the ego. He explained people's experience of mania as the ego finding itself in an ecstatic state of exaltation, triumphing as though the super-ego has lost all its power (Freud, 1933).

Karl Menninger, another eminent psychiatrist of the time, also disagreed with Kraepelin's theories. Menninger argued that diagnosing a disease was not the first step in treatment and that diagnosis was irrelevant because diseases were truly not different from one another (Barondes, 1998; Dolnick, 1998). He argued there was only one type of mental illness and that the various classifications of mental illness should be discarded (Barondes, 1998; Dolnick, 1998;). These
prominent thinkers influenced the thought of the day away from classification and "objective" phenomenology, back towards the psychoanalytic model as the most popular theory of mental illness.

The theory of mental illness as brain disease became less prominent over the next forty years, until medications were accidentally discovered which could treat patients suffering from mental disorders. While working on experiments with lethargic guinea pigs, in 1948, John Cade discovered that lithium salts had surprising effects on mood (Barondes, 1998). He applied his research to people and stumbled on the discovery that lithium salts wiped out mania, enabling patients to be released from hospital on maintenance doses of the drug (Barondes, 1998).

The discovery of medication effective in treating patients with mania firmly re-established the relationship between the brain and mental disorders. The discovery also gave momentum back to the movement of mental health professionals interested in classification and "objective" phenomenology as psychiatrists looked to match disorders with the medications that would be most therapeutic. Opposition to the classification and biological base of mental illness remained, even after the discovery of lithium's efficacy in treating mania. In his book, The Myth of Mental Illness, Thomas Szasz, a prominent psychiatrist and psychoanalyst, wrote that study, diagnosis, and treatment of mental illness was a waste of time because psychiatrists should not be focused on illnesses and their treatment, but rather on working with personal, social, and ethical problems in living (Szasz, 1961). He also argued that mental illness was a myth with no biological substrate and that psychiatric diagnosis was a politically and socially motivated judgment (Kiesler, 1999). He encouraged patients not to take medication, arguing that medications were an oppressive strait jacket (Barondes, 1998).

By the nineteen seventies, despite psychiatrists like Szasz, the tide had turned back
towards the biomedical model. Increasing neurobiological evidence linked mental illness and brain physiology. The advent of the DSM III (APA, 1980) and its revision advanced the process of psychopathologic diagnosis, increasing diagnostic reliability and reducing inconsistent variations. The process of development of the DSM model was long and included the input of 800 clinicians in field trials (Spitzer et al., 1980).

Though the DSM classification system has advanced the process of psychopathologic diagnosis, there has been much criticism of the manual and the thinking behind it. Much of the controversy surrounding the DSM is that it is atheoretical and does not address etiology nor what is underneath the diagnosis; it only identifies symptomology (Vaillant, 1984). Barron (1998) effectively outlines the heart of the criticisms of the DSM model:

What is the nature of the knowledge that can be obtained by diagnosticians and researchers carefully crafting operational definitions of mental disorders and then observing, counting, and categorizing (according to predetermined rules) the signs and symptoms of those disorders? Will the pursuit of those positivistic ideals bring clinicians closer to understanding and effectively treating individuals whose complex mental states and interpersonal behaviours result in harmful dysfunction? (p.xvi).

Another criticism of the DSM classification system is that it is biased against women:

"Masculine biased assumptions about what behaviours are healthy and what behaviours are crazy are codified in diagnostic criteria; these criteria then influence diagnosis and treatment rates and patterns" (Kaplan, 1983, p. 786).

Postmodern theories.

The disease model of mental illness, that is, mental illness as brain disease, is currently the dominant theory of mental illness. This model, though, has its detractors among postmodern
theorists and clinicians. Postmodern approaches dissent in important ways from dominant trends in modern psychotherapy and psychiatry, both theoretical and applied:

What unites them is a shared ‘negative identity’ deriving from their repudiation of traditional ontological assumptions (bearing on the nature of ‘reality’) and epistemological frameworks (bearing on the nature of knowledge). For modernists, reality is single, stable, and in principle knowable-qualities that modern psychologists attribute to the ‘self’ as part of this same natural order. Accordingly, various modern psychotherapies have been viewed in terms of improving the client’s ‘reality contact’ by minimizing nonconscious cognitive distortions. . . . Much of this effort is legitimised through the discourse of scientific research, which is seen as measuring essential structures of the ‘healthy’ personality, reliably diagnosing deviations from the norm, and empirically establishing the efficacy of preferred interventions designed to correct such disorders (Neimeyer & Raskin, 2000, p .5).

The postmodern approaches differ in almost every respect from modern traditional psychotherapeutic approaches and are described by Neimeyer and Raskin (2000) as follows:

Postmodern approaches turn nearly every feature of this modern, objectivist orientation on its head. The fundamental faith in a single reality that provides a common point of orientation across people, cultures, and historical periods has been eroded and replaced by a recognition, or even a celebration, of the multiple realities conditioned by individual, social and temporal factors. In this view, language-broadly defined to include all symbolic acts-represents a matrix of meaning that actually constitutes, rather than merely reflects, the reality in which one positions oneself. For psychologists adopting this perspective, the self also loses its standing as an essential, stable, and knowable point of
departure or destination, becoming instead an elusive process, a contingent construction of persons-in-context that is amenable to reflexive deconstruction and reconstruction in the ever-changing relational medium of psychotherapy (p.5).

The clinician who works from a postmodern perspective relates to the patient very differently than the traditional psychiatrist. Rather than being the expert in charge of treating, or acting upon the patient, as is the case in the medical model, the postmodern practitioner works in conjunction with the individual. The practitioner seeks to empower the patient and does so through affirming their experience, recognizing the truth in it, rather than assessing the reality of it.

Among the postmodern perspectives there are variations. The constructivists "tend to focus on experiential exploration of the tacit processes of self-construction" emphasizing how "each individual creates personal representations of self and world as well as the ability of persons to transcend problematic constructions and construe things in wholly new ways" (Neimeyer & Raskin, 2000, p.5). Constructivist theorists do not attack the DSM for not being objective or scientific enough but rather they reject the very idea that the DSM-IV can ever be objective at all "if objectivity means ignoring the centrality of subjective human involvement in constructing definitions of psychological disorder" (Raskin & Lewandowski, 2000, p.15).

**Kelly's personal construct theory**

An important part of this research paper's discussion will focus on how constructivist theory can be integrated into the treatment of individuals diagnosed with mental illness. The criticism of constructivists is that they are "long on theory and short on practice". The challenge of postmodern practitioners is to integrate their theoretical beliefs with real world treatment schemes. Using Kelly's personal construct theory as a template, I will show how constructivist
theory can be applied to treatment of mental illness.

Personal construct theory was developed by the American psychologist George Kelly (1905-1967); it is a comprehensive personality theory that encompasses a diagnostic and therapeutic system and is centered around the concept and process of transitive diagnosis (Johnson, Pfenninger & Klion, 2000). Johnson et al. (2000) summarize Kelly's construct theory this way:

The central philosophical position of Kellian PCT is constructive alternativism: This philosophy assumes that the universe is real, in constant flux, and both integral (ultimately interconnected) and temporal (unfolding along the axis of time) yet can never be known directly "in and of itself." Human beings individually and jointly construct versions of reality that permit them to understand their world. An infinite range of such constructions is theoretically possible. All events are therefore subject to revision and reconstruction; those constructions, including diagnostic systems, that are useful tend to be retained, whereas those that offer little predictive value tend to be revised and discarded.

PCT maintains that people understand and create meaning through personal construct systems. Kelly defined the basic process and goal of psychological activity (and more broadly, life) as one of anticipation . . . “a person's processes are psychologically channelized by the ways in which he [or she] anticipates events” (Kelly, 1955, p. 46). A construct is defined as a dichotomous or bipolar dimension abstracted from and subsequently imposed on the raw perceptual and ideational experience of life. Recurrent themes across time are perceived, abstracted, and organized into a meaning system . . . PCT does not draw sharp lines among cognition, behaviour, and affect. Thus,
anticipation involved not only cognitive expectancies and emotional evaluations of events or outcomes but also concurrent behaviours aimed at manipulating reality to create those outcomes (p. 146-147).

In modern psychiatry, diagnosis presumes that static disease entities reside within the person. The therapist's role is to diagnose pathology based on a series of symptoms, using categorization of psychopathology. The diagnosis itself does not have practical implications for change in the client's life. In receiving the diagnosis, the individual in distress becomes the patient. Treatment involves extinguishing the symptoms, rather than attempting to understand the individuals understanding of their world. The psychiatrist is the expert, holds the knowledge and becomes expert on the reality of the patient.

Kelly rejected the conceptualisation of disorder that presumed emotional and psychological distress was caused by static disease entities residing within a person and he was opposed to categorization of psychopathology. Rather, Kelly's believed that a disorder resulted when an individual continued to use constructs that have been invalidated. Transitive diagnosis involves the therapist exploring the client's construct system to identify where and how a client is "stuck" so that the therapist might help the client more successfully anticipate and control his or her world (Johnson, Pfenninger & Klion, 2000). He believed that diagnosis should have utilitarian and realistic implications for change and transition in the client's life.

**Bipolar Disorder Clinical Definition**

The next segment of this literature review provides a conceptual definition of abnormal behavior and an overview and clinical definition of Bipolar Disorder as defined by the DSM.IV (APA, 1994).
Abnormal behaviour: a general overview.

Bipolar Disorder is a specific psychiatric diagnosis which is resultant upon an individual exhibiting behaviour considered to be abnormal. Rosenham and Seligman (1995), authors of *Abnormal Psychology*, describe seven elements that ordinary people and professionals use to determine whether the behaviour of a person is abnormal.

1. Suffering: people are called abnormal if they are suffering psychologically, the more they suffer, the more certain we are.

2. Maladaptiveness: whether a behaviour is functional and adaptive is a fundamental element in deciding whether the behaviour is normal or abnormal.

3. Irrationality and incomprehensibility: when a person's behaviour seems to have no rational meaning, we are inclined to call that behaviour and that person abnormal. . . One kind of incomprehensibility is thought disorder. Beliefs that are patently absurd and bizarre, perceptions that have no basis in objective reality, and mental processes that ramble from one idea to another unrelated one constitute thought disorders.

4. Unpredictability and loss of control: we expect people to be consistent from time to time, predictable from one occasion to the next, and very much in control of themselves. . . The judgment that behaviour is out of control will be made under two conditions. The first occurs when the ordinary guides and inhibitors of behaviour suddenly break down. The second occurs when we do not know what causes an action.

5. Vividness and unconventionality: generally, people recognize as acceptable and conventional those actions that they themselves are willing to do...What is conventional and acceptable in any society is always changing. Those who are on the leading edge of that change are visibly compared to the rest of us (whose behaviour is conventional), and they run the risk of
being labelled as deviants, and therefore abnormal.

6. Observer discomfort: We are most likely to experience vague observer discomfort when someone violates unwritten rules of behaviour. Violation of those rules creates the kind of discomfort that leads to the designation "abnormal."

7. Violation of moral and ideal standards: There are times when behaviour is assessed, not against our judgments of what is common and conventional, but against moral standards and idealized norms that are believed to characterize all right-thinking and right-acting people. This view starts with the notion that people ought to behave in a certain way, whether they really do or not, and it concludes with the view that it is normal to behave in the way one ought, and abnormal to fail to behave properly (Rosenhan & Seligman, 1995, p.6-10).

Clearly, the conceptualisation of abnormal behaviour is dependent upon prevailing societal norms. It is important to be mindful of how these norms have come to be adopted and how our understanding and acceptance of abnormal behaviour continues to grow and evolve.

**Definition of bipolar disorder.**

The aetiology of Bipolar disorder remains unsolved, though investigation continues into the involvement of several different neurobiochemical systems (Goodnick, 1998). Berrettini and Pekkarinen (1996) provide a concise definition of the kinds of abnormal behaviour that result in a diagnosis of Bipolar disorder. They describe the symptoms as follows:

The symptoms tend to be episodic and impair social and vocational functioning. A return to pre-morbid functioning during intervals between episodes is common. Mania and hypomania are both states of elevated mood with increased activity, decreased need for sleep, gradiosity, excessive energy, increased libido, racing thoughts and impulsive, reckless behaviour. Mania is differentiated from hypomania by impairment in
functioning and is often characterized by psychotic symptoms. Untreated episodes of mania or hypomania are often 1-3 months in duration. Depression is a syndrome of persistent and pervasive sadness, with decreased energy, suicidal ideation, decreased libido, anhedonia (inability to experience pleasure), decreased cognitive ability, sleep dysfunction (insomnia or hypersomnia) and appetite disturbances (with or without weight change) (p. 191).

**DSM-IV definition of bipolar disorder.**

Bipolar disorders are a category, classified in the DSM-IV (APA, 1994) as an Axis 1 (Clinical Syndrome that may be a focus of clinical attention) Mood Disorder, that has a median age of onset in the 20s, although onset in adolescence is not uncommon, and appears to equally common in both men and women (Berrettini & Pekkarinen, 1996); however, the first episode in males is more likely to be a manic episode while the first episode in females is more likely to be a major depressive episode (Diagnostic and Statistical Manual of Mental Disorders (4th ed.), 1994, p. 353).

Bipolar disorder is subcategorized according to the combination and severity of mania and depression. The two subcategories are Bipolar I and Bipolar II. According to the DSM-IV (APA, 1994), Bipolar I disorder is characterized by the occurrence of one or more manic episodes or mixed episodes (mania with some elements of depression). Bipolar I has a lifetime prevalence in community samples of .4% to 1.6% and is recurrent disorder, with more than 90% of individuals who have a single manic episode going on to have future episodes (DSM-IV, APA 1994, p. 353). The DSM-IV states "roughly 60-70% of manic episodes occur immediately before or after a major depressive episode. Manic episodes often precede or follow the major depressive episodes in a characteristic pattern for a particular person" (p. 353). The intervals
between episodes tend to decrease with age; however, if four or more mood episodes occur within a given year, this form of the illness is referred to as rapid cycling (DSM-IV, 1994). There is some evidence that changes in sleep-wake schedule such as occur during time zone changes or sleep deprivation may precipitate or exacerbate a manic, mixed, or hypomanic episode. Though most people suffering from BP I return to a fully functioning level between episodes, 20-30% continue to experience mood instability and have relationship and employment problems. Ten to fifteen percent of individuals with Bipolar I successfully commit suicide.

From the clinical definition in the DSM-IV (1994), Bipolar II disorder is characterized by the occurrence of one or more major depressive episode, with a prevalence of approximately 0.5%. The interval between episodes tends to decrease with this form of bipolar illness, as well. Though most patients will return to a fully functional level between episodes, approximately 15% continue to experience mood instability (DSM-IV, 1994). Other information also included in the DSM-IV (1994) about Bipolar II includes the facts that psychotic symptoms appear to be less frequent in major depressive episodes in bipolar II disorder than occurs in Bipolar I disorder; disruptions in the sleep/wake cycle, as seen in time zone change or sleep deprivation, also may precipitate or exacerbate hypomanic or major depressive episodes in Bipolar II.

Treatment Modalities for Bipolar Disorder

Pharmacotherapy (drug therapy).

There is considerable evidence to support the use of pharmacotherapy in the acute and prophylactic phases of Bipolar (Post, Frye, Denicoff, Leverich, Kimbrell & Dunn, 1998(a), Post, Frye, Denicoff, Leverich, Dunn, Osuch & Speer, 1998(b), Sanchez, Hagino, Weller & Weller, 1999, Mendlewicz, Souery, Riveli, 1999), though the efficacy of interventions is far from being completely successful, with patients with bipolar disorder experiencing significant relapses and
recurrences (Kusumaker, Yatham, Haslam, Parikh, Matte, Sharma, Silverstone, Kutcher & Kennedy, 1997). The classic antimanic agent used in bipolar disorder is lithium, while "divalproex sodium and carbamazepine also demonstrate antimanic properties comparable to those of lithium" (Mendlewicz et al., 1999, p.80). Though lithium has been considered as an effective drug for maintaining bipolar patients, Calabrese and Woyshville's study (as cited in Mendlewicz et al., 1999) reports that no more than 50% of bipolar patients respond to lithium salts. Divalproex, also used to treat mania, has been reported to have an efficacy comparable to lithium with Freeman, Clothier, Pazzaglia, Lesem & Swann (as cited in Mendlewicz et al., 1999) reporting improvement in 54% of patients. Carbemazepine is an anticonvulsant that has also been used to treat Bipolar Disorder. Placidi, Lenzi, Lazzerini, Cassano & Akiskal (as cited in Mendlewicz et al., 1999) report in their randomized, three year double blind study, that carbemazepine is effective with 55% of patients with Bipolar Disorder. Lamotrigine and gabapentin and other anticonvulsant neuropeptides are currently being investigated for their utility as mood stabilizers (Post et al., 1998).

In the acute phase of treatment, additional supportive drug therapy may be used: benzodiazepines are useful for patients without psychotic features, for lessening hyperactivity and to restore the sleep cycle; antipsychotics, such as haloperidol or perphenazine, help bring about the control of severe manic episodes, though antipsychotics may provoke depression, leading to other treatment complications (Mendlewicz, 1999). Mendlewicz (1999) also reports that restoration of sleep patterns may, by itself, help to control the manic episode.

Psychosocial Treatment.

Though pharmacotherapy is the primary treatment of bipolar disorder, there is increasing evidence that the course of bipolar disorder can be modified by psychosocial factors (Callahan &
Bauer, 1999). Bloch, Hafner, Harris, et al. estimate (as cited in Callahan & Bauer, 1999) that psychosocial factors may contribute 25% to 30% to the outcome variance in bipolar disorder. Ellicot, Hammen, Gitlin, et al., (as cited in Callahan & Bauer, 1999) found that experiencing a negative life event increased patients likelihood of relapse by four times when compared to those who did not experience such an event. Johnson and Miller (1997) (as cited in Callahan & Bauer, 1999, p.676) found that “patients who experienced a severe negative life event during an affective episode took more than three times as long to recover, despite compliance with pharmacotherapy, than those who did not experience such an event.”

Psychosocial interventions for bipolar disorder include both psychotherapy and patient education (Callahan & Bauer, 1999). Effective psychosocial interventions should encourage the patient to "gain insight into the interpersonal styles, habits, or emotional reaction patterns that in the past have been associated with his or her mood disorder episodes" (Miklowitz, Frank & George, 1996, p. 614). Managing stressors and improving communication patterns are two other facets Miklowitz (1999) describes as important to the intervention. Psychotherapy may help patients address emotional reactions to the illness and will have a strong psycho-educational component regarding the necessity of long-term medication maintenance. Given the significant detrimental effects of medical non-adherence, it is important for therapists/clinicians to establish a trusting relationship with the patient. Grieving the loss of the healthy self, separating their lives into separate periods, before versus after they became ill, may help some bipolar patients accept taking medication to treat the disorder (Miklowitz et al., 1999).

Current Research

The vast majority current research being conducted is quantitative. Of the research papers published in 2000, there were 106 articles on the subject of bipolar disorder. I reviewed the
article abstracts and chose the following studies to represent the current research.

Weiss, Griffin, Greenfield, Najavits, Wyner, Soto, & Hennen (2000) conducted a study on the efficacy of group therapy for patients with Bipolar disorder and substance dependence. In an open trial, patients with DSM-IV Bipolar disorder and substance dependence (N = 45) were recruited to receive either group therapy (N = 21) or 6 monthly assessments, but no experimental treatment (N = 24). When compared with patients who did not receive group therapy, patients who received IGT had significantly better outcomes on the Addiction Severity Index drug composite score (p < .03), percentage of months abstinent (p < .01), and likelihood of achieving 2 (p < .002) or 3 (p < .004) consecutive abstinent months.

In another recent study, Piontek, Baab, Peindl, and Wisner (2000) studied the serum valproate levels in breastfeeding mother-infant pairs. These researchers collected serum valproate levels from 6 breastfeeding mother-infant pairs. All mothers had a diagnosis of Bipolar disorder (Research Diagnostic Criteria) and were taking divalproex sodium as treatment for a recurrent affective episode. None of the mothers received valproate during pregnancy. The results of this study were that while the mothers’ had valproate levels within the therapeutic range (39.4 to 79.0 ug/mL), the infant serum levels were low, ranging from 0.7 to 1.5 u/mL (0.9%-2.3% of maternal serum levels), no adverse clinical effects were observed in the infants.

Frye, Kettler, Leverich, Huggins, Lantz, Denicoff & Post (2000) conducted research into the increasing use of multiple drug therapy in the treatment of refractory mood disorders. After completing a formal structured blinded research protocol, patients entered a treatment phase in which all agents in the community could be utilized. Each patient’s retrospective life chart and all prospective double-blind nurse and self-rated NIMH (National Institute of Mental Health) were reviewed. The overall degree of improvement at discharge was assessed by a rating on the
Clinical Global Impressions scale (CGI) modified for bipolar illness (CGI-BP). The results of this study were a 78% improvement rate was achieved at the time of discharge. There was a significant relationship between the number of medications utilized at discharge date (r = 0.45, p < .0001). The percentage of patients discharged on treatment with 3 or more medications were 3.3% (1974-1979), 9.3% (1980-1984), 34.9% (1985-1989), and 43.8% (1990-1995). No correlation was found between polypharmacy and age (r = -0.03, p = .66). Patients more recently discharged from the NIMH had an earlier age illness onset, more lifetime weeks depressed, and a higher rate of rapid cycling than patients in the earlier cohorts.

In a study conducted looking into suicidal behavior in bipolar mood disorder, Oquendo, Watermanuz, Brodsky, Parsons, Haas, Malone & Mann (2000) researched the clinical characteristics of attempters and nonattempters. Forty-four patients ranging in age from 18 to 75 with a DSM III-R Bipolar Disorder were enrolled. Acute psychopathology, hopelessness, protective factors, and traits of aggression and impulsivity were measured. The number, method, and degree of medical damage were assessed for suicide attempts over their lifetime. The results of the study were as follows: Attempters had more lifetime episodes of major depression and twice as many were in a current depressive or mixed episode, compared to nonattempters. Attempters reported more suicidal ideation immediately prior to admission, and fewer reasons for living even when the most recent suicide attempt preceded the index hospitalization by more than six months. Attempters had more lifetime aggression and were more likely to be male; however, attempters did not differ from nonattempters on lifetime impulsivity.

A recent study had been conducted into the treatment outcomes of patients taking lithium or divalproex. Bowden, Calabrese, McElroy, Gyulai, Wassef, Petty, Pope, Chou, Keck, Rhodes, Swann, Hirchfeld & Wozniak (2000) conducted a randomized double blind, paralell-group
multicenter study of treatment outcomes over a 52 week maintenance period. Patients who met the recovery criteria within 3 months of the onset of an index manic episode (n = 372) were randomized to maintenance treatment with divalproex, lithium, or placebo in a 2:1:1 ratio. The primary outcome measure was time to occurrence of any mood episode. The results of the study were that the divalproex group did not differ significantly from the placebo group in time to any mood episode. Divalproex was superior to the placebo in terms of lower rates of discontinuation for either a recurrent mood episode or depressive episode. Divalproex was superior to lithium in longer duration of successful prophylaxis in the study and less deterioration in depressive symptoms and Global Assessment Scale scores.

In another recent study, Greenhouse, Meyer and Johnson (2000) analyzed the relationship between coping and medication adherence in Bipolar disorder. Thirty-two participants diagnosed with Bipolar I disorder were administered scales from the Brief COPE and an adherence self-report measure which measure coping and compliance. The results of the study suggest low levels of acceptance and high levels of denial undermine medication adherence. The authors of this study conclude that more work is needed to clarify the theoretical and empirical nature of coping strategies; however, they did find that age and number of years ill correlated with acceptance, which suggests that experience can lead to a more accommodating attitude towards one’s illness.

**Bipolar Research: the Gap**

Through the process of reading for this review, it became clear to me that there is an abundance of nomothetic research, literature on the general patterns and statistics on the topic of Bipolar disorder, and a scarcity of ideographic research from the perspective of the individual living with the disorder. The research literature on mental illness fails to capture the complexity
of the lived experience of mental illness. Barron (1998) describes the essence of the gap:

The object of investigation, the person being diagnosed and treated, is simultaneously a subject who is actively construing the self and others and shaping her or his interpersonal world. Although the observable behaviours of different individuals may appear remarkably similar, the meaning and motivation may be quite different, and, when taken into account, may yield different diagnoses or perhaps no diagnosis at all"(xvii).

The research literature studies are quantitative. The nature of the description of these research studies does not reflect the qualitative experiences of the individuals living with this disorder. Each person who comes for assistance to a mental health practitioner is an individual, with a distinct personal story. No two people have the same identical personal history. Therefore, much can be learned from these personal narratives:

The label can assist in treatment but should not define the person or the clinician's expectations of the person. I would argue that there needs to be more personal narratives in the research literature to remind clinicians to view the mental patient as an individual case, to look beyond the DSM diagnosis and the drug therapy to the stories of unique lives, interrupted, devastated, lost, or perhaps recovered, and regained.

I would argue that more personal narratives in the literature would also help to diminish societal stereotypes and the stigma of mental illness. The essence of the singular experience, the stories of the relationship between the individual and the social structures, in this case the medical system, the mental health system, the medical model, are missing. These personal stories, involving issues of loss, self discovery, self worth, personal dignity, power struggles, courage, hope, could help bring those living with mental illness from the margins, from the place of "Other", to a place of better understanding and acceptance and hopefully better, more
meaningful diagnosis, effective treatment and positive prognosis.

Therefore, this thesis will endeavour to provide a descriptive personal narrative of one person's lived experience of the diagnosis and treatment of Bipolar disorder. This thesis is about living through the diagnosis and treatment of Bipolar disorder. Hopefully, this narrative account will help make very clear the need for personal insight oriented counselling to be included in the treatment of mental illness. This means that counselling and psychiatry need to come closer together, to integrate their strengths, working together rather than enforcing arbitrary distinctions in their domains.
Chapter 2

Methodology

Introduction

Having reached the conclusion that there is a lack of research literature on Bipolar disorder which provides insight into the lived experience of diagnosis and treatment of Bipolar from a personal, first person perspective, the next question to answer was whether there was an acceptable research methodology that can be used to address this gap.

One possibility would have been to conduct some type of traditional ethnographic study, conducting interviews with people who have experienced living with Bipolar disorder, using the data from these interviews to provide a descriptive account of the lived experience. However, for the purposes of my thesis, I felt there were limitations to this approach. I did not want to speak for the people I study because there is no shortage of research written about people with mental illness.

Another possibility was to use a “self narrative” or autoethnographic approach (Denzin, 1997; Ellis, 1997; Richardson, 1992) to write about my personal experience living with Bipolar disorder. In this way, I could provide a first person account, writing about experiences I’ve had, as a person with a mental illness. This is the methodology I selected because I felt it would enable me to address the gap in the research literature since self-narrative and autoethnographic research accounts are autobiographical, personal narratives.

This methodology chapter outlines the arguments supporting personalized research and will describe three models of self narrative: Ellis’s (1997) autoethnography, Richardson’s (1994) self narrative and Denzin’s (1997) interpretive autobiography. I outline how these forms of qualitative writing meet the academic requirements to be considered valid research. The last part
of this chapter describes the specific form my personal narrative will take.

The "I"

Qualitative researchers in the human disciplines are confronted by the challenge of directly capturing lived experience. Traditional ethnographers attempt to write texts that capture a world out there (the real) through careful transcription (and analysis) of field materials (interviews, notes, journals) (Denzin, 1997). Social scientists using traditional qualitative methods use their authority and privilege to talk about the people they study (Richardson, 1992). In the discourses of poststructuralism and postmodernism, the qualitative researcher is not an "objective, authoritative, politically neutral observer standing outside and above the text" (Bruner (1994) as cited in Lincoln and Denzin, 1994). Rather, the qualitative researcher is interwoven within the text and his or her past experiences help shape the course and outcome of the research. Writing about the "Other" from the traditional ethnographic stance becomes problematic according to Denzin (1997) who refers to this dilemma as the crisis of representation: "language and speech do not mirror experience: They create experience and in the process of creation constantly transform and defer that which is being described" (p.5). The self/selves of the writer/researcher are an inherent part of the text, as the writer's choices of questions, words, and language are a result of the writer's history/mindset/philosophical framework.

If this is true, then, this needs to be acknowledged in the text. The writer's presence needs to be apparent to the reader. The writer cannot separate himself/herself from the text, so, he/she must tell the story reflexively, representing the self in the text. In choosing to write my own story, I am choosing not to grapple with the effects my history/mindset may have had on the capturing of “the world out there.” I feel that too much interpretation of “the other” is already
being done in both traditions of qualitative social science and quantitative biological science when “the other” is a person diagnosed with a mental illness. Therefore, I have chosen not to find subjects to interview, but rather I chose to share my own story and in so doing, I hope to make this research an act of self interpretation.

The process of writing the self into the text is both challenging and rewarding. As the writer reaches back to relive the experiences she/he wishes to share with the reader, new understandings and memories are evoked. Writing this way, using a form of method acting to relive the emotions of the experiences, the writer’s material emerges from within in an act that combines both conscious and unconscious processes. "Nurturing our own voices releases the censorious hold of ‘science writing’ on our consciousness, as well as the arrogance it fosters in our psyche. Writing is validated as a method of knowing" (Richardson, 1994, p.518). The writing itself is an emergent form of coming to know, an emergent form of interpreting the self. In this way the self becomes the research data and the reader gains a clearer picture of the insider’s view.

**Autoethnography**

Carolyn Ellis (1997), a prominent sociologist at South Florida University, argues that research writing in the human sciences has for too long been written for a limited audience of academics. Ellis writes research with the intention of making the writing accessible to the reader outside the academy. Ellis advocates writing research that is therapeutic for the author and evocative for the reader. Ellis argues that research has too often ignored the emotional for the cognitive, privileging theory, concepts and taxonomies over stories, examples and cases. She breaks out of the form of the omniscient narrator describing abstract concepts and instead she uses multiple voices in a dialogic multi-vocal narrative.
Carolyn Ellis (1997) proposes a model of writing, called autoethnography, which presents one way to reframe the narrative voice, where the author is present in the text, combining "the autobiographical impulse with the ethnographic impulse" (p. 132). Ellis argues that writing about the self is a natural extension of ethnography: "If we accept the argument that ethnography should be reflexive and include the self/selves of the writer, writing about the self is a logical extension" (p. 123). In support of this argument, she cites Jackson as saying "our understanding of others can only proceed from within our own experience, and this experience involves our personalities and histories as much as our field research" (Jackson, 1989, cited in Ellis, 1997, p. 17).

Ellis contrasts autoethnography with realist ethnography. Her research method arose out of a desire to do writing that was therapeutic for herself and evocative for the reader. Her intention was to produce research and scholarly writing as healing texts. Her stories focus on the self in the social context, writing in a manner that is "emotional, personal, therapeutic, interesting, engaging, evocative, reflexive, helpful, concrete, and connected to the world of everyday experience" (Ellis, 1997, p. 120).

To achieve her purpose of evocative scholarly writing, Ellis writes "creative nonfiction with scene setting, dialogue, and unfolding dramatic action: showing details instead of telling abstractly" (p. 128). Her focus using this methodology is to articulate the significance and meaning of her experience, committing to a narrative account, capturing the truth of the experience, rather than being focused on "historical truth" of getting all the "facts" in the exact order and time sequence.

She describes the telling this way:

In addition to telling what took place, I was intent on probing my psychic defences and
emotional complexities of this experience, although I understood that my attempts would be limited by what is possible to know and admit to oneself about oneself. More intent on showing ambivalences and contradictions that occurred along the way than on declaring an outcome, I wanted to let the reader in on the emotional process. My hope was that readers would see my "self-absorption" as an avenue to learn from exposure to candour and vulnerability. My open text consciously permitted readers to move back and forth between being in my story and being in theirs, where they could fill in or compare their experiences and provide their own sensitivities about what was going on. Sometimes I could explain situationally or historically why seemingly contradictory details had occurred. Often features of culture and social structure, gender and conventions and commitments had narrowed my vision and understanding of myself (p. 130-131).

Since I am embedded in my personal life and can't always see, in the moment, what is impinging on or narrowing my vision and understanding of myself, the rigor of my research lies within the depth and level of reflexivity I am able to engage in. To be able to evaluate myself, I have allowed years to pass between the time of the experiences and the time I am writing about these experiences in this thesis. In so doing, hopefully I have been able to more effectively stand back from the direct lived experiences. During the in between time period, I have engaged in the process of examining, analysing, reframing these experiences both on my own and with the help of a counsellor, my friends, family, colleagues and thesis supervisor.

I believe that in all research, the self of the researcher enters into the process of the research. In some research traditions, this is more clearly recognized and acknowledged. I recognize and acknowledge that I cannot truly and completely stand outside of my own
experience to provide an objective account, nor is it my intention to do so. I endeavour to be as transparent as I can about my own subjectivities as a result of my personal lived experience. Using my colleagues, supervisor, and committee members as readers, hopefully I have been able to pry loose from my embeddedness in this personal account.

**Narrative of the Self**

Laurel Richardson (1994) also advocates bringing the authorial voice into research writing. She argues that our Self is always present, no matter how much we try to suppress it and that in our writing, we repress parts of ourselves, too. As a result of this, we are freed to tell and retell: there is "no such thing as 'getting it right,' only 'getting it' differently contoured and nuanced" (Richardson, 1994, p. 521).

Richardson suggests using different genres to make scholarly writing more powerful and practical. One category of experimental genres she advocates is "literary devices to re-create lived experience and evoke emotional responses", which she calls evocative representations (Richardson, 1994, p. 521).

One form of evocative representation she describes is narrative of the self, which, in many ways, is similar to Ellis' autoethnographic method:
This is a highly personalized, revealing text in which an author tells stories about his or her own lived experience. Using dramatic recall, strong metaphors, images, characters, unusual phrasings, puns, subtexts, and allusions, the writer constructs a sequence of events, a 'plot,' holding back on interpretation, asking the reader to 'relive' the events emotionally with the writer. Narratives of the self do not read like traditional ethnography because they use the writing techniques of fiction. They are specific stories of particular events. Accuracy is not the issue; rather, narratives of the self seek to meet literary criteria of coherence, versimilitude, and interest. Because narratives of the self are staged as imaginative renderings, they allow the field-worker to exaggerated, swagger, entertain make a point without tedious documentation, relive the experience, and say what might be unsayable in other circumstances. Writing these frankly subjective narratives, ethnographers are somewhat relieved of the problems of speaking for the 'Other', because they are the Other in their texts (p.521).

Using the writing techniques of fiction to reflect an experience based on an actual experience serves several important functions in my story. It enables me to tell my story while ethically meeting my responsibilities as a researcher to respect the privacy of the people involved in my life story. Without the techniques of fiction, I would not have been able to disguise the identities of the people in my life story. These techniques allowed me to say what under other circumstances would indeed be “unsayable”.

The techniques of fiction allowed me to use characters and other perspectives so that I can re-tell my story, including events that were too painful to write about from the “I” perspective. I was also able to highlight issues relevant to the points I was trying to make in this research paper.

Richardson (1994) proposes deconstructing the traditional definition of validity, arguing
that since there is no single truth, that using interviews, exploration of census data, and
document checking cannot validate findings, as there is no "fixed point" or object. Rather, reality
is deeply complex, multidimensional, with transmutations, changing, growing and therefore, she
argues, we understand and accept that we can only partially know a topic.

This is also true for autobiographical writing. We can never really and truly know
ourselves at any given time because we are constantly in the process of becoming. The text is a
still frame picture of a time in a person’s life, recollecting our lived experience from the
experiencing “now”.

The benefits of writing alternative texts, according to Richardson (1994), are that the
writer relates more deeply and complexly to their material. The writer understands the material
in different ways. The deepened understanding of a Self deepens the text. The text will be less
boring because the writer will be more consciously engaged in its production, more present to
self and others as meaning is created.

Interpretive Biography

Denzin (1997) also challenges the traditional realist system of thought, where "firm and
steady truths" and "accurate representations of the world can be produced, and these
representations truthfully map the worlds of real experience" (p. 265). He argues that
ethnographers do not have an "undisputed warrant to study others," that this right has been lost:
"Self-reflection is no longer an option, nor can it be presumed that objective accounts of
another's situation can be easily given. Truth is also always personal and subjective. An
evocative and not a representational epistemology is sought" (Denzin, 1997, p. 265).

Denzin (1994) has created a new term, interpretive biography, to define a style of writing
where the self of the researcher is the prime focus of the research: "The events and troubles that
are written about are one the writer has already experienced and witness firsthand. The task is to
produce 'richly detailed' inscriptions and accounts of such experiences” (p. 510). Interpretive biography is a form of research that allows the writer to focus on life experiences that "radically alter and shape the meanings persons give to themselves," where "having had these such experiences, the individual is often never quite the same again" (Denzin, 1994, p. 510).

Denzin (1997) describes a form of writing that is very similar to that of Ellis. It is to be personal, biographical, narrative, audience based, where

the truth of life's fictions in which experiences are evoked, not represented or explained. . .Writers resist the efforts of those who would turn ethnography into stable, realist systems of meaning. In dealing with the truth of life's fictions, the dividing line between fact and fiction is tested. . .The new writers deal with the facts of experience anchored in specific scenes and situations. Text and dialogue bring composite characters and persons-as-performers alive (p. 267).

Denzin (1997) describes multiple narrative styles, including narratives of the self, where the writer is situated in the world studied, creating a reflexive text that allows the reader to re-experience the events in question, coming to see the truth of the narrative, as it is grounded in the process of self-formation and self-understanding.

Denzin (1997) calls for a rethinking of the terms validity, generalizability, and reliability as means to judge the authority of poststructural texts. He advocates the evaluation of these materials by their ability to "illuminate phenomena as lived experience," where the "competing models of truth and interpretation (rationality and emotionality) that operate in the subject's situation should be revealed" (Denzin, 1994, p. 510).

Critics of poststructural texts argue that there is no way to evaluate these texts. Proponents of poststructural texts counter by saying that the criteria of positivism or postpositivism represent an attempt to establish legitimacy and authority of the text, where
knowledge, "under the guise of objective research" has been produced "too often used for the purposes of social control" (Clough (1994) cited in Denzin, 1994). Poststructural texts, according to Denzin (1994), "celebrate uncertainty and attempt to construct texts that do not impose theoretical frameworks on the world. They seek to let the world speak for itself, while they remain mindful of all the difficulties involved in such a commitment" (p. 510).

**My Thesis**

The thesis I have written takes the form of a self-narrative, describing the lived experience of Bipolar disorder. I share my experiences of acute episodes, focusing mainly on the process of recovery and return to normalcy, while also addressing the lasting effects these episodes have had on my self development (self esteem, self image) and my relationships with others.

My intention in writing this thesis was to provide an account of my experiences that the reader can enter into, one that will be evocative to read. The text is based on my experiences. The narratives of my life are depicted in the form of a creative non-fiction, written in the form of a third person narrative. My thoughts and feelings that occurred during the depicted events will be represented through the thoughts and feelings of the main female character. I have written specific stories about actual events that have occurred to me, in settings that actually existed; however, I have focused on creative non-fiction, capturing the emotional truth of the experience, rather than the historical truth with exact facts. I use dialogue, interior monologue, poetry, flashback and other devices of fiction writers to present the material from different points of view. These different points of view include the thoughts and feelings I had in moments of being acutely ill, how I presented to others at these times and what was actually going on in my mind and body.

I also try, as a qualitative researcher, to make some sense of the experiences, to find
concepts and patterns that might explain how certain actions, even contradictory ones, fit together. Again following Ellis' (1997) lead, I try to provide enough details about "culture and social structures, structural constraints, and social conventions" that have impacted my understanding of myself (p. 130).

I have endeavoured to recreate the situations in detail, portraying the ambivalences and contradictions that occurred, rather than trying to prove a point or declare an outcome. I have been as vulnerable and as candid as I can be, exposing my uncertainties and self doubts. I try to present the ambiguous and contradictory thoughts and feelings that are a part of psychotic episodes and the traumatic effects of these episodes.

I have chosen to write about events that have occurred several years in the past. The emergent writing of these events is the bulk of my data. Through the composite depictions of events that I have experienced, I hope to give the reader an insider perspective of the issues that go along with suffering an acute episode of Bipolar Disorder.

As I share the "in the moment" narratives, my intent is that the reader will have a real sense of how each of these events affected my life, my self worth, my self-identity. Since I have focused on events that happened several years ago and I have been in therapy spending considerable effort working through these events, I am confident that I have developed many new insights into these experiences. I believe that having allowed time to pass since the events along with working through these events in therapy has helped me to step outside the events I have chosen to write about.

In the discussion chapter of the thesis, I will discuss my feelings about the negative and positive effects the psychiatric approach to treatment, the DSM diagnosis system and the medical model in general had on my recovery and growth and development as a person. I share my feelings about my experiences with a more client centered treatment approach and how being in
counselling, with trained counsellors has helped me integrate my illness into my self identity and move beyond survival to recovery and freedom. I also discuss my feelings about the implications for practise focusing on how the psychiatric system can be integrated with a client centered counselling approach to provide the most effective diagnosis and treatment regime for people living with mental illness.

The validity of the text is to be judged by whether it evokes in the reader a feeling that the experience described is authentic and believable; the generalizability can be judged by whether the text "speaks to the reader about their experience" (p. 133). The question to ask is whether the text resonates with the reader. Ellis (1997) describes her overall intent as striving to write a text that allows the reader to move back and forth between her story and their own. In writing this way, she aspires to create a text where the reader can feel or compare her or his own experiences, allowing the reader to "feel the specificity of my situation, yet sense the unity of the human experience" (p.131). This is my intention as well. I hope to have provided a space where the reader can enter into the world of “mental illness”, gain a better understanding of the experience and recognize elements of this experience in their own lived experience.

Like Ellis' autoethnography, the validity of my story will be judged by whether it evokes in readers a feeling that the experience described is authentic and lifelike, believable and possible; the stories generalizability can be judged by whether it speaks to readers about their experiences.

The worth of my study should be judged on the ability of my writing to bring the reader into the experience through clarity of prose and thickness of description. To be a worthwhile research project, my writing needs to be evocative, allowing the reader to move back and forth between the world of my experience and that of their own. The effectiveness of this thesis should be judged by my ability to enable the reader to better understand the trials and tribulations of
living with mental illness and by my ability to provoke the reader to re-think old stereotypes and conceptions of mental illness. As well, this thesis should help the reader see that an urgent need still exists for the further development of theoretically coherent alternatives to the DSM IV classification that have better treatment outcomes and that are less iatrogenic (harmful) to the individual in treatment.

Ethics of Researching the Self

There are a number of significant ethical considerations involved in researching the self. In contemplating this research, I have been very aware of the potential for re-traumatizing myself and I have taken steps to ensure that this effect was minimized. I was extra careful during this process to focus on self care and I utilized many different coping strategies to effectively deal with the difficulties that emerged during this research process. This included therapy, journaling, poetry, sharing and de-briefing significant revelations with my partner, close friends and my family. As well, I was careful with regard to maintaining healthy eating, sleeping and exercise habits.

One very important aspect of the writing process that was different from my original experiences living through the events I have written about is that during the writing process I have had more control over the experience. I was able to select what I wrote about and how I wrote about it. This is a very significant difference for me because a key reason the original experience was traumatizing was because I felt that I had lost control and that I had little control in the process of my treatment. Decisions were made about me, without my input.

Another aspect of doing this type of research is the issue of confidentiality of the third parties involved in my personal experiences. To ensure these people are not recognizable in my research, I have written this as a creative non-fiction. I am not giving a historical account, but rather, I have presented a narrative account that articulates the significance and meaning of my
experience through characters and a plot that based on my experiences but that is fictionalised enough to protect the identities of the third parties. The actual people involved in my real life experiences exist in these narrative only as composites. Careful consideration was given to concealing the original identities of those involved, other than myself.

The third key ethical consideration concerns the fact that I have chosen to do autobiographical research and, in doing so, will not have anonymity in this project. Initially, I had some concerns about the possible personal implications involved in a project like this. These concerns, however, are far outweighed by my convictions that it is necessary for the personal stories of people like myself, people who have chronic mental illness and are managing effectively, to be represented in the research literature. For this reason, I am willing and motivated to share my experiences and thoughts on this subject matter. My very intention in doing this thesis is to encourage the reader to reconsider their personal conceptualisation of mental illness and in this pursuit I am more than willing to give up my anonymity.
Chapter 3

The Data: The Narratives

Out Of The Closet

Today, I begin the telling
of a story.

The story is about
my life
my reality.

It is my story, though I do not own it outright.
My life.
Perhaps you’ve lived it?
My life.
Perhaps you or someone like you
Has been a part of it?

About me,
for you, the reader,
through me,
the writer.

I expose my-self,
courageously or foolishly,
to connect the experience,
the hidden story
from the margin
to the centre of the page,
to connect,
with you and a wider audience.

It’s been a hidden story,
a closeted story,
associated with blame
and victim shame.

Now,
The untold story...
to be shouted
from the mountain tops!
Research, re-search, search my-self
Auto-ethnography
Self story
Self discovery
Self recovery.

Once upon a time,
(in a land far, far away...)
Sixteen years ago
There was a teenage girl,
   Confident
   Talented
   Care free...
Living with an undetected time bomb
   Inside her.

   Tick tock...
   Tick tock...
   Until one day,
   BOOM!
   It went
   off!

The sky came crashing down...
Her life became the twilight zone...
Darkness and paranoia clouded
her previously ordered mind.

Imbalanced brain chemistry
Neurotransmitters awry...
Voices in her head.
Sleep a distant memory.

Thoughts racing racing racing racing
Around and around and around and around,
In her head.

Scenarios replayed,
Ideas for inventions,
Grandiose notions, Passionate notions
I AM THE ONE; THE SAVIOUR;
WHO ARE YOU! WHY CAN'T YOU UNDERSTAND ME!!!
Energy and confidence abounding.
Ending on a bridge, or running hysterically down an alley at 2 a.m.
Running...running...confused...psychotic
Necessary incarceration
in the psych ward.
Medication.
Hospital Pyjamas,
Bell ringing summons the patients
Green Pills. Blue Pills. White Pills
Medication.
Necessary incarceration.
Nurses Doctors
Guards Wardens
Unlimited sentences

Free at last.
The road to recover begins.
To rediscover the self.
To leave the memories of psychotic thoughts,
hospital indignities.

Always a long road to recovery,
to rediscover the self,
to grieve the loss of the healthy self,
to move on,
to move beyond
the fear of recurrence
or closed doors.

I have decided to be silent no longer.
To move out of the closet
of mental illness.

It has been a painful road,
a lonely one,
but a road I am passionately and confidently embarking on.
The fire, the spirit of hope inside me,
dormant for so, so long
has begun to smoke,
smoldering, ashes warming.

And so,
I am searching for the dry wood,
the twigs
the branches
to build the fire
into a great, warm pyre.

A funeral pyre, perhaps,
for all the pain, the rejection,
the self doubt, the shame, the blame,
the confusion,
the despair.

As the wood crackles and smokes,
I go back,
back before all this became a part of
my life,
before mental illness became a part of me.

I was hopeful, perhaps crazier than I am now.
I believed that anything in life was possible,
that dreams could, and were meant, to become reality.

Long, long before someone had to tell me
what is real.
Long before I retreated from the edge
of possibility, of wonder, of belief.

Today, I find myself with the ashes of that fire,
cold, grey, soft.

I take them,
and mix them,
with the water from
my tears.
I begin to apply this mixture
to my naked body,
to hide my scars,
to hide my shame.

And to prepare myself for the passage,
the rite of passage,
back to innocence.

I recognize, begrudgingly, that life is not fair.

I know, with certainty, that I do not deserve the pain and suffering this illness has brought me.

I know also that I did not cause this disease,

And, most assuredly of all

I know I fear and hate this enemy.

It has stolen friends,
dreams,
self esteem.

This I recognize and grieve,
for in a better world,
perhaps in a world just a few days,
weeks,
months,
years,
away,

I wouldn't have to be writing about these feelings.

But, now is the time,
to break the silence,
to end the blame,
to be rid of the shame.

To point the finger at you!
Whoever you are,
wherever you are,
who cannot deal with your fear,
the fear of the uncontrollable in you.

And so, I stand under a cool, clear mountain spring and come clean.
I have an illness, mental yes, and I am OK.

I am a survivor.

I am coming out of my closet,
standing before you
showing my wounds and vulnerabilities.
And, I am ready to defend my self,  
    if I have to...  
And, I am ready to forgive you,  
    if you ask me to...  
And, I am hoping to embrace you and share with you  
    if you invite me to.

I must live with this illness,  
    how I do so is my choice,  

    how you respond  
      is yours.
Depression: The Battle To Recover

Two days had passed since her release from the hospital and Sonya was returning to her “normal” life feeling very much less than normal. She had been in the hospital for a month. Fortunately her month long stay had coincided with a scheduled month holiday arranged before she had gotten ill. Of course, she had planned to spend her time golfing and hanging out at the beach, not doing arts and crafts and playing ping pong on the psychiatric ward.

Sonya began swallowing her evening dose of pills, thankful to be back in the real world, out of the surrealness and mind numbing boredom of the hospital. Feeling the carpet of her bedroom floor beneath her feet, seeing her own bed, a door she could close and lock. The comfort of being in her own home enveloped her.

Privacy at last she thought to herself.

She was glad to be going to sleep, to be slipping away from consciousness, from thinking, from feeling.

The next morning she awoke to the sound of a truck rattling to a stop outside her bedroom window. The alarm clock read 9:00 am.

OK, up and at em, she thought.

She struggled to find the will to get out of bed, the initial relief and happiness at being released from the hospital beginning to wear off and the familiar post mania depression beginning to settle upon her. The feelings of hopelessness and worthlessness returning slowly to weigh upon her heart and mind.

“Am I going to be okay today? Am I going to make it?” she wondered.

She paused to reflect on the upcoming day, unwanted thoughts began flooding her mind: the imminence of loss, the unavoidable truth of her parents’ mortality, the state of the environment, the plight of the homeless. The bleakness of these realities came to rest on her heart
and tears quickly welled up in her eyes, rolled down her cheek and into her ear. Wiping her
tears with the back of her hand and pajama sleeve she shook her head to clear the negative
thoughts from her mind.

She rolled over and closed her eyes, wishing herself to sleep again, hoping to avoid the
start of another day. Another day in what felt like a very bleak future.

She dozed fitfully for another hour and awoke to the sound of the phone.

"Hello?" She tried not to give away the fact she had just been sleeping.

"Hi Sonya, how are you?"

"Oh hi Julie, fine. You?"

"Good. Hey, I didn’t wake you up did I?"

"Don’t worry about it. I needed a wake-up call anyway. What’s up?"

"Well, I just wanted to call and say hello. I’m off today so I thought maybe we could go
for lunch or something."

Julie was Sonya’s friend from work. Sonya had gotten to know her in the four years since
coming to her new job. Julie had always been very supportive and understanding about Sonya’s
illness and was one of the few friends who knew about Sonya’s stay in the hospital and had been
comfortable enough to visit with her while she was on the ward.

Pausing a moment to consider the invitation, Sonya was aware that she couldn’t let
herself stay in bed all day, though she wanted to.

"OK. That would be a great idea. Got any place in mind?"

"How about the Barn? At noon?"

"Sounds good. I’ll see you there."

"Great. See ya."

Sonya hung up the phone and sat up at the edge of bed.
Hmmm, clothes. She walked towards her closet looking for clean clothes, stumbling over the pile of dirty clothes that overflowed the laundry hamper. She looked in the mirror at the face that stared back at her.

Strange, she thought. Nothing seems different, from the outside. No noticeable sign of her inner struggles to fight off the temptation to cease existing. If someone had looked closely though they may have noticed a slight furrow in her brow and eyes lacking their usual vitality.

Better do something about this matted hair, she thought. In the shower, she let the hot water run down over her head, her face. She began looking at the deep blue bathroom tiles, the sunflower shower curtain, everything feeling slightly new again, renegotiating the familiarity of her own home. She paused, allowing the comfort of being home to soak in, pushing the hospital memories a little further in her memory.

After drying off and putting on her jeans and a navy t-shirt, Sonya looked at her watch, noticing that it was eleven am. Monday morning. Her thoughts drifted back to what she would have been doing if she were still in the hospital: the routines of the ward remaining very ingrained in her mind.

Ah, Monday. Things would be buzzing on the ward, as they always were following the weekend. Doctors and nurses in meetings, doing rounds, day programs in full swing. The less functioning patients shuffling the halls, shoulders hunched, staring blankly into space; the smokers negotiating with the nurses for their cigarettes. The majority of patients involved in various activities, depending on the doctor’s orders: relaxation or exercise with the physiotherapist, pool or ping pong in the lounge.

It was in the psych ward that Sonya had learned to hold a pool cue properly. She laughed remembering her fierce ping pong battles with fellow patients. It was always a challenge to find someone who wasn’t too drugged up to play.
Her favorite opponent during this hospital stay had been an unfortunate woman who had already been on the ward for a month by the time Sonya arrived. She was still in her pajamas, not having received her clothing privileges yet. The woman, in her late thirties and the mother of three lovely boys, had only recently begun to experience mental health problems. She didn’t talk much and hadn’t yet been diagnosed. Thinking of this woman shuffling around the ward for six weeks in hospital blue, confined to the ward, Sonya momentarily clenched her teeth in anger.

No outside privileges. Sonya had always resented the restrictive system used on the psych wards. She had come to appreciate what it must be like to be locked up in prison. The psychiatric wards had this same type of feel to her. The dingy pale blue, poorly lit hallways, usually in the oldest part of the hospital. Privileges, assigned as seen fit by the doctor.

Sonya ran her hands through her hair, reminding herself that she was no longer in that place. Feeling her hands touching her head somehow releasing her from the memories of the ward and she began to think ahead to her lunch date with Julie. Her newly acquired freedom was not yet quite comfortable and familiar after being on the pysch ward schedule for a month. The memories too fresh, too present.

Sonya packed her wallet, disc-man and journal into an old green packsack. Having to use this old packsack was another reminder of her recent health problems. For reasons no longer clear to her, during her late night road sugar circle ritual, she had found it necessary to leave her MEC backpack and her black satchel. So, she was forced to make use of this old knapsack. Unfortunately, this green knapsack had been bought around the time she had experienced another episode a few years back. There seemed no getting away from the reminders.

She made her way out the front door and locked it. As she walked to the bus stop, she forced herself not to look down the alley where she had fled on the night of her admission to
hospital. The embarrassment and the shame were too fresh for her to handle in her present fragile state.

Arriving at the restaurant, Sonya looked at her watch, realizing she was twenty minutes early. She chose a booth in the corner, nice and private and took out her journal. Pausing for a moment, she took a deep breath and began to write

*Depression, the depth of despair. The thermometer mercury reads zero esteem, confidence, hope.*

*The road ahead seems endless. Night's darkness brings a respite from the despair, from the pit, the struggle; from contemplating pills and bullets, funerals and goodbyes.*

*Too tired to care. Another day. Lights shines through the window and tears begin to form. Disappointment as another day begins, in the life sentence.*

*Helpless, hopeless, almost.*

*Something deep inside, perhaps, reminds me that this will end,*

*Eventually.*

*But eventually seems a lifetime from now.*

*My mind is numb. Only anxiety lingers.*

*Where does the monster come from and what will it take to slay it?*

*People seem two dimensional. Goals and hopes and dreams fade into the distance.*

*Life's previous meanings disappear down the drain.*

*Try as I might, I can't concentrate on more than a paragraph.*

*My curiosity trampled and covered over with cement blocks.*

*Sticky molasses pull your feet and keep you in this hell.*

*Thinking is quicksand. Life is suffering.*

*On the outside looking in. On the bubble.*

*Wearing scuba gloves and trying to feel the texture of life.*

*Bitter – why me, now?! I've worked so hard. Give me my life back.*

*Now!*

*Reaching out for a lifeline.*
God help me...

But while I remain here, locked in this cage, looking out between the bars,
Waiting for the gate keepers,
I know the day will come, again,
When the sun will warm my skin.
The deepfreeze that is my heart will again beat with vigor,
The life blood will run free through my veins.
And this certainty keeps me here,
Alive, barely,
waiting to feel
the warmth of that sun,
Waiting...

As she completed the poem, she looked up in time to see Julie come walking into the restaurant. Sonya motioned with her arm. Julie rose to embrace Sonya. It was all Sonya could do to hold back her tears.

“Hey there sweetie”

“Hey.” Sonya took out a kleenex and wiped her eyes. She didn’t want her friend’s pity. She hated for anyone to see her out of control like this and she had always needed to keep her pain a very private affair. Sonya did not like to cry in front of anyone, to expose her vulnerabilities, her pain. Those emotions she saved for when she was alone, when she was safe with her journal or her music. It was too hard to share these feelings with others, to deal with the depth of sadness, despair, frustration, anger, shame, loss, and fear that had been locked away in that trunk, deep in her heart.

Sonya took a deep breath and exhaled, relieved to have kept the dam that held the flood of her tears from bursting forth. It was important to her to be in control of her emotions. She didn’t want to fit any stereotypes of a person with a “mood disorder”. This meant she had to be
strong, crying in public places was not to be allowed.

“Hey, it’s okay. If you need to cry, go ahead. It doesn’t bother me,” Julie said empathically.

“No, I’m fine, thanks.” Sonya replied, relieved at having found her voice again.

“Okay… I’m glad to see they finally let you go home. I am so sorry that you had to be in there for a month… I can’t imagine it.”

“Thanks, Julie. That means a lot to me you know, that you came to see me in there.”

“I don’t know what you mean. You’re my friend, of course I’m going to come see you.”

“A lot of people get freaked out by that stuff, you know. I mean seeing people shuffling along sort of out of it…” She stopped herself, feeling her voice tremble. “I mean… I just wanted to say how much I appreciate not being forgotten, when I’m in there.” Despite her best efforts, tears began to roll down her cheeks. “It’s such a lonely place, you know.”

“I know. You don’t have to explain, or talk about it if it’s too hard,” Julie replied softly, handing Sonya a tissue. “I shouldn’t have brought it up. How bout those Canucks!?!?”

Together they laughed, Sonya appreciating Julie’s obvious efforts to change the subject, knowing that Julie couldn’t stand hockey. “No, it’s really okay. You know, I appreciate your willingness to discuss these kinds of things. It’s really hard to just pretend that everything is fine and I’m glad I don’t have to do that with you. I guess I’d rather shed a tear or two, and have my feelings acknowledged than have avoid the subject all together.”

Sonya paused for a moment, lost in thought, remembering the awkward silences with friends and family members who never asked or talked with her about her illness. Although she was beginning to understand their awkwardness around her mental illness was most likely associated with feelings of frustration or helplessness at not being able to do something for her,
she felt particularly hurt and angry at not being able to discuss being bipolar and her struggles around it with her family.

“Well, you know you can always talk to me, okay?”

“Okay.”

They picked up their menus.

“God, it’s good to be having some real food, you know? That hospital food can get to you after a while. Can’t explain the relief at finally getting out.”

“I bet.”
Here is another poem that taps into my experience of depression.

Tired

Today if I wasn’t a coward
And death wasn’t so complicated
I’d be gone.

I’m tired
   Of feeling the pain
   Of wanting to sleep the day away
   Of deciding it’s time to get up
I’m tired of grey
   Of worrying
   About the planet
   About death
   About life
   About tooth decay
   About cancer
   About anything and everything
I’m tired of feeling like this
   And trying to hide it
I’m tired of feeling like this
   And sharing it
I’m tired of feeling like this
   And tasting it
       Like bitter dark fucking coffee
   And smelling it
   And feeling it
       Like cold rain in your face, over and over again
Am I alone in this?
Perhaps not, but the walls of this prison are thickening.

Yet, I’m out of bed,
   I made it today.
I’m here and I’m alive
And I need to talk
   So I’m writing to you, whoever you are, wherever you are
And I feel better,
The cloud is lifting, there are hints of blue sky
And I'm glad death is complicated,
My heart is beginning to beat again,

Ba boom, Ba boom
That ancient drum again, the rhythm of life is once again
Filling my soul,
Ba boom, Ba Boom.
She sat quietly at the end of the hall, waiting for the doctor to arrive. The usual set of old Reader's Digest and Time magazines lay strewn on the table. She thumbed through a travel magazine, examining pictures of sandy beaches and emerald blue and green oceans, waiting for the telltale clicking of her psychiatrist's shoes on the cold stone hallway floor.

Finally, the familiar clicking could be heard and Dr. Brown appeared around the corner, wearing a grey pantsuit with a white cotton blouse.

"Come on in," the doctor said, as she unlocked her office door and turned the door sign to Do Not Disturb.

She sat down in her usual chair, glancing around the dimly lit room, and waited.

"So, how are you?"

"Well, not too well actually," as her eyes scanned the now familiar surroundings.

"So, tell me..."

"Well, as I was coming up the steps coming here, I found myself getting angrier and angrier. You know, and I'm trying to figure out what that is about. Sitting there waiting for you, I realized that whenever I come to see you I get angry."

Dr. Brown adjusted her yellow note pad and scribbled a note to herself.

She examined the expressionless face of her doctor and wondered what thoughts lay hidden behind the solemn masked face staring at her from across the room. She sat collecting her thoughts, feeling her face turn red.

"Actually, I want to talk to you about the summer, about how I felt when I was in the hospital. I want to talk to you about... about not feeling respected."

"Well, tell me what you think happened in the hospital that bothered you."

"I don't need to tell you what I think happened to me. I need you to hear what my
experience was, my truth."

She stopped for a moment. She examined Dr. Brown's face, looking for some sign of empathy, of understanding, but found none.

"Well, to begin with, I'm talking about you setting up meeting times and not showing up"

"Well, as a doctor I'm busy. Sometimes things come up on the ward, you know, unexpected things."

"But this happened on numerous occasions. On several of those occasions, you were just late. You wouldn't come late or not show up late to these appointments, so why was it different when I was in the hospital? It's like when you're a patient, suddenly you're not a person. Like because you're a doctor you can come and go as you please, and I have no choice but to put up with it. Like, no apology necessary and none offered. That bothered me and it still bothers me."

As she waited for Dr. Brown to respond, her mind drifted back to that hellish summer night that precipitated her dreaded return visit to the psych ward. To running down the alley at midnight, fleeing invisible stalkers, terrorized. Wondering now, how her mind had gone so far off track... If only my memory wasn't so good, she thought, wishing that sometimes she didn't possess such vivid recall of those bizarre events, wishing to escape the flashbacks of humiliating things she'd said or thought.

The hum of the air conditioner brought her back to present. She waited, hoping for some words of conciliation or recognition of her feelings. But as usual, nothing came.

"It wasn't just waiting for you, it was waiting around for the nurses too. Like standing at the nurses' station, trying to get some shampoo or whatever, and the nurses don't seem to notice you're standing there. Sometimes I would stand there for five or more minutes, waiting patiently, while one of the nurses is telling the other nurses a story about her dog being sick. Finally I
would make some kind of sarcastic comment to get their attention, and then they would make a
note in my chart about me being hostile. I mean, come on!?!"

"You know you're not an easy patient to deal with when you're manic. Like other difficult
manics"

"What do you mean 'difficult manic?' You mean because I want to be treated with some
measure of respect that makes me a 'difficult manic'?!"

"Your sarcastic comments, and impatience..."

"Isn't that interesting. Why are you making this about me? From my point of view, the
nurses and doctors make you sit around, waiting, not showing up for meeting times, chit chatting
when they're supposed to be helping you, and I'm the one with the problem. Because I'm the
patient, the one with no power? Whose versions of the events of the truth are accepted? It seems
to me, my perception of reality is completely discounted here."

"When you're ill like that, do you really see things clearly?"

"It wasn't just me who felt disrespected in there. Talking to the other patients,

"Well, you know how it is. It's a union situation. There are good nurses and there are
some not so good ones..."

"Why are you trying to justify the situation? Why can't you just acknowledge how
frustrating it is to be in that place? That's all I'm asking for..."

"You know that is the best place for you when you are not well."

Tears of frustration began to well up in her eyes. It always came down to this. As she sat
there, hoping desperately to be validated, to be heard, she already knew that when she was ill,
her thinking could become disordered. Yet, this time, as she sat in Dr. Brown's office, she was
determined not to be judged, diagnosed, evaluated, spoken down to. She was determined to be
treated as an individual and with dignity. She also knew she would never put her trust in this woman again.

"I'm not disputing that. I don't think you realize that your experience on the ward is subjective as well, that you see things through your own rose coloured glasses. That as a doctor, you see things a certain way, but that doesn't make your opinion "the truth". It is your truth. And my experience is my truth. My experience is my reality. I'm not saying that my delusional thoughts are not delusional thoughts. I'm just saying I'd like my personal experiences to be validated, for you to have a little empathy rather than having to be right all the time."

Dr. Brown stared back at her, her face now cold and almost accusing.

"I think right now you might still be manic".

She could not believe her ears. She had left hospital over three weeks ago and had returned to her regular life. Her anger, sometimes a symptom of mania, was situational, arising to engulf her on her return visits to this office.

"I wanted to come to tell you that I am no longer interested in having you as my psychiatrist."

As the words rolled off her tongue, she felt a great weight lift from her shoulders.

"Well, many of my female manic patients have a problem with me, so you are no different."

She bristled at being included in the "female manic patient" category. She was fed up with being identified by labels, with these labels superceeding her individuality. She was simply not going to accept being treated this way. She had met several people in her mood disorder support group who had excellent doctors, psychiatrists who enabled their patients by working
with them, rather than exerting their power over them. She had decided that she was going to find herself a doctor like that.

As she got up to leave, she felt her anger and frustration evaporate. She walked out of the office holding her head up, and for the first time in a long time, she noticed the ceiling instead of the floor. She smiled.
Dear Elly, Aug./00

Hey Sweetie, sorry it's been so long since the last letter. I hope the Toronto summer heat is bearable. I've been having some health problems again over the last couple of weeks and I haven't really been feeling like writing. Before you start getting all worried, please don't. I didn't really do anything too stupid, this time. We caught it pretty early.

Unfortunately though, I did have to spend some time in that hell hole of a hospital. You know the sky blue pyjama clad prisoner routine has never really been my favourite act. Actually, I'm feeling pretty pissed off about the whole thing. I don't really want to get into all the details, but I figure it's better coming from me than from mom. You know how she always blows these things out of proportion.

I guess the trouble started about six weeks ago, in the middle of July, as things were getting really busy at work. There was some misunderstanding between Linda (my new boss) and myself about the deadline for an upcoming project. Anyway, the important detail is that I ended up doing an all-nighter to get the damn thing finished. Linda doesn't know me yet and I was trying to make a good first impression.

I know, I know. This was really stupid of me, and I knew it at the time too. I didn't really feel like I had a choice, though. Needless to say, my sleep pattern got screwed up as a result. It didn't help that my bedroom window faces east and the sun was blasting into my window by five o'clock in the morning. Even with the fan going and window blinds, the bedroom was still like an oven, making sleep impossible as soon as the sun began rising.

So, after a couple of weeks of sleeping less and less, and then not at all, I started feeling the usual symptoms.

As she sat there contemplating how much to disclose in the letter to her older sister, Sonya couldn't help but be drawn back into the events of that late summer night when she had gone into the hospital. The thought of that night evoked distinct memories. Sitting there reliving these memories, she felt her face go red and she closed her eyes, trying to block out these images and the overwhelming pain and embarrassment that accompanied them.

Unfortunately, the events of that night continued to play out before her eyes like a three dimensional horror movie, one that she couldn't escape from, the targeted victim. The scene begins as she awakens with a start, at two in the morning, convinced that an earlier phone call from her uncle had been an encrypted message that someone was going to try and harm her that night.
She checks the three stories of the house for signs of intrusion. Finding the basement entrance door ajar, she becomes intensely afraid that someone in her family had snuck in through the basement door to set fire to the house. Hurriedly, she packs a few prized possessions in her knapsack and flees from the house down the steps of her front porch. The thought of that night evoked distinct memories. Sitting there reliving these memories, she felt her face go red and she closed her eyes, trying to block out the images and the overwhelming pain and embarrassment that invariably accompanied them.

Unfortunately, the memories continued to flood her mind. She remembered sprinting down the back alley that early morning, convinced that someone was chasing her, trying to hurt her. The fear was palpable and real. As she came to the street at the end of the alley, she saw a car driving towards her. She turned to face this car, ready to confront her attackers. The car drove slowly by, continuing on past her; however, this did not pull her out of the delusion that someone was after her.

In order to create a zone of protection from these attackers, she lay down in the middle of the road, drawing a circle of sugar around her on the asphalt. To complete the ritual, she got down on her hands and knees and licked the sugar off the ground. Following that she prayed to the street lamps, convinced that the light shining down upon her was God. And then, she ran off, as fast as she could, through the night, ending up on the playground of a nearby elementary school.

When the police arrived she had not been hostile, surprised, or even confused. Thinking back, she wondered who had called the police. The two police officers had been very nice. She had realized immediately they were there for her. She remembered that she was listening to the new Madonna CD on her Discman and let the female officer listen. It was the first time in her
fifteen years of illness and her five trips to the psych ward that the police had become involved.

When the ambulance came, she had gone willingly. Somehow, in the deep recesses of her mind, she had known she needed help and was almost relieved to be going to the hospital. She remembered feeling very embarrassed to recognize the ambulance attendant as an acquaintance of hers from several years ago. Though he was completely professional about the whole incident, she hated for anyone to see her in that circumstance, in that state, even if it was someone she barely knew.

She picked up the pen and prepared to continue the letter. She had never felt particularly comfortable sharing the details of her delusional moments, not with her family, not even with her psychiatrist. The shame and guilt had always been too overpowering. For her, to be that out of control was hard to accept. Even though she knew it was not her fault and that she suffered from a biologically based disorder, she still could not reconcile the fact that her thinking could become that disordered.

Sonya was not one of those patients who sought the thrill of mania. For her, the coincidental experiences of paranoia and depression far outweighed any high she experienced along the way. In general, her life was very rewarding and challenging as it was and she deeply resented the media portrayal of psychotic people as non-compliant patients who discarded their medication in order to “feel good”. In her life, any experiences of going manic, along with the accompanying depression, only served to severely disrupt her life’s ambitions and to demolish her self esteem.

Even as she sat, pondering her next words, Sonya’s eyes welled up with tears. Tears of frustration. Tears of fear, that somewhere beneath the balance of medication and carefully
practiced coping strategies lay an overpowering monster that threatened everything she valued and cared for in her life.

Though she knew that her sister had generally tried to be supportive through her ordeals, she felt her sister had always blamed her for getting sick, silently implying that if she took her illness more seriously these episodes would not reoccur. Her episodes had been the result of ineffectively managed stress accompanied by disruptions in her sleep pattern. She had broken through the safety net she had tried to assemble using medication and psychiatry. She had never simply stopped taking her medication for the fun of it. The subtly implied societal messages that she brought these nightmarish episodes on herself continued to enrage her.

Elly had never seemed particularly comfortable hearing about the details of her episodes, like the rest of her family, except that is for her uncle Alfred. But that was different. He too was a veteran of the dark halls of the psych wards.

*I'll spare you the details,* she wrote. *I'll spare you the details,* she thought.
Epilogue: Recovering the Self: an Autoethnographic Journey

Finding a Voice

My original intention in choosing a thesis topic was to select an area of study that I would find interesting to research. I wanted to find a meaningful, yet manageable, topic. Early in my Master's program, I was able to find a topic that fit this description. I then proceeded to find a thesis supervisor whom I respected and whose area of interest corresponded with my thesis idea.

As I continued to work my way through my graduate program, though, I began to realize that my best papers, the ones I enjoyed most and was most motivated to write, involved topics that were of personal significance to me. I began to reconsider my thesis topic. Could this thesis project be more than an exercise in learning research practice?

With trepidation, I began to consider changing my thesis topic. Prior to entering the Master's program, I had vowed myself that I would use my education to become an advocate for the mentally ill. Since having been diagnosed with Bipolar Affective Mood disorder when I was fifteen, the accurate and respectful portrayal of people with mental illness has been become a personal cause, a passion in my life. I was well aware that I had a unique perspective, an insider perspective that was missing from research literature. I also felt a sense of responsibility to educate people about the lived reality of mental illness and that perhaps through this research project I finally had an opportunity to do something in this regard. Never one to back down from a challenge, I decided I wanted to proceed with this endeavour.

Many experiences remained I thought needed telling; stories that reflect a more “real” perspective of what it is like to live with a mental illness. Over a period of time, I weighed my options. Would I be able to write about this personal and emotionally charged topic? Would I be
up to the task? Was I prepared to publicly acknowledge that I have a mental illness? Would it be worth it?

I consulted with my therapist, my psychiatrist and my friends. They all encouraged me to go ahead with the project, if I felt I could. I talked a lot about the possibility of doing this research, about why I wanted to do it, about what purpose it could serve in the world at large. Through the process of dialogue with these various people and after thinking about it a lot on my own, I became clearer about why I needed to do this.

The last question remaining was whether this thesis idea would be acceptable to my department and the university. The advisor who I was to be working with listened supportively to my idea and encouraged me to follow my passion; however, this type of research and the topic were out of her area of expertise. So, she gave me the name of a professor to approach about my idea.

I was interested in finding some method that would enable me to share my personal experience, to combine research and scholarly writing as healing. The professor I saw was enthusiastic about my idea and informed me other students had written about their personal experiences, using autoethnography. This was the first I'd heard of this type of research and I was very excited.

Using this methodology, I could write about my personal experience, provide a first person account of what it is like to live with mental illness, in order to help people enter in to the experience themselves, while working to facilitate a deeper awareness of the issues involved. Using this methodology, I could also provide a critique of the medical model, looking at issues of power, accountability, stigma, issues that readers who have not been on the receiving end of psychiatric care need to understand better. I felt it was important to provide an alternative
perspective to the clinical, third person research accounts that describe people living with mental illness as patients, subjects/objects with symptoms and medications, and recurrence rates etc., while denying their individuality.

Finding autoethnography as a methodology has been a mixed blessing. Approaching my research using this methodology has turned out to be difficult because autoethnography is not a traditional quantitative research practise. There is controversy regarding the utility of this method as viable research. The perception of the "traditionalists" is that autoethnography, or any writing about oneself, is self indulgent, self involved, not sufficiently objective. I have grappled with issues of validity and reliability, as they apply to this research, questioning whether autoethnography can be considered a legitimate approach to research.

Strengthening the Voice

As I'm trying to understand autoethnography, I've been forced to reconsider the nature of research. Initially, when I was deciding whether to do this kind of research, I wondered whether I could be objective enough to make a point, without falling into the trap of grandstanding or overstating. Providing valuable support in understanding the nature of this qualitative method has been my thesis supervisor. She has encouraged me to follow my own path, to make this research my own while providing necessary theoretical resources and moral support.

As I've done more reading about autoethnography, I have discovered the writings of scholars like Caroline Ellis, Norman Denzin, Laurel Richardson, to name a few.

Ellis' description of her writing process during the construction of Final Negotiations mirrors what autoethnography means to me and corresponds with the process I am using in my research process Recovering the self: an Autoethnographic Journey.

It took nine years to construct and reconstruct the story of my relationship with
Gene...During this time, I moved from conceiving of my project as science to viewing it as interpretive human studies and narrative inquiry, transforming the process of writing the text from realist ethnography to a narrative story, and my primary goal from representation to evocation. (p.127)

Ellis describes autoethnography as "moving closer to an evocative account and dramatic story and farther away from trying to get all the ethnographic details 'right'" rather, she "showed interaction so that the reader might participate more fully in the emotional process, not merely observe the resolution."(p. 127). This approach resonates with my intentions. I have struggled with whether I can fully tell "the truth", the historical truth, realizing that I do not have field notes or videotapes. The emotional impact of the events, though are much more vivid. I feel more comfortable sharing my story in this way.

The shift in focus from representation to evocation has been significant in my process as well. As I’ve worked on this research, I’ve given a lot of thought to whether or not the value of the message can still be as powerful if the “truth”, (that is the personal meaning I’ve derived from the events) are presented in a context or setting that based closely enough on “the facts”(the actual historical account, as I recall) but yet also fictionalised enough to protect the identities of the other people involved.

Ellis describes this process this way:

I began to concentrate more on being true to the feelings that seemed to apply in each situation I described than to getting all the "facts" in the exact order and time sequence. More and more I moved away from trying to make my tale mirror representation of chronologically ordered events and toward telling a story, where the events and feelings cohered, where questions of meaning and interpretation were emphasized, and where
readers could grasp the main points and feel some of what I felt. (p.128)

Setting the Stage

One goal I continue to share with traditional social science is a commitment to writing a truthful account. The stories I tell in this thesis are based on my own personal experiences, my journal writing, and my poetry. The narratives, though fictionalised to protect the identities of the other people involved in my lived experiences, are closely based on my experience. Although I am not providing a traditional account based specifically on the historical factual events, it is important to me that people hear the "truth" about what it is like living with mental illness. It is of ultimate importance to me that I effectively articulate the significance and meaning of my personal experience.

Along with a realistic narrative account of the events that took place, I want to be able to step back and reflect on the experience, sharing and exposing my "psychic defences and emotional complexities...more intent on showing ambivalences and contradictions that occurred along the way than on declaring outcome"(Ellis, p.130 1997).

The Writing Process: “The How”

The following are some excerpts of journal writing I have done in the year and a half I have been contemplating and grappling with this project. I think these writings are an effective means of communicating the process, as it has gone for me.


Writing this ethnography – auto form- is difficult, to say the least. How is it possible to re-enter the past, to lose the now, when I am ever present, reminded and distracted by the garlic smell on my hands from last night’s dinner, when the slam of my partner angrily leaving the house echoes in my head.
I don’t have time for that life – that plane of existence – in this moment I am going down deeper, one level at a time, finding that place where the tears are, the place of authenticity; I must start my journey by escaping the problems and distractions. In this, I must be selfish, ruthless; this is my story.

Fifteen years ago now, my life changed forever. I had been an excellent student athlete, happy go lucky girl growing up in a small industry based town. My childhood and adolescence to that point had been almost perfect. I was very happy.

My parents were loving and supportive and provided a home, a place where there was enough discipline and church going that we, my two brothers and my sister developed a sense of morals, but where the discipline and limits were not so restrictive that we felt a strong need to rebel.

I had always been a motivated young person, very goal oriented with high aspirations. As I was writing this, trying to find a form, experimenting with different ways to start the writing process, waiting for a way to enter in to the writing process, I quickly realized that this style of narrative was much too based on the historical facts of my life. I knew from my discussions with my thesis supervisor that there could/would be problems with the University if I was to name other people. I would have to keep things very vague so that the reader would not be able to specifically identify the people involved in the narratives I was writing.

At that point in time, certain members in my family expressed concerns about what I was going to write about in the thesis.

I was also very aware that this writing was too “surface-y”; it didn’t really capture the underlying emotions in the way that I was hoping. I didn’t want to write an autobiography, I wanted to write something that would allow the reader to FEEL the EXPERIENCE.
So, it was back to the drawing board. . . (once again with feeling 😞)

Wednesday, July 5th 8:40pm.

OK, start again. Re-invent the wheel. Re-invent myself. Let the past fly away. Let the light shine in.

The what if’s, if only’s, have haunted me for a long time. Though I may not have admitted this, the extent to which this illness has affected me – in the context of my expectations of myself, I was talking with my therapist today, wondering where I’d have been if this illness was not embedded in my genes.

I remember wanting to become a lawyer; I remember having been a straight A student. I remember being a popular camp director and a successful coach. I remember wanting to make the Sr. National volleyball team. I remember being interested in the police. . .

Some of these dreams disappeared after I experienced my first episode of the illness, at fifteen. When my thinking about possibilities for my life changed. I can’t know the why’s. A protective mother steering me in the direction “Isn’t that stressful?” Oh, I used to hate that, feeling annoyed by that worry, that fear. I don’t remember anyone telling me I couldn’t be a lawyer or a cop but I do know that I internalised that message, somehow.

At that point in time, certain members in my family expressed concerns about what I was going to write about in the thesis. I also realize that ethically I am bound to protect the identities of the individuals who have also been involved in my lived experiences. So, I need to find a way to tell the story that is true to the essence of what happened without actually giving a historical, factual account. With this in mind, I continued experimenting with form.

It’s taken me a long time to refocus on dealing effectively with stress, and taking those expressions of concern as a sign of love. Now, I know how to protect myself, to take care of my
self and stress is not really an issue. But back then these concerns were little doubts in the back of my mind, enough to steer me away from these dreams.

   So, in order to leave the historical account format I attempt to write from the perspective of the present, to be in the moment, to re-enter one of my more vivid memories and it came out as a poem:

   Teardrops,
     streaming
     salty and warm
         upon my lips.

   Reclaiming my life
     surviving
     the moments
     of reliving.

   Sitting, in Canadian Lit.
     travelling into the bush
     with Susanna Moodie,

     trying to see the forest for the trees
     listening, discussing...

   Without warning,
     the classroom fades

     I am transported back
     to a place in time, in my life time,
     that I had escaped from. . .
         to a place in time, in my life time,
     that I had escaped from. . .
     that I wanted to escape from.

     I am alone.
     I am out of touch, out of sync, out of time.
     I am ashamed.
     I am disgusted
     with my self
     my inability to control
         my craziness, my reality, my thoughts
How could I think!!!

I am numb,
    hot,
trying to breathe
    to escape
    the why's.

Trying to close the lid.
to push down
the confusion
the pain
the vivid memories
of wild thoughts
of paranoid delusions.

Trying to find myself
in here,
in the now.

Trying to recover
the senses
the taste of life,
    the texture
    the color.

As I wrote this I was overcome by a lot of strong emotions and memories. Although I was prepared for this and expected it, I realized there was too much there, perhaps too much force yet to tell the narratives this way, writing using the "I" perspective. I was much happier, though, at the authenticity and depth of feeling I am able to touch with the use of poetry. I decided at this point to look at the poems I had already done in my own personal writing previous to the thesis to see if there were any poems that I could include. There were in fact several, as you can see.

There remained aspects of the experience that I wanted to touch on. I realized that it would be challenging to write the thesis if the experience was too intense. I was aware of the potential of re-traumatizing myself. After some consideration, I decided to write from the third person. Writing myself as the main character, using my own name, was an idea that came later
but just seemed like the appropriate way to go. I found I could still access the emotions of the events I wanted to write about; yet, writing it using the third person perspective gave me enough distance that I could enter into the writing process without being too overcome. This realization was the last piece of the puzzle for me, as the writer. After this idea emerged I was able to successfully complete the missing pieces of the narrative.

The final narrative product is a conglomeration of pre-thesis personal writing, elements of writing formed in a writing course that explored alternative methods of academic writing, and pieces wholly conceived of and written for the purpose of this thesis during the journey of this thesis project.
Here’s a poem that represents some of the warmup initial writing that I used to enter into the emotional space to write, the emotional struggle of trying write about a painful experience, a process that has been a challenge through the whole of this writing project.

Today, as I hold this pen, I seek the door that
Will enable me to transcend the limitations of space and time,
   Of life’s present responsibilities
   Of life’s frustrations,
   Challenges that lie ahead.

I need to draw in,
Focus
Enter in.

To where?
The narrative, the story
   Without judgment
   Not trying
to do it all
   at once.
So, deep breath
   In through the nose
   Out through the mouth
And
   Out through the fingers
   Onto the screen.

It’s a struggle, a muddle, let it flow, let it go,
It’s hard to release,
To escape
To enter in
To find that place
   Of vulnerability
   Of remembrance
   Of authenticity
   Of creativity
Release, fade away, disconnect,
   Peel away the layers of the onion, the defenses
To find the core,
   My meaning
   My experience
Laid bare
No holds barred
   Honestly, boldly, compassionately
Me.
Chapter 4

Discussion

The Disease Model: A Patient’s Experience

Having grown up in a society where the medical model was (and remains) the status quo, I had come to view the doctor as “the expert”; I had become used to accepting the doctor’s view of things as being "the truth." As an adolescent, it was natural for me to put the doctor in the place of authority and I accepted my diagnosis of a mental illness without question.

Generally speaking, I tried to get on with my life despite this label. I learned more and more about myself in relation to the disorder each time I experienced an episode of illness. I tried to gain insight into the causes of the manic episodes so I could maintain health.

I accepted the role of the psychiatrist and medication in my life. I learned that it was important to have an external reference, at times, when one has a mental illness. This being especially true during acute phases of the illness when doctors and nurses can be effective in helping the patient to distinguish between reality and delusional thinking.

After having several experiences of psychotic episodes, I had become extremely motivated to avoid repeating the experience. As a result, I became afraid of strong emotions, as these mood states have, at times, been precursors to the onset of an acute episode. So, for a long time, I lived very much under control, only comfortable with emotions that were within a safe band. Anything too exciting was too scary to contemplate and I used my psychiatrist as a sounding board to help me distinguish if my feelings or thoughts were getting too “crazy.”

On a number of occasions over the past fifteen years, despite the continued care of psychiatrists and medication, I experienced full blown manic episodes and required hospitalization. These occasions were always extremely distressing experiences.
When I would get discharged, I would try to return to my life, usually in the midst of a
post-manic depression, and I would do my best to forget the experience. When I tried to share
and debrief my experiences in hospital, I found that people were uncomfortable talking about
mental illness or treated me different after I had disclosed my illness. So, I fell silent.

This silence may have continued were it not for some timely advice I received from a
psychologist, during my most recent stay in hospital. She was working on my ward and saw my
frustration and took me aside one day, to have a talk. Basically, what she told me to do was to do
what I had to, to get out of the hospital, and then to become an advocate for people with mental
illness. This thesis has been the first step for me in working towards this goal.

From Patient to Client

From my personal experience in the psychiatric system, under the care of a psychiatrist, I
had become a patient. The psychiatrist, trained as a doctor in the medical model, assesses the
patient against a set of generalized patterns and statistics and diagnoses the patient according to a
set of criteria, known as the DSM model. The doctor’s role is to ensure that the patient does not
exhibit a set of symptoms and to treat these symptoms if they occur. The doctor is the objective
observer, the authority, the one who has an objective point of view. The doctor guides patients,
or looks after them, providing a paternalistic type of care, focused on symptom management.

In my view, this is a major flaw in the model of psychiatric care and perhaps the medical
model in general. The patient is looked after by the doctor, acted upon by the doctor, the expert.
As a result, patients give up their personal agency, their sense of self control. Patients are
disempowered because the system teaches them to rely on the doctor. The patient is put in the
position of deferring to the doctor. Because the doctor has a range of experience with other
patients and is aware of the way the illness and its symptoms can play themselves out, the doctor
becomes an expert on the patient’s experience and emotions. Therefore, the patient is
disempowered and made dependent upon the doctor’s expertise.

Unfortunately, though, this dependence on the psychiatrist can have definite debilitating
effects as well. It fosters a reliance on an outside source to validate or invalidate the patient’s
inner world of feelings and thoughts. Speaking from personal experience, this reliance can
undermine the patient’s confidence in her/his own feelings and sense of what is real and what
isn’t. It becomes harder to distinguish for oneself.

I became unsure of what was normal excitement or inspiration and what was hypomania.
To compensate, I stayed in the zone where I could be sure that my feelings were “real.” I avoided
contemplating any dreams or aspirations that I wasn’t relatively sure I could accomplish. This
was quite in opposition to the way I had been previous to this illness when I was a confident,
hopeful dreamer. It is only since receiving counselling in a counselling psychology context that I
have begun to be aware of how much I was limiting myself because of my fears of becoming ill
again.

In counselling I have learned to be aware of what’s going on in my life and to measure it
against what could be expected in the circumstances. The focus has shifted to dealing effectively
with stress and knowing my body so that I can be confident in my feelings. I am very aware of
what the trouble signs are for me. And I now have tools to be proactive in response. I feel like I
have some control in this. I use the doctor and the therapist as part of my safety net but the onus
is very much on me to be vigilant.

This is different from being afraid of strong emotions. This trust that I have in myself has
developed out of my awareness that I am the expert on my life, my emotions, my lived
experience. Being able to trust in my own intuition has been a very important piece of this
puzzle. In the context of the psychiatric system, I think I learned that I couldn't really trust myself. I became dependent on the doctor to differentiate between what was real and what wasn't. Through counselling, within the context of a Rogerian model, I was able to redevelop this trust in myself while being aware that at times I can feel okay about checking things out if they don't feel "right."

In the process of doing my Master's degree I have also learned more about postmodernism. I realize that my feelings and perceptions are valid in and of themselves and that the doctor's perceptions of reality are his/her perceptions, that there could be more than one truth to an experience.

This was very freeing because it allowed me to acknowledge my feelings as valid, without having to question them. In the counsellor's office, it is no longer important to figure out what really happened. We talk about what the experience was like for me. Period. My perception of reality is acknowledged. There is no sense of one true reality that my perception is being measured against. I can't emphasize enough the difference that this has made for me, to be listened to in that kind of a way. I am recognized to be an individual and to be the expert on my feelings and my experiences. This is very empowering especially after my previous experiences with psychiatrists who do not validate their patients experiences in this way.

Another significant reclaimation occurred for me when I started receiving psychotherapy from a counsellor. I became an individual again. I reclaimed my personal identity, separate from the label of "bipolar." When you receive a diagnosis, you lose a degree of your individuality. You become one of a group. You are no longer the expert on your experience because the psychiatrist has seen many people like you. Working with in that space, I felt increasingly stigmatised and dehumanized. This was particularly true of my experience with the psychiatric
wards. I will address this more fully in the section where I talk about implications for practise.

Receiving client centred counselling I feel very free and safe to push the boundaries of what the illness means, in my life. The focus shifts away from being centred on symptom management. Still an important aspect of therapy, it is not the central and sole purpose of the sessions.

Rather than fearing a re-occurrence and measuring the likeliness of this each week in a self report, I explore many life issues. Sometimes these issues relate to the illness, often times they don’t. In this way, I have learned to think of myself differently. Rather than a person with a mental illness, I am a person and the mental illness is but one part of me. The disorder is more of an integrated part of my self.

If I have a concern about a symptom that may be reoccurring, my therapist will communicate this to my psychiatrist and an appointment may be arranged with him. In this style of multidisciplinary treatment, I receive therapy from therapist and medical advice from a doctor. Each profession is doing what they do best.

In this way, I am able to take more of the responsibility for my health on my own shoulders. I am able to be proactive and I am recognized to be an expert on my own experience. I feel that my voice is heard and acknowledged.

**Recommendation for Practice**

**Changing the way we view mental illness.**

In an ideal world, the client would be able to incorporate the strengths of psychiatry and client centred counselling in developing a safety net yet empowering individuals towards wellness, where they feel they can walk the line on their own. I believe each discipline has an important role to play and we are beginning to see this with the emergence of multidisciplinary
teams in the mental health field.

Presently, we see mental illness as a one-dimensional biologically based brain disease and treatment consists of extinguishing the symptoms, relying primarily on pharmacology. The self is viewed in a positivistic modern perspective where the self is an essential, stable, and knowable entity. Various modern psychotherapies seek to improve the client's "reality contact" by minimizing nonconscious cognitive distortions. The healthy person is one who does not deviate from the norm.

**A postmodern view of mental illness.**

In order to more effectively treat mental illness, I believe that clinicians and researchers need to revisit the conceptualisation of reality using a postmodern wellness oriented empowerment approach. Rather than assuming a single reality that is common across people, cultures and historical periods, clinicians and researchers need to recognise that individuals vary as a result of individual, social and temporal factors and that individuals are in a constant state of reflexive construction and deconstruction.

Clinicians and researchers operating from this stance would recognize that they are not the experts in charge of treating, studying or acting upon patients. Rather, their work would be in conjunction with the individuals living with the disorder. In this paradigm, the clinician and researcher's work would empower the individual through affirming their experience, recognizing the truth in it. The research and the treatment would be oriented towards maintaining wellness rather than on decreasing pathology.

The discourse of research on bipolar disorder is rooted in the disease model. Treatment is focused on treating symptoms. As described in the literature review, the research literature focuses on the symptoms and discusses episodes of time where symptoms do not occur as "a
return to pre-morbid functioning between episodes” (Berrettini and Pekkarinen, 1996, p. 191).
Reading this, my feeling is that the sense of the person is lost. The symptoms come to define the person; the individual’s personality becomes secondary, though the person may be well for years at a time.

In the literature, we read interesting statistics and trends. The DSM provides an accurate descriptions of symptoms: intervals between episodes tend to decrease with age; though most people suffering from bipolar I return to a fully functioning level between episodes, 20-30% continue to experience mood instability and have relationship and employment problems; 10-15% of individuals with bipolar I successfully commit suicide. These are interesting statistics; however, it is not enough to report statistics.

The postmodern perspective encourages the researcher or clinician to explore how each individual creates personal representations of self and world in order that the individual can transcend problematic constructions and construe things in a wholly new way. I think the real story lies in the “why.” Of the 70-80% who return to a fully functioning level – how do they manage it? Do they approach their illness differently? Are they able to learn about their illness triggers? Why are they different from those who suffer further? Are we trying to find out why so many of those who have suicidal ideation do not attempt suicide?

The large variety of studies have been conducted on the efficacy of medication as an effective treatment for mania. There is a much smaller amount of research on the efficacy of psychosocial treatment. Ellicot, Hammen, Gitlin, et al., (as cited in Callahan & Bauer, 1999) found that experiencing a negative life event increased patients likelihood of relapse by four times when compared to those who do not. Other research suggests that psychotherapy and patient education can be used to gain insight into the interpersonal styles, habits, or emotional
reaction patterns that have been associated with past episodes. The research also focuses on using psychotherapy to increase compliance.

I believe that there is less research into psychosocial treatments because these approaches involve studying and working with individuals, rather than with general symptoms and statistics. This would involve more personal qualitative types of research. Unfortunately, the research in the field of study of bipolar disorder is predominantly quantitative.

The research into psychosocial treatment is also more suited to the postmodern perspective because these types of treatment address the individual's need to gain insight into her/his own interpersonal styles, habit, and communication patterns. This insight process may involve new information but it may also be focused on helping the individual reconstruct their self image, incorporating the illness into the fabric of their lives. The individual may come to seen the illness as a part of who they are, rather than as the entity that defines them.

The individual can be empowered to use the disease process and the introspection this treatment involves as a means to self-discovery and transformation. Rather than viewing the therapy as a means of symptom control, the individual can use the therapy as a means for personal growth. It is especially important that the clinician working with the client towards this aim sees the client is seen as the expert on her/his own experience. The individual needs to gain confidence in his/her self. So, it is important that the doctor or person counselling does not assume the role of the expert.

**Personal construct theory and “delusions”**.

There is very little in the research literature that addresses the need to treat the traumatic effects of mental illness episodes. There is little or no research presently being done to “normalize” the experience of mental illness. Kelly's personal construct theory may enable us to
see the possible connections to reality that even delusions or psychotic thinking may have.

A common goal of From Kelly's personal construct theory, people understand and create meaning through personal construct systems, where a construct is abstracted from and subsequently imposed on the raw perceptual and ideational experience of life. Recurrent themes across time are perceived and organized into a meaning system.

I believe that this conceptualisation of how people understand and create meaning could help us normalize people who experience delusions as well as help the individuals themselves see the reality that their abnormal thoughts and behaviours may be based in. When we treat an individual with post-traumatic stress disorder, we often conceptualise their difficulties as a normal reaction to an abnormal experience. This abnormal experience is an externally inflicted trauma: sexual assault, torture, war are some examples.

To exemplify how people with delusions may also be having normal reactions to abnormal experiences I will use an example from my own life. Prior to having my first manic episode, I began losing sleep. After a period of time of not sleeping, I began to have unique perceptual experiences. I remember having auditory hallucinations. Having been brought up in a faith environment, I interpreted that experience using the meaning-making framework I had. I assumed that the voice must be God. That was the only explanation that I had for that type of experience.

The perceptual stimuli arose from within myself and I tried to make sense of using the meaning making system that I had. Voice in your head – that must be God. Since that first experience, I have come to know that voices in my head experienced after losing sleep for a period of time is not God. Subsequently, in the manic episodes that have occurred since then, I have not had the delusion of being God as I did that first time.
Conceptualising my delusional thinking as a “normal” reaction to perceptual stimuli that does not fit my current meaning making framework has enabled me to let go of my feelings of shame around not being able to control these “crazy” thoughts. In each set of delusions, I can see the connections to my usual everyday meaning making system.

For those people who have engaged in recreational use of psychedelic drugs have similar types of delusions but they usually can maintain the insight that they are on a drug induced perception experience.

I feel strongly that mentally ill is an incorrect label to use to describe people who experience altered internal perceptual stimuli. Rather than diagnosing and treating the symptoms, I think we need to help the individual to learn what brings on these altered perceptual states in order to enable the individual to identify the causes. By identifying the factors that contribute to my episodes I have been able to be proactive in maintaining my own health.

This process is one that has developed over time from various lessons I’ve learned. It involves leading a healthy lifestyle: solid relationships with a supportive network of friends and family; an active lifestyle with regular exercise and effective stress management. The stress management involves simple things like baths, walks in the park, relaxing, talking to family and friends. I’ve learned to use a variety of strategies when necessary to combat depression: these include being aware of my self talk, visualization and relaxation, journaling, poetry writing.

Maintaining sufficient sleep and taking medication are the final two components of my “wellness regime.” With these strategies, I am focused on wellness in much the same way that is beneficial to all people, not just those living with mental illness. The one aspect of my health that I do pay extra attention to is my sleep pattern. I am very aware of any times when my normal sleep pattern begins to change. Now, I have medication to take, at my discretion, if I am
concerned that I may be losing sleep. I am empowered in this way to monitor my own situation and to act in maintaining my own wellness. I think that empowered people to act in a proactive manner is needed in order to move towards a focus on recovery, health and wellness, rather than on fear, symptom avoidance and psychopathology.

**Changing how we treat the mentally ill.**

I believe that psychiatry and counselling need to bridge the philosophical gap and combine the strengths of each discipline. Psychiatrists and medication are an important element in the treatment of “mental illness” however pharmacotherapy is not sufficient in and of itself.

Counselling has a valuable role to play in helping the individual come to grips with the emotional challenges of dealing with these “illnesses.” This role ranges from helping the individual accept the benefits of medication to helping the individual determine the individual, social and temporal factors that may contribute to precipitating the onset of illness episodes. Perhaps most significant of all is the role the counsellor can play in empowering the individual to integrate the illness into their self identity, rather than allowing it to become the self identity. The counsellor can also act as a support and a witness to the trauma the client may have experienced as a result of the illness episodes and hospitalisations.

In general, I know that advances are being made. Multidisciplinary teams involving psychiatrists, psychologists, counsellors, social workers, and psychiatric nurses exist already. Yet, I don’t feel that enough emphasis is being placed on the role of counselling in these settings. When counselling is done it is often being done by professionals trained in the medical model, rather than by trained counsellors using humanistic models of healing. People living with mental illness need to be empowered and the medical model tends not to do that.

Specifically psychiatrists being trained in empathic listening is a step in the right
direction. My opinion is that psychiatrists in general need to treat their patients more as individuals and they need to respect the wisdom of the client as it relates to their own personal experience. I also feel that counsellors need to become more aware that there is less of a distinction between those who need psychiatric help and those who benefit from counselling.

To conclude this section, I want to address what good care might look like on a psychiatric ward, based on my personal experience. One could write an entire thesis on this topic, however I will be brief. I feel a key component to good care is a good staff. This means a staff that is respectful and caring towards the patient. As on any hospital ward, on the psychiatric ward there are good nurses and bad ones; good doctors and not so good ones. There are a lot of frustrations and stresses while staying on the ward. Your movement is restricted; it is very boring.

The good nurses, even though they are busy, take a moment to talk to you. They are not so bound up by the rules and regulations that they are totally inflexible. On a psych ward, the good nurses treat you like a human being. They talk to you without being condescending or threatening. The bad ones give you the sense that you are a child, and they speak to you with that kind of parent knows best attitude.

The good doctors are reliable – they keep appointments with you and they are willing to listen to you, to how you feel. The good doctors seem to appreciate that the psych ward is not a pleasant place to be and they give you as much of an idea as they can how long you will be there and what their concerns are.

Quality hospital care is an essential component of the mental health system. In the future, I hope that more thought is given to the assumptions we hold about the way psychiatric wards are run. Being in such a place feels like a sentence, like being in prison, rather than like being in
a safe quiet place where one can heal.

The mental health system is not well designed, as I see it. Services are not well coordinated and the different professional disciplines often work in isolation. Access to services is based on a reactive model where the individual needs to be in crisis in order to access certain services. I feel strongly that more emphasis needs to be placed on prevention and a more proactive model that provides services in order to prevent crises. With this in mind, I restate my belief in the importance of counselling in the treatment of people living with mental illness. This autoethnography regarding my struggles within the current model of psychiatry is offered to provide an inside perspective on the lived experience of mental illness and to show the importance of including personal insight oriented counselling in the treatment of mental illness.

By sharing from my lived experience of mental illness, I hope that you, the reader, have gained a clearer understanding of the strength and courage involved in living with these types of illness. I have offered this narrative as a statement that mental illness is not something to be ashamed of. I have decided to move out of the closet of mental illness and I offer you the challenge of allowing me, and others like me, the space to do so.

I believe that narratives can be helpful tools in instructing and informing about psychiatric conditions and treatments. This piece has shown how psychiatry and counselling can be integrated by incorporating client centred personal counselling along side the effective use of pharmacotherapy to transform patients into active and empowered participants in their own recovery process. In this way, most significantly, the role of the counsellor may be to empower the individual to integrate the illness into his/her self identity, rather than allowing it to become the defining feature of the self identity.
References


Kiesler, D. J. (1999). *Beyond the disease model of mental disorders* London: PRAEGER.


