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Exploring men's experiences and sense-making of bipolar disorder diagnoses and mood management: a photo-elicitation investigation

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ABSTRACT

Objective: Men's experiences of living with and managing the symptoms associated with bipolar disorder are poorly understood. There is also a lack of qualitative studies focused on men's experiences of bipolar disorder despite the clinical importance of this understanding for successfully supporting men to live well and manage mood symptoms.

Method: This qualitative study used a photo-elicitation approach to explore how men made sense of managing their mood symptoms when living with bipolar disorder. Six participants took photographs representing their experiences of managing their diagnosis and mood symptoms, which formed the basis of in-depth participant-led semi-structured interviews.

Results: An interpretative phenomenological analysis identified four themes: (1) "managing symptoms: living with the enemy"; (2) "we're not just managing mood episodes"; (3) "managing goes beyond a list of strategies"; and (4) "medication is a necessary evil". Common across the sample's experiences was the importance of accommodating the disruption caused by mood-related triggers and symptoms. Notably, explicit descriptions of masculinity or male identity were absent from the participants' sense-making.

Conclusions: Findings support a clinical focus on promoting idiosyncratic recoveries and living well, focusing on life beyond symptom reduction and relapse prevention, and facilitating "sense making" of men's bipolar diagnoses and experiences in practice.

KEY POINTS

What is already known about this topic:

- (1) There is a roughly equal prevalence of bipolar disorder amongst men and women, but some evidence in quantitative studies of potential sex-differences in experiences between men and women.
- (2) Despite several qualitative studies focusing on women's experiences, no qualitative studies have purely focused on men's experiences of living with bipolar disorder.
- (3) How men experience and make sense of living with bipolar disorder and managing ongoing mood symptoms is unclear. Men's experiences appear to be seldom heard in the clinical bipolar disorder literature.

What this topic adds:

- (1) Men living with bipolar disorder talked about the importance of engaging in meaningful and valued activities for effectively managing their mood and diagnosis, and in facilitating their sense-making of living with bipolar disorder.
- (2) Men were open about experiencing and making room for the potential disruption caused by future mood symptoms.
- (3) Clinicians should work with men living with bipolar disorder to identify personally meaningful activities to help manage their mood and diagnosis, promote idiosyncratic recoveries, and avoid enforcing approaches focusing only on symptom reduction and/or relapse prevention.

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Bipolar Disorder; qualitative; men's mental health; photo-elicitation; IPA

Introduction

Bipolar disorder is characterised by experiences of elevated and depressed moods, interspersed by periods of more stable moods (Goodwin & Jamison, 2007; Jones et al., 2010). Outcomes associated with bipolar disorder

can be highly variable, including risks of relapse and early mortality (Amann et al., 2015; Crump et al., 2013). Although, many people live well with bipolar disorder and experience extended periods of mood stability (Jones et al., 2010; S. J. Russell & Browne, 2005;

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Warwick et al., 2019). Therapeutic approaches for bipolar disorder therefore tend to emphasise symptom reduction and relapse prevention, often via medication and psychological therapy (e.g., National Institute for Health and Care Excellence, 2014).

There is a roughly equal prevalence of bipolar disorder between men and women (Diflorio & Jones, 2010), but somewhat mixed evidence from quantitative research that there are meaningful sex differences in the experience of bipolar disorder (Buoli et al., 2019). Although, some studies do suggest that men are more likely to have current or past histories of co-morbid substance abuse, experience more hypo/manic symptoms, and manic episodes at first onset compared to women (Buoli et al., 2019; Nivoli et al., 2011). Such studies are, however, limited by their focus on group-level statistics and lack an understanding of how people subjectively experience and make sense of living with a bipolar disorder diagnosis.

Men also tend to be under-represented in bipolar disorder research, particularly in qualitative studies exploring how individuals live with and manage bipolar disorder (L. Russell & Moss, 2013). There is some evidence to suggest that there may be select differences between men's and women's subjective experiences of bipolar disorder, such as men perceiving that they have a poorer quality of social support available to them compared to women (Kriegshauser et al., 2010). There have also been several in-depth qualitative studies exploring how women live with bipolar disorder often in the context of life events and experiences unique to women such as pregnancy, childbirth, and the menopause (e.g., Dolman et al., 2016; Fernandez et al., 2014; Perich et al., 2017). No published qualitative studies to date have, however, solely focused on men's experiences of living with bipolar disorder and managing its associated symptoms.

The lack of qualitative data on men's subjective experiences of living with and managing bipolar disorder means it is unclear what men find helpful in terms of managing mood symptoms, including any specific factors which may be unique to men. There have also been prior calls for more gender-sensitive approaches in clinical practice to improve the experience of living with bipolar disorder and in promoting treatment adherence (Kriegshauser et al., 2010). Indeed, there is evidence that being male is a predictor of increased attrition from, and low adherence to, treatment approaches for bipolar disorder, including medication and psychosocial interventions (Leclerc et al., 2013; Nicholas et al., 2010). It has been suggested that improving social support available to men living with bipolar disorder, such as through group therapy and

support groups, may be one avenue of improving such outcomes (Kriegshauser et al., 2010). There is, however, a limited literature on men's subjective experiences of living with bipolar disorder and better understanding these experiences may be important for informing more effective, gender-sensitive, clinical approaches to support men to live well with bipolar disorder.

The current qualitative study aims to explore men's experiences of managing mood symptoms when living with a bipolar diagnosis using a photo-elicitation approach and interpretative phenomenological analysis (IPA). Photo-elicitation methods allow participants to become more active agents in directing interviews and are a means of reducing power imbalances between researchers and participants (Burton et al., 2017; Sandhu et al., 2013). There is also emerging evidence of the value that elicitation approaches offer when exploring men's experiences of other health-related issues (Olliffe & Bottorff, 2007; Olliffe et al., 2019). In addition, Burton et al. (2017) outline a case for combining photo-elicitation with IPA, describing how this combination facilitates the process of sense-making and personal reflection inherent to IPA. For the present study, we aimed to recruit a sample of 6-8 men with a bipolar disorder diagnosis. A small sample for this type of study is necessary considering past health studies using combining IPA with photo-elicitation and the richness of the data yielded from this approach (Hughes et al., 2019; Mansfield & Burton, 2020), plus recommendations for IPA, including the use of smaller homogenous samples (e.g., 4-10 participants) and the need to focus on individual meaning-making (Smith et al., 2009).

Materials and methods

Design

The study used photo-elicitation and IPA to explore how men make sense of managing mood symptoms when living with a bipolar diagnosis. Participants were instructed to take images of salient aspects of their experiences of managing bipolar disorder over the course of one week, with the photographs used to guide a one-to-one semi-structured interview with a researcher at the end of the week. The transcribed interview data was then analysed using IPA following the steps outlined by Smith et al. (2009).

Sample

A sample of six men with a diagnosis of bipolar disorder was recruited based on the below inclusion/exclusion criteria:

Inclusion criteria

- Men aged over 18 years, living in the UK, and fluent in English.
- Self-reported diagnosis of bipolar, supported by The Mood Disorders Questionnaire (MDQ; Hirschfeld et al., 2000) following scoring outlined by Twiss et al. (2008).
- Euthymic in mood, confirmed by an Altman Self-Rating Mania Scale (ASRM) score of ≤ 5 (Altman et al., 1997) and a Centre for Epidemiologic Studies Depression Scale (CES-D) score of ≤ 15 (Radloff, 1977).
- Able to take and send photographs.

Exclusion criterion

- Self-reported diagnosis of schizophrenia, schizoaffective disorder, or borderline personality disorder.

Participants' mean age was 47 years (range: 28–71 years), and mean time since diagnosis was 6 years (range: <1–36 years) (see, Table 1).

Procedure

Ethical approval was granted by Staffordshire University University and the West Midlands Black Country NHS Research Ethics Committee (19/WM/0240). Study adverts were posted online (e.g., social media), on noticeboards at support group or drop-in clinic venues, with brief presentations also delivered to participating NHS teams. Participants with an interest in the study were directed to contact the first author for additional information. The first author used a set of basic screening questions to identify potential participants (e.g., whether the participant had a received a bipolar diagnosis) before they were provided with the participant information sheet and a consent form to sign. Then, the MDQ, ASRM, and CES-D were completed to confirm self-reported bipolar diagnoses and screen for current mood symptoms. For those eligible, a date for the interview was arranged approximately one week after screening questionnaires were completed. Participants were advised to begin taking photographs leading up to this date, considering the following questions when taking photos:

- What has it been like managing symptoms since I was diagnosed?
- What has been helpful?
- What has been unhelpful?

Table 1. Participant clinical & demographic information.

Pseudonym	Age	Bipolar Sub-Type	Years Since Diagnosis	Episodes of Depression (Approximate)	Episodes of Hypo(Mania) (Approximate)	Relationship Status	Highest Level of Education	Employment Status	Support for Mood Symptoms
Nelson	42	Bipolar-II	5	2	2	Married	National Vocational Qualification	Full-Time	Counselling Wife Friends
Ted	28	Unknown to Participant	<1	10	20	In a Relationship	Certificate of Higher Education	Full-Time	Psychiatrist Counselling
Jamie	45	Unknown to Participant	3	50	70	Married	Higher National Certificate	Full-Time	Psychiatrist GP CBT Support Group
Steve	37	Bipolar-I	3	10	4	In a Relationship	Bachelor's Degree	Unemployed	Psychiatrist GP Family
Fred	71	Unknown to Participant	10	400	100	Married	City & Guilds	Retired	Psychiatrist Support Group
Sam	60	Unknown to Participant	36	10	4	Married	Bachelor's Degree	Retired	Wife Psychiatrist

Participants chose six photographs to discuss during the interview and sent them to the first author via email. Two interviews were conducted face-to-face in private NHS clinic rooms, the remaining four were conducted via telephone. Participants were instructed to keep copies of their chosen photographs to facilitate the discussions and all participants had their photographs to hand via their own personal electronic devices during the interview (e.g., on a smartphone or laptop). All interviews were audio recorded and were guided by generic questions about the photographs as used in previous research (e.g., Hughes et al., 2019; Mansfield & Burton, 2020; see Supplementary File 1 for the generic interview questions). Follow-up interview questions focused on exploring the participants' sense-making elicited by their chosen photographs to facilitate further discussion of their experiences. For example, during a discussion about exercise and physical activity with "Sam", to gain a sense of Sam's sense-making the researcher asked "So, in terms of exercise and endorphins, what's the significance of that (for) managing moods?" Participants were verbally debriefed at the end of the interview, with a wellbeing check (via telephone) arranged for the following week.

Data analysis

The interviews lasted an average of 81 minutes (range: 71-104 minutes). All interviews were transcribed verbatim by the first author to support data familiarisation. Analysis of the transcription data was led by the first author and in line with IPA guidance (Smith et al., 2009). Transcripts were read numerous times to facilitate further immersion in the data. Preliminary responses to participants and the transcripts were noted down to slow the process of data summation. Next, in a process of line-by-line commenting, annotations were made around the transcript identifying descriptive, linguistic and conceptual features. Emergent themes were subsequently developed through analysis of these annotations; concise statements capturing both descriptive and interpretative information. Themes were then clustered together within each case before connections were made across the dataset, delineating super-ordinate and sub-ordinate themes.

Reflexivity

To maintain reflexivity, a research diary was maintained by the first author throughout data collection and analysis. Regular analytic discussions were also held between the first and second authors. The first

author has a close relationship with someone diagnosed with bipolar disorder, prompting an interest in people's experiences of living with the symptoms and diagnostic label. Being male, the first and second authors were particularly interested in the experiences of men. During the process of bracketing, preconceptions included an assumption that self-criticism linked to traditional notions of masculinity may be a barrier to managing mood symptoms.

Results

Four super-ordinate themes, including a total of eleven sub-ordinate themes, are presented.

Managing symptoms: living with the enemy

Diagnosis: taking the symptoms seriously

Most participants discussed the significance of their diagnosis, how it facilitated taking their symptoms seriously, and how this in turn supported them to make changes in their lives. Though no participant described management of bipolar to be straightforward, some spoke about the diagnosis as being a turning point following a "very long road" (Jamie) or a "lengthy battle" (Ted). For many, the road to a bipolar diagnosis was paved with short-term medication or counselling for the presenting problem, typically depression. Anti-depressant medication alone was viewed as ineffective or actively harmful.

A common feature of this turning point was the participants' reappraisal of their elevated mood states as a symptom or problem, enabling them to develop ways of managing these. Jamie described the point of diagnosis as instrumental in abstaining from alcohol by facilitating an understanding that "binge drinking" was often a response to elevated moods:

... it was like 'I'm feeling really good I want to go out' and it's almost like wanting to keep that feeling going ... it did end up causing issues but like it caused issues for years ... the day before I was diagnosed umm I was admitted to a psychiatric hospital and I'd been drinking heavily ... I've not drank since ... that's two and a half years ago ... [the photo] represents a couple of things for me it represents kinda pre-diagnosis and post-diagnosis (Jamie)

Awareness of triggers: avoiding the symptoms

For all participants, an awareness of the stimuli which can trigger or exacerbate their mood symptoms is an important aspect of managing. Such awareness facilitates the development of strategies to avoid triggers (and therefore symptoms). The need to rest and preserve

energy levels was common, with other triggers including ruminative thinking and a perceived lack of control. For example, Fred described rumination to be a trigger for mood episodes. He explained how attending a bipolar education group enabled him to build on such awareness by developing a strategy for managing rumination by imagining his brain as having “faulty wiring”:

... so when that comes into my mind I think ‘oh right, yeah, but that’s in the past, that means the frontal lobe and the amygdala aren’t working together at this second in time ... it just seems to help ... (Fred)

Making room: expecting disruption

As well as avoiding triggers and symptoms, some participants made sense of their mood management strategies by describing how they make room for triggers and symptoms. Ted spoke about painting as a way to channel his heightened energy during manic episodes, satisfying the need to be “*constantly moving constantly doing something constantly thinking*”.

Sam made sense of managing bipolar through a metaphor:

... one model is thinking of it in terms of a bank account ... at times when you’re depressed the amount of money coming in each day has been reduced quite a lot so you’re wise to only spend what’s there ... (Sam)

Consistent with this, Sam spoke about the importance of activities which “*put cash in the bank*” to mitigate against inevitable withdrawals made by episodes of depression. Similarly, he spoke about the importance of maintaining regular activities like exercise (see, [Figure 1](#)):

... since then, depressions I have always managed with um trying to keep stuff going, then there’s a less sharp hill to climb once you’re better ... again it’s this business of not dropping too many things so you don’t have to go through the business of picking them all up again ... (Sam)

Though such activities were described as helpful for maintaining stable mood, the key difference is the mitigation, rather than avoidance, of unwanted symptoms. Sam’s account indicates an inevitability of experiencing mood episodes, whilst not feeling resigned to this. Keeping usual routines going does not mean that depressive episodes will be stopped, but that they will be less impactful.

We’re not just managing mood episodes

Living with stigma

Though the word stigma was rarely used, its presence was reflected on by all participants. For some,

stigma actively impacts the way that they manage life with bipolar, including a perceived need for “social performance”. For Fred, internalised stigma made it difficult to disclose his diagnosis to others and seek support:

... if I actually wanted to be umm come out if you like, come out, I’m thinking ... there were two things: the fear that I’ve got [pause] this thing, bipolar, and then ... the challenge ... to actually accept it and ... get some somebody that could help me (Fred)

Fred’s repeated use of the metaphor “coming out” draws a parallel with the shame and stigma which can be perceived to be associated with the self-disclosure of one’s sexual identity. Nelson described being “treated differently” by colleagues in a former job, but also felt strongly that being open about his diagnosis is important. As part of his ongoing management, Nelson described ways that he attempts to subtly challenge others’ perceptions of him, holding in mind the potential for stigmatising beliefs or attitudes. One of the functions of organising his clothes for the week ahead ([Figure 2](#)) was to portray an identity beyond Nelson’s diagnosis:

... people’s experiences of people with bipolar can vary and some of them think that they’re unpredictable and I like to portray a picture of predictability y’know? ... because I come in in the same stuff all the time ... they know they can rely on me ... I’m there at the same time every day, I leave at the same time every day, I go for lunch at the same time every day, and they soon forget about the bipolar, it becomes secondary (Nelson)

Threat

Over half of the participants described ways in which bipolar disorder can be a source of threat to various aspects of their own lives and the lives of others, including to freedom, control, certainty, and a sense of safety. For some, their own thoughts were described as a source of threat from which they sought refuge.

When recounting a recent social event Sam spoke about the strength of his mood symptoms, reflecting on the fragility of social plans and how bipolar poses a threat to upholding them:

Obviously that was going to be quite dependent on where I was emotionally at the time, fortunately I was fairly well ... had I not been in that same place I would not have been able to go so y’know the impact on life and what I feel I’m able to do is part of the cost of the mental health issue (Sam)

Ted particularly reflected on the ways bipolar threatens his future, including his freedom to make choices, and to live the life he expected to. When discussing a place of respite, the expansive grounds of an



Figure 1. Sam's photograph (expecting disruption).

abandoned psychiatric hospital (Figure 3), Ted spoke of the threat of hospitalisation imposed by bipolar:

I've got quite a fear of being admitted into the hospital umm but it is something that my psychiatrist likes to talk at length about ... I am quite glad that it's not a regular occurrence anymore that people are kinda locked up in asylums for prolonged periods of time um

'cause it does always kind of worry me what my future is going to be like (Ted)

Ripple effects

Half of the participants described ways in which the consequences of mood episodes created difficulties of their own. Whilst major mood symptoms may not be

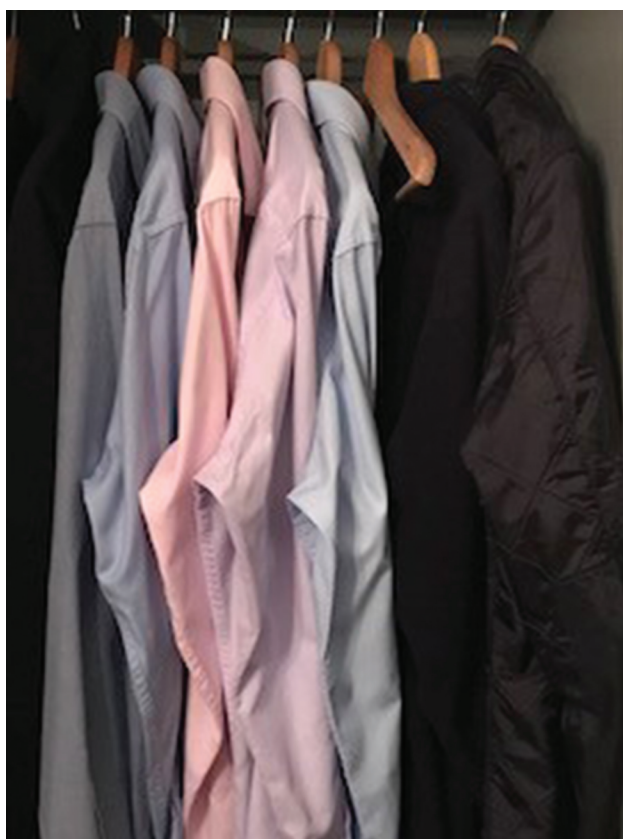


Figure 2. Nelson's photograph (living with stigma).



Figure 3. Ted's photograph (threat).

present, these “ripple effects” can increase the chances of experiencing subsyndromal symptoms. For these participants, a detrimental impact on relationships was common, limiting the availability of social support.

For Steve, his depressive episodes have had a wide range of impacts. As well as the impact on his familial relationships, the frequency and duration of his depressions have left him without employment. Due to the long periods of time spent socially withdrawn, he also described a loss of confidence, exacerbated by weight gain linked to “comfort eating” :

... because now I'm in a good place – I'm not in a great place but I'm in a good place, I'm getting better – and I'm now stuck with two extra stone in weight and I look at myself and it reminds me that I've done this because I wasn't well, I'm not how I used to be and it's a reminder every time I look at myself. So, I can style my hair, I can trim my beard, but I don't feel good about how I look because of my excess weight ... (Steve)

Managing goes beyond a list of strategies

The importance of feeling supported

Though not directly captured by many of the photographs, all of the men spoke about the value of feeling

supported. For some this was positively framed (i.e., feeling supported is helpful), for others it was negatively framed (i.e., not feeling supported is unhelpful). Emphasis on what it meant to feel supported varied between participants, including acceptance, understanding, a sense of community or connection, and an ability to rely on others. Jamie expressed how being given space during depressive episodes can feel supportive, whereas Sam spoke about acceptance from his wife and church community as being the foundation of his mood management.

The importance of feeling supported was illustrated by Ted, whose photograph of an empty armchair was used to represent the profound sense of loneliness he felt after receiving his diagnosis:

[The photograph] was to try and convey how alone I felt after I got diagnosed ... by the time I actually went and got help most people had left my life already because of some of the stuff I'd been doing ... then when I got my diagnosis it was kind of a 'right we've decided you're bipolar umm here's medication we'll see you again in 3 months' and then that was kinda me sent on my way with a prescription for pretty strong medication and I was just kinda like I don't know what to do with this information or myself (Ted)

Though he had been seen by healthcare professionals for assessment, Ted describes feeling directionless, unsupported, and uncontained by his diagnosis. There was a contrast between Ted being “sent on [his] way”, indicating that he was not in need of regular professional support, and the strength of his medication, indicating that something must be wrong.

Part of something bigger

Most of the men spoke about the importance of being part of something beyond themselves. Examples ranged from having a duty of care for their pet, a commitment to a loved one, and using their own experiences to help others. Jamie spoke about his dog and how a sense of duty to look after him superseded the absence of motivation during depressive episodes, which helped him to get out of bed and get some exercise:

... when I've not been well mentally umm and I've been spending a lot of time at home struggling to get outside ... having the dog has made me go out the house, makes me get up in the morning, makes me walk at least two times a day ... (Jamie)

Right tools for the job

Having access to the right resources was part of mood management for most participants. Fred reported a personal “fascination” with Bipolar, which he saw as key to maximising his attendance at support groups. For Jamie, mindfulness only became accessible when it was facilitated by a smartphone application, providing him with a way to be guided through the process without feeling overly self-conscious about being observed.

Nelson spoke about existing skills in developing and adhering to routines, following his service in the military as well as having work colleagues with shared interests with whom he could socialise. He acknowledged the benefits of social activity when experiencing low mood, but explained how the benefits of this are dependent on a number of factors, including the “right” activity (Figure 4):

... even when you're low y'know it's good to try and push yourself to go out and socialise ... the benefit of a gig is you don't have to interact with people ... the feeling and emotion and everything else comes from all the people around you ... everyone else is jumping up and down and excited so their emotion is coming from other people ... it doesn't take me going putting

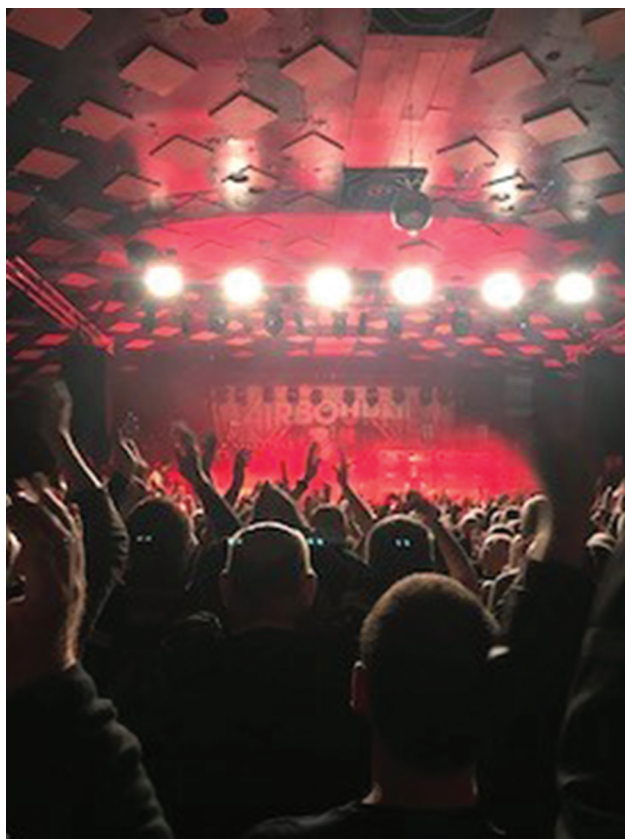


Figure 4. Nelson's photograph (right tools for the job).

my hands up for everyone else to start putting their hands up (Nelson)

When low in mood, the pressure to perform socially can be a key barrier for Nelson, particularly if asked to attend social activities such as going out for dinner, where maintaining conversation is a central component. For Nelson, it is important to access activities where the need to “do something” is met whilst removing the pressure to contribute to others’ enjoyment.

Medication is a necessary evil

Side effects are a misnomer

Participants described how side effects can become primary concerns; superseding their initial mood symptoms. Since his diagnosis three years ago, Steve has struggled to find medication that has felt helpful. He reported side effects including weight gain, sexual dysfunction, emotional blunting, and cognitive impairment, all of which have profound implications:

I know I need to take some form of medication but the side effects ... are really depressive. I don't feel like myself anymore, I don't feel like I can articulate myself anymore, I don't feel like I uh I feel very foggy all the time, I [pause] even now I have brain fog when I'm trying to speak ... (Steve)

Steve's description of a “loss of self” reflects the way in which side effects can exacerbate the low mood symptoms he was trying to alleviate. The significance of such side effects appears to be linked to their personal significance. Both Nelson and Steve have experienced weight gain on their current medications. As a former model, Steve found this particularly distressing as the additional weight impacted considerably on his sense of self-worth. However, this was not important to Nelson.

Medication isn't just taking pills

As well as side effects, some participants drew attention to the processes involved in taking medication. Ted described feeling overwhelmed by the number of pills he had to take. He also described medication to be a series of processes which in itself can feel exhausting:

I initially was thinking of laying out all of my pills umm, but I find it really difficult when I lay them all about because I just have to take so many of them ... (Ted)

... there's just times where it's just exhausting and I would much prefer not to have to go to appointments and much prefer not to have to go to take medication and not to have to go and get tests and stuff like that trying to make sure that everything's fine (Ted)

Conclusions

Research into how people live with and manage a bipolar disorder diagnosis has lacked a focus on men's experiences. This qualitative study explored how men make sense of managing their mood symptoms in the context of a bipolar diagnosis, using a novel photo-elicitation approach to empower participants to direct the focus of the interview discussions towards personally relevant experiences (Burton et al., 2017). Living with bipolar disorder was a challenge for our participants, involving a sometimes-lengthy process of identifying the personal strategies which are effective in managing and mitigating the impact of future symptoms. Getting the correct diagnosis of bipolar disorder for our participants was the first step towards better understanding their experiences and managing their symptoms, especially after receiving other diagnoses and being prescribed the associated (ineffective) treatments, points which have been reported in other, mixed gender, studies of people living with bipolar disorder (S. J. Russell & Browne, 2005). For our men, living with a bipolar diagnosis went beyond merely managing mood episodes and medications to managing other aspects of life (e.g., the expectations of, and perceptions from, other people). Our participants were also living with challenges to their quality of life between episodes as well as ongoing subsyndromal symptoms. They experienced medication as a “necessary evil”; a key aspect of mood management which often had profound effects on their lives. The men also emphasised a need for appropriate resources and meaningful support from others and healthcare professionals to help manage their moods and diagnosis.

A key part of living with bipolar disorder for our male participants was accepting that future mood symptoms may occur, accommodating the disruption that symptoms brought rather than trying to completely avoid them. Previous qualitative research has described how people living with bipolar disorder often channel their elevated moods into something desirable (Cappleman et al., 2015). Our participants extended this to describe ways of making space for low mood, reflecting an open stance towards experiencing both high and low moods. Tolerating difficult feelings and understanding that these do not always develop into mood episodes appears to be important in recovery in the context of a bipolar diagnosis (Warwick et al., 2019). Our findings suggest that a willingness to experience mood episodes themselves, as well as acceptance that some triggers of mood symptoms may be outside of one's control, can be helpful for men living with bipolar disorder.

Living with a bipolar diagnosis was more than a mood-related experience and had many “ripple effects” for our participants beyond their primary mood symptoms. These “ripple effects” impacted on many important areas of the men’s lives, including their social functioning and support networks, as well as living with the perceived stigma associated with their diagnosis, and the sense of “threat” as bipolar looms over their daily lives. Our participants also discussed the need for engaging in personally meaningful and valued activities when managing their moods, particularly those which gave them purpose and helped with their sense-making of living with bipolar.

Caution is, however, needed when comparing our findings from our male sample to other qualitative studies of how individuals live with and make sense of a bipolar disorder diagnosis as most prior qualitative studies tend to feature mixed or female-only samples. Past studies have focused on the relationships between a bipolar diagnosis and experiences unique to women, such as how bipolar mood symptoms and changeable moods are experienced during the menopause (Perich et al., 2017), and the factors associated with women’s decision-making during pregnancy and childbirth when living with bipolar disorder (Dolman et al., 2016). However, in contrast to Fernandez et al.’s (2014) study which focused on how women’s identities were influenced and changed by a bipolar diagnosis and living with bipolar more broadly, our sample of men did not tend to explicitly or exclusively focus on identity in the interviews. This difference may be due to the different methodologies and analytic approaches used between studies, with our use of a more participant-led photo-elicitation approach versus a more traditional researcher-led semi-structured interview schedule in Fernandez et al.’s (2014) study.

Our findings are, however, consistent with a move away from solely focusing on symptom resolution towards more holistic and systemic therapies and support clinical approaches which promote an idiosyncratic and personally meaningful sense of recovery when living with bipolar disorder (Todd et al., 2012). Practitioners working with men living with bipolar diagnoses may need to consider how men engage in valued and meaningful activities which are important for both mood management and the sense-making of their experiences and avoid attempts to “prescribe” strategies without exploring the personal significance and meaning of these strategies with service users. Indeed, past research has highlighted the importance of individual “stay well” plans when living with a bipolar diagnosis which are developed and adapted

by the individual for their own experiences (S. J. Russell & Browne, 2005).

Therapeutic approaches like acceptance and commitment therapy (ACT) may be helpful for men with bipolar disorder given its focus on embracing unpleasant experiences with openness (Hayes et al., 2006). Whilst few studies have investigated the effectiveness of ACT for bipolar disorder, there may be merit in promoting psychological flexibility, acceptance, and a focus on valued living, for those with bipolar diagnoses (Pankowski et al., 2017). Psychological formulations may also facilitate both sense-making and decision-making for service users and professionals (Division of Clinical Psychology, 2010), and should facilitate more collaborative working, promoting greater transparency in the development of treatment plans, and greater parity between clinicians and service users. This may go some way to meeting the need to “feel supported”, particularly the value people with bipolar disorder place on respectful collaborative relationships with healthcare professionals as a means for staying well (Murray et al., 2011). Support from healthcare professionals was something highlighted by our participants as a key aspect of managing their moods, but it was not always available. This finding complements previous research identifying the importance of social support when living with bipolar disorder (Owen et al., 2015, 2017; S. J. Russell & Browne, 2005; Warwick et al., 2019), further emphasising the underlying need to *feel* supported and what this means to the individual.

As previously mentioned, it was notable that male identity and masculinity were not explicitly discussed by our participants as part of their sense-making, which may suggest that masculinity is not an intrinsic part of living with a bipolar diagnosis or managing moods, or a specific lens through which bipolar disorder is made sense of. It has been suggested that living with a potentially stigmatising label like bipolar disorder overshadows other aspects of an individual’s identity, such as gender (Sajatovic et al., 2011). Indeed, there were some possible implicit references to masculinity in the data, such as concepts relating to performing male social roles (e.g., a need for purpose, portraying a public persona that is predictable and in control). Whilst we are unable to clarify that such pressures only apply to males and are not experienced by others living with bipolar disorder, it may be that men’s experiences are further restricted by a need to conform to social expectations of masculinity at least implicitly.

A key strength of this study is the combined use of photo-elicitation and IPA (Burton et al., 2017), which allowed our participants to share concepts and stories which they felt were important and meaningful to their

experiences of living with bipolar disorder and making sense of mood management, something which may not be easily accomplished when using researcher-derived topic schedules or researcher-led questioning. Allowing participants greater control and direction over the focus of interviews in studies of this nature is important for empowering participants and promoting findings which are reflective of the complexity of their individual experiences. This approach is uncommon in qualitative studies with clinical populations which tend to be dominated by researcher-led interviews and topic schedules.

Whilst we did not set out to exclusively recruit those who are “higher functioning”, the sample consisted of men who were in relationships, who were or had engaged with clinical services, and many possessed higher education qualifications and/or were in full-time employment. It may be that the men who took part in this study are relatively further along in their recovery, which may be reflected in the themes identified from the interviews, the lack of discussion of masculinity, and participants’ histories of engagement with clinical services and other sources of support. There is a well-established link between masculinity and help seeking, and men in general appear to be particularly sensitive towards the perceived stigma associated with seeking help and treatment for various mental health-related issues (Clement et al., 2015). It may be that men who are more recently diagnosed, yet to engage in therapy or other interventions, and/or who are adjusting to and starting to make sense of their bipolar diagnosis, have different perspectives of how their masculinity relates to their bipolar disorder experiences compared to the current sample.

There are some additional limitations to consider with this study. The participants were interviewed at one point in time, providing a cross-section of their meaning-making when they were not experiencing a mood episode. Given bipolar disorder’s often chronic nature (Goodwin & Jamison, 2007), future research may benefit from exploring the ongoing sense-making and experiences of mood management and how these may change over time. Also, we used a mixture of telephone and in-person interviews for this study due to participant preferences and their geographical spread throughout the UK, future studies using similar photo-elicitation approaches should be mindful of the importance of the photographs to guide the interview discussions, something which may be more challenging via remote interviewing (e.g., online or telephone interviews). However, men can be a seldom-heard group in qualitative health research, and this is the first published qualitative

study, to our knowledge, to exclusively to focus on men’s experiences of bipolar disorder.

In summary, this novel photo-elicitation study explored men’s experiences of living with a bipolar disorder diagnosis and managing its associated mood symptoms. For our participants, living with bipolar disorder was challenging, involving a lengthy period of adjustment to the diagnosis and medication, and this impacted across a wide range of life domains. Our sample’s experiences were not particularly made sense of through an understanding of their identity as men, rather there was a greater focus on learning to accommodate the potential recurrence of mood symptoms, as well as finding meaningful activities and purpose more broadly. Our findings support a clinical focus on promoting idiosyncratic recoveries, focusing on life beyond symptom reduction and relapse prevention, and facilitating individuals’ “sense making” of their diagnosis and experiences.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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