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An Examination of the Experience of Living with Mood Disorders
by

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A Dissertation Submitted in Partial Fulfillment of the
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DOCTOR OF PHILOSOPHY

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We accept this dissertation as conforming
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ABSTRACT

There is little research which examines the real life experience of those who have Mood Disorders, and yet studies suggest that in North America as many as one in four people in the general population will develop a major episode of Mood Disorder at some point during his or her lifetime (O'Connor, 1997). The researcher has adopted the classification of Mood Disorders as described in the Diagnostic and Statistical Manual of Mental Disorders (APA, 1994), a manual developed by the American Psychiatric Association to guide medical practitioners, psychiatrists and psychologists in the diagnosis and treatment of mental illness.

This research study, "an examination of the experience of living with Mood Disorders", focuses on the unique experiences of five participants who live with the condition. The researcher conducted a narrative study of individuals who met the research criteria: men and women between the ages of 25 and 55 who had been diagnosed with a Mood Disorder by a medical practitioner. In one-to-one interviews, the participants told their "stories" of living with the condition. The researcher explores the impact of Mood Disorders on the lives of each of the five participants. The study examines the literature with respect to the causes, diagnosis and treatment of Mood Disorders, and surveys from an historical perspective, the field of human science research in general and narrative studies in particular.

The distorted and distorting lens of an individual with Mood Disorders interferes, in a profound way, with the recognition and identification of the symptoms, and with the diagnosis and the treatment of the condition. With

the passage of time, all areas of functioning become affected; the affective, cognitive, occupational, philosophical, physical, psychological, social and spiritual lives of those with the condition become influenced by the distorting quality of their lens. The research identifies five predominant states encountered by individuals with Mood Disorders. These five states are episodic, sporadic, overlapping and ambiguous: state 1) dismissing the symptoms, state 2) externalizing the cause, state 3) internalizing the cause, state 4) accepting the diagnosis, and, state 5) developing the management strategies. The researcher presents implications for educators, for professional practitioners, for those who live or work with individuals with Mood Disorders, and for those who experience Mood Disorders themselves.

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CHAPTER 1

In the middle of our life,
I found myself in a dark wood,
For I had lost the right path. . . .

~Dante

Introduction

Throughout the process of refining my research question, I was guided by a phrase from a book I read several years ago, a phrase which seemed to rise from the page. William Bergquist (1995), an educational psychologist at a university in California, advises his doctoral students “to ‘enter the mouth of the dragon’ ” when they attempt to isolate a dissertation topic, “to write about something that is of deep personal concern to them, even if it means that they must struggle with the issues of objectivity and bias” (p. xii).

When I embarked on my doctoral program in 1995, I began the research process for my dissertation topic “an examination of the psychosocial impact of declaring bankruptcy on a bankrupt”. I gathered articles, journals, periodicals, and personal accounts about the impact of the declaration of personal bankruptcy on individuals and their families, and I informally piloted my topic with friends, acquaintances and colleagues. I had planned to focus on the issues of fear and of shame that one experiences after declaring personal bankruptcy. But, my informal research uncovered another path. My real interest lay not in the precipitating

event of bankruptcy, but in the all too common consequence, a prolonged episode of depression.

Throughout my life, I have had a profoundly deep reaction to and abiding interest in Mood Disorders¹. My preferred reading has always been biographic and autobiographic accounts of the lived experience. As a child, I devoured all the books that our local library could provide about the lives of musicians and composers; I was startled by the incidence of suicide. As a teenager, I was shaken by the attempted and the successful suicides of several university friends. And as an adult, I have extended a helping hand, whenever possible, to friends, colleagues and students who have struggled with feelings of inadequacy, negativity and futility. I have felt compelled to help them shift their thinking, to help them reframe their outlook.

As the first born child with three siblings born at five year intervals, I assumed a protective, “little mother” role in my birth family.² I concentrated on psychology as an undergraduate student and pursued further studies in education and counselling as a graduate student. I counselled and taught in the secondary system in Ontario before moving to British Columbia where I accepted a teaching assignment in the academic upgrading department in the community college system. For

¹ Mood Disorders: the heading used by the American Psychiatric Association in the Diagnostic and Statistical Manual (1994), to describe the various forms of the disorder.

² Throughout the writing of my dissertation, I have struggled with issues of confidentiality and ethics concerning the disclosure of facts about my birth family. I have decided that out of respect and affection for members of my family, I will not identify any details about the prevalence of mood disorders amongst my relatives.

the last twenty years I have taught adult students who are returning to formal education, many following an absence of many years. They have brought with them a wealth of life experiences - not the least of which is their struggle to manage Mood Disorders.

I have taught and counselled a number of students who have revealed deep concerns about their emotional and mental health. I have witnessed the devastating impact of performance anxiety on students as they anticipate examinations and oral presentations. Also, I have observed symptoms of Mood Disorders amongst numerous colleagues; as the faculty advocate, a post that I held for five years, I witnessed the the impact of the condition on the workplace. The National Institute of Mental Health³, the primary funding agency for American research studies in mental illness (Shulman, Tohen & Kutcher, 1996), has recently produced startling figures about lost time in the workplace as a result of Mood Disorders.

In order to comprehend Mood Disorders, I immersed myself in the literature following two parallel but very different paths. Firstly, I poured through medical, psychiatric, psychological and sociological journals and texts in order to develop an understanding from an historical perspective of the causes, the clinical characteristics and the treatment of the condition. Secondly, I examined personal accounts written by individuals who have lived with Mood Disorders in order to develop a sense of the lived experience and its psychosocial impact. It is this path which held the

³ The introductory statement welcoming readers to the web site for the National Institute of Mental Health ([//www.nimh.nih.gov/](http://www.nimh.nih.gov/)) describes its purpose: "the mission of the National Institute of Mental Health is to diminish the burden of mental illness through research".

greater intrigue for me. Reading the first person accounts was an engrossing experience, one that whetted my appetite.

In the development of my research proposal, I needed to ask myself some fundamental questions:

What is the purpose of the study?⁴

I want to examine the experience of individuals living with Mood Disorders. I want to develop a greater understanding of the condition. I want to learn from my participants the meaning one derives from the experience of living with a Mood Disorder and, I hope that by engaging in dialogue about their experience, they will develop a greater understanding of their own condition. I want to assist them in recording their “stories” so that others might read of the experience of living with Mood Disorders. I want to help increase the level of awareness with respect to the impact of living with the condition in hopes that others might come to understand Mood Disorders better. . . . My goal is to educate my readers about the characteristics, the prevalence and the management of Mood Disorders, and, ultimately, to help dispel the stigma that is attached to the condition in our culture.

Why conduct a narrative study?⁵

I want to conduct a narrative study, recognizing that the narrative is both a product as well as a process. I believe that the reflexive relationship between living a story, telling a story, reliving a story and retelling the story has the potential of providing both the

⁴The following two sections, “What is the purpose of the study?” and “Why conduct a narrative study?” are extracted from my research proposal which I proposed and was accepted by the University of Victoria during the fall of 1999.

⁵ Ibid.

participants as well as the researcher with a rich, enlightening experience. I have explored the literature concerning methodologies in human science research; I have attempted to find an approach which both acknowledges the uniqueness of the individual and the existence of consciousness in the study of human behavior, and, at the same time, acknowledges the researcher's own values, interpretations, and feelings in the process of inquiry.

I believe that the most effective way of understanding the condition is to encourage participants to tell their "stories" about their experience of living with Mood Disorders. I will use naturalistic inquiry methods: I will conduct one-to-one interviews, audiotape each interview, transcribe the sessions and analyze the transcripts. I am hopeful that there will be a therapeutic component . . . to the telling and the retelling of their stories. I have a strong belief that we learn both by telling the "story" of our own experience as well as by engaging with others in the recounting of our experience. I am hopeful that my research will be read; I believe that narrative studies are eminently readable.

Terminology

There exists enormous lack of clarity with respect to the nomenclature used to depict "Mood Disorders". Many descriptors are used arbitrarily: Melancholy, Depression, Mania, Hypomania, Manic-Depression, Unipolar Affective Disorder, Bipolar Affective Disorder, Cyclothymic Disorder, Dysthymic Disorder, Anxiety Disorder (see Appendix A: Definitions - Mood Disorders). The medical, psychiatric and the psychological communities have compounded the confusion with conflicting theories about the causes, the identification and the treatment of the disorder. Practitioners and researchers have been unable to agree amongst themselves to a commonly accepted vocabulary to depict the

various components of the disorder. In the 1950's, the American Psychiatric Association (APA) developed a system to classify mental illness in its Diagnostic and Statistical Manual (DSM) (APA, 1952), a manual designed to guide medical practitioners, psychiatrists and psychologists in the diagnosis and treatment of mental illness. The manual is periodically reviewed and revised by the APA: DSM-II in 1968; DSM-III in 1980; DSM-III-R in 1987; DSM-IV in 1994 (Goodwin & Jamison, 1990; Keck, McElroy, Kmetz, & Sax, 1996; Suppes & Rush, 1996).

For the purposes of this study, I have accepted the distinction made in the DSM-IV (APA, 1994) between “Depressive Disorders” and “Bipolar Disorders”⁶ (both of which are described under the heading “Mood Disorders”) and Anxiety Disorders”. Because of the coexistence of Anxiety Disorders with Depressive Disorders (Boland & Keller, 1996; Klein & Wender, 1993), I have extended my examination of Mood Disorders to include Anxiety Disorders along with Depressive Disorders and Manic-Depressive Disorders. Throughout my dissertation, I will refer to the overriding condition as “Mood Disorders” and will periodically refer to the clarifying terminology as described in DSM-IV (APA, 1994) (see Appendix C: Mood Disorders; Appendix D: Anxiety Disorders).

In order to design a research method compatible with my dissertation topic, “an examination of the experience of living with Mood

⁶ Bipolar Disorders: In the most recent DSM-IV (1994), the American Psychiatric Association labels Manic-Depressive Disorders as “Bipolar Disorders”. In current medical, psychiatric and psychological literature, the illness is most frequently called “Manic-Depressive Disorder”. I have chosen to refer to the illness throughout my dissertation as “Manic-Depressive Disorder” or “Manic-Depression”.

Disorders”, I examined the history of the development of research methodologies used in human science research. As I investigated the literature, I pondered my own beliefs and engaged in the process of uncovering a research method that was both consistent with my own epistemology and appropriate for my topic. At times, I felt overwhelmed by the vocabulary and devised various schemata to help make sense of overlapping and confusing terminology (see Appendix B: Definitions - Human Science Research). After examining the literature, I concluded that the most effective research method, given the sensitive nature of the topic, was a narrative study of individuals with Mood Disorders.

Overview of the Research Study

During the preparatory phase of my research, I conducted a pilot study, very informally, with people within my sphere of influence. I discussed my topic, living with Mood Disorders, with academics, medical and psychological practitioners, and with friends, colleagues, students and family members. I was buoyed by the reaction of practitioners, many of whom volunteered to contribute to my study; several offered to assist me in finding research participants. I was encouraged by the enthusiasm of colleagues at both the university and the college. Many people confided that they knew a friend, a relative or a co-worker who struggled with the condition. But, I was struck by the reaction of many close friends and family members when I described my desire to examine the experience of living with Mood Disorders. Their initial reaction was hesitation, a distinct pause followed by a quizzical or apprehensive look. Several people

suggested that the topic was too “depressing” to contemplate.

I have gravitated to the literature about Mood Disorders for as long as I can remember. Increasingly throughout my adulthood, I have come to recognize many of the symptoms of Mood Disorders in family members, friends, colleagues and students. I believe that many of the inappropriate behaviors which I have observed may be attributed to the prevalence of undiagnosed, untreated and mistreated Mood Disorders. These inappropriate behaviors often result in wounded relationships and unresolved ill will amongst family members, friends, colleagues and students. Regardless of the circumstance, many such individuals attempt, with over-the-counter medication or with recreational drugs and alcohol, to self-medicate as a way of managing the symptoms of their condition.

I summarized my reasons⁷ for wanting to examine the experience of individuals living with Mood Disorders:

The primary purpose of my study is to develop a greater understanding of the experience of living with Mood Disorders. Secondly, I hope to provide my participants with a greater understanding of their condition and help them uncover a new level of meaning . . . about living with Mood Disorders. And, thirdly, I am hopeful that my readers might derive a greater understanding of the experience of living with Mood Disorders; some few might even find some resonance with their own experience.

I have organized my dissertation in the following manner. In Chapter 2, firstly, I examine the literature with respect to the history of Mood Disorders, in general, and the causes, diagnosis and treatment of

⁷ Concluding remarks extracted from my research proposal.

Depressive Disorders, Anxiety Disorders and Manic-Depressive Disorders, in particular. I include summaries of the autobiographical accounts by Kay Redfield Jamison and William Styron of their experiences living with Mood Disorders. Secondly, I examine the literature with respect to the field of human science research, in general, and narrative studies, in particular. In Chapter 3, I describe the methods which I use in my research study, “an examination of the experience of living with Mood Disorders”. In Chapter 4, I write summaries of the “narrative stories” of each of my five participants: Anne, Erica, Jeremy, Johnny and Katie. In Chapter 5, I present my findings by exploring the prevalent themes in five states, including my impression of the impact on the participants of contributing to my study. And finally, in Chapter 6, I present my conclusions, recommendations for further research and closing thoughts.

CHAPTER 2

Part I:

Review of the Literature - Mood DisordersAn Historical Perspective of Mood Disorders

Early in the seventeenth century, Robert Burton wrote a remarkably detailed account of Mood Disorders in his tome, Anatomy of Melancholy (1621, 1651). “Melancholia” was the term used by medical practitioners of the day to describe the symptoms of behavior currently referred to as Manic-Depressive Illness (Goodwin & Jamison, 1990). The word melancholy takes its roots from the Greek “melaina chole” meaning an excess of black bile; Greek physicians believed that the liver was the culprit in cases of melancholy (Thompson, 1994, p. 9). Anatomy of Melancholy is a literary work which stands, even today, as one of the most comprehensive accounts of the condition; the original manuscript was over 900 pages long. Burton was a cleric and a scholar who immersed himself in reading and writing at Oxford University; he spent most of his adult life immersed in books - he loved words and ideas. He first published Anatomy of Melancholy, his life’s work, in 1621 with reprintings in 1624, 1628, 1632, 1638 and 1651 (posthumously), each edition augmented with thoughtful and detailed annotations.

Burton himself experienced “an unconstant, unsettled mind” (1651, p.2) which he classified as “a disease of the soul” (p. 15), and he strenuously resisted the commonly held view of his day that melancholy was a sign of weakness. He acknowledged that he wrote his innermost thoughts to relieve his own melancholy as a refuge from morbid low

spirits. He recorded with startling candor his observations of the symptoms and described in meticulous detail the treatment and strategies to ease the physical and spiritual pain of melancholy. In the preface to the reader, included in the third printing, Burton explained his motivation:

I had a just cause to undertake this subject . . . that men might acknowledge their imperfections, and seek to reform what is amiss; yet I have a more serious intent at this time . . . to anatomize this humour of melancholy, through all its parts and species, as it is an habit, or an ordinary disease . . . to show the causes, symptoms, and several cures of it, that it may be the better avoided. (p. 73)

Burton (1651) concluded that melancholy had two fundamental causes, supernatural and natural. Supernatural causes included “as from God . . . or from the devil . . . or magicians and witches”; natural causes included “old age, temperament and “parents, it being a hereditary disease” (p.78). He offered a comprehensive list of additional causes of melancholy:

Offending diet . . . bread coarse and black . . . drink: thick, thin, sour, water unclean . . . flesh parts: head, feet, entrails, fat . . . exercise: unseasonable, excessive, or defective of the body or the mind . . . sleep: unseasonable, inordinate, overmuch, overlittle . . . passions and perturbations of the mind: sorrow, fear, shame, envy, hatred, anger, ambition, covetousness, love of pleasures, gaming in excess, love of learning, study in excess. (p. 79)

Many of Burton’s ideas have been hotly debated and his work has fallen in and out of favour over the past three and a half centuries, but close scrutiny of his thoughts in light of developments in the late twentieth century suggests that many of his theories have some merit.

In nineteenth century Europe, the German psychiatrist Emil Kraepelin simplified the myriad of mental disorder classifications into two predominant categories, Manic-Depressive Illness and “dementia praecox” which he later renamed Schizophrenia (Goodwin & Jamison, 1990, p. 4). In his most famous work Psychiatrie which he first published in 1886 and last revised in 1913, he consolidated the major affective disorders into the category which he named “Manic-Depressive Illness”. He grouped the disorders primarily because of the similarity of the symptoms, the family history of the condition and the common pattern of recurrence over a lifetime. Kraepelin saw mania as simply one manifestation of the illness, not as a separate diagnosis. He believed that the presence of depression (with or without mania) and the cyclicity of the disease were the fundamental characteristics of Manic-Depressive Illness. He included psychological and social factors in his clinical observations and was one of the first to acknowledge that “psychological stresses could precipitate individual episodes” (p. 60).

In the mid twentieth century, the American psychiatric community adopted the phenomenon of polarity, distinguishing between unipolar and bipolar Mood Disorders, based on the research of another German psychiatrist, Karl Leonhard. Leonhard studied the family histories of patients with Mood Disorders and concluded that genetics was a primary factor for those with Manic-Depression. Earlier in the century, American psychiatrists adopted Sigmund Freud’s theories of human behavior classifying mania and depression as Personality Disorders (O’Connor, 1997). Only since the 1960’s and the adoption of Leonhard’s

classification system have mania and depression been classified as Mood Disorders with biological underpinnings (Goodwin & Jamison, 1990). The DSM-III (1980) classified Manic-Depression as a Mood Disorder; revisions in DSM-III-R (1987) and DSM-IV (1994) increasingly distinguished amongst the many forms of the illness (Kocsis & Klein, 1995).

The Artistic Temperament and Mood Disorders

In her book, Touched with Fire: Manic-Depressive Illness and the Artistic Temperament, Kay Redfield Jamison presents an historical picture of the relationship between Mood Disorders and culture. Using the journals and archival records of writers, musicians and painters, she traces the incidence of Mood Disorders which she defines as “Manic-Depression” in the families of hundreds of artists. She contends that throughout history the artistic temperament, “that fine madness” (1993, p.2), has been an essential condition in the development of culture:

the nature of moods - their variety, their contrary and oppositional qualities, their flux, their extremes (causing, in some individuals, occasional episodes of “madness”) - and the importance of moods, in igniting thought, changing perceptions, creating chaos, forcing order upon that chaos, and enabling transformation (p. 5). . . . It is the interaction, tension and transition between changing mood states as well as the sustenance and discipline drawn from the periods of health that is critically important; and it is these same tensions and transitions that ultimately give power to the art that is born in this way. (p. 6)

She provides compelling evidence that Mood Disorders are predominately

genetic, and that the most critical issue in the management of the condition is the monitoring of appropriate and sustained treatment; she believes that the illness is ultimately manageable.

The Causes of Mood Disorders

Psychoanalytic theorists suggest that Mood Disorders develop as a result of conflict at the unconscious level of awareness, conflict that arises from the trauma of an illness, fright or other emotionally laden event during infancy or childhood. According to this theory, the symptoms that characterize Mood Disorders can be alleviated by identifying and resolving the unconscious conflict (Goodwin & Jamison, 1990). Learning theorists suggest that many of the symptoms of Mood Disorders are learned behaviors that can be unlearned by exercising cognitive behavioral strategies (Seligman, 1990, 1993). Recent studies indicate that biochemical imbalances are the cause of Mood Disorders. According to this theory, the symptoms of Mood Disorders can be alleviated by correcting these biochemical imbalances (Baldessarini, Tondo, Suppes, Faedda & Tohen, 1996; Jamison, 1995). Many scientists believe that thoughts and feelings result from complex electrochemical interactions in the central nervous system, and that biochemical changes can occur as a result of emotional, behavioral, or physical alterations (Damasio, 1994).

There is little doubt that each of these theories is true to some extent. Individuals who have inherited a biological, genetic susceptibility to the condition, and who experience traumatic events in childhood or adulthood may develop Mood Disorders.

The Diagnosis and Treatment of Mood Disorders

The distinction between depression, the healthy emotion, and Depression, the debilitating illness, remains unclear and openly debated in medical, psychiatric and psychological circles (Goodwin & Jamison, 1990; Klein & Wender, 1993; O'Connor, 1997). Moments of depression are a natural human response to many of life's negative experiences, and as a result Depression, the illness, is often undiagnosed or misdiagnosed. Similarly, moments of mania are a natural human response to many of life's positive experiences and as a result Mania, the illness, is often undiagnosed or misdiagnosed. Certainly, there are degrees of depression and mania which help practitioners differentiate between the two.

Over the last fifty years the American Psychiatric Association has developed and refined its Diagnostic and Statistical Manual (DSM), with revisions released every five to ten years, to provide practitioners with diagnostic criteria to improve the reliability of their diagnostic judgments (APA, 1952, 1968, 1980, 1987, 1994). The DSM attempts to quantify the qualitative differences between a healthy emotional response to the lows and highs of life, and an unhealthy emotional response. The most recent revision, DSM-IV (APA, 1994), describes the diagnostic criteria (see Appendix C: Mood Disorders) for "Mood Episodes" (Major Depressive Episode, Manic Episode, Mixed Episode, and Hypomanic Episode) as well as the criteria sets for each of the "Mood Disorders" (Depressive Disorders, Bipolar I and II Disorders, Mood Disorders Due to a Medical Condition, Substance-Induced Mood Disorder and Mood Disorder Not Otherwise Specified).

Jamison (1993) describes the most prevalent symptoms of a Depressive Episode:

apathy, lethargy, hopelessness, sleep disturbance (sleeping far too much or far too little), slowed physical movement, slowed thinking, impaired memory and concentration, and a loss of pleasure in normally pleasurable events . . . suicidal thinking, self-blame, inappropriate guilt, recurrent thoughts of death . . . and significant interference with the normal functioning of life. (p. 13)

Those who suffer from Depressive Disorder alone, or Unipolar Affective Disorder, may not experience Manic Episodes or even Hypomanic Episodes, but those who suffer from Manic-Depressive Disorder usually experience both Manic (or Hypomanic) and Depressive Episodes, hence the descriptor, Bipolar Affective Disorder.

Jamison (1993) describes the most prevalent symptoms of a Manic Episode:

mood is generally elevated and expansive (or, not infrequently, paranoid and irritable); activity and energy levels are greatly increased; the need for sleep is decreased; speech is often rapid, excitable, and intrusive; and thinking is fast, moving from topic to topic . . . an inflated self-esteem . . . spending excessive amounts of money, impulsive involvements in questionable endeavors, reckless driving, extreme impatience, intense and impulsive romantic or sexual liaisons, and volatility. (p. 13)

The most confounding aspect to the manic phase of the condition is the seductive nature of such an episode. Those who experience Mania often delight in the euphoric state and dismiss suggestions (internal or external)

that their Manic Episodes are extraordinary or that they warrant treatment.

Anxiety is a healthy human emotion which heightens alertness and readies the body for action in the face of danger. People prepare for upcoming events, spurred on by anxiety and fear. But, periodically, such feelings result in overwhelming, paralyzing symptoms that interfere with daily living. The symptoms of an Anxiety Disorder can be so severe that patients are almost totally disabled, unable to leave their homes, to enter elevators, to attend social functions or to shop for food.

The term "Anxiety Disorders", as described in the DSM-IV (APA, 1994) (see Appendix D: Anxiety Disorders), refers to a group of illnesses: Panic Disorder, Agoraphobia, Specific Phobias, Obsessive-Compulsive Disorder, Post-Traumatic Stress Disorder, Acute Stress Disorder, Generalized Anxiety Disorder and Substance-Induced Anxiety Disorder. The characteristic symptoms of Anxiety Disorders^a include:

unrealistic or excessive worry, unrealistic fears concerning objects or situations, exaggerated startle reactions, "flashbacks" of past trauma, sleep disturbances, ritualistic behaviors as a way of dealing with anxieties, shakiness, trembling, muscle aches, sweating, cold/clammy hands, dizziness, jitteriness, tension, fatigue, racing or pounding heart, dry mouth, numbness/tingling of hands, feet or other body part, upset stomach, diarrhea, lump in throat, high pulse and/or breathing rate.

^a Anxiety Disorders: The symptoms of Anxiety Disorders as described on the American Psychiatric Association's web site which was first posted in 1996. The document was prepared and distributed for educational purposes by the APA Joint Commission on Public Affairs and the Division of Public Affairs.

Individuals who suffer from Anxiety Disorders often worry, in an obsessive way, that something bad may happen to themselves or loved ones. They feel apprehensive about life and frequently become impatient, irritable and easily distracted.

Most medical practitioners rely on diagnostic interviews in the diagnosis of Mood Disorders. Some also rely on “symptom rating scales” which have been designed for the measurement of “symptom presence and severity” (Kutcher & Marton, 1996, p. 102). The most frequently used scales are the Beck Depression Inventory (1961) and the Hamilton Depression Rating Scale (1960) both of which are questionnaires completed by the patient and rated by the clinician according to the norming tables provided. Recently, a number of self-rating scales for all types of Mood Disorders have been developed but the medical community has tended to discredit such questionnaires as not clinically valid diagnostic instruments, preferring the diagnostic interview above all.

In their guide to the diagnosis and treatment of Mood Disorders, Understanding Depression, Doctors Donald Klein and Paul Wender declare their conclusions about the causes of Depression and Manic-Depression (1993):

The majority of cases of Depressive and Manic-Depressive Illness appear to be genetically transmitted and chemically produced. Stated differently, the disorders seems to be hereditary, and what is inherited is a tendency toward abnormal chemical functioning (sometimes called a “chemical imbalance”) in the brain. Antidepressant medications have a compensating effect, correcting the imbalances that are believed to cause Depressive and Manic-Depressive Illness. (p.87)

The incidence of Mood Disorders or, more precisely, the record of the incidence of Mood Disorders has risen steadily in the past century. Recent studies conducted by the National Institute for Mental Health, estimate that as many as one in four people in the general population will develop a major episode of Mood Disorder at some point during his or her lifetime (O'Connor, 1997). Unfortunately, not all will receive proper diagnosis nor appropriate treatment.

The diagnosis and treatment of people with Mood Disorders is an inexact science at best (Dowling, 1991; Gold, 1995; Goodwin & Jamison, 1990). Many individuals who experience mild to moderate symptoms of the disorder are either misdiagnosed or not diagnosed by medical practitioners, and they manage as best they can with little or no medical intervention; such individuals frequently self-medicate with recreational drugs and alcohol. Sadly, there exists enormous ignorance, stigma and fear in our culture with respect to the identification, diagnosis, treatment and disclosure of Mood Disorders, and as a result many individuals who could benefit greatly from the pharmacological therapy available in the 1990's, are not receiving the help they need to manage their condition. Compounding the problem is the fact that most people with symptoms of Mood Disorders are ashamed of their troubled state of mind and often mask their emotions in an attempt to hide their "unquiet mind" (Jamison, 1995) from friends and family (Gold, 1995; Miklowitz & Goldstein, 1997; O'Connor, 1997; Wolpert, 1999).

The North American culture fosters a deeply rooted stigma with respect to Mood Disorders (Goodwin & Jamison, 1990). As recently as the

1950's, those with a history of Mood Disorders were refused employment, institutionalized and subjected to crude treatments such as primitive electroconvulsive therapy or radical surgery to deaden or remove segments of the brain: desperate attempts to eradicate the condition. Perhaps as an enduring legacy of Freud, many Americans adopted the philosophy that all their problems were entirely the "fault of forces beyond their control" embracing "status found in victimhood" attributing Mood Disorders to "a bad upbringing, societal ills, or rotten genes" (Thompson, 1994, p. 9). The enormous stigma that envelopes those who experience Mood Disorders creates a sense of shame; if only they worked harder, exercised more, ate better food at regular intervals, had healthier sleep habits, they would feel well.

Family members often withhold information about the occurrence of Mood Disorders resulting in generations remaining ignorant of the incidence of the condition in their own families (Birmaher, Ryan & Williamson, 1996; Imber-Black, 1998; McGoldrick, 1995). When engulfed by an episode (mania, anxiety or depression), those who suffer the debilitating effects of Mood Disorders become all the more devastated by the misunderstanding and judgment of family, friends and colleagues; as a result they may detach themselves from loved ones and become isolated, immersed in their own worlds.

The shame of being diagnosed with a Mood Disorder remains a fundamental barrier to the normalization of individuals who receive the diagnosis. Ignorance and fear interfere with the disclosure, diagnosis and treatment of Mood Disorders and ultimately inhibit recovery from the

condition. Those who suffer from the illness experience such symptoms as confused thoughts, lack of concentration, temporary impairment of cognitive acuity and flat emotions resulting in a terrifying fear that they are losing their mind. With the passage of time, there is a steady erosion of self-esteem.

The distorted thoughts and distorting lens of an individual with Mood Disorders interfere with the identification of the symptoms, the diagnosis and the treatment (Klein & Wender, 1993; O'Connor, 1997; Suppes & Rush, 1996). The often reluctant patient may agree, initially, to follow a prescribed drug treatment, but as soon as the mood swings have stabilized, will discontinue the drug therapy. Unfortunately, many of the drugs have unpleasant side effects that contribute to the desire to cease taking the medication: dry mouth, loss of appetite, water retention, constipation, diarrhea, loss of sexual desire, nausea, light headedness, headaches, blurred vision, slurred speech - to name a few. All too frequently, not long after ceasing to take the medication, the patient will experience the recurrence of a major episode.

Since the 1960's, there has been an explosion in the pharmaceutical industry with respect to the research and development of drugs for use in the treatment of Mood Disorders (Dowling, 1991; Gold, 1995; Goodwin & Jamison, 1990; O'Connor, 1997). In the 1970's, the identification of the salt, lithium, as an effective medication in the treatment of mania provided immense relief for those with manic episodes, and countless anti-depressant medications introduced over the last thirty years provide relief from the debilitating symptoms of anxiety and depressive episodes. But

with the growth in the psychopharmacology industry, medical practitioners have had great difficulty remaining informed about the myriad of prescription drugs available (Baldessarini, Tondo, Suppes, Faedda & Tohen, 1996; Essom & Nemeroff, 1996).

Drug intervention requires close scrutiny. The chemistry of individuals varies greatly and the effect of medication must be measured frequently until a “chemically acceptable therapeutic range” (p. 212, Thompson, 1995) is reached. Regular blood tests must be conducted even after appropriate medication has been identified to monitor the chemical state of balance in the body: regular measurement of the chemical readings in the blood and serum must be undertaken to ensure that the chemical readings are maintained within a predetermined range. Such testing is prohibitively expensive. Furthermore, many medical practitioners, including some psychiatrists, have received little recent training, in general, about the diagnosis and treatment of Mood Disorders and, in particular, about the impact of new generation anti-depressant medication (Essom & Nemeroff, 1996; Viguera & Rothschild, 1996; Zarate & Tohen, 1996).

While mood stabilizing and antidepressant medications have a compensating effect on the chemical functioning of neurotransmitters in the brain, there is compelling evidence that patients who have been prescribed such medication require constant monitoring and that chemical intervention is not enough (Beck, 1987; Goodwin & Jamison, 1990; Klein & Wender, 1993). Research studies which examine the effectiveness of psychotherapeutic strategies in the treatment of Mood

Disorders, support the view that the combination of psychopharmaceutical therapy with cognitive and behavioral “talk” therapy is the most effective treatment strategy for individuals with Mood Disorders (Cormier & Cormier, 1991; Gold, 1995; Miklowitz & Goldstein, 1997; O’Connor, 1997; Schulman, Tohen & Kutcher, 1996; Seligman, 1990, 1993; Whybrow, 1997; Wolpert, 1999).

Unfortunately, a great deal of misinformation and disagreement still exists amongst medical practitioners, psychiatrists, psychologists, and others in the helping professions about the diagnosis and treatment of Mood Disorders. Since the 1950’s, the practice of administering electroconvulsive therapy in cases of suicidal depression or acute mania has remained fairly constant in the psychiatric community despite the negative exposure it received during the late 1960’s with the movie “One Flew over the Cuckoo’s Nest” (Goodwin & Jamison, 1990; O’Connor, 1997). The efficacy of electroconvulsive therapy in the treatment of Mood Disorders is hotly debated, today.

The American Psychiatric Association is constantly revising and refining its diagnostic manual, DSM, which offers guidelines for the diagnosis, the classification and the treatment of psychiatric disorders (APA, 1952, 1968, 1980, 1987, 1994). During the last decade, many practitioners in the field have linked Mood Disorders with anxiety and panic disorders, attention deficit disorder, post traumatic stress disorder and seasonal affective disorder (Gold, 1995; Klein & Wender, 1993; Kocsis & Klein, 1995). Furthermore, many believe that Mood Disorders may be the root cause of the addictions: eating disorders (anorexia nervosa and

bulimia nervosa), alcoholism, gambling abuse and narcotic abuse (Dowling, 1991; O'Connor, 1997). The APA in its DSM-IV (1994) separates Anxiety Disorders from the Mood Disorders of Depression and Mania (see Appendix C: Mood Disorders; Appendix D: Anxiety Disorders). The European system of classification does not differentiate between the disorders of depression, anxiety and mania but describes them as different behavioural manifestations of the same underlying condition under the rubric, Mood Disorder (Goodwin & Jamison, 1990).

The treatment strides made in the last twenty-five years have provided hope and relief for those with Mood Disorders (Goodwin & Jamison, 1990; Klein & Wender, 1993; Miklowitz & Goldstein, 1997; O'Connor, 1997; Schulman, Tohen & Kutcher, 1996; Seligman, 1990, 1993). It appears that the most effective treatment includes a two faceted approach; firstly, psychopharmaceutical intervention to correct the chemical imbalance and secondly, after chemical balance has been restored, psychotherapeutic (cognitive and behavioral) intervention to examine and adjust unhealthy, inappropriate behaviors. The combination of both psychopharmaceutic drugs and psychotherapeutic interventions became the preferred method of treatment during the 1990's and as a result many individuals with Mood Disorders are now able to function as able bodied, contributing members of society.

The Personal Accounts of Mood Disorders

Having spent much of my professional life working with students and colleagues who have suffered varying degrees and forms of Mood

Disorders, I have gravitated to research and scholarly writings about the condition. Since time immemorial artists have recorded the depth of their passions on their canvases, through their music and in their writing and have provided others with a comfortable haven to reflect on the patterns which resonate in their own experience (Jamison, 1995). Personal journal writing provides a form of expression which assists in the introspective process of examining the lived experience. Some write to better understand themselves; others read to better understand their own experience by examining, through the eyes of another, the human condition.

One of the courses in my doctoral program, a self-directed course in Mood Disorders, helped stimulate my research interest. I gathered the names of a number of authors who had written first person, autobiographical accounts of the experience of living with the disorder. I read reviews of the titles I had collected and narrowed my selection to the books written by Kay Redfield Jamison (1995), John Bentley Mays (1995), William Styron (1990), Tracy Thompson (1994) and Elizabeth Wurtzel (1994). I immersed myself in their writing. I was struck by the indomitable nature of the human spirit. I have chosen to include my summary of the two most compelling accounts, those of Jamison and Styron, because of the illustrative nature of their “stories”.

Kay Redfield Jamison

Kay Redfield Jamison, a psychologist who teaches psychiatry at Johns Hopkins University, has carved a niche for herself as an authority

on Mood Disorders. She is the author of Touched with Fire, the widely acclaimed account of the effect of Manic-Depression on numerous artists, musicians and writers, and the co-author (with Dr. Frederick Goodwin) of Manic-Depressive Illness a standard medical text about Manic-Depression. An Unquiet Mind is her own story: Jamison recounts her thirty year encounter with Manic-Depression, beginning with her ten year struggle as a young adult trying to grapple on her own with mood fluctuations which were both exhilarating and terrifying in their intensity and frequency.

Jamison felt both seduced and shamed by her mood swings. The seductive nature of the manic phase - the pervasive optimism, the creative energy, the consuming enthusiasm, the mental acuity, the focused productivity, the unbridled joy, the emotional exhilaration, the love of life - followed by the shameful nature of the depressive phase - the heavy dread, the black moods, the unfocused thoughts, the terrifying images, the unsettling nightmares, the flat emotions, the fear of waking, the fear of sleeping, the longing for death - held her hostage to the illness for ten long years. The seduction and shame prevented Jamison from recognizing her symptoms as Manic-Depressive Illness in spite of her emerging knowledge of Mood Disorders. As a graduate student at UCLA, Jamison studied clinical psychology with a specialty in psychopathology. She acknowledged her periodic "black moods" and even rated the degree of her mood swings; she devised a scale of subjective ratings ranging from -3 which she described as "paralytic and utterly despairing" to +3, "magnificent mood and vitality" (p. 54). Throughout this period of her life, she failed to recognize her symptoms as the telltale signs of one of the

very illnesses she was studying.

In the summer of 1974 as Jamison began her first teaching appointment in the faculty of psychiatry at UCLA, her mood swings manifested themselves in the first of several psychotic episodes she was to endure over the next eighteen months. During her first episode, Jamison had remarkable presence of mind to seek the professional services of a colleague in psychiatry in whom she had trust and confidence. He conducted a thorough psychiatric examination and made the diagnosis, Manic-Depressive Illness; he prescribed lithium and weekly psychotherapy sessions. She accepted the diagnosis but not the prescription; she railed against the prospect of taking pills for anything but a very short period of time. She was convinced that she only needed medication while she was in a psychotic state and that she would not require pills once she was better. The “war had just begun” (p. 105): the internal war she raged within herself, and the external war she waged with her psychiatrist. She described, in graphic detail, the symptoms of a patient with Manic-Depressive Illness who has descended into a psychotic state: she used vague memories of her own experience augmented by entries from her psychiatrist’s case file and her observations of patients she subsequently treated. She vacillated between acceptance and rejection of the drug therapy, and the consequences of failing to remain on the lithium had potentially tragic results. Fortunately for Jamison, after 18 months of seeing through a series of manic and depressive episodes culminating in a failed suicide attempt, she finally accepted her doctor’s advice that she remain on the prescribed medication. Drug therapy was the essential

ingredient in the stabilization of her mood swings.

Jamison's own experience with Mood Disorders fueled her desire to help others who suffered from the condition. With financial support from the hospital at UCLA, she founded the UCLA Affective Disorders Clinic which served as both an outpatient clinic in the diagnosis and treatment of Depressive (unipolar) and Manic-Depressive (bipolar) Illness, as well as a teaching and research facility. The clinic staff treated patients with Mood Disorders and conducted medical, psychiatric and psychological research studies; residents in both psychiatric medicine and clinical psychology completed rotations at the clinic.

In the 1970's Jamison told few colleagues about her own condition; she lived in fear that powerful, narrow-minded colleagues would dismiss her as an academic should her illness be revealed. She was terrified that her illness might impinge on her ability to obtain her license with the American Psychological Association or to secure tenure at the university; she was overjoyed when she was granted tenure. She established an enduring reputation in the field of psychopathology, obtaining research grants, conducting comprehensive studies, developing a successful practice and fulfilling her demanding teaching responsibilities. Her secret was well guarded, and those few colleagues who were aware of her illness did not betray her nor stand in the way of her professional aspirations.

In the mid 1980's, Jamison moved to the east coast of the United States and obtained a teaching position at Johns Hopkins University, as the only psychologist in the faculty of psychiatry in the school of medicine. Again, her reservations about disclosing her illness presented a potential

barrier to her obtaining approval to practice. But her department chair at Johns Hopkins accepted her illness as a matter of course. She took all the necessary steps to ensure that, should she slip into a Manic or Depressive Episode, colleagues were granted the authority to approach her psychiatrist or intervene with clients if her behaviour appeared to affect her work adversely.

William Styron

William Styron, the American author who is perhaps best known for his novels Lie Down in Darkness and Sophie's Choice, has written an intensely personal account of his own struggle to accept and accommodate the Major Depressive Episode which began to overtake his life in the fall of 1985. Darkness Visible had its genesis as a lecture about Affective Disorders which Styron gave at a symposium sponsored by the Department of Psychiatry of The Johns Hopkins University of Medicine in the spring of 1989. He was encouraged to write, in expanded form, his account of the experience of depression as it unfolded: hence, Darkness Visible - A Memoir of Madness, which he published in 1990.

In the fall of 1985, Styron and his wife, Rose, traveled to Paris where he was being presented with a prestigious literary award, the Prix Mondial Cino del Luca. He had been experiencing increasingly troubling bouts of depression during the summer of 1985. But it was not until he and Rose were sitting in a Paris hotel room awaiting the presentation of his award that they came to realize that his escalating sense of foreboding was more profound than any sadness he had previously experienced. He knew that

he required professional help. They made arrangements to return to America, immediately following the award ceremony, foregoing their planned European holiday.

The richness of Styron's language helps depict the profound emotional, physical and spiritual manifestations of his condition. During this Depressive Episode, which was six months in duration, his "unfocused stirrings" of gloom which prevailed early in the summer, "descended far past those familiar, manageable doldrums" in the fall, to the "near-violent denouement" (pp. 7-8) in December. Throughout his life Styron had established a reputation amongst friends and family members as a lay expert on medicine. However, by his own admission, he was both fearful and woefully ignorant of psychiatric medicine. His reluctance to recognize and to publicly acknowledge his condition and his pride in his remarkable knowledge of medical facts prevented him from seeking professional help until it was almost too late.

Two years before this Major Depressive Episode, Styron's family doctor had prescribed Ativan, a mild sleeping pill, telling him that he could take as many as he needed and as casually as aspirin. As the symptoms of depression crept upon him in the summer of 1985, Styron asked his doctor to prescribe a stronger medication to help him sleep. He believed that the disruptive sleep patterns were contributing to his encroaching sense of dread. He was given a commonly prescribed drug, Halcion, a member of the benzodiazepine family of tranquilizers which has since been implicated by the American Medical Association as a "causative factor in producing suicidal obsession and other aberrations of thought in

susceptible individuals” (p. 71). Unwittingly over the course of that summer, Styron often increased his dosage of Halcion believing it to be a safe sleeping medication.

His struggle with a Mood Disorder culminated in the very systematic, almost robotic manner in which he settled all his personal, financial and professional affairs upon returning from France; he was preparing for his suicide. At the last moment, he “drew upon some last gleam of sanity” and alerted his sleeping wife to “the mortal predicament” (p. 67) in which he was immersed. Styron was admitted to hospital in December of 1995 where, finally, he found a way to manage his depressive condition. Hospital provided him the seclusion, the supervision and the time to heal. Only after his medication was adjusted, monitored and adjusted again, did his terrifying ordeal with oppressive despair come to an end.

The Management of Mood Disorders

Styron declared in Darkness Visible that Mood Disorders are “conquerable” (p. 84). Jamison, Mays, Styron, Thompson and Wurtzel all experienced varying degrees of denial, fear and anger after they were diagnosed with the condition, but they developed increasing understanding and acceptance as they found their own respective strategies of living with the disorder. The disease manifested itself in unique ways at different stages in their lives. All encountered problems with alcohol and “street” drugs and finally determined that alcohol and drugs exacerbated the unbalanced chemistry in their bodies. Following

years of trial and error experimentation with lithium, antidepressants or some combination of the two, they all reached chemical and emotional equilibrium. They succeeded in managing their condition; after reaching equilibrium with the appropriate drug intervention, they all engaged in long term psychotherapy. Eventually each one of them grew to recognize the symptoms of impending episodes and developed strategies to manage the condition before becoming engulfed.

Recently, Jamison's research has led her into the arena of genetics: she believes that, in most cases, Mood Disorders are caused by a genetic predisposition. She acknowledges that other factors are also implicated - biochemical causes as a result of the abuse of drugs or alcohol, environmental causes as a result of prolonged or significant exposure to light or the absence of light, extreme sleep deprivation and childbirth. She believes that Mood Disorders are primarily biologically induced by a chemical imbalance affecting the function of neurotransmitters in the brain, and that some individuals have a predisposition to this chemical imbalance. Her research (Jamison, 1993) has focused on an examination of the lives of numerous artists, musicians and writers, the family histories of countless patients, as well as her own family history: all of which has reinforced her belief that there is a genetic underpinning in the case of most individuals with Mood Disorders.

The most pervasive impression one is left with having read the personal accounts of those living with Mood Disorders is one of hope. Certainly, the erratic course of the illness coupled with the frequency of recurrence create a frustrating challenge for those who have the

condition. However, armed with appropriate effective medication and awareness of the telltale symptoms of an encroaching episode, people with Mood Disorders can learn to manage the chemical imbalance under the guidance of skilled professionals and prevent the mood swings from overpowering their lives.

Part II:

Review of the Literature - Methodology

An Historical Perspective of Human Science Research

Throughout the nineteenth century, academics increasingly, if reluctantly, began to acknowledge that (in addition to education, history and political science) sociology, anthropology and psychology were legitimate fields of study in the social sciences. Traditionally, social science scholars had adopted the long-established research paradigm of the natural sciences, positivism, with its emphasis on the collection of objective data using the scientific method (Borg & Gall, 1989; Denzin & Lincoln, 1994; Kvale, 1996; Tesch, 1990). Borg & Gall (1989) define positivism as a “system of philosophy that excludes everything from its consideration except natural phenomena and their relationships” (p. 17). Quantitative and qualitative research methods are fundamentally different from one another on the basis of the data: quantitative data are objective (numerical) and concerned with quantity, and qualitative data are subjective (non numerical) and concerned with quality or meaning (Tesch, 1990). However, many social scientists struggled with the old paradigm and attempted to uncover different research approaches: approaches which would acknowledge the uniqueness of the individual and the existence of consciousness in the study of human behavior (Polkinghorne, 1988).

Throughout the twentieth century, tension developed between the two camps amongst scholars in the social sciences. While anthropology which is a predominately descriptive science avoided, for the most part,

the qualitative-quantitative debate, by mid century the disciplines of education, psychology and sociology became embroiled in the tension. Egon Guba and Yvonna Lincoln (1994) describe their view of the competing paradigms which prevail in academic research. They define quantitative and qualitative as the “type of method of inquiry” (p. 105) and suggest that there are four paradigms prevalent in quantitative and qualitative methodology: positivism, post positivism, critical theory and related ideological positions and constructivism” (p. 105). They describe paradigm as “the basic belief system or world view that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways” (p. 105). They trace the emergence of quantitative (positivist and later post positivist) methodology as the predominant method of inquiry, the “received view of science”, in academic research. Positivism,

focuses on efforts to verify (positivism) or falsify (post positivism) a priori hypotheses, most usefully stated as mathematical (quantitative) propositions or propositions that can be easily converted into precise mathematical formulas expressing functional relationships. Formulaic precision has enormous utility when the aim of science is the prediction and control of natural phenomena (p. 106).

Formulaic precision is essential in the “hard” sciences: mathematics, physics and chemistry. The “soft” sciences, biology and the social sciences, all sciences which are less quantifiable, struggle to legitimize research in their fields: the data are by nature imprecise. Guba and Lincoln hold that

“there exists a widespread view that only quantitative data are ultimately valid or of high quality” (p. 106). They methodically question the applicability of quantitative research methods in social science research and declare their own commitment to “constructivism”, a paradigm they had earlier (1985) defined as “naturalistic inquiry”.

North American universities during the late 1800’s and well into the 1900’s were guided by “technical rationality” as the “prevailing epistemology” (Schon, 1995, p. 30). Research studies which did not adhere strictly to the framework of the scientific method were viewed with suspicion and derision. However, by the late 1900’s, there appeared to be growing acceptance of the new epistemology. Many social scientists today argue that the positivist approach is too theory-laden, too narrow and too limiting to be effective as a research methodology in the study of human behavior, and that research conducted in a positivist or post positivist manner does not acknowledge the researcher’s own values, interpretations, and feelings in the process of inquiry (Tesch, 1990). In his book InterViews: An Introduction to Qualitative Research Interviewing, Steinar Kvale (1996) acknowledges that in social science research, there has been a gradual move from the emphasis on the “observation of the social world” to the “conversation and interaction with the social world” (p. 289). But, old habits linger, and the post modern shift from knowledge as an objective reality to knowledge as a social construct has been threatening and frightening to those who remain entrenched in old research methodologies.

Norman Denzin and Yvonna Lincoln (1994) introduce their

Handbook of Qualitative Research with an historical overview of the development of qualitative research methodology during the twentieth century. They describe in detail five overlapping periods from 1900 to the present: the “traditional” period from the early 1900’s to 1950, the “modernist” or the “golden age of rigorous qualitative analysis” period from 1950 to 1970, the “blurred genres” period from 1970 to 1986, the “crisis of representation” period during the late 1980’s, and finally, the present period from 1990 onwards (p. 8). They describe the current period in the evolution of qualitative research as one characterized by “a new sensibility that doubts all previous paradigms” (p. 2). They conclude that

multiple histories and theoretical frameworks . . . now circulate in this field. Today, positivism and post positivism are challenged and supplemented by constructivist, critical theory, feminist, ethnic and cultural studies paradigms and perspectives. . . . We now understand that we study the other to learn about ourselves (Denzin & Lincoln, 1994, p. 561).

The authors define the research process in five phases: the researcher, the theoretical paradigm(s), research strategies, method of collection and analysis and the art of interpretation and presentation. They acknowledge that the interactive component is evident in all five phases. They identify five points of difference between quantitative and qualitative research methods, philosophies and forms of representation: i) the uses of positivism, ii) the acceptance of post modern sensibilities, iii) the emphasis on the individual’s point of view, iv) the examination of the constraints of life, and v) the use of rich descriptions (p. 5-6). Denzin and Lincoln contend

that “there have never been so many paradigms, strategies of inquiry, or methods of analysis to draw upon and utilize” (p. 11).

The distinction between the two methodologies in social science research continues to be debated and refined: during the last decade the two approaches have appeared to co-exist in relative peace (Denzin & Lincoln, 1994; Guba & Lincoln, 1994; Ochberg, 1996). Throughout the literature there exists a myriad of labels used to describe the two research paradigms: “positivist versus post positivist, scientific versus artistic, confirmative versus discovery-oriented, quantitative versus interpretive and quantitative versus qualitative” (Borg & Gall, 1989, p.23). I will use “interpretive inquiry” to represent my research epistemology, in place of what is frequently referred to as “qualitative research”.

Interpretive Inquiry

The goal of interpretive inquiry is to understand “the complex world of lived experience from the point of view of those who live it” according to Thomas Schwandt (1994, p. 118). In order to understand “the world of meaning one must interpret . . . the process of meaning construction and clarify what and how meanings are embodied in the language and actions” of those being studied. The interpretivist researchers are principally concerned with “matters of knowing and being”, and “the aim of attending carefully to the details, complexity and situated meanings of the everyday life world” can be achieved by employing a variety of methods in the course of their studies: they must “watch, listen, ask, record and examine”. Schwandt makes a distinction between the goal of

research in the natural sciences, “scientific explanation”, and the goal of research in the human sciences, “understanding the meaning of social phenomena” (p. 119). Schwandt believes interpretive inquiry is a “unique form of human inquiry” with a “profound respect for and interest in socially constructed meaning and practice” based on “a set of theoretical commitments and philosophical assumptions about the way the world must be in order that we can know it” (p. 132).

Lous Heshusius believes that, in the past, the attempts of many educational researchers to remove themselves from their methodology and from their findings are both unrealistic and unethical, and their actions have limited the potential impact of their research studies. She maintains that the attempt to control, manage, eliminate and restrain any connection between Self and Other in the early qualitative research studies has been detrimental to our “knowing” the world in which we live (Heshusius, 1994). She contends that researchers must concentrate on developing and fostering a participatory mode of consciousness as the essential, first step in the inquiry process. She asserts that the researcher as Self must reach an “awareness of a deeper level of kinship between the knower and the known” (p. 16). The researcher must enter into the process of inquiry with an “attitude of profound openness and receptivity”, and “temporarily let go of all preoccupation with self and move into a state of complete attention” (p. 17). Heshusius suggests that the Self must merge with those being studied, by losing oneself in a “self-forgetful” way: she believes that by merging one “can come to know even from silence” the lived experience of the Other. She argues that “participatory

consciousness”, defined as “the recognition of kinship and therefore of ethics”, was prevalent in research accounts conducted several hundred years ago but was set aside by modern researchers for “ideological, political, scientific, and technological reasons” (p. 18).

Heshusius (1994) describes her experience of “participatory consciousness” (p.16), a phenomenon which developed as she immersed herself in a year long study of retarded subjects in a group home: she discovered that once she was able to let go of her initial need to manage or direct her subjects, she was able to be fully “attentive” with them.

I was moving into a state of merging, a mode of consciousness which I think resembled what I have referred to as participatory consciousness. I had to completely and non evaluatively observe my personal reactions and in that attentiveness, dissolve (rather than manage or restrain) them, which opened up a mode of access that was not there before. (p. 19)

She concludes that researchers cannot both control their participants and fully attend to them at the same time. Her own experience is a compelling reminder that as a researcher I must be mindful at all time of the potential impact of my person on those with whom I am engaged in research.

Peter Reason (1994) advocates that human science researchers adopt one of three research approaches, each with a participatory focus: 1) cooperative inquiry, 2) participatory action research, and 3) action inquiry. He presents compelling arguments that participatory research is “more holistic, pluralist, and egalitarian” (p. 324). He describes the distinct characteristics of each of the three methodologies and compares

their strengths, weaknesses and applications. All three approaches support the view that “people can learn to be self-reflexive about their world and their action within it” (p. 334). He concludes that cooperative inquiry would be most successful with a relatively empowered group, participatory action research with a relatively disempowered community, and action research with individuals who may not feel comfortable participating in a group.

Narrative Study

All social science research is fundamentally based on the study of experience, and scholars engaged in interpretive research believe that the relationship between the researcher and the participant must be both acknowledged and respected in the process of inquiry, regardless of the methodology (Clandinin & Connelly, 1994; Denzin & Lincoln, 1994; Guba & Lincoln, 1994; Fine, 1994; Heshusius, 1994; Josselson, 1996; Lincoln & Denzin, 1994; Ochberg, 1996; Reason, 1994; Schon, 1995; Schwandt, 1994). Experience, recorded in the shape of the narrative, is the most meaningful frame of reference for social science research; “meaning is contained in texts” (Clandinin & Connelly, 1994, p. 414). Narrative inquiry, researching the “stories people live”, is described as complex and “messy” and those engaged in experiential research are cautioned to be tolerant of the complexity and messiness (p. 417).

Jean Clandinin and Michael Connelly present a detailed description of the various research methods currently employed in personal experience research: a rich summary of the various means of collecting

data from the field using oral histories, annals (schematic lifelines depicting momentous events and people) and chronicles (descriptions of the people and events on the annals), memory boxes, family stories, research interviews, journals, letters, conversations, field notes and autobiographical writing. They believe that “it is important for those who study personal experience to be open to a rich and sometimes seemingly endless range of possible events and stories” (1994, p. 417). They highlight the ethical considerations of conducting narrative studies; researchers must pay “the closest attention to the aftermath of the research” when they ask their participants to share their personal stories (p. 422).

In the preface of his seminal book, Narrative Knowing and the Human Sciences, Donald Polkinghorne (1988) explains the reasons for his commitment to qualitative research in general and to narrative studies in particular. Over the course of his career as an academic researcher and as a clinical psychotherapist, he became disenchanted with quantitative studies of human behavior. He describes his own feelings of “discontinuity” with respect to “integrating research and practice” (p. ix); the findings of academic research were not very helpful to him in his work as a clinician. He believes that the “traditional research model, adopted from the natural sciences is limited when applied to the study of human beings” and sought a new paradigm that was “sensitive to the unique characteristics of human existence” (p. x).

Polkinghorne acknowledges that practitioners had developed remarkably successful strategies of working with their clients using

“narrative explanations” as a means of deriving meaning from their clients’ experiences. During the 1980’s, he began to promote the use of narrative studies in human science research by building on the practitioners’ model. He argued that Piaget’s theories of cognitive development arose from his years of clinical practice and the countless narratives he uncovered with each of his patients. Polkinghorne contends that qualitative methodology is particularly useful for 1) “the generation of categories for understanding human phenomena” and for 2) “the investigation of the interpretation and meaning that people give to events they experience” (1991, p. 112). He recognizes the narrative as both a “product” as well as a “process” and promotes narrative research studies as “significant for creating and organizing our experience” into the “realm of meaning” (p. 182).

Vittorio Guidano, a constructivist psychotherapist, believes that when practitioners observe the experience of their clients as “an objective external order that exists independently from people’s observations of it”, they (the practitioners) “overlook their own characteristics and processes as observers” (1995, p. 93). He argues that the most effective framework for investigating human experience consists of two basic assumptions: one, an “evolutionary epistemological perspective”, based on the “continuing study of evolving knowledge and knowing systems”, and two, the belief that the “ordering of our world is inseparable from our experiencing of it”. Guidano holds that “knowledge should be considered from an ontological and epistemological perspective in which knowing, consciousness, and all other aspects of human experience are seen from the point of view of the

experiencing subject” (p. 94).

Lisa Hoshmand argues that the “traditional, reductionistic, quantity-oriented approaches are often discordant with the practice of counselling” (Goldman, 1989, p. 81) and proposes “conceptual and methodological expansions in counselling research” (Hoshmand, 1989, p. 61) which recognize the complex, intangible and interactive nature of human science research.

Janet Helms, expanding on Hoshmand’s theories, raises some questions with respect to obtaining the cooperation of potential research participants in the field of cultural studies. Many cultural researchers experience “personal and interpersonal dilemmas” (p. 98) as they collect their data. These methodological dilemmas include:

- (a) how to best establish rapport with their potential samples so that they would be willing to self-disclose to strangers about extremely personal problems, (b) how to overcome cultural barriers against discussing certain matters with female persons, and (c) how to resolve their own practitioner-researcher conflict when asking participants to relive often extremely painful life experiences. (p. 99)

Helms’ observations can be attributed beyond cultural psychology to counselling psychology and to psychology in general. She agrees with Hoshmand that the “positivist research tradition of reductive experimentation” (Hoshmand, 1989, p. 3) fails to provide an adequate or appropriate framework by which the researcher can conduct human science studies. Hoshmand proposes an alternative paradigm which

would:

(a) allow one to account for the reciprocal influences of the researcher and research participants, (b) permit the methodology to shift according to the particular context in which the data were collected even within the same study, (c) value the use of small samples, and (d) encourage usage of nonstandardized measures. (Helms, 1989, p. 99)

Hoshmand promotes alternative research paradigms (alternative to the positivistic tradition of reductive experimentation) which she argues have greater relevance to counselling practice and the therapeutic process.

Clandinin and Connelly, contend that the author's own voice must be acknowledged and evident in the research account; the "veil of silence" must be removed in narrative research to give the researcher the power of her own voice (1994, p. 424). Michelle Fine argues that qualitative researchers must insert themselves, consciously, in their research acknowledging the relationship between and among the "Self" (the researcher) and the "Other" (the one being researched). She believes that in the past, qualitative researchers reproduced a "colonizing discourse of the 'Other' " (1994, p. 70): she is particularly critical of social scientists who early in the twentieth century studied other cultures from a dominant position (the oppressor), assuming the role of the all-knowing expert, observing and analyzing those in a subservient position (the oppressed).

Fine encourages researchers to question universally-held truths, to engage in dialogue at a fundamental level with their informants, "to work

the hyphen” (1994, p. 71): to create “occasions for researchers and informants to discuss what is, and is not, ‘happening between’ ” them in the process (p. 72). She defines the hyphen of “Self-Other” as that which “both separates and merges personal identities with our inventions of Others” (p. 70). She believes that social scientists in the past have failed to recognize a fundamental flaw in their approach: the presence of the researcher may have had an impact on the behavior of the individuals being studied. She challenges contemporary scholars to examine their practices, to acknowledge the possibility of their presence having an effect on their studies; she asks researchers to reveal their own faces and voices in the research process. Fine describes a number of prominent studies which exemplify the phenomenon of colonizing/oppressing the Other in feminist, critical and Third World research. She raises a number of questions about the methods, the ethics and the epistemologies in these studies. Researchers were constantly “othering”; in their findings, in their writing, in their portrayal of the individuals they were studying; researchers spoke for them, as if the Other was unable or unwilling to speak for herself/himself. The Self often remained faceless and voiceless, an invisible “authority”, a neutral, dispassionate observer/recorder of the life of the Other. She questions how reliable and valid were their findings.

Richard Ochberg explores the interpretive process involved in the narrative study of people’s lives. He advocates that the researcher be cautious, even suspicious, of accepting the details of a participant’s life as “not merely descriptions but efforts at persuasion” (1996, p. 97). Often, a “latent subtext” lies behind the details presented and the author believes

that it is the researcher's challenge and responsibility to uncover that subtext. He makes use of a remarkably graphic illustration, drawn from a research study of middle-aged businessmen, of an aggressive, self-destructive man who brought about his own bankruptcy, a bankruptcy which he could have readily avoided. He uncovered the man's feelings of inadequacy and rage towards an overly critical, abusive father as he interpreted the patterns of behavior which revealed themselves in the vignettes of the man's life story. The researcher attempted to make sense of the events of the life story, not merely by describing the events themselves, but by interpreting the repeating patterns of experience. While Ochberg acknowledges that experiences in adulthood may reflect formative experiences in childhood, he cautions that researchers must remain cognizant of the fact that all accounts, including accounts of childhood, are infused with the narrator's own interpretation.

Ruthellen Josselson describes her feeling of discomfort when she embarks on narrative research: a feeling which she refers to as "the dread, guilt and shame that go with writing about others" (1994, p. 69). She writes, "No matter how gentle and sensitive our touch, we entangle ourselves in others' intricately woven narcissistic tapestries" (p.70). She fears that the act of writing down the stories of others is something of "a violation" since the written word can never convey the complexity of the "whole person" (p. 62). She contends that

the renarrating we do when we write about someone is a form of psychotherapy, cloaked not in the authority of the therapist-patient relationship but in the authority of the written word. To renarrate a

life unasked, therefore, robs the Other of a piece of his or her freedom no matter how exhilarating an experience it might be. (p. 67)

Josselson identifies a number of ethical issues which she believes all researchers must consider when engaged in the narrative study of lives. She describes narrative research as “an ethically complex undertaking” but one which “we must do in anguish” (p. 70). She posits that by maintaining a cautious eye on the fact that narrative research has its limitations, the researcher will safeguard against intruding in a disrespectful way in the lives of others.

Laurel Richardson believes that the act of writing is an integral component in narrative inquiry; writing is part of the learning process, the process of attaining knowledge, of “knowing” (1994, p. 516). She asserts that we must put ourselves in our writing - the very antithesis of the prescribed strategies in quantitative, positivist research. She asks, “How do we create texts that are vital?” (p. 517) which will attract and hold the reader. She argues that qualitative research studies must be read; however, unless researchers concentrate their energies on writing in such a manner as to hold their readers, much of their work will go unnoticed and unread.

Richardson contends that in the post modernist climate of social science research, all methodology is suspect or called into question. Post modernists acknowledge the “situational limitations of the knower” but respect subjective perceptions of the world as perceived by the writer. Furthermore, the post structural way of thinking links subjectivity, social organization, power and language. The process of writing and rewriting is

critical to the clarification and honing of the research itself. She maintains that language is the central feature of the process: language not only reflects social reality but also produces meaning and creates social reality. Language allows us to understand ourselves reflexively and liberates qualitative writers to “nurture their own voices” (1994, p. 518).

Clandinin and Connelly conclude that in the “construction of the narratives of experience, there is a reflexive relationship between living a life story, telling a life story, retelling a life story and reliving a life story” (1994, p. 418). They continue:

we live out stories in our experiences, tell stories of those experiences, and modify them through retelling and reliving them. The research participants with whom we engage also live, tell, relive and retell. . . . All inquiry may, therefore, be seen as interactions of experiences of participants in a field and researchers’ experiences as they come to that field. . . . We try to gain experience of our experiences through constructing narratives of that experience. (p. 418)

They believe that human science researchers who engage in personal experience research create for themselves and by extension their participants, the opportunity to “enter into and participate with the social world in ways that allow the possibility of transformations and growth” (p. 425).

Interviewing Strategies

In his book, InterViews: An Introduction to Qualitative Research Interviewing, Steinar Kvale (1996) describes the interview as an essential

tool for qualitative researchers. He outlines his framework for the interview process in seven distinct stages: 1) formulating the purpose and thesis, 2) designing the method, 3) conducting the interviews, 4) transcribing the interviews, 5) analyzing the interviews, 6) verifying the findings, 7) reporting the findings (Kvale, 1996). He challenges the researcher to continually question the ethics of eliciting information from others for the purpose of research, and he underscores the importance of the researcher's own social conscience throughout the interview process.

Robert Weiss (1994), in his book Learning from Strangers, defines qualitative interviewing commonly used in sociological and psychological research, as "an effort to elicit from respondents detailed, dense, and coherent reports of external or internal experiences from which descriptions, inferences, and conclusions can be drawn" (p. 210). Weiss defines quantitative interviewing, frequently used in political polls, as an effort "to report how many people are in particular categories or what the relationship is between being in one category and another" (p. 2). He argues that while the quantitative interview method allows for the collection of information which can be converted to tables and statistical measures from a large sample, it is a very limiting methodology. He recognizes that qualitative interviewing may focus on fewer samples and be more labour intensive than quantitative interviewing, but his experience has taught him that the qualitative methodology provides a far more detailed, in-depth summary of responses.

David Karp, a professor of sociology at Boston College, was diagnosed with depression in early adulthood. Over the years he unearthed a great

deal of scholarly research about Mood Disorders, most of which had a medical perspective. But, he was struck by the dearth of information about the lived experience. Almost twenty years after his own diagnosis, Karp designed a research study to examine the experience of those with Depressive Disorder, a study which he describes in his book, Speaking of Sadness. He interviewed 50 subjects with Depressive Disorder and 10 people who were closely associated with an individual with the Mood Disorder. His goal was to collect information about the impact of the illness “from the subjective point of view of the person undergoing it” (1996, p.11). He wanted to describe the common symptoms experienced by those who live with the Mood Disorder in order to help his audience, both those with depression as well as those who live with an individual with depression, develop a greater understanding of the condition.

Karp discovered that the experience of conducting his interviews gave him profound new insights into his own condition. He derived enormous benefit from conducting research in an area that had so much meaning in his own life. He describes with great passion his ambivalence, an ambivalence which is confirmed in his findings, about the medication which is prescribed to stabilize mood swings. But, Karp’s study did not take into account the face and voice of the researcher. His methodology does not acknowledge the hyphen between Self and Other (Fine, 1994) and as a result his account lacks depth. He has interviewed those with a Mood Disorder and recorded their responses, but he has not engaged in the reflective process with his respondents about the lived experience of Mood Disorders.

Andrea Fontana and James Frey (1994) present a comprehensive history of interviewing techniques used in social science research. Interviewing takes many forms: face-to-face one-to-one verbal exchanges, face-to-face group exchanges, mailed or self-administered questionnaires and telephone surveys, structured or unstructured (p. 361).

They define structured interviewing as the process in which the interviewer “asks each respondent a series of preestablished questions with a limited set of response categories” (p. 363). They present the basic elements of structured interviewing: the responses are recorded according to a coding scheme, the interview is conducted following a prescribed script and the interviewer remains neutral and impersonal.

They define unstructured interviewing which is variously referred to as open-ended, in-depth and ethnographic interviewing as a process used to “understand the complex behavior of members of society without imposing any a priori categorization that may limit the field of inquiry” (p. 366). They present the basic elements of unstructured interviewing: the setting is accessed, the language and the culture of the respondents is understood and the researcher establishes trust and rapport with the respondents prior to conducting the interview.

Fontana and Frey (1994) conclude that with respect to the practice of interviewing individuals about personal and sensitive issues, in order to ensure that the research question will be answered fully, the interview must be conducted person-to-person in an unstructured fashion (p.374). Their position is reinforced by Borg and Gall (1989) who conclude that the “semi-structured interview technique is the most appropriate . . . for

interview studies in education” (p. 452).

Narrative Study of Mood Disorders

As I engaged in the critical analysis of interpretive inquiry, I felt challenged to assess my own knowledge and beliefs about conducting research of the lived experience, in general, and of the lived experience of Mood Disorders, in particular. I was heartened by Kvale’s acknowledgment that in human science research today, there is a gradual move from the emphasis on the “observation of the social world” to the “conversation and interaction with the social world” (p. 289). I became convinced that the interview methodology employed by Karp in his study (1996) would not satisfy my research needs. I needed to employ a method which acknowledged the importance of the interaction between the participants and the researcher throughout the course of the study; so many scholars (Clandinin, Connelly, Denzin, Fine, Goldman, Guba, Helms, Heshusius, Hoshmand, Josselson, Lincoln, Ochberg, Polkinghorne, Richardson, Schon, Schwandt) have recognized the importance of the Self-Other relationship in the research process.

As a result of my abiding interest in Mood Disorders and the sensitive nature of the topic, “an examination of the experience of living with Mood Disorders”, I came to believe that the most appropriate research method was a narrative study: that as a researcher I would engage in one-to-one dialogue with participants who volunteered to tell me their stories of the experience of living with their Mood Disorders; that I would audiotape our sessions together and transcribe their stories, verbatim;

that I would seek further input from them after giving them an opportunity to read the transcription. Throughout the process of conducting the study, I reminded myself that I needed to ensure that my presence did not unduly affect the telling of the stories and that my interpretation did not veer too far from their own (Josselson, 1996).

However, I am sensitive to the belief that as researchers, it is, ultimately, our “interpretive framework” (Josselson, 1996, p. xii) that shapes the interpretation of the data we collect in our studies even when we obtain corroboration from our participants. “Each observer interprets from . . . her own meaning-making horizon. This is the essence of a reflexive hermeneutic stance” (p. xii). Josselson’s commitment to examine the lived experience of others and to convey her “findings” as accurately as possible provided an exemplary model for one engaged in a narrative research study. Her words have guided me: “No matter how gentle and sensitive our touch, we entangle ourselves in others’ intricately woven narcissistic tapestries” (p. 70).

CHAPTER 3

Method and Analysis of Data

Method

In late January 2000, I received approval from the Human Research Ethics Committee at the University of Victoria to begin my doctoral study: an examination of the experience of living with Mood Disorders.

Seeking Participants

I prepared the “Letter of Initial Contact” (see Appendix F) outlining the purpose of my study and inviting potential participants to volunteer to tell me their stories of living with Mood Disorders. I distributed the letter among counsellors, therapists and psychologists (counselling staff at both Camosun College and the University of Victoria, as well as private practitioners in the Greater Victoria area) who were willing to offer my letter to interested clients. Several potential participants learned about my study as a result of the “Letter of Initial Contact” and several by word of mouth.

I received expressions of interest from many more potential participants than I needed for the study. I accepted the first three women and the first two men who met the research criteria: men and women between the ages of 25 and 55 who had been diagnosed with Mood Disorders by medical practitioners.

I arranged to have introductory conversations, in private, with all of my potential participants to allow them the opportunity to meet me and

to answer any questions they might have before making the final determination to contribute to the study. At the initial meeting, I told them about my professional history and a little about my personal history. I gave them a copy of the "Letter of Informed Consent" (see Appendix G) for their consideration. I described the purpose of my study and the design of the research. I outlined the nature and extent of their role as participants, focusing on the fact that they would have the option of withholding any information they were uneasy about discussing and of withdrawing at any time during the process.

Data Collection

I conducted the initial interview with the first participant during the last week in February. Over the next four weeks, I conducted the initial interviews of all five participants. I met with three in my office at Camosun College and with the remaining two in their homes; I left the choice to them. I audio taped the sessions with a portable tape recorder. I used a series of interview questions (see Appendix H) that I had developed to guide me during my initial interview. Each of the initial interviews lasted approximately one hour and 45 minutes.

My focus was to encourage the participants to tell me their stories. I tried to reinforce the rapport and trust established at our previous meeting. I had composed my questions following the guidelines for interviewing as detailed in Cormier's book, Interviewing Strategies for Helpers (1991). Purposefully, I tried not to lead the interviews; my goal was to facilitate the story-telling. Each interview was unique. I tried to

give the participants an opportunity to tell me their experience of living with the mood condition, encouraging them to tell me their story in their own way. There was no rigid structure to the interview. I asked them to describe the symptoms they encountered, the timing of the diagnosis, their reaction to the diagnosis and the treatment. We examined close members of their family-of-origin for symptoms of Mood Disorder. I encouraged them to explore the impact their condition had had on their interpersonal relationships with family, with friends and with co-workers. Throughout the interview, I tried to remain attentive to the fact that the process of eliciting the narrative was equally important as the recording of the data: the narrative was both the process as well as the product.

I then prepared a verbatim transcription of each interview and gave the participants a copy of their transcript within two weeks of the interview. I asked them to read their transcripts with a sensitive and critical eye. I encouraged them to consider their initial reaction to reading their “story” inviting them to edit if they wished. I had typed the transcripts double spaced with one inch borders in order to facilitate their editing. I invited them to write their thoughts and reactions directly on the transcript.

After each participant had had an opportunity to review the transcript, we met one more time, at least one month after the first interview, to discuss their experience of the first interview and their reactions to the transcript. This second interview was more unstructured than the first interview: I encouraged them to reflect aloud in an introspective way about the meaning of their experience with their Mood

Disorder. Each participant lent me the original transcript with their notes in order that I might take a copy for my own records: I returned the original transcript to them. The second interviews, which were audio taped as well, lasted approximately 45 minutes.

Again, I typed a verbatim transcription of the second interview. The preparation of the transcript of the second interview completed the data collection phase of the research study. The audio tapes of the ten interviews (two interviews with each of the five participants) and the three transcripts (the transcript of the first session, the revised transcript and the transcript of the second session) constituted the data for use in the analysis phase of the research.

At the end of the second interview, I asked each of the participants if they would like to select a pseudonym which I would use in the dissertation. They all chose a name which had special meaning for them in their lives: Anne, Erica, Jeremy, Johnny and Katie.

Analysis of Data

The process of identifying the themes and the process of writing the narratives were interdependent, one enhancing the other. I alternated between the two endeavours as I analyzed the data.

Identification of Themes

During the research design phase, I had difficulty conceptualizing a strategy for the analysis of the data: fifteen hours of audio taped interviews and several hundred pages of typed transcripts of the interview

sessions with the participants. How would I analyze the data? Their stories were as unique as they were individuals. I returned to the literature about the researcher's role in the process of interpretive inquiry; I had to trust that by immersing myself in the transcripts, I would live, if briefly, their unique experience, and by "living their experience", I would come to "know their reality".

I was not disappointed. In fact, the analysis of the data came easily. In order to prepare for the writing of the narratives, I followed a very systematic process of listening and re-listening to the tapes, reading and re-reading each transcript, immersing and re-immersing myself in the lived experiences of the participants. I listened to and read their words over and over again. I reminded myself that as an interpretive researcher, I had to rely on my own ability to "merge" with them in order to genuinely "know" their experiences (Heshusius, 1994). As I wrote the narratives, I became aware at an intuitive or "gut" level of the prevalent themes experienced by those who live with Mood Disorders. This process was not one that I could force, nor schedule: I had to grant myself the time to allow the themes to emerge, and as they emerged I captured them on record.

I recorded the themes using whatever means were available to me: I jotted them down on the transcripts, on scraps of paper, on post-it notes, on the backs of envelopes, on napkins; I sent email messages to myself; I sent voicemail messages to myself. I classified the themes under the following headings: affective, cognitive, occupational, philosophical, physical, psychological, social, spiritual. And as I wrote the narratives, I became

aware of a common pattern of the phenomena of living with Mood Disorders: All of the participants experienced their Mood Disorders in five predominant “states”.

Writing the Narratives

I wrote each of the participants’ stories in the form of a narrative. In order to protect confidentiality, I changed several potentially identifying facts about their lives, facts which in my opinion had little bearing on the essence of their stories. I gave them a copy of their respective narratives offering each one the “final say”: I wanted to be certain that I had accurately portrayed the experience of living with Mood Disorders. I acknowledged that the narrative was more precisely the “re-narration” of their experiences. It was my construct, and I wanted to ensure that my construct was as true to the lived experience of the “Other” (Fine, 1994) as I was able to compose.

CHAPTER 4

The Narratives

The following narratives are a distillation of the interviews which I conducted over a two month period with each of the five participants. I have struggled with the issue of legitimacy: I recognize that these “stories” are not my own but rather, the stories of five individuals who generously and trustingly shared many of their deepest, and some of their darkest thoughts with me. I am keenly aware of the limitations of my trying to accurately convey the life experiences of another (Bakan, 1996; Josselson, 1996). I have also struggled with issue of ethics and confidentiality (Widdershoven and Smits, 1996): the narratives are remarkable stories of the unique experience of five individuals whose lives are complicated by their need to manage a mood condition. In each case, I have tried to adjust the facts to ensure anonymity, but I have made changes only where the details have little impact on the essence of their experience (Bar-On, 1996; Josselson, 1996).

At the end of our last encounter together, I gave the participants the opportunity to select a pseudonym for me to use in the writing of my dissertation. Two of them seemed curious as to why I would use a pseudonym and not their given names, and the remaining three appeared eager to suggest a name which had special meaning for them in their lives: Anne, Erica, Jeremy, Johnny and Katie. Here are their “stories”.

Anne

Anne is the first child born forty-eight years ago in England to a British mother and a German father. Her only sibling, a sister, was born when she was two years old. The family emigrated to Canada when the children were in elementary school settling in central Canada. Anne's childhood was defined by "high expectations" and strict rules that felt increasingly confining as she entered her adolescence. She has happy memories of her childhood years, but recalled the difficult relationship that developed with her father during her teen years as she tried to resist his "controlling" way. Her father's "unpredictable moods" and "temper problems" were very unsettling for her and her sister. The two girls reacted very differently to their father: Anne resisted openly, being "a bit of a battler", by challenging her father's rule, and her sister retreated very quietly to her room, saying nothing. Her sister was criticized by her parents for succumbing to a depressive way of being. Anne worked very hard to adopt a "cheer up and get on with life" attitude to life, an attitude which was heartily supported by her parents.

Anne entered teacher's college as soon as she completed high school and began teaching at 19. She then moved to the west coast of British Columbia where she attended university. After graduation, she followed close friends to the interior of B.C. where she met and married a young man. They had two children in quick succession but the marriage did not have a strong foundation and after two years, Anne left with her children and settled in a coastal city. She began a new relationship, landed a teaching position and purchased a house; she was determined to establish

roots for her young family in their new community.

Anne's sister remained in Ontario to complete her university education maintaining a close relationship with her parents. She has struggled much of her adult life with chronic depression and has recently been diagnosed with an immune deficiency disorder as well. She has worked at a university in eastern Canada on an intermittent basis, between bouts of ill health. She has never married, has no children and has endured a series of unsatisfying relationships with men. The two sisters remain in close contact, primarily by telephone, each enjoying vicariously, the advantages of the other's life. Anne has been a constant sounding board and confidante for her sister, particularly throughout her sister's periods of ill health and episodes of depression.

Anne and her family nested well. Anne secured a teaching appointment in the secondary school system and her two children settled into their new life in a new environment. Three years ago, Anne's eldest child, a daughter, seemed to change overnight from a child who was "almost perfect" to a teenager who seemed "to go off the tracks": she began to eschew family values once held so dear, and she resisted all attempts on Anne's part to have her conform to household rules. Her daughter began to run with the wrong crowd, often staying out all night, immersing herself in the world of alcohol and drugs on the streets of the city. Anne (with some assistance from her new husband) worked with school teachers and counsellors, social workers, youth workers, police officers, parent support groups: in short, she tapped all of the resources available in a desperate attempt to retrieve her daughter from an external force that seemed more

powerful than anything Anne had ever encountered. It was a “terrifying time”.

Then, last year, Anne detected a “breakthrough”: her daughter began reimmersing herself in family matters. She bonded “almost like a child” again with her mother and began to spend time at home, happy to be involved in the household again. Anne was relieved but somewhat confused by her daughter’s change of heart. What had caused the turnabout?

One Friday morning in the fall of 1998, as the household was preparing to leave for work and school, Anne’s daughter complained of sharp pains in her stomach, pains which were cause for alarm. Anne took her daughter to the emergency department at a local hospital where a healthy baby boy was born later that morning. The family was in “utter shock”.

Anne dove into “being there” for her daughter; she felt a compelling need to give her daughter, who was in obvious physical and emotional pain, all the support that she could muster. The next few days proved to be most challenging for the startled mother and grandmother. The baby flourished; the new mother and the new grandmother bore the strain of the predicament well, nurturing one another and the wee babe, stumbling in a resilient way through the challenges together.

During the next days and weeks the logistics of preparing the household for an infant monopolized Anne’s time. The intrusion of the social services authorities created enormous tension in the household but Anne’s focus never wavered. She was determined to be the ultimate

support for her daughter, encouraging her to assume primary responsibility for the wee babe. Anne took a part-time leave of absence from her teaching position in order to assist her young daughter to learn the strategies of motherhood.

Two weeks after the baby's birth, once Anne was satisfied that her household was settled, she called her family in Ontario to announce the child's arrival. Her mother's reaction was guarded but supportive, but her father's response was devastating: "That makes me sick", he thought aloud. Apparently, his cousin in prewar Germany had borne a child in her teens and was subsequently banished, out of shame, from the family. Anne's family were of no support to her and even as the little boy approaches two years of age, have not traveled to the west coast (normally an annual event) to meet their great grandchild. Anne has enormous regret that her birth family are unable to extend themselves to embrace their first great grandchild, their granddaughter or their daughter, at a time when the acknowledgement and support would fill an "huge hole".

By Christmas of 1998, the household had settled into a workable routine. Anne finally confronted the head worker at the Ministry about the intrusion into Anne's family life over the previous three months: she was told that there had been some suspicion that "some funny stuff was going on in the family". Anne was able to convince the official that there was no inappropriate behaviour, that her daughter was assuming responsibility for the baby, and that the remaining family members were adjusting well to the new addition in the household. The ministry inquisition ended.

But for Anne the next few months were unsettling. She developed 'flu-like symptoms, extreme fatigue culminating in the loss of her voice. The symptoms forced her to bed and only began to subside after several days of bed rest. She struggled to return to work. Then a couple of weeks later, the symptoms emerged once again. This cycle occurred seven times, even while she was on summer holidays from her teaching position, over the next eight months. During this period of time, she began to notice that she "had no interest in anything", that she "didn't want to attend meetings", that she "was afraid to see people" fearing that she had "nothing to give" or that she would "collapse in tears".

Previously in 1997, during the time when her daughter was first "acting out", Anne had taken "a couple of months off work". She had been prescribed some antidepressant medication and as soon as she was feeling better, she resumed her duties at work and stopped taking the medication. Then, during the winter, spring and summer of 1999, with the recurring 'flu-like symptoms, Anne kept probing her family doctor as to why she kept getting sick; she declared that she was "sick and tired of being sick and tired". Her doctor focused on a possible immune system deficiency and scheduled numerous tests, but "the word depression never came up". She returned to work in September at half time assignment, but by the end of the month she had lost her voice and was as sick as ever, again.

Administrators at the school suggested that Anne submit a long term disability claim as she had all but exhausted her accumulated sick days. She met with a representative of the insurance company armed with a list of her symptoms, a list which she had prepared prior to the

meeting. Anne believed that she had classic symptoms of depression; she kept “bursting into tears”; she was overwhelmed with the “practicalities of work”; she was feeling “antisocial”; she “lost all ambition and drive”; she “didn’t want to do anything” not eat or cook; life “was just too much” for her. Anne returned to her doctor and announced that she was convinced that she had depression. Her doctor immediately prescribed antidepressant medication which she encouraged Anne to take “for at least six months”, suggested that she read a couple of books about managing depression, and encouraged her to continue seeing, on a regular basis, the psychologist with whom she had established a therapeutic relationship several years earlier.

Anne initially returned to her teaching position on a part time basis but has recently returned in a full time capacity. She continues to take her medication and meets on a regular but less frequent basis with her psychologist. She practices regular relaxation techniques using a variety of strategies and has reimmersed herself in her old hobbies. Anne feels that she is returning to her “old self”, but is determined to heed the warning signs of an impending episode of depression should she experience the symptoms in future.

Erica

Erica is the third child and only daughter born forty-one years ago to a Canadian couple living in British Columbia. She has two older brothers, the elder being ten years her senior. The family moved frequently as the father’s work assignments took them abroad on foreign

postings and during her teen years, Erica remained in B.C. at a private school to complete her schooling. She entered university, completed three years of an undergraduate degree and secured steady employment in the administrative office of a large retail chain. Fifteen years ago, she married a young man who was a close friend of one of her brothers, but after ten years of marriage following a year of intense work with a marriage counsellor (both together and separately), they agreed to divorce. Erica and her husband have remained strong friends and continue to see one another on a regular basis.

Erica's father had a very powerful influence on the children. She and her brothers feared their father's anger and, particularly her middle brother, lived in terror of his explosive temper. Her father would fly into a rage whenever the children expressed any emotion, and she learned that when she was upset, she needed to retreat to the closet of her bedroom where she would curl into a small ball and cry in silence. Her elder brother, a full ten years older than she, assumed a very protective role with Erica, but he left home when he was 18 and was not present in the household at a time when the young girl needed a nurturing father figure in her life. Her father spent much of her teen years on international assignments, leaving home for months at a time, sometimes alone and sometimes taking his wife with him. Erica was placed in boarding school for the first two years of high school and then, spent her final two years looking after the family home while her parents moved in and out of her life. Her mother and she enjoyed a very close relationship, although Erica felt abandoned on occasion when her mother followed her husband on his

travels. Her mother failed to recognize Erica's weight loss, but it became a contentious issue between her and her father.

Her elder brother became her "supplier" early in her teens as she began to experiment with street drugs. She discovered that drugs were helpful for those times when she felt "anxiety-ridden" about life, a common occurrence for Erica. Periodically, she had negative reactions to the drugs sending her into "anxiety attacks". While she was grateful for her brother's attention, she continued to feel abandoned during this period of her life. The pattern of drug and alcohol abuse became entrenched: it was a pattern that would prevail for twenty years.

Several doctors, on several occasions, suggested to Erica that she might have a Mood Disorder, but she vehemently resisted the diagnosis. She described herself at this stage of her life as "mentally vibrating" like she was "taking speed": she recalled the alternating moods: one moment, being "inappropriately high and happy and hyperactive" and filled with a "sense of elation" and then, in the next moment, "crashing" and retreating to a private place in the back of her cupboard "curled up in a ball". On one occasion, her doctor ordered a battery of tests to determine whether she had hypoglycemia because of her erratic mood swings; but her tests revealed that she did not have hypoglycemia. He was convinced that she had Manic-Depression, but she could not accept the diagnosis.

Beginning in her early teens, Erica experienced a "great sense of loneliness" and "free floating anxiety": she was living "in a grey world". She began to struggle with anorexia; she had periodic binges with alcohol and later moved to hallucinogenic and hard drugs. For almost twenty

years, she swung between anorexia, bulimia, cycles of heavy drinking and chemicals “to the culmination in the summer of ‘94 - becoming fully addicted to cocaine”. During the fall that year, she tried to “come off the cocaine . . . without rehab”. She began “planning and preparing” for her suicide that Christmas. The psychiatrist whom she and her husband had been seeing intervened at the critical time.

In the winter of 1995 she began intense and frequent sessions with her psychiatrist. He encouraged her to examine the issue of abandonment as a result of her parents’ moving abroad during her teen years, leaving her at boarding school. Erica had adopted abusive habits with alcohol and street drugs early in her teens, and she had developed “full-blown” anorexia and bulimia by the time that she was 16. After several months of increasingly intense scrutiny with her psychiatrist about her life and, in particular, her birth family experience, the memory of her abuse at the hands of her middle brother, revealed itself to her.

Erica immediately slipped into a “deep, deep depression”. Her psychiatrist wondered aloud with her about a new diagnosis, “Borderline Personality Disorder” as well as “Manic-Depression”. Her head reeled. She was loath to take psychopharmaceutical medication, but he eventually convinced her that she would emerge from the depression if only she would take the antidepressant medication that he prescribed. Initially, her bulimia interfered with the treatment; there were days when she wondered how much of the antidepressant medication actually stayed in her system. But, in time she began to “emerge from the fog”.

When Erica was five years old, her second brother began to

physically and sexually abuse her, a practice that seemed to be acknowledged but was largely ignored by both her parents and her other brother. Her parents' reaction to the abuse was to try to keep the youngsters apart and to dismiss the topic as sibling rivalry. The abuse continued intermittently for several years until Erica entered her teen years, but she buried the memory for almost thirty years. It was not until she became immersed in the the intense therapy following her suicide attempt at Christmas of 1995 that the memory of the abuse revealed itself to her. She has since discussed the experience with her elder brother who acknowledged that the family knew, all along, that young Erica was being abused; it was a "family secret".

Erica's parents were not forthcoming about their family history and as a result her knowledge of her family background came in small bursts. There were many "family secrets". But, since the death of her father almost 7 years ago, Erica has gathered more of the story and is piecing together the puzzle with the passage of time. The stories are unfolding. Her father's sister was institutionalized with unrelenting depression thirty years ago at a time when shock therapy was the preferred method of treatment. Faint details of the her aunt's lifelong battle with bulimia have become evident to Erica. Only recently, she and her mother have begun to discuss the post partum depression that her mother experienced after the birth of her children. Both her parents were very heavy alcoholic drinkers having "several martinis a day", a fact that causes Erica to wonder if their heavy drinking might have been masking an underlying Mood Disorder.

Erica's elder brother studied psychology during the sixties and

seventies and immersed himself in therapy as a young adult, a practice which he continues to follow when he feels the need to examine life's issues or when the stress of day to day living begins to overwhelm him. He has been married to the same woman for twenty five years with whom he has raised one child, and he has lived a "very productive and happy life". But her second brother has struggled with a lifetime of substance abuse, uncontrollable anger and has only recently "acknowledged his homosexuality". Her relationship with her elder brother and his family continues to flourish, but her relationship with her second brother is cordial but strained.

Several years ago Erica requested a transfer from her long standing employer in the lower mainland and was transferred within the company to a smaller community on Vancouver Island. Three years ago she resigned her position with the company as a result of a particularly untenable situation in the workplace and entered into a series of short term contracts. She no longer had access to the benefit of psychological services, a benefit which she had enjoyed at her previous employment. She has not established a connection with a psychiatrist or psychologist in her new community. She continues to struggle with her eating disorder, encountering periodic episodes. She has taken no alcohol nor street drugs in five years. She takes no medication for her mood swings. She monitors and tries to control the mood swings as they arise with exercise and sleep, with relative success. She remains in close contact with her elder brother, her mother and her former husband. She has recently embarked, very tentatively, on a new relationship.

Jeremy

Jeremy is the only child born fifty years ago to a Canadian couple in British Columbia. The family lived in the same house in the lower mainland for all of Jeremy's developing years - he went to the same schools and lived in the same neighbourhood until after he graduated from university. Many years earlier, his father had disassociated himself from his birth family when he left home (in England) as a teenager. He and Jeremy's grandfather (whom Jeremy never met) had a falling out: the grandfather wanted his son to pursue a career in music and the son wanted to pursue his love of soccer. He never reconnected with his family after he emigrated to North America and, as a result, Jeremy had no knowledge of nor connection with his father's family. His mother was Canadian born and maintained her connection with her birth family. She was a very strong woman who nurtured her son and her husband well.

Jeremy's father settled in western Canada and began to work as a labourer on the docks on the coast of British Columbia. Although never fully satisfied in his work, he rose to the top of the union ranks, but he deeply regretted not having the opportunity to pursue higher education. Every evening he would leave the house for long walks by himself; Jeremy and his mother assumed that his sadness was as a result of his regrets. His father had periodic bouts of deep depression: he would speak very little and spent long hours by himself, lost in his own thoughts, often for days or weeks at a time. But, his father "always coped".

Jeremy completed two degrees at university and married a young nurse when they were in their mid twenties. He secured a teaching

position and the young couple settled into life in a small town in the interior of B.C. Two children were born within three years and the young family seemed content.

But, all was not well with Jeremy. His father had become ill, had resisted treatment until it was too late and subsequently died, only five years after retiring. Jeremy had difficulty coping with his father's death: he grew disenchanted with his life, questioning his effectiveness as a husband, a father, a teacher. He blamed himself for perceived failures. Usually, these low periods only lasted for a few days, but sometimes, for several weeks. He engaged in self-talk, urging himself to "snap out of it", hoping that the episode would pass. During one of these low periods, he turned to a teaching colleague for friendship and comfort: he found some "escape" in the affair that developed. The "high" of the affair acted as an antidote to his depressive thoughts. However, his sense of guilt overwhelmed him and he returned to the family fold, revealing all to his wife - a revelation that was very painful for the young couple to process.

As a result of the downturn in the economy and waning enrolments, he was laid off from his teaching position. In an effort to salvage a job for Jeremy, the school board offered him an administrative position in an adjacent district. He struggled to find satisfaction in his administrative work and he longed for the classroom. Jeremy gravitated to another colleague for friendship and comfort, "escaping" into a second affair. Again, his sense of guilt overwhelmed him and he returned to the family fold, filled with intense remorse. His wife and he were determined to make the marriage work, and he attributed the affairs to "a phase he was going

through". Jeremy did not consider that depression might have been the "triggering" factor.

Over the next ten years, Jeremy moved further and further away from classroom teaching and assumed more and more responsibility for school administration. He relocated his young family, one more time, to be closer to his aging mother in the lower mainland. He had grown most disenchanted with administration but his career path seemed to be fixed: he could not find a way to return to the classroom.

In 1995, his mother was diagnosed with cancer and moved into the family home with Jeremy, his wife and their children. At the time, there was immense strain on the household: Jeremy was beginning to regret his move to the new district and was feeling overwhelmed with his administrative responsibilities, the family was having difficulty adjusting to life in a new community, his wife was enduring a protracted recovery as a result of delicate surgery, their teenaged son was behaving in troubling ways, and his mother's health was deteriorating swiftly. As an only child, Jeremy was responsible for the closure and eventual sale of his mother's home. The pressure was intense, but Jeremy coped: he "went through the motions" dealing with his mother's death in a very pragmatic way. But, he grew increasingly aware of an engulfing, "overwhelming" state of mind. His work felt like a "plunge into the darkness" from which there was no relief. He had difficulty making decisions and confided to his supervisor that he knew that he was making "mistakes", saying "Yes" when he should be saying "No". He began to have frequent, persistent headaches - headaches which were cause for alarm. His supervisor drew

him aside and confided that he was “concerned about him” and about his performance at work.

Jeremy first developed the recurring headaches when he assumed the administrative responsibilities; but his headaches were growing both in intensity, leaving him with numbness in his lips and tingling in his fingers and, in frequency, occurring several days a week. Initially he resisted seeing his doctor, but, fearing the worst, he finally made an appointment. His doctor scheduled some tests. The medical tests uncovered no conclusive reason for his headaches, but revealed that he had developed the early stages of skin cancer in a form which was eminently treatable. He immediately took leave from his position with the school district, underwent the surgery and spent the next couple of months healing and recuperating. He did not divulge to his doctor at the time that he was not “performing well” in his job.

Jeremy had a deep seated fear that the root of his problems was a mental illness. He recalled witnessing the demise of the father of his daughter’s friend, some ten years ago, an accountant who was diagnosed as Manic-Depressive: a man who could never “cope with a job” and who wandered the streets of their community “looking lost and aimless”. Jeremy was terrified that he might “be like this guy”, that he might be unable to “hold my job” or to “provide for my family”. He feared what his colleagues might think if he were found to have Manic-Depression. He realized that he knew little about the disorder, but was too terrified to enquire of his doctor or to read on his own in case his worst fears were confirmed.

A full six months after initially seeking medical help for the headaches, he finally admitted to his doctor that he was not “performing well at his work”. Anxious about returning to his job, he and his doctor finally discussed his lack of enthusiasm for his work and his doctor recommended that he spend some time with a psychiatrist. Jeremy flinched at the suggestion, admitting to his wife that he “was really scared” about going to a psychiatrist. But, his family doctor recognized the reluctance and assured him that if he felt any discomfort with the psychiatrist that he would refer him to another, and another, and another until they found one with whom Jeremy felt comfortable. He advised him to trust his reactions to the psychiatrist, assuring him that sometimes it takes as many as “three referrals before finding a psychiatrist” that is the “right fit” for the patient.

Fortunately, the first referral worked well for Jeremy. Over the next few months, the two men met to discuss how and why he “got to this point”, what he was experiencing and how to “manage this condition”. They looked back at Jeremy’s life, identified repeating patterns of behavior and examined the unresolved grief following the deaths of his father and his mother. After three months work, his psychiatrist declared that he thought that Jeremy was “ready to go back to work”; he recommended that he not return to his administrative position, but that he return to a teaching assignment. Jeremy was delighted that the school district accepted his request to leave his administrative post and return to the classroom.

It had been ten months since Jeremy had initially left work for his

cancer treatments. As part of his reentry to work, Jeremy proposed to the school district that he present a workshop to his colleagues as part of a “Wellness” initiative: a workshop about his own experience with a mood condition. He believed that his “story” might resonate with others in the workplace; he wanted to help educate his colleagues about the facts about the condition. While he feared that he might be judged harshly when others learned of his condition, he was willing to trust that there was much that both he and his colleagues might learn from his disclosure. He was buoyed by the numbers of his colleagues who attended the workshop in spite of the fact that it was a voluntary event, and was heartened by the reaction of those who attended his presentation.

Since returning to the classroom over two years ago, Jeremy has delighted in his work. He has immersed himself in extra curricular activities with his students and actively participates in events with teaching colleagues. He no longer takes medication for his condition but he is very sensitive to the “signs of depression returning” and has become very knowledgeable about the symptoms of an impending episode. He and his wife have found new meaning in their marriage, and together they have withstood the challenges of managing her aging father who has been living with them for a couple of years. Jeremy plays an active role in the household.

In the summer of 1999, he experienced enormous trauma when his twenty-something son attempted suicide. After years of growing concern about their son’s resistance to setting and pursuing some goals, Jeremy and his wife were horrified that he had attempted to end his life. His was a

“cry for help” and the resulting interventions on the part of the mental health system came as a relief to the parents. Finally, there was a reason for the years of strange, erratic behavior they had witnessed in their son - Borderline Personality Disorder. Jeremy assumed a leadership role during the crisis, at a time when his wife found the experience overwhelming. His son was referred to an excellent psychiatrist who recommended an extended therapeutic program. Remarkably, throughout this period of trauma, Jeremy has provided the nurturing support that his son and his wife so desperately needed.

Johnny

Johnny⁹ is the second son of three boys born twenty-nine years ago at two year intervals to a young couple who were European immigrants to Canada. His mother and father both worked long hours in the bakery and restaurant industries all the while trying to operate a small farm in their new land. As youngsters the boys were left a great deal of the time to fend for themselves while their parents worked long, often late, shifts in order to support the family. The boys were expected to keep up with their household chores and to do well in school. His mother was a constant support in his developing years and his father left the family home when

⁹ On the day of my first interview with Johnny, he disclosed that he was feeling particularly upset; he wondered if he might be entering another manic episode. I gave him the option of rescheduling the interview, but he preferred to proceed. His demeanour was decidedly agitated. He moved constantly, tugging at his clothing and shifting in his seat. We needed to take frequent breaks in the taping so that he could move around the room, have a cigarette - a graphic illustration for this researcher of the distracted, agitated, disrupted and disquieting state of mania. Remarkably, throughout the interview, Johnny attempted to focus on the dialogue with extraordinary effort.

Johnny was still in elementary school.

Johnny was an active, sensitive, “very emotional” child who periodically got into trouble at school when other kids got “under his skin”. He learned at an early age that “boys don’t cry”; he was actively discouraged from discussing his innermost thoughts with anyone. When he was eight years old a family friend sexually abused him on several occasions, an experience that left the little boy confused and filled with feelings of guilt. He kept the knowledge of the abuse to himself, and he did not reveal the experience to anyone until he made the disclosure to his psychologist in the spring of 2000. During the intervening years the memories of the abuse were never far from his thoughts. When Johnny was fourteen years old he witnessed the death of his best friend under the wheels of a car. He held his young friend as he took his last breaths: a vivid memory that haunts Johnny today.

In his early twenties, Johnny and his common-law wife bought a restaurant in Ontario and established a healthy business, working 14 to 16 hours a day, six days a week. Long hours at the restaurant (Johnny resisted letting anyone assist him) and the strain of his deteriorating relationship with his partner, began to take its toll. In a moment of impulse, Johnny accepted an enticing offer to sell the thriving business and moved West with a new partner who soon became his wife. The young newly weds used the proceeds from the sale of the restaurant to purchase a home in a small British Columbia community where they settled into jobs in the food industry.

In July of 1999, Johnny injured his back on the job after twenty

days of constant work - relieving for another employee who had been injured. He had felt obligated as the “new kid on the block” to accept the extra shifts. As a result, he spent the next two months flat on his back under his doctor’s strict instructions that he allow his back adequate time to heal before resuming his normal activities. Meanwhile, the Workers’ Compensation Board (WCB) consultants pressured him to return to work as soon as possible. But the lingering back pain prevented an early return to the workplace.

By early September, Johnny was growing anxious about his lingering inactivity. He was “going crazy” with the endless idle hours. Having been a very active and fit person all his life, he had relied heavily on his strength and endurance and had always engaged in very physical work. He was having difficulty sleeping, he dreaded waking in the morning, he brooded over his back pain, he worried that his back would never heal, he was consumed by the inefficiency of the WCB process and ultimately, his marriage began to suffer. His wife turned to another man, eventually leaving Johnny. He slipped into a deep depression with disturbingly morbid thoughts. He spent days and nights alone.

Fortunately a close friend who had recently experienced a depressive episode herself, recognized the changes in Johnny and urged him to talk with his doctor about his depressive thoughts. His family doctor prescribed medication to help reduce the mood swings and recommended that he make an appointment to see a psychiatrist and a psychologist.

Initially resistant, Johnny recognized that he needed some assistance to shake his morbid thoughts. Reluctantly, he accepted the

prescription for Paxil for his anxiety and Ativan for his sleeplessness and he engaged in the therapy sessions with both the psychiatrist and the psychologist on a regular basis. After four weeks of treatment, it was evident that he needed more than the Paxil and the Ativan: he was then given the antidepressant, Carbamazepine. By the middle of October, his sleeping patterns had become more regular: he was able to sleep for more than four uninterrupted hours during the night. His wife moved out of their home - the marriage appeared to be over - but he was adjusting well to living alone in their home. By November, while his back pain was still evident, he was able to walk his dog again on a regular basis - he felt himself emerging "from the fog" of September. He still required between 10 and 15 Advil pills each day to manage the back pain.

Throughout the critical stage of his depression, a period that he refers to as his "breakdown", Johnny wrote a daily journal entry and periodically some poetry¹⁰. These journals and poems are composed of very graphic descriptions of the state of his mind during that very bleak period. He seriously pondered suicide wondering if it might be "best" if he simply "stepped in front of a bus". He questioned how he could feel "so empty" while "never hungry". His poems reflected the sense of futility and confusion that permeated his thoughts during his bleakest periods. He struggled to "forget where I put my head"; he desperately wanted to "figure out my mind disease".

Johnny's doctors were very candid with him about his condition:

¹⁰ At the end of our first interview, Johnny offered to give me copies of his journals and his poems written during the period of his breakdown. I am encouraging him to publish this body of writing - a poignant illustration of the unquiet mind.

the rapidity with which his moods shifted suggested that he was experiencing rapid cycling Manic-Depression. His care givers worked consistently, consulting with one another, over the winter months to help find the best combination of medications and talk therapy to help Johnny find equilibrium. Although he had periodic setbacks, his mood swings lessened in intensity and he came to recognize the early symptoms of the onset of a new phase, and he adjusted his medications accordingly.

Johnny recognized a pattern of restlessness in his father's life: he believed that his father's periodic episodes of depression contributed to his moving from one job to another throughout his life. He recounted numerous occasions in the past when his erratic behaviour had interfered with his own life. Johnny worried about the fact that he had had "so many careers" and that he never seemed to be able "to nail one down". Not long after Johnny received his diagnosis of Mood Disorder, he reached out to his birth family, eager to discuss his condition. He was buoyed and a little surprised by their empathy. His father acknowledged for the first time that he, too, had a history of mood swings that on occasion had interfered with his life. Johnny's youngest brother acknowledged that he felt down for "weeks at a time" but he has not sought help for those periods: he told Johnny that he did not believe "taking pills" could possibly help.

Johnny has long recognized that some of his behaviours are compulsive or erratic in nature, but he always assumed that they were as a result of his personality. He recognizes that he had a deeply felt prejudice about mental illness and was resistant to acknowledging that he might have a Mood Disorder. But as he came to accept the diagnosis, he hungered

for knowledge about the disorder. He reads books and frequently accesses the Internet to obtain information about his condition. He continues to remain vigilant about impending episodes and is committed to managing his mood swings with a combination of medication and talk therapy. He has, just recently, returned to less strenuous work after completing an employment placement program through the WCB.

Katie

Katie is the third and last child born forty years ago to a Canadian couple in British Columbia. The family lived in a small coastal town until the year before Katie entered elementary school at which point they moved to a city on Vancouver Island; she has remained in the same city since she was four. Katie's home life was stressful with a "domineering, critical" father who frequently "bellowed" at his children for minor transgressions. The children were fearful of their father, a man who "mentally, verbally and emotionally" abused all members of his family. Her mother "protected us as best she could" . . . but she "dismissed all of the atrocities because he was the breadwinner". Her father struggled with periodic alcoholic binges and died at the age of 47, when Katie was 17, of cirrhosis of the liver.

Katie's only brother, her elder sibling, assumed a protective role with her. He has always been very reserved about his emotions, and has been "reluctant to discuss his feelings with any family member". He has a "tendency to blow up" and "be nasty" especially when he drinks alcohol. He has always held a steady job, has been married to the same woman for

over twenty years, and they have two growing children. Katie believes that he has the characteristic symptoms of a mild Mood Disorder, but that he manages his condition on his own as well as possible. She does not believe that her brother has had any intervention by either medical or psychological professionals.

Katie's sister has been "detached" emotionally from her birth family for many years. She has always had difficulty discussing her emotions and harbours a great deal of unresolved resentment towards her family, including Katie. She has recently begun trying to find effective medication for her depressive, periodically angry, moods. Katie and her sister have always had a tumultuous relationship. As youngsters they bickered endlessly and even as young adults, they continue to fight bitterly. Katie does not believe that her sister has engaged in "talk therapy" as part of her treatment for a Mood Disorder. In fact, she does not believe that her sister has accepted the diagnosis.

Katie has worked in the same job for over 17 years in the communications centre, as part of the emergency response team at a large hospital. In her job she is required to handle emergency calls, often of a critical nature, dispatching emergency response personnel in critical cases. She is required to document all interactions in precise detail using the most recent technology available to her. For many years, Katie has struggled with the stress of working in a critical response centre.

One of the benefits of her work in a large institution is the Employee Assistance Plan which affords employees access to psychologists. Almost ten years ago, Katie sought the help of a local psychologist as she struggled

with interpersonal relationship problems, both at work and at play. She has continued to see the same psychologist intermittently over the last ten years, and regularly since the summer of 1999. The critical nature of the job as well as the fact that there is little opportunity for advancement in the workplace have contributed on two occasions to her taking leaves of absence for several months in order to restore her sense of well being.

The first episode occurred six years ago. Katie required a leave of several months to help her deal with the “stress of the job”. After a series of traumatic events in her life, she found the need to take a break from work: her companion cat of 12 years had died, a longstanding relationship had dissolved and the strength of her ties with colleagues at work, “a surrogate family”, had broken down. It became essential that she take a “breath of fresh air”. At that time, Katie engaged in talk therapy with her psychologist in order to develop strategies to cope with both the stress of her work and the challenge of her interpersonal relationships. She returned to work with a “detached attitude” about her colleagues which allowed her to work at peace with herself and her job.

The latest episode began with a choking experience. One Saturday in the summer of 1999 following a particularly arduous shift, Katie was eating dinner with friends when she began to choke on a bland appetizer, a most uncharacteristic episode for her. She removed herself from the dinner table and returned five or ten minutes later, shaken but composed. Sufficiently alarmed, Katie called her family doctor first thing on Monday morning and was seen later that day. Her doctor felt that the stress of her job had probably precipitated the choking attack and suggested that she

might consider taking a “leave of absence” from work of “at least six weeks”. She re-established regular sessions with her psychologist and continued to meet with her family doctor on a regular basis over the next few months. But, she required more than talk therapy to help her weather this episode.

Her family doctor and her psychologist consulted with one another “several times”, and she continued to meet regularly with each of them every two weeks during the fall and winter. Initially, Katie was most reluctant to take any medication and only after struggling through several weeks of debilitating symptoms, did she agree to try the antidepressant Wellbutrin, a medication frequently prescribed in cases of anxiety and depression. The drug did not improve her condition for several weeks during which time she suffered annoying side effects; nausea, mild headaches, constipation and insomnia. But, after six weeks the side effects subsided, and the symptoms of the episode began to lift.

Katie felt very guilty about being absent from work on “stress leave”, constantly questioning whether she had a right to be claiming sick pay when she “wasn’t really sick”. And yet, her symptoms were classic symptoms of a major depressive episode. She had difficulty sleeping and she struggled to get up in the morning, often rising late and moving to the couch. She had no interest in seeing friends and family members, nor talking to anyone on the telephone. She lost her appetite: she would force herself to “choke down a couple of pieces of toast for breakfast”, mostly to please her husband. She would seldom eat again until supper time when she had great difficulty eating more than a couple of bites, finding nothing

palatable. She lost weight steadily, a fact that concerned her as she had not been overweight. Uncharacteristically, Katie began having frequent, nagging headaches. She had no energy and no interest in participating in any physical activity, normally a constant in her life. She reported that she felt “miserable” and “angry”, “short on patience”, “irritable” and “easily frustrated”. She worried that her state of mind and her “acting out” behaviour would undermine her young marriage; but, her husband remained concerned and supportive, a heartwarming constant in her life.

The prospect of returning to work was terrifying for Katie. For several years, she felt very discouraged about her work. She had lost a job competition, an opportunity to advance, a couple of years ago, and she felt “trapped” with nowhere to go. She was not eligible to move out of her union with any of her seniority intact, and there were few opportunities for advancement. She had been harbouring deep resentment towards many of her colleagues at work; she resented the fact that she was “unable to transfer to another job” and still maintain her pension. She had reached her limit during the summer of 1999, when she realized that she “had no control” over her life at work; she felt “stuck” in a hopeless job. After the choking incident, she slipped into a deep depression, a depression that would last over 6 months. The prospect of returning to her former employment had become an “inconceivable” option; it was a “toxic work environment” for her.

In the spring of 2000 as she emerged from her depression, Katie began to actively research other employment options with her Long Term Disability (LTD) rehabilitation consultants. She has resumed a regular

fitness program and is eating and sleeping normally again. She continues to take her antidepressant medication and spends time with her psychologist on a regular but less frequent basis. She is pursuing a career in a new arena and she has returned with renewed interest to her hobbies.

CHAPTER 5

Findings

Throughout the process of re-constructing the narratives, I became aware of common patterns of experience which I refer to as “states”. These states were not constant, linear, sequential or distinct but were episodic, sporadic, overlapping and ambiguous. The participants encountered five unique states to varying degrees, in a variety of ways and in a different sequence. But, each of them experienced all five states at one time or another:

State 1: Dismissing the Symptoms

State 2: Externalizing the Cause

State 3: Internalizing the Cause

State 4: Accepting the Diagnosis

State 5: Developing the Management Strategies

I will describe the five states of living with Mood Disorders by examining the characteristic themes of each state.

The Five States of Living with Mood Disorders

The participants all received the diagnosis of a Mood Disorder from their family practitioner or the psychiatrist to whom they had been referred, within the last five years. They received the specific diagnosis of Depressive Disorder, Anxiety Disorder, or Manic-Depressive Disorder¹¹, but most of them suspected that they had had the disorder all of their adult life (up to thirty years): two of them suspected that they had had the

¹¹Manic-Depressive Disorder: Please refer to Footnote 6. in Chapter 1.

condition as children. All of them recounted anecdotes of extended bouts of sadness or lethargy or excessive worry or boundless energy, but none recalled having been diagnosed or treated for these early episodes.

Throughout the interview process, the participants examined these early events in their lives, events which bore the classic signs of an episode of Mood Disorder. They realized after examining the transcripts of their interviews that they had all endured “black periods”, “panic attacks” or “deep slumps” many years previously: times which had probably been episodes of Depression, Anxiety, Mania or Manic-Depression. They were able to examine the symptoms they experienced, the effect the episodes had on their lives and the consequences, often disastrous, that the unacknowledged, undiagnosed and untreated or mistreated episodes had in the course of their lives.

In their early years the participants tended to “self treat” with alcohol or a combination of alcohol and street drugs in order to alleviate their anxious, tormented, troubled or grandiose thoughts. They vacillated between periods of dismissing the symptoms, of blaming others - their families, friends and coworkers - and of blaming themselves, for their “unquiet minds” (Jamison, 1995). The distorted lens of the Mood Disorder dominated the first three states. But once the participants accepted the diagnosis of Mood Disorder and once the course of treatment was established, they began to develop both the strategies to effectively manage their condition and the early warning system to alert themselves and others to an impending episode.

State 1: Dismissing the Symptoms

The first state is one of dismissing the symptoms. The Mood Disorder creates a distorted lens which prevents the individual from recognizing the symptoms: cognitive and affective “blindness” inhibit awareness of the fact that the symptoms may be characteristic of a Mood Disorder. Often challenging or confronting questions from family members, close friends or co-workers alert the individual to the fact that their symptoms may be outside the range of “normal”.

All of the participants experienced physical symptoms long before they, or their doctors, came to recognize their symptoms as characteristic of a particular Mood Disorder; they recalled having persistent or recurring ailments - headaches, backaches, neckaches, sore throats, laryngitis, episodes of choking, digestive upsets, muscle aches. They frequently dismissed other symptoms such as insomnia, fatigue, trembling, dizziness, racing or pounding heart, shortness of breath, dry mouth, numbness or tingling in the hands, feet or lips or an excess of manic energy as being of no import.

Throughout this state, the participants hoped that if they ignored these sensations, they would go away. They all resisted revealing or acknowledging their early (and often not so early) symptoms of depression, anxiety and/or mania to their loved ones or to their doctors because of an overpowering sense of fear and dread. They were overwhelmed with terrifying thoughts that they might be “losing their minds”; that they might be candidates for the “loony bin”; that they might be judged by others as weak; that they might lose the respect of

those close to them - family, friends and colleagues; that they might be unable to contribute to the support of their household; that by acknowledging their condition, they might “fall apart”; that they might be losing control of their lives; that they may become suicidal.

Initially, and especially while immersed in this state, the participants were apprehensive about learning new information about mental illnesses in general and Mood Disorders in particular. They actively avoided reading or talking about their mental health. They feared that they might recognize themselves in the literature, or that by reading or talking about the condition, they might feel worse: they were terrified that by reading or talking about Mood Disorders, they might become more despondent, anxious or manic.¹² The participants all disclosed that they felt “stuck” in this state for extended periods of time and that even after fully accepting the diagnosis (state 4) and after developing the strategies to manage their condition (state 5), they acknowledged that with each recurring episode, they often found themselves back in this state.

State 2: Externalizing the Cause

The second state is one of externalizing the cause. During this state, individuals with the symptoms of a Mood Disorder may have faint stirrings that they have an underlying condition, but through their

¹² It was not until the participants had come to accept the diagnosis of their mood disorder (in State 4) that they really began to explore the medical and psychological literature, the self-help books and magazines and the relevant websites on the Internet for more information about the condition.

distorted lens, they tend to concentrate their focus on the external causes of their troubled state of mind: they blame the job, the supervisor, the coworkers, the marriage, the children, the birth family, the house, the car, the economy, the weather and even bad luck. Their view of the world is bleak.

All of the participants experienced intermittent and recurring “stress leaves”: on several occasions in the past, they had taken leaves from work ranging from 6 weeks to 6 months. But, until the latest episode, none had been diagnosed (or recalled being diagnosed) with a Mood Disorder as classified by the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) (1994). During their early leaves, they had simply stayed home for “a couple of months” after which they returned to their jobs. Several of them had regular sessions with a counsellor or psychologist as a result of a benefit available through their employer, the Employee Assistance Plan. During those sessions, they recalled focusing on relationship problems in the birth family or on problems in the workplace. A couple of them changed jobs following these stress leaves.

While in this state the participants were convinced that they needed a break from their jobs and from their families; they “needed a vacation”. They felt that their moods were the result of undue stress in the workplace, unreasonable coworkers, relentless financial strain, unhappy childhood experiences, unresolved relationship problems, the challenges of parenting, the frustration of unruly children. They were consumed by a negative and pessimistic way of thinking that served to reinforce their

firmly held belief that there was nothing that could be done to improve the challenges of work and family. Life seemed overwhelming.

All of the participants fluctuated in and out of this state and returned with each recurring episode to focus their thoughts on externalizing the cause of their condition. They vacillated, some for years, between dismissing the symptoms, externalizing the causes and internalizing the causes; but, for a couple it seemed natural and preferable to attribute blame for the mood swings to external causes.

State 3: Internalizing the Cause

The third state is one of internalizing the problem. Immersed in this state, individuals with Mood Disorders focus through their distorted lens on themselves as the root cause of their sense that all is not well. They blame themselves for not being smart enough, not being strong enough, not being attractive enough, not being slim enough, not being successful enough - financially or professionally. They experience a steady erosion of all ambition and hope. Internal recriminations become all consuming.

With the passage of time, particularly after recurring episodes of depression, anxiety and/or mania, several of the participants lost confidence in their relationships with friends and colleagues. Solid family ties and very close friendships appeared to be the most negatively affected: marriages dissolved and long standing friendships disappeared. The period of withdrawal (in the case of depressive episodes) or hyperactivity (in the case of anxiety or manic episodes) had a deleterious impact on almost all their interpersonal relationships. The stigma about the condition

reinforced the secrecy and prevented the participants from revealing their experience of the disorder: they were reluctant to discuss their symptoms and their behaviours with anyone. The profound stigma further isolated and alienated them from those held most dear.

A couple of the participants felt that their social skills eroded as a result of repeated episodes of depression, anxiety or mania: they were consumed by a lack of interest in fostering friendships and relationships with family members. They steadily withdrew from social situations. They felt that they "dug themselves into a hole": their embarrassment and shame about how they had behaved (or how they perceived that they had behaved) prevented them from reaching out to former close friends and family members to remedy bruised feelings and rebuild wounded relationships. Their weakened self-image further inhibited them from mustering the courage to confront those they feared they may have disappointed.

The distorted lens of the state of dismissing the symptoms and of externalizing the blame is equally confounding during the state of internalizing the cause of the Mood Disorder. As a result, the participants experienced what one described as "woolly thinking": irrational thoughts overpowered rational thoughts. In this state, they were overwhelmed by a pervasive lack of interest or pleasure in all the events, hobbies and activities that they had once deemed pleasurable. While they vacillated between dismissing the symptoms, externalizing and internalizing the cause of their troubled thoughts, they remained "stuck" in these three states for extended periods of time, as many as thirty years.

State 4: Accepting the Diagnosis

The fourth state is one of accepting the diagnosis of the Mood Disorder. In this state, individuals acknowledge the diagnosis, examine the symptoms, explore the treatment possibilities and comply with the effective remedies. Once the course of treatment is established, the distorted lens begins to clear.

The initial identification of the diagnosis, “Depression”, “Anxiety Disorder” and “Manic-Depression”, was a frightening concept for all five participants to both comprehend and accept. A couple of the medical practitioners who worked with them compared the Mood Disorder to diabetes or to allergies; those participants clearly benefited from the analogy and seemed to accept the diagnosis with little resistance. Although they came to acknowledge their diagnosis, they were most uncomfortable with the label “mental illness” and preferred to name their illness as a “condition” or “disorder”. Several practitioners offered either the Beck Depression Inventory (1961) or the Hamilton Depression Rating Scale (1960) engaging their patients in the process of identifying the condition. It was essential that the participants assimilate the information and take ownership of both the diagnosis as well as the treatment. But, the medications posed an enormous challenge.

Initially, all of the participants resisted, some vehemently, the suggestion that they take psychopharmaceutical therapy. They were reluctant to take medications for their condition, burdened by many preconceptions about the “mind altering” nature of psychopharmaceutical interventions; they feared that they might develop an unhealthy

dependency, and that they would “never be able to function” on their own. They all encountered feelings of frustration about their experience with the process of identifying effective medications. They were issued prescriptions and given little information about the drugs; no monitoring process was established to evaluate the impact of the medication on their lives. The drugs were prescribed in a trial and error manner. Each participant had unique experiences with the medications and suffered through numerous unpleasant side effects: the loss of libido, a metallic taste, dry mouth, slurred speech, sleepiness, frequent headaches, skin rash, diarrhea and constipation, to name a few. All of them repeatedly declared their intention to end the medications “as soon as possible”; they looked forward to the day when they could get “back to normal” and be “drug-free”.

Once the psychopharmaceutical interventions restored their chemical balance, the participants all engaged in regular sessions, or “talk” therapy, with a psychologist. They all felt that the talk therapy that they had engaged in before they reached this state was not as successful as the sessions they had after accepting the diagnosis. While immersed in the states of externalizing and internalizing the cause of the mood swings, they were not fully responsive to the benefit of psychotherapeutic discourse. A couple of them likened the process of talk therapy to the peeling of an onion; they felt that it was only when they had genuinely accepted the diagnosis and had embraced the medications that they were able “peel away another layer” and examine their fundamental “life issues”.

The two participants who experienced suicidal ideation were treated in a very direct and inclusive manner by their family practitioners. These doctors openly discussed their suicidal thoughts with them, and after referring them to psychiatrists and psychologists, frequently consulted with all the professionals involved, all the while maintaining close contact with their patients. The professionals remained in close contact with one another about the treatment program; they monitored the effectiveness of both the medication and the talk therapy; and, their combined efforts probably saved their patients' lives.

All of the participants had some difficulty with both their employers and with the carrier of long term disability insurance with respect to the diagnosis and treatment of their Mood Disorder. Regardless of the medical diagnosis, the employers' term for their leave of absence from work was always "stress leave". The participants received their diagnosis from practicing medical practitioners (family doctors and psychiatrists), but they were reluctant to use the medical/psychiatric labels for their various Mood Disorders; they were too pejorative to be cited as the reason for the leave. While all of them privately acknowledged that their symptoms were characteristic of "Depressive Disorders", "Anxiety Disorders" and "Bipolar Disorders" (Manic-Depressive Disorders) as defined by the diagnostic criteria in the DSM-IV (APA, 1994), they were most uncomfortable using the medical/psychiatric labels. They frequently referred to their condition as "stress" and preferred to cite "stress leave" as the reason for their absence from work.

State 5: Developing the Management Strategies

The fifth state is one of devising the effective strategies to manage the condition; these strategies are unique to each individual and include the development of an early warning system. In this state, individuals engage in the process of experimentation to identify the factors which contribute to the successful management of the condition. They view their world through a clear lens. They become knowledgeable about Mood Disorders in general and their own manifestation of the disorder in particular.

In this state the participants examined all aspects of their lives with their counsellors, partners and closest friends. They examined their working environment and a couple decided to leave their current jobs and find one that was more suited to their interests and abilities. They tried to adopt habits to assist in the management of their condition, habits which were specific to each one's particular needs: immersing themselves in hobbies such as gardening, woodworking, furniture refinishing, reading, writing, knitting, sewing, photography, golfing: following rituals on a regular basis such as walking, jogging, biking, hiking: pursuing healthy practices such as eating smaller meals, examining food allergies, avoiding alcohol and caffeine, limiting work projects, adopting regular sleep hours; exploring "alternative" therapies such as meditation, aroma therapy - a variety of holistic remedies.

Several of the participants developed an early warning system that heralded the first stirrings of a recurrence of mood disruption. They alerted their closest relatives, friends and colleagues to the characteristic

symptoms of impending episodes: fatigue, insomnia, fretting, choking, sore throat, backache, headache, anxiety, apathy, rage, loss of pleasure, relentless pessimism and negativity, relentless optimism and grandiosity. They asked their confidantes to confront them in the event that the telltale symptoms of their Mood Disorder became evident.

Three of the participants had developed very thorough and sophisticated techniques to assist them in the management of their Mood Disorder: they had perfected both their management strategies and their early warning system. They were fully confident in their ability to contend with an impending episode should one occur. The remaining two participants were immersed in the process of cultivating effective management strategies and developing an efficient early warning system. All five individuals were resolute about their commitment to return to their medical practitioners, psychiatrists and psychologists for immediate assistance at the first sign of an impending episode of Mood Disorder.

Unanticipated Findings

I needed to unravel and examine a phenomenon that presented itself in the interviews of one of the participants: the possibility of a diagnosis beyond the Axis I Mood Disorders and Anxiety Disorders. The presentation of symptoms characteristic of “Borderline Personality Disorder” one of the Axis II Personality Disorders (see Appendix E: Personality Disorders) had been identified by her psychiatrist. The blurred lines between the symptoms of the Personality Disorders of Axis II (DSM-IV) and the symptoms of the Mood Disorders (Depressive Disorders and Manic-

Depressive Disorders) and Anxiety Disorders of Axis I (see Appendix C: Mood Disorders; and Appendix D: Anxiety Disorders) may have complicated the treatment strategies and compromised the success of the treatment. The difficulty of teasing apart the distinction between the Mood Disorders of Axis I and the Personality Disorders of Axis II, especially Borderline Personality Disorder, was clearly a challenge for the medical practitioners. The confusion surrounding the medical diagnosis compounded the patient's frustration.

All of the participants vacillated between two poles with respect to the cause of their mood swings. On the one hand, they acknowledged that their depressive, their anxiety and their manic episodes were likely caused by a biological chemical imbalance. But, on the other hand, they wondered if their depressive episodes, anxiety episodes and manic episodes might have been caused by life experiences - living with an alcoholic parent, suffering sexual abuse as a youngster, witnessing the accidental death of a friend as a teenager, working in a "toxic" environment as an adult. One participant described the dichotomy as a question of, "Which came first, the chicken or the egg?".

Impact on the Participants

At the outset of the study, all the participants appeared to be fascinated with the research process and were hopeful that by contributing to the narrative study they might learn more about the condition with which they were contending. After our second interview together, they all expressed an interest in reading the results of the study;

they conveyed a sense of satisfaction having participated in the study; they all thanked me for the opportunity to discuss their experience of living with Mood Disorders. Their commitment to the research process was evident throughout the study and their boundless interest in the topic was inspiring.

All of the participants were initially upset when they first read their transcript. They reported that they felt “disturbed” and “agitated” when they began to read the transcript of their first interview. One was “appalled” at the poor grammar in the speech patterns and another described the dialogue as “truncated”. One reported that after reading two or three pages she had the impulse to “throw the transcript across the room”; she set the document aside for a full week before returning to read the remaining pages. One reported that reading the life story in print, “seeing it in black and white”, made it seem more “permanent and real”: she was left feeling very “vulnerable and naked” gasping “Oh, my God, that’s my life!”.

When probed about the root of their reactions, the participants said that initially they felt embarrassed that their lives looked so “horrible” on paper. They were filled with an overpowering sense of shame. They were mortified that they may have said or done some inappropriate things during those episodes of depression, anxiety or mania; that friends, colleagues and family members may have lost faith in them because of their erratic or unresponsive behavior; that they may have “let down” friends, colleagues and family members who had been unable to rely on them; that they may have been unproductive both at home and at work.

They feared that they may have caused irreparable damage to the relationships (friends, colleagues and family members) that really mattered in their lives.

Two of the participants said that by standing back from the transcript and reading the story as if it were the experience of someone else, they began to develop some empathy. They were able to acknowledge their own courage and strength in accepting the diagnosis and in developing the strategies to manage the Mood Disorder. They both admitted that reading the transcript of their “life story” had helped them develop pride in their accomplishment.

All of the participants had become quite knowledgeable about Mood Disorders but when asked if they thought that members of their immediate family had the condition, their initial response was “No”. Upon further discussion they revealed that a sister had been on various forms of antidepressant medication for over twenty years, that an aunt had undergone electric shock therapy on several occasions, that a grandmother had been hospitalized for unrelenting depression, that a brother had always had a “drinking problem”, that a father had spent long periods of time off work on “stress leave”. They dismissed such symptoms as normal or commonplace and only after further reflection did they “see” the probability of the prevalence of Mood Disorder in their family-of-origin. One described the revelation as an “epiphany” that occurred as she was reading the transcript of the first interview: she had never before thought of the condition as one which prevailed throughout her family.

Following the first interview all of the participants initiated discussions about Mood Disorders with family members with whom they had never before broached the subject. The stigma of Mood Disorders had been, and continues for some to be, silencing and stifling. In some of their families, the presence of Mood Disorders was a “family secret”; it had never before been discussed openly. In a couple of cases, as a result of initiating the discussion, facts about the prevalence of manic, anxiety and depressive episodes amongst family members tumbled out, facts that had long been hidden from one generation to the next. All of the participants were eager to take the opportunity to examine some of those details and derive some meaning from their newfound knowledge about their family history.

Impact on the Researcher

Throughout the process I tried to remain mindful of the impact of the research on me, the researcher. I engaged heartily in the interview process, thoroughly immersing myself in the lives of the participants. I recognized my need to dedicate myself to one individual at a time, and I consciously spaced the initial interviews one week apart. After each initial interview, I felt exhausted.

After completing the transcription process, I became aware of a growing reluctance on my part to immerse myself once again in their stories. Reliving the complexity of their lives became increasingly onerous. In myself, I began to recognize a phenomenon to which medical practitioners, psychiatrists and psychologists had, over the course of my research, alluded: there exists the very real possibility that repeated

exposure to patients and clients with Mood Disorders can be detrimental to the well being of professionals.

I wrote and re-wrote the narratives of the participants' lives with a sense of enormous responsibility. I agonized over the inclusion of their very private disclosures, disclosures which they had entrusted to me. Revealing such disclosures in my narratives of their stories felt like a betrayal. In order to ensure their anonymity, I sought to change several identifying details about their lives, details which in my opinion had little impact on the "essence of their experience" (chapter 4, The Narratives). But, how could I be certain that the details which I changed were not germane to their lives? In making those small changes, I felt like I was in some ways being deceitful in "renarrating" (Josselson, 1994) their true narratives.

Denzin and Lincoln reminded me that "we study the Other to learn about our Selves" (1994, p. 561). Throughout the process of immersing myself in the lives of the participants, I have developed a greater understanding and deeper compassion for members of my own family who live with Mood Disorders.

I have aspired to follow Laurel Richardson's assertion that as researchers we must reveal ourselves in our writing and that in order to ensure that our studies are read, we must "create texts that are vital" (1994, p. 517). I have struggled with this concept for two reasons. Firstly, I have found it difficult to reveal much about myself. As I declared at the beginning of my dissertation, I have not identified "any details about the prevalence of Mood Disorders amongst my relatives" (see Footnote 2 in Chapter 1). Secondly, I have found it challenging to insert myself in my

writing as a result of years of training that discouraged the use of the first person point of view in formal writing. I have attempted to acknowledge my presence in every aspect of the research process and have tried to write in such a way that my work will be read by those both within and beyond the academy.

CHAPTER 6

Conclusions

In the early stages of the development of my research proposal, one of my committee members asked, perhaps rhetorically, “Doesn’t everyone get depressed?” At the time I was confounded by his question; I struggled to respond, and I returned to the literature with renewed interest. I re-examined the diagnostic criteria for Mood Disorders, criteria used by medical practitioners, psychiatrists and psychologists in North America since the early 1950’s, in the Diagnostic and Statistical Manual-IV (DSM-IV) (APA, 1994). But, the DSM-IV only partially provided me with an answer to his question. I re-examined the autobiographical accounts of living with Mood Disorders, and I reviewed the countless medical, psychiatric and psychological texts that examine Mood Disorders. But, it was not until I vicariously “lived” the experience of Mood Disorder with the five participants that I genuinely knew how to respond.

The Lived Experience of Mood Disorders

Living with Mood Disorders is a baffling and complicated experience. Those with the condition develop the symptoms very slowly and in an insidious way; every aspect of their being becomes affected as the distorted lens of the condition grows increasingly more powerful. The very lens which helps them function in their world begins to deceive them. With the passage of time, all areas of functioning become affected; their affective, cognitive, occupational, philosophical, physical, psychological, social and spiritual lives become modified by the the distorting quality of their lens.

The world is misrepresented to them, leaving them at times confused, disoriented, disengaged, distracted, angry and frustrated. Many individuals struggle for years to cope with the life they “see”, locked in the first three states of Mood Disorders: dismissing the symptoms, externalizing the causes, and internalizing the causes of their sense of disharmony. They know nothing else.

A colleague who has struggled to manage his Mood Disorder for all of his adult life once described his condition as “soul destroying”. At the time I recall having difficulty understanding the depths of his conviction that his condition could possibly have had such a destructive impact on the core of his being. I am coming to fathom what he meant by those words. Over the years, those who experience Mood Disorders suffer an accumulation of insults to their sense of self worth. The alternating episodes of mania and depression for those with Manic-Depressive Disorders, the alternating episodes of anxiety and depression for those with Anxiety Disorders and the interminable depressive episodes for those with Depressive Disorders, over time, erode the spirit.

During episodes of mania, anxiety and depression, individuals with Mood Disorders become profoundly self-absorbed. Their distorted lens contributes to their losing sight of the needs of those around them; their social skills may become eroded and interpersonal sensitivities may become heightened as a consequence. While relationships may be restored during the periods of calm, for those individuals who remain stuck in the first three states, the cycle continues with the emergence of each new episode. But, those who have embraced the fourth and fifth states, in

accepting their diagnosis, and in developing the strategies to manage their condition, have broken the endless cycle of being engulfed by recurring episodes of mania, anxiety and depression. With the emergence of new episodes, their early warning systems ensure that they receive critical intervention promptly.

The Causes of Mood Disorders

There is a substantial body of evidence that supports the theory that there is a genetic predisposition to most Mood Disorders (Goodwin & Jamison, 1990; Jamison, 1993, 1995; McGoldrick, 1995). This evidence is well documented through the examinations of multi generational families in which there exists a prevalence of the condition. As we examined their own families, each of the participants traced back through several generations to find examples of cousins, aunts, uncles, grandparents and especially siblings and parents whose behaviours indicated the likelihood of the presence of Mood Disorders. Most such individuals had not been diagnosed or treated for the condition; in several instances, the troubled and often inappropriate behaviours of these individuals had tragic consequences in the family history.

I believe that there are environmental stressors - stressors unique to each individual - which have the potential of triggering an episode in those with a genetic predisposition to the condition. Each of the participants experienced a series of stressful events prior to the emergence of their latest, diagnosed episode: the death of a pet, the move to a new community, the change of a job, the loss of a job, the sale of a business, the

breakdown of a relationship, the death of a parent, the birth of a grandchild.

The Stigma of Mood Disorders

The stigma attached to Mood Disorders is profound. The shame of being diagnosed with a Mood Disorder remains a fundamental barrier to the normalization of individuals who receive the diagnosis. Those who suffer from the condition are reluctant to become informed about its facts and become frozen with fear about its impact. Ignorance and fear interfere with the disclosure, the diagnosis, the treatment, and ultimately inhibit the management of the condition.

Blinded by the stigma of mental illness, well meaning family members, friends and colleagues may undermine the diagnosis, treatment and management of the condition. Inadvertently, they may interfere with their loved one's commitment to drug therapy, "Are you off your drugs, yet?" and confidence in talk therapy "Are you still seeing your psychologist?". As a result, many individuals with Mood Disorders are loath to disclose their experience of the condition even to those who are closest to them.

Family members often withhold information about the presence of Mood Disorders amongst relatives resulting in generations remaining ignorant of its prevalence. Concerned family members often tolerate unreasonable behavior from one who has the condition out of fear that confrontation (regardless of how tender) might further disturb the person with the disorder. Families unwittingly contribute to the erosion of social

skills as the anti-social or asocial behaviours of the individual with the Mood Disorder become tolerated in the family unit. They fear that their actions might contribute to an angry outburst or, ultimately, to suicide. The perceived or real fear of suicidal ideation can hold a family hostage, inhibiting healthy, open communication amongst family members.

The Diagnosis and Treatment of Mood Disorders

The distorted lens of individuals with Mood Disorders interferes with the identification of the symptoms, the diagnosis and, often, the treatment. Reluctant patients may agree to follow their doctors' prescribed drug treatment, but as soon as the mood swings have stabilized, will discontinue the drug therapy; frequently, such patients will experience the recurrence of a major episode. In the case of some individuals with Mood Disorders, drug therapy may be required as a lifelong treatment, akin to the administration of insulin in the case of individuals with diabetes. The most effective treatment for those with mood conditions consists of a combination of drug intervention and cognitive behavioural approaches in talk therapy. The drug intervention must precede the talk therapy as chemical balance must be restored to the system before the talk therapy will be effective.

Psychologists must help those with Mood Disorders to examine their patterns of interactive behaviours: these behaviours must be reviewed and relearned through talk therapy. The depressive, anxious or manic way of thinking often leads to inappropriate reactions which elicit negative responses from those who live and work with people with Mood

Disorders. This negative response further isolates those who suffer from the mood swings; they need to feel embraced and accepted not rebuffed and rejected by those around them. Furthermore, if left untreated, those with the condition may develop antisocial behaviours which become entrenched over time. The insidiously slow development of the symptoms often results in the failure of friends and family members to recognize the increasingly erratic, irrational behaviour as extraordinary.

At the outset of this study, I accepted the distinction made in the DSM-IV (APA,1994) between Mood Disorders (Depressive Disorders and Bipolar Disorders) and Anxiety Disorders. But over the course of my research, I have come to believe that “Mood Disorders” ought to encompass all three conditions. The prevalence of Anxiety Disorders co-existing with Depressive Disorders suggests that Anxiety Disorders are simply one manifestation of an underlying mood condition: some people with the condition experience depressive episodes, some experience alternating manic and depressive episodes, some experience alternating anxiety and depressive episodes. On the basis of my research, there is a case to be made for including Anxiety Disorders under the rubric “Mood Disorders” along with Depressive Disorders and Bipolar Disorders (Manic-Depressive Disorder).

One of the participants was advised by her psychiatrist that she may have Borderline Personality Disorder, an Axis II Personality Disorder, as well as the Axis I Mood Disorder, Manic-Depression. I cannot help but wonder if the predisposition to Mood Disorders might be the precursor to many of the Axis II Personality Disorders. The relationship between the

Axis I Mood Disorders and the Axis II Personality Disorders is ill defined. There remains little doubt in my mind that recurring episodes of severe and prolonged Mood Disorders may develop irrational beliefs and entrenched behaviours which have the potential of developing into full blown Personality Disorders. The Personality Disorders of the Axis II are so much more formidable to treat than the Mood Disorders of Axis I: the individual with a Personality Disorder often resists treatment and the entrenched behaviours are very difficult to reshape.

Recent studies support the view that changes occur in the brain chemistry during the extreme mood swings, and that extended episodes of such swings may result in permanent changes to the brain creating very real changes in the brain functioning. It is imperative that those who experience prolonged and/or recurring episodes of depression, anxiety and mania receive appropriate treatment to alleviate the symptoms and to help reduce the potentially devastating impact of such episodes on their lives.

The Management of Mood Disorders

All of the participants wanted to have greater involvement in the treatment of their condition; they recognised the benefit of being an integral part of the treatment team. They preferred to work in partnership with the medical practitioners, psychiatrists and psychologists in determining the most effective strategies to treat their condition, especially with respect to the medications prescribed.

One of the most helpful approaches taken by medical practitioners

was to compare the condition to diabetes or allergies. The participants who had the benefit of such comparisons clearly benefitted from the analogy; they seemed to accept the diagnosis with little resistance. Those whose practitioners offered them either the Hamilton Depression Rating scale or the Beck Depression Rating scale appeared to assimilate the information and take ownership of both the diagnosis as well as the treatment far sooner than those who had not been given the scales.

The condition is most effectively managed in much the same manner that diabetes is now managed: those with diabetes are encouraged to take primary responsibility for the management of their condition. In the event of an episode of mania, anxiety or depression, those with Mood Disorders benefit by maintaining a daily record of their condition, recording the medications ingested as well as their overall affect. The critical details of each day are on record. The requirement to maintain accurate records is extremely important because individuals with the condition lose mental acuity and cognitive capabilities during manic, anxiety and depressive episodes. It is most helpful when practitioners provide their patients with a clear, written record of the medication dosages, including the frequency and timing, to ensure that they fully comprehend the prescription. Often, individuals with Mood Disorders are unable to absorb verbal instructions: both a verbal and a visual record of the prescription is essential.

The management strategies adopted by the five participants were tailored to their specific interests, sensitivities and needs. They adopted several new habits: sleeping 8-10 hours nightly, exercising regularly,

getting fresh air daily. They embraced favourite hobbies: reading, carpentry, sewing, knitting, photography, golf, bridge, music. They limited their social obligations and engagements; they reorganized household responsibilities; they practiced relaxation exercises; they limited work commitments. And, they examined what they ingested: reducing or eliminating caffeine and alcohol, eating small meals regularly, avoiding food allergies and sensitivities, avoiding foods contraindicated with antidepressants and avoiding over the counter medications contraindicated with antidepressants.

The participants who had developed the strategies to manage their Mood Disorder and who had established an early warning system to alert them and their closest confidantes to an impending episode, were clearly in control of their condition. They felt confident that could withstand the onslaught of an encroaching episode. They had an enormous sense of pride in their ability to manipulate and control a condition which for most of their adult lives had manipulated and controlled them.

The Impact of Mood Disorders

Numerous studies have estimated that as many as one in four people in the general population will develop a major episode of Mood Disorder at some point during his or her lifetime (O'Connor, 1997). But, this figure may underestimate the actual prevalence of the condition: real numbers are difficult to calculate as a result of the fear, the ignorance and the stigma surrounding the disorder. The failure to diagnose and treat those with Mood Disorders has an enormous impact on society. Recurring and

prolonged episodes of depression, anxiety and of mania, if not managed, have the potential of resulting in wounded personal relationships, in failed business ventures, in bankruptcy, in lost time in the workplace, in broken marriages, in estranged families, in suicide.

Limitations of the Study

The study has several limitations. It consists of an examination of the lives of five individuals only. The study was conducted over a four-month period which may not have afforded them adequate time to fully process their reactions to the experience of a narrative study. The participants did not have the opportunity to examine the findings in general or to consider the proposed theory of the five states of Mood Disorders in particular.

The study does not take into consideration a large body of research with respect to the relationship between depression and the role of women in our culture. I have not taken into account the feminist literature nor the emerging male identity research; I have chosen not to address the issue of gender roles for either women or men with respect to Mood Disorders.

Due to the nature of the research design, a self-selecting process occurred with respect to the participants' willingness to examine their experience of Mood Disorders. The research design attracted individuals who have accepted the diagnosis of their Mood Disorder and who are inquisitive, reflective and self aware. However, individuals who have not accepted the diagnosis and who are not introspective, nor inclined to

examine and understand the disorder, in all likelihood would not volunteer to participate in such a study. The voices of such individuals are not reflected in this research.

Recommendations for Further Research

This research raises the possibility of future studies. A follow-up study of the five participants' reactions to the findings and conclusions might reveal a greater depth of understanding, another level of Polkinghorne's "realm of meaning". Another possibility might be a narrative study which examines the lived experience of those who reside with an individual who has a Mood Disorder. Finally, a study which examines the impact on health care practitioners who work with individuals with Mood Disorders, might disclose significant insights about their experience.

"Doesn't everyone get depressed?"

Throughout the research process, I have been guided by my desire to develop a greater understanding of the lived experience of Mood Disorders, and to help my participants as well as my readers develop a greater understanding of the condition. I have been committed to the challenge of composing an adequate response for the question, "Doesn't everyone get depressed?".

I have reworded the question: "How does one differentiate between the very human emotion of depression and the disorder of depression?". The former is an appropriate response to the experiences of life, and the

latter, an unrelenting, prolonged sadness that has a negative impact on the affective, cognitive, occupational, philosophical, physical, psychological, social and spiritual areas of functioning. By extension, I have asked myself how does one differentiate between the very human emotions of anxiety and of elation, and the corresponding disorders? Similar distinctions apply. The former is an appropriate response to the experiences of life; the latter, is an unrelenting and prolonged period of abnormally “intense fear or discomfort” in the case of Anxiety Disorders (APA, 1994, p. 199), or “elevated, expansive or irritable mood” in the case of Manic-Depressive Disorder (p. 161) that has a negative impact on all areas of functioning. The experience is complicated by a distorting lens which misrepresents the world to those who live with Mood Disorders.

All five of the participants seized the opportunity to join me in the examination of the lived experience of Mood Disorders. They embraced the invitation to participate with energy and enthusiasm. As a researcher, I have been humbled and heartened by their courage, their strength, their determination and their candour. I am forever grateful that they allowed me to become entangled in their rich tapestries, if only briefly. They are inquisitive, self-aware individuals who, I suspect, will continue to pursue life with an introspection and curiosity that will reinforce their ability to effectively manage their conditions.

. . . . And so we came forth,
And once again beheld the stars.

~ Dante

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APPENDIX A

Definitions - Mood Disorders

Anxiety Disorders: excessive prolonged feelings of distress or worry. The DSM-IV¹³ (APA, 1994) stipulates that the symptoms must be present more days than not over a six month period to constitute “Anxiety Disorder”.

Bipolar Affective Disorder: synonymous with “Bipolar Disorder” and “Manic-Depressive Disorder”. A term introduced in the 1970’s by the American Psychiatric Association.

Cyclothymic Disorder (Cyclothymia): recurring (cyclic) and alternating episodes of “Hypomania” and “Depression”. The DSM-IV stipulates that there must be numerous recurring episodes over a two-year period to constitute “Cyclothymic Disorder”.

Depressive Disorder (Depression): a series of long periods of unrelenting low spirits with the loss of interest and pleasure. The DSM-IV stipulates that the symptoms of a Major Depressive Episode or of Dysthymic Disorder must be present to constitute “Depressive Disorder”.

Depressive Episode: a prolonged period of unrelenting, low spirits with the loss of interest and pleasure. The DSM-IV stipulates that the symptoms must be present over a two-week period to constitute a major “Depressive Episode”.

¹³ DSM-IV: The Diagnostic and Statistical Manual - 4th edition (1994), which is published by the American Psychiatric Association for the use of medical practitioners, describes the diagnostic criteria for the classification of mental disorders.

Dysthymic Disorder (Dysthymia): mild form of “Depression”. The DSM-IV stipulates that the symptoms of a mild depressive mood must be present, more days than not, over a two-year period to constitute “Dysthymic Disorder”.

Hypomanic Episode (Hypomania): a mild form of “Mania”. The DSM-IV stipulates that the symptoms of a mild manic mood must be present for a minimum four-day period to constitute a “Hypomanic Episode”.

Manic Episode (Mania): a prolonged period of persistently elevated or expansive or irritable mood. The DSM-IV stipulates that the symptoms must be present for a one-week period to constitute a “Manic Episode”.

Manic-Depressive Disorder (Bipolar Affective Disorder and Manic-Depressive Disorder): a prolonged period of alternating episodes of “Depression” and either “Hypomania” or “Mania”. The DSM-IV distinguishes between Bipolar I Disorder for those having a first episode of Mania with or without Depression, and Bipolar II Disorder for those with recurring episodes of Mania and Depression.

melancholy: persistent low spirits, derived from the Greek words “melaina” and “chole” meaning black bile. The Greeks believed that an excess of black bile from the liver caused low spirits.

Unipolar Affective Disorder: synonymous with “Depressive Disorder”. A term introduced in the 1970’s by the American Psychiatric Association.

APPENDIX B

Definitions - Human Science Research

constructivist inquiry: a research method which is based on the philosophical position that each individual is unique and can only be studied holistically (pre-1990 “constructivist inquiry” was known as “naturalistic inquiry”).

epistemology: “knowing”, the method one uses in order to acquire knowledge.

heuristic inquiry: (in education) those research methods that encourage the use of personal investigation and observation in the discovery.

interpretive inquiry: many theorists equate “interpretive inquiry” with “qualitative research”.

narrative inquiry: the research method which concentrates on organized discourse, written or spoken, which is expressed in the form of a story. The “narrative” refers both to the process and to the result of the process.

naturalistic inquiry: see “constructivist inquiry”.

ontology: “being”, the aspect of philosophy that deals with the nature of reality.

paradigm: a theoretical framework or pattern on which the research methodology is based.

participatory action research: the research approach which attempts to empower participants with knowledge and action: consciousness-raising, by inclusion, for the benefit of all.

positivism: the philosophical position that only objective accounts of the world are considered to be representative of reality.

postpositivism: the philosophical position that subjective and partially objective accounts of the world are considered to be representative of reality.

qualitative research: a holistic and idiographic method of inquiry concerned with the quality or meaning of the data (also referred to as “interpretive inquiry”).

quantitative research: an analytic and nomothetic method of inquiry concerned with the quantity of data.

APPENDIX C

Mood Disorders

from Diagnostic and Statistical Manual of Mental Disorders

(APA, 1994, pp. 161-198)

Mood EpisodesMajor Depressive Episode

A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning: at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

- (1) depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others. **Note:** In children and adolescents, can be irritable mood.
- (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others.)
- (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.
- (4) insomnia or hypersomnia nearly every day.

- (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- (6) fatigue or loss of energy nearly every day.
- (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or observed by others)
- (9) recurrent thoughts of death (not just fear of dying) recurrent suicidal ideation without a specific plan, or suicide attempt or specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e. after the loss of a loved one, the symptoms persist for longer than 2 months

or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Manic Episode

- A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).
- B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
- (1) inflated self-esteem or grandiosity
 - (2) decreased need for sleep (e.g. feels rested after only 3 hours of sleep)
 - (3) more talkative than usual or pressure to keep talking
 - (4) flight of ideas or subjective experience that thoughts are racing
 - (5) distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli)
 - (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
 - (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

- C. The symptoms do not meet criteria for a Mixed Episode.
- D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or psychotic features.
- E. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

Mixed Episode

- A. The criteria are met both for a Manic Episode and for a Major Depressive Episode (except for duration) nearly every day during at least a 1-week period.
- B. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

- C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Mixed-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

Hypomanic Episode

- A. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days that is clearly different from the usual nondepressed mood.
- B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
- (1) inflated self-esteem or grandiosity
 - (2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
 - (3) more talkative than usual or pressure to keep talking
 - (4) flight of ideas or subjective experience that thoughts are racing
 - (5) distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli)
 - (6) increase in goal-directed activity (either socially, at work or

school, or sexually) or psychomotor agitation

- (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

- C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.
- D. The disturbance in mood and the change in functioning are observable by others.
- E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.
- F. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar II Disorder.

Depressive Disorders

- 296.2x Major Depressive Disorder, Single Episode
- 296.3x Major Depressive Disorder, Recurrent
- 300.4 Dysthymic Disorder
- 311 Depressive Disorder Not Otherwise Specified (NOS)

Bipolar DisordersBipolar I Disorder

- 296.0x Bipolar I Disorder, Single Manic Episode
- 296.40 Bipolar I Disorder, Most Recent Episode Hypomanic
- 296.4x Bipolar I Disorder, Most Recent Episode Manic
- 296.6x Bipolar I Disorder, Most Recent Episode Mixed
- 296.5x Bipolar I Disorder, Most Recent Episode Depressed
- 296.7 Bipolar I Disorder, Most Recent Episode Unspecified

Bipolar II Disorder

- 296.89 Bipolar II Disorder, Recurrent Major Depressive Episodes with Hypomanic Episodes
- 301.13 Cyclothymic Disorder
- 296.80 Bipolar II Disorder, Not Otherwise Specified (NOS)

Other Mood Disorders

- 293.83 Mood Disorder Due to Medical Condition or Substance-Induced Mood Disorder
- 296.90 Mood Disorder Not Otherwise Specified (NOS)

APPENDIX D

Anxiety Disorders

from Diagnostic and Statistical Manual of Mental Disorders

(APA, 1994, pp. 199-218)

Because Panic Attacks and Agoraphobia occur in the context of several disorders in this section, criteria for a Panic Attack and for Agoraphobia are listed separately at the beginning. They do not, however, have their own diagnostic codes and cannot be diagnosed as separate entities.

Panic Attacks

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

- (1) palpitations, pounding heart, or accelerated heart rate
- (2) sweating
- (3) trembling or shaking
- (4) sensations of shortness of breath or smothering
- (5) feeling of choking
- (6) chest pain or discomfort
- (7) nausea or abdominal distress
- (8) feeling dizzy, unsteady, lightheaded, or faint
- (9) derealization (feelings of unreality) or depersonalization (being detached from oneself)
- (10) fear of losing control or going crazy

- (11) fear of dying
- (12) paresthesias (numbing or tingling sensations)
- (13) chills or hot flushes

Agoraphobia

A. Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed Panic Attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile.

Note: Consider the diagnosis of Specific Phobia if the avoidance is limited to one or only a few specific situations, or Social Phobia if the avoidance is limited to social situations.

- B. The situations are avoided (e.g. travel is restricted) or else are endured with marked distress or with anxiety about having a Panic Attack or panic-like symptoms, or require the presence of a companion.
- C. The anxiety or phobic avoidance is not better accounted for by another mental disorder, such as Social Phobia (e.g., avoidance limited to social situations because of fear of embarrassment), Specific Phobia (e.g., avoidance limited to a single situation like elevators), Obsessive-

Compulsive Disorder (e.g., avoidance of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with severe stressor), or Separation Anxiety Disorder (e.g., avoidance of leaving home or relatives).

Anxiety Disorders

- 300.01 Panic Disorder Without Agoraphobia
- 300.21 Panic Disorder With Agoraphobia
- 300.22 Agoraphobia Without History of Panic Disorder
- 300.29 Specific Phobia
- 300.23 Social Phobia (Social Anxiety Disorder)
- 300.3 Obsessive-Compulsive Disorder
- 309.81 Posttraumatic Stress Disorder
- 308.3 Acute Stress Disorder
- 300.02 Generalized Anxiety Disorder (includes Overanxious Disorder of Childhood)
- 293.84 Anxiety Disorder Due to Medical Condition or Substance-Induced Anxiety Disorder
- 300.00 Anxiety Disorder Not Otherwise Specified

APPENDIX E

Personality Disorders

from Diagnostic and Statistical Manual of Mental Disorders

(APA, 1994, pp. 275-286)

General Diagnostic Criteria for a Personality Disorder

- A. An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
- (1) cognition (i.e., ways of perceiving and interpreting self, other people and events)
 - (2) affectivity (i.e., the range, intensity, lability and appropriateness of emotional response)
 - (3) interpersonal functioning
 - (4) impulse control
- B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
- C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.

- E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
- F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

Cluster A Personality Disorders

- 301.0 Paranoid Personality Disorder
- 301.20 Schizoid Personality Disorder
- 301.22 Schizotypal Personality Disorder

Cluster B Personality Disorders

- 301.7 Antisocial Personality Disorder
- 301.83 Borderline Personality Disorder
- 301.50 Histrionic Personality Disorder
- 301.81 Narcissistic Personality Disorder

Cluster C Personality Disorders

- 301.82 Avoidant Personality Disorder
- 301.6 Dependent Personality Disorder
- 301.4 Obsessive-Compulsive Personality Disorder
- 301.9 Personality Disorder Not Otherwise Specified

APPENDIX F

Letter of Initial Contact

To: Interested Participants
From: Barbara McCallum, Doctoral Candidate, University of Victoria
Date: February 1, 2000
Re: The Experience of Living with Mood Disorders

I am a doctoral student in Educational Psychology at the University of Victoria in the Faculty of Education. I am embarking on a research study titled "An Examination of the Experience of Living with Mood Disorders".

During the next few months, I will be interviewing volunteers who live with Mood Disorders (Depression or Manic-Depression). I am inviting men and women, between the ages of 25 and 55 from the Greater Victoria area who have been diagnosed with a Mood Disorder, to engage with me in one-to-one interviews about their experience of living with the condition.

There is little research which examines the real life experience of one who has a Mood Disorder, and yet studies suggest that in North America as many as one in four of us will experience a major episode of Mood Disorder in our lifetime. I believe that your experience will be familiar to many and will provide essential information with respect to the identification, the knowledge and the management of the condition.

Your anonymity will be maintained throughout the process, and all identifying information will be kept in the strictest confidence. Your participation will include two interviews for approximately two hours and an opportunity to review the transcripts of your interviews. You may withdraw at any time during the process.

Please consider this invitation to contribute to my study. If you are interested in being a participant, please contact me by phone (#####) or email (mccallum@address).

I look forward to hearing from you.

Sincerely,

Barbara McCallum, Doctoral student,
Department of Educational Psychology and Leadership Studies,
Faculty of Education, University of Victoria.

Supervisors: Dr. Geoff Hett,
Dr. Marcia Hills.

APPENDIX G

Letter of Informed Consent

I, _____, consent to participate in the research study titled "An Examination of the Experience of Living with Mood Disorders".

I understand that my participation is completely voluntary and that I may withdraw from the study at any time without consequence and may determine what will become of any data that has been collected. I also have the right to refuse to answer any questions I do not wish to answer without consequence.

I understand that I will be interviewed twice by the researcher for between one and two hours per session and that I will be asked open-ended questions about my experience of living with a Mood Disorder. I also understand that I will be asked to read the transcriptions of my interviews with the purpose of clarifying, and/or modifying the transcript in order to assist the researcher in preparing a narrative depicting the experience of each participant.

I understand that the interviews will be audio taped and transcribed: all tapes, notes and transcriptions will be kept in a locked cabinet in the researcher's locked office: all data collected in this study will remain confidential and only the researcher will have access to the data. No identifying information will be revealed in the narrative accounts: my name will not be attached to any published results, and my anonymity will be protected. I understand that the tapes, notes and transcripts will be destroyed following the completion of this study.

I understand that as a participant in these interviews, there is the possibility that deep emotions may be stirred. Should the need arise, the researcher will refer me to a registered counsellor or psychologist for appropriate support services.

I understand that, at the end of the study, the researcher will provide me with a summary report of the study and the opportunity to have access to the complete dissertation if I so choose.

I understand that I will receive one copy of this consent form and the other copy will be stored separately from the research data.

Signature of Participant: _____ Date: _____

Signature of Researcher: _____ Date: _____

Barbara McCallum, Doctoral student,
Department of Educational Psychology and Leadership Studies,
Faculty of Education, University of Victoria.

Supervisors: Dr. Geoff Hett,
Dr. Marcia Hills.

APPENDIX H

Interview Questions

How did you know that you were experiencing symptoms of a Mood Disorder (MD)?

Describe the experiences which led up to your being diagnosed with a MD. Describe how/when were you first aware that you were experiencing symptoms of a MD.

In what way, have you been affected by your experience of having a MD?

Describe the most frustrating aspect to the condition.

Describe the most enlightening aspect to the condition.

Describe how you manage your condition.

What is the most effective way for you to manage the condition?

What is the least effective way for you to manage the condition?

Has this condition affected your relationship with family members?

If so, how?

Describe your relationship with your family members.

Has this condition affected your relationship with friends?

If so, how?

Describe your relationship with your friends.

Has this condition affected your relationship with co-workers?

If so, how?

Describe your relationship with your co-workers.

Has this condition affected your relationship with your doctor?

If so, how?

Describe your relationship with your doctor.

How has this condition affected your relationship with your counselor/psychologist?

Describe your relationship with your counsellor/psychologist.

How have you come to terms with your condition?

What meaning can you make of your experience of living with a MD?