A Discourse Analysis of Self-management for Bipolar Disorder

Lynere Wilson

A thesis submitted for the degree of Doctor of Philosophy
Department of Psychological Medicine
University of Otago, Christchurch
New Zealand

18 April 2016
Abstract

In line with a movement across all areas of health concerned with chronic illness, self-management practices have become an important part of what it means to provide contemporary mental health care to people with the psychiatric diagnosis of bipolar disorder. In mental health settings it is a taken-for-granted practice. The aim of this thesis is to use Foucauldian Discourse Analysis to explore how the discursive practices of self-management for bipolar disorder produce particular forms of subjectivity for those understood to have the condition and the implications of this for processes of self-formation.

In order to consider how discourse is used to both govern others and govern the self, two sources of text are used for analysis. The first source is the Psychoeducation Manual for Bipolar Disorder (Colom & Vieta, 2006) which details how mental health professionals can teach people with bipolar disorder about their condition in order that they might better manage themselves. The questions guiding the analysis of this text as how discourse constructs bipolar as an object, what subject positions it makes available and what relationship people are expected to have with the object named as bipolar disorder.

The second source of text are the transcripts of semi-structured interviews completed with 25 people with bipolar disorder as part of their entry to a clinical trial of psychotherapy and medication management as a means to reduce rates of acute psychiatric assessment and hospitalization. Analysis of these texts is concerned with how discourse is used to govern the self and is developed in a two stage process. The analysis is guided firstly by questions that ask how bipolar disorder is constructed, how is self-management constructed as an object, how is life with bipolar disorder constructed and what discourses are drawn on the process. The second stage of analysis of these texts focuses on the subject positions being made available in self-management discourse.

This analysis finds that as an object, bipolar disorder is constructed as both an illness of the brain and an object the produces an unreliable mind such that it is an object that is separate from a person’s sense of self while also being an object that interferes with the mind’s capacity to know itself. This results in persistent tensions to be
negotiated within self-management practices such that self-management discourse produces subject positions characterised by dividing practices and contradiction.

The discourses of medicine and psychology can be seen to act to tightly regulate how bipolar disorder can be understood which results in all aspects of a person’s self being shaped by the condition they are understood have. These discourses have become the only way a person can legitimately construct a sense of themselves and through the workings of pastoral styles of power relationships psychological discourse can be seen to be used ultimately in the service of medical discourse.

With self-management discourse seen as operating on the basis of division and contradiction, this thesis proposes that the nature of the problem in the self-management of bipolar disorder is not the disorder or the person it is understood to inhabit but rather the norms of the self on which contemporary Western society bases its understanding of what it means to be a normal subject. The thesis concludes firstly with two alternate constructions of selfhood; the self as formed through connection and the self as formed through the management of the abject and then with a proposal for an alternate approach to psychoeducation as a particular strategy of self-management discourse for bipolar disorder.

The significance of this thesis lies in its use of a Foucauldian methodology to question the assumptions of beneficence understood to drive the promulgation of self-management practices in health care. Its resulting re-evaluation of the nature of the self in the discursive practices of self-management for bipolar disorder and its proposal for an alternate approach to psychoeducation is put forward as a contribution to the project of a contemporary critical psychiatry.
A Word Picture – Buy Polar

buy...
buy buy
Buy buy buy
Buy! Buy buy
Buy! Buy! Buy!
BUY! BUY! BUY!
BUY! BUY! BUY! BUY!
BUY! BUY! BUY! BUY! BUY!

DEBT!!??
Debt!? Debt!?
Debt? Debt? Debt?
Debt? Debt? Debt? Debt?
Debt? debt? debt? debt?
Debt? debt debt debt
debt? debt debt debt
debt? debt debt
debt? debt
debt?
Shit

Used with the permission of Dr Joe Dunn

Acknowledgements

A colleague once told me that a PhD was a degree in patience, persistence and perseverance. I now understand what she meant.

Over the years of this project there have been many people who through their words or actions have encouraged and supported me. Naming them all would be impossible but I do want to acknowledge my family (who had little choice in putting up with me) for putting up with me. A special 'thank you' must go to Nick for my writing shed which gave me the space away from work and family to think and write. A very practical demonstration of love if ever there was one. I also want to thank my supervisors – Drs Marie Crowe, Anne Scott and Cameron Lacey. None of this would have happened without their guidance and encouragement.

Because of you all I have finally managed to finish. Thank you.
List of Publication and Presentations

Publications


Presentations


# Table of Contents

Abstract .................................................................................................................................................. 2
Acknowledgements .................................................................................................................................. 5
List of Publications and Presentations .................................................................................................. 6
Table of Contents ................................................................................................................................... 7
List of Figures ......................................................................................................................................... 10

**Chapter 1 – Introduction** .................................................................................................................. 11
Critiques of Self-Management ................................................................................................................ 14
Processes of Individualization ................................................................................................................ 17
Surveillance Medicine .............................................................................................................................. 21
Bipolar Disorder ...................................................................................................................................... 25
Foucault .................................................................................................................................................... 30
Aims of this Discourse Analysis ............................................................................................................. 33
Structure of the Thesis ............................................................................................................................. 36

**Chapter 2 – Foucauldian Discourse Analysis:**

**Theoretical Context** .......................................................................................................................... 38
Post-Structuralism ..................................................................................................................................... 39
  - Language and meaning .................................................................................................................... 40
Discourse .................................................................................................................................................. 41
  - Discourse and subjectivity ............................................................................................................... 43
Power, Discourse and Subjectivity .......................................................................................................... 45
  - Governmentality ............................................................................................................................... 47
Summary .................................................................................................................................................. 50

**Chapter 3 – Foucauldian Discourse Analysis: Historical Context** .................................................. 52
Psychoeducation ....................................................................................................................................... 53
  - Psycho-education ............................................................................................................................. 54
  - Self-help .......................................................................................................................................... 55
  - Shaping behaviour through rational scientific knowledge ............................................................. 57
  - Mental hygiene ................................................................................................................................. 60
  - Deinstitutionalization: Who will manage these people now? ......................................................... 64
  - Moral treatment: re-learning self-control ....................................................................................... 69
Summary .................................................................................................................................................. 74
**Chapter 4: Method** .................................................................................................................. 76

Aim ............................................................................................................................................ 77
The Social and Cultural Context of the Analysis ....................................................................... 78
‘Doing’ Discourse Analysis ....................................................................................................... 80
  - Applying theory to method ................................................................................................. 83
  - Writing as analysis ............................................................................................................. 86
Context and Production of Interview Text ................................................................................ 86
  - Choosing the transcripts for analysis ............................................................................... 88
  - Transcription process ....................................................................................................... 89
  - Limitations of the data collection method ....................................................................... 89
Rigour ........................................................................................................................................ 91
Summary ................................................................................................................................... 92

**Chapter 5 – Analysis: Governing Through Psychoeducation** ..........93
Psychoeducation and Bipolar Disorder ...................................................................................... 94
Bipolar Disorder as an Object .................................................................................................... 96
The Bipolar Patient – Constructing Subjectivity ....................................................................... 104
  - Emotional regulation ........................................................................................................ 105
  - Attitude, insight and intentions ......................................................................................... 106
  - Reflexivity ........................................................................................................................ 107
  - Defer to the expert ............................................................................................................ 111
  - Absent subjectivity ........................................................................................................ 114
Power Relations ....................................................................................................................... 115
Summary ................................................................................................................................... 117

**Chapter 6 – Analysis: Constructing Bipolar Disorder** ................................. 121
Bipolar Disorder as a Brain Illness ........................................................................................... 123
Bipolar Disorder as an Unreliable Mind ............................................................................... 127
Mind or Body ............................................................................................................................ 133
Summary ................................................................................................................................... 138

**Chapter 7 – Analysis: Enacting Self-Management Discourse** .............. 140
Acceptance and Recognition .................................................................................................... 143
  - The active patient .......................................................................................................... 144
  - Obligations and responsibilities ..................................................................................... 145
Chapter 8 – Discussion: Re-Evaluating the Self in

Self-Management ............................................................................................................. 163
Language and Discourse ................................................................................................. 163
Summary of the Findings ................................................................................................. 165
The Ethics of a Life with Bipolar Disorder ....................................................................... 167
- The ethical substance ....................................................................................................... 168
- Mode of subjection ........................................................................................................... 169
- Self-forming activity ........................................................................................................ 171
  - Self or illness ................................................................................................................ 172
  - Becoming a creature of habit ......................................................................................... 172
  - Pastoral power ................................................................................................................. 174
- The telos ........................................................................................................................... 176
Ontological Pluralism ........................................................................................................ 178
Managing the Abject ........................................................................................................... 181
Rethinking the Self in Bipolar Disorder ........................................................................... 182
Rethinking Psychoeducation ............................................................................................. 184
- Guiding principles ............................................................................................................ 187
- Learning through social connection .............................................................................. 188
- Foundational conversations ......................................................................................... 188
  - Discourse and power .................................................................................................... 189
  - Constructing bipolar disorder as an object ............................................................... 189
Limitations of this Discourse Analysis ............................................................................. 190
Conclusion ........................................................................................................................ 192
References ........................................................................................................................ 195
Māori Glossary ................................................................................................................... 222
Appendices ....................................................................................................................... 223
List of Figures

Figure 1 "Life chart in which the patient noted the trigger, certain key treatments and facts." Colom & Vieta (2006) ........................................ 101
Chapter 1

Introduction

“There are times in life when the question of knowing if one can think different than one thinks, and perceive differently than one sees, is absolutely necessary if one is to go on looking and reflecting at all.” (Foucault, 1990b, p. 8)

Self-management practices have become an important part of what it means to provide contemporary mental health care to people with the condition known as bipolar disorder (Bond & Anderson, 2015; Morriss, Faizal, Jones, Williamson, Bolton, & McCarthy, 2007; Russell & Browne, 2005; Straughan & Buckenham, 2006; Vieta, 2005; Yatham, Kennedy, Parikh, Schaffer, Beaulieu, Alda, O’Donovan, MacQueen, McIntyre, Sharma, Ravindran, Young, Milev, Bond, Frey, Goldstein, Lafer, Birmaher, Ha, Nolen, & Berk, 2013). Most commonly defined as “the individual’s ability to manage the symptoms, treatment, physical and psychosocial consequences and lifestyle changes inherent in living with a chronic condition” (Barlow, Wright, Sheasby, Turner, & Hainsworth, 2002, p. 178), it can be seen as both an expression of the growing attention to the psychosocial needs of people who are understood to have a chronic relapsing condition and as a reflection of a movement across all health arenas toward a construction of chronic illnesses in all their forms as escalating in prevalence and burdening health services with ever growing costs (Carrier, 2015; Kemp, 2011; Ministry of Health, 2014; National Health Committee, 2007; New Zealand Guidelines Group, 2011).

This concern with a person’s ability to manage a life with what is variously called a chronic illness or a long-term health condition has seen the development of structured and manualized health education programmes that seek to teach a person about their illness, how to manage the symptoms, limit relapse and cope with the difficulties that arise from having to accommodate a long-term health condition. The work of Lorig and her colleagues in the USA (Lorig & Holman, 2003; Lorig, Ritter, Stewart, Sobel, Brown, Bandura, Gonzalez, Laurent, & Holman, 2001) on the Chronic
Disease Self-Management Program has had a particular influence upon the development of techniques to teach people what they need to know in order to become a better ‘self-managers’ of their condition. This work has had an international influence upon health systems with it being taken up in UK health policy with its ‘Expert Patient’ model of care for chronic disease (Department of Health, 2001), in Australian health services (Catalano, Kendall, Vandenberg, & Hunter, 2009) and further developed by Flinders University in Australia (Lawn, Battersby, Pols, Lawrence, Parry, & Urukalo, 2007).

In New Zealand, it has been the responsibility of each regional District Health Board to develop their own response to chronic conditions rather than a government led health policy such as in the UK (National Health Committee, 2007). Despite this, the documents that are available to guide the development of health services that are responsive to the needs of people with long-term health conditions all emphasise the importance of systems that prioritise self-management.

“A mounting body of evidence supports the notion that if a person with a long-term condition is a good self-manager then, in the context of a structured CCM [Chronic Conditions Management] programme, they are more likely to experience an increased sense of wellbeing, improved health outcomes and decreased secondary care utilisation.” (Connolly, Barber, Clinton, Devlin, Doughty, Dyall, Kenealy, Kerse, Kolbe, Lawrenson, Moffitt, Sheridan, Johnstone, Girling, & Boyd, 2011, p. 26)

Within mental health settings, self-management practices can be seen to be implemented through a range of programmes and strategies that are concerned with teaching people how to manage their illness. The work of Lorig et al (Lorig & Holman, 2003; Lorig et al., 2001) on the Chronic Disease Self-Management model has been adapted for mental health settings through such programmes as HARP (Druss, Zhao, von Esenwein, Bona, Fricks, Jenkins-Tucker, Sterling, Diclemente, & Lorig, 2010) and in the approaches detailed by both Lawn (2007) and Urukalo (2003).

Psychoeducation groups have been developed for people with specific mental disorders (Bauml, Frobose, Kraemer, Rentrop, & Pitschel-Walz, 2006; Colom & Lam, 2005; Terkselsen, 2009) and it is Colom and Vieta (Colom & Vieta, 2006; Colom, Vieta, Martinez-Aran, Reinares, Goikolea, Benabarre, Torrent, Comes, Corbella, Parramon, &
Corominas, 2003a; Colom, Vieta, Sanchez-Moreno, Goikolea, Popova, Bonnin, & Scott, 2009) who are particularly known for their work in this area in relation to bipolar disorder. In addition there are programmes that teach skills in relapse prevention (Stevens & Sin, 2005), Stern and Sin’s (2012) psychosocial group programme, Wellness Recovery Action Planning (WRAP) (Cook, Copeland, Jonikas, Hamilton, Razzano, Grey, Floyd, Hudson, Macfarlane, Carter, & Boyd, 2012; Copeland & McKay, 2002), Illness Management and Recovery program (Mueser, Corrigan, Hilton, Tanzman, Schaub, Gingerich, Essock, Tarrier, Morey, Vogel-Scibilia, & Herz, 2002; Mueser, Meyer, Penn, Clancy, Clancy, & Salyers, 2006), and the Life Goals Program (Sajatovic, Davies, Bauer, McBride, Hays, Safavi, & Jenkins, 2005; Simon, Ludman, Unutzer, & Bauer, 2002); all programmes that seek to take the expertise of psychiatric and psychological experts and teach people how to better manage their illness. While most of these programmes are led by health professionals, some like WRAP (Cook et al., 2012; Copeland & McKay, 2002), and HARP (Druss et al., 2010) are led by peers i.e. people who identify as also living with a mental illness. This promotion of the self-managing capacities of a person understood to have a mental disorder is now considered ‘state of the art’ practice in mental health care (Kemp, 2011; Morriss et al., 2007; Russell & Browne, 2005; Straughan & Buckenham, 2006; Vieta, 2005).

Despite its status as a marker of contemporary mental health practice, self-management practices in a mental health context are a generally uncontested construct. It is as if they have taken on a ‘common sense’ status that has resulted in questions rarely being asked of self-management policy or practices. This introductory chapter seeks to highlight some of the cultural and social forces that shape how both self-management and bipolar disorder are constructed and the resulting assumptions that are made about the nature of the people expected to engage in these practices. After first considering some of the critiques of self-management practices and policy that do exist in the literature, social theories of individualization and trends in contemporary health care named as surveillance medicine are both used to explore some of the cultural and social forces shaping how self-management can be spoken of. Following this, consideration is given to how bipolar disorder is constructed and the place of self-management practices within
this. The chapter then makes a case for using Foucauldian Discourse Analysis as a means to investigate the discursive practices of self-management for bipolar disorder with a focus upon how they then shape how a person with bipolar disorder comes to make sense of themselves.

**Critiques of Self-Management**

While self-management is generally an uncontested construct within mental health settings and for bipolar disorder specifically, it is critiqued by some authors as part of a broader debate about how to manage chronic illness in health systems more effectively. The criticisms levelled at self-management primarily arise from the way a medical discourse of illness dominates how self-management is thought of and practiced and these are now addressed in turn.

As a construct based upon a medical model, self-management is seen as privileging a focus upon the individual with the illness as the ‘problem’. This results in the ‘answer’ to the problem becoming how to educate the individual to follow medical advice and develop the necessary skills to follow such advice (Thirsk & Clark, 2014; Thorne, 2008; Wilson, Kendall, & Brooks, 2007). This attention upon the individual’s lack of skills and knowledge as the focus of self-management is argued to lead on to a tendency to ignore both the moral qualities within it and the social and cultural context within which it is practiced. Williams (1993) argues that the construction of health as something that comes about as a result of one’s virtuous actions upon oneself is a well-developed notion therefore there are routinely, but not necessarily explicitly, moral qualities to how people engage with health practices. Lorig et al’s (2003; 2001; Marks, Allegrante, & Lorig, 2005) work on Chronic Disease Self-Management is further argued by Bury (2010) to take the sociological work of Corbin and Strauss (1988) and their observations of how people with chronic illness live, and transform ideas about what people do into ideas about what people should do. When this operates in tandem with a focus upon an individual’s lack of ability to self-manage, poor health runs the risk of being attributed to a problem within the person, most particularly their lack of personal responsibility (Kendall, Ehrlich, Sunderland, Muenchberger, & Rushton, 2011).
The attention of self-management discourse upon an individual’s deficit that needs to be rectified results in a moral quality to the practice but it also results in self-management policy and practices as themselves lacking in an appreciation of the social and cultural context of people’s experiences of living with a long-term health condition (Howard & Ceci, 2013; Lindsay, 2008, 2009) such that self-management policy and practice is critiqued for underestimating the conditions that make self-management impossible (Kendall et al., 2011). Thorne (2008) argues that in the move in health care from constructs of cure to ideas of stewardship, actions cannot be separated social factors yet self-management remains steadfastly focused on expert driven definitions.

Self-management policy and practices are also criticised for a tendency to take a ‘one size fits all’ approach where it becomes assumed that it is an approach that always works for all people. Any difficulty negotiating self-management practices becomes a problem that belongs to the person rather than the practices themselves as individual responsibility for health is assumed to be a universal and culturally transferable norm (Kennedy & Rogers, 2009).

While self-management is concerned with the skills, knowledge and confidence of people with long-term health conditions, it also becomes concerned with the promotion of certain sorts of people; how to teach people to see themselves as autonomous, active, and confident decisions makers who can follow medical advice. The literature that critiques self-management also draws attention to its effect upon identity and sense of self. From their work with older people who live with asthma, Koch et al (2004) draw attention to how the ‘self’ in self-management is ignored as a result of the domination of a medical discourse of adherence to medical advice. Despite the attractiveness of the notions of empowerment that are attached to contemporary health care practices and self-management in particular (Paterson, 2001; Salmon & Hall, 2003; Wilson et al., 2007), Koch’s (2004) work suggests that there is limited opportunity for the person with a chronic condition to be positioned as an expert in their own right who chooses to use medical knowledge and skills to augment their own. In a similar vein, by focussing on how older people with arthritis talk about their experiences of living with a chronic condition, Kralik et al (2004) draw attention to the way self-management practices involve both ‘doing’ and
‘becoming’ such that actions that manage an illness cannot be separated from how one comes to see oneself.

Moore et al (2015) argue that the imperative within self-management practices for people with heart disease focused upon the development of success, skills and self-control brings normative and moral notions to self-management such that it promotes subjectivities based upon either success or failure. This construction of deficit based identities through the very programme designed to give people greater agency is a potential that is also identified by Scott & Wilson (2011) in their critique of Wellness Recovery Action Planning: a programme that was developed by people who identify as experiencing mental health problems rather than by health professionals. Rogers et al (2005) identify how a Chronic Disease Self-Management programme assumes that norms of individualism, self-control, responsibility and autonomy are transferable across culture and social context. As a result of the norms that self-management operates under, Kendall et al (2011) argue that self-management has the potential to contribute to health inequalities through the way that people become disenfranchised as a result of their positioning as people in need of instruction by experts regardless of their cultural or social context.

Overall, these critiques of self-management policy and practices draw attention to the view that it can be seen as “…an oxymoronic phrase that neither reflects the complexities of how disease is truly managed nor how humans actually behave” (Thirsk & Clark, 2014, p. 692). It would seem likely that this concern is as relevant to self-management practice focused on mental health conditions as it is to physical health conditions.

This importance now placed upon the promotion of a person’s ability to engage in self-management of their chronic condition whether it is of the mind or of the body can be seen to have come about from the confluence of a number of social and cultural factors to which this discussion now turns as a way to understand some of the broader social forces that make it possible to think that self-management is a logical and sensible response to health conditions that cannot be cured.
Processes of Individualization

Constructing members of society as individuals can be seen to have become the trademark of modern life where “the choosing, deciding, shaping human being who aspires to be the author of his or her own life, the creator of an individual identity, is the central character of our time.” (Beck & Beck-Gernsheim, 2002, p. 23). Beck and Beck-Gernsheim (2002) argue that contemporary western society can be seen to be characterised by the disintegration of ways of life shaped by industrialized societies where notions of class shaped family structure, gender roles, education and employment. In this mode of life social categories could be relied upon to guide how life should and could be lived. The old rules of society were shaped around categories of social class, and as such, compelled people into togetherness (Beck, Giddens, & Lash, 1994). In the context of the welfare state in western societies there has been abrupt change in modes of life. Social class, gender and religion no longer offer the certainty of how to live and institutions of welfare and employment act against family cohesion and prioritise the individual recipient. Contemporary society is characterised by a life “tied to a network of regulations, conditions and provisos” (Beck & Beck-Gernsheim, 2002, p. 2); from education, employment and welfare regulations to every day rules of car warrant of fitness, and refuse disposal. These regulations are not imposed through strong prohibitions to action as was the case in traditional and industrial societies but rather individuals are incentivised to take action for themselves as social advantage and disadvantage are no longer something a person is born into, rather they are something that an individual creates for themselves with greater or lesser degrees of success in the context of constant change and risk.

The globalization of life creates a need to live with constant movement in time and place. People communicate across the globe, spend a life in cars, trains and aeroplanes, and are parts of communities that are local, regional and virtual. The decisions and options for how to live one’s life are now open to worldwide influences. In parallel, society is also constructed as in a period of transition; moving from modern industrialisation with its certainty, optimism and belief in the rational action of Enlightenment ideals into a period of concern with uncertainty and risk, and becoming a ‘risk society’ (Beck, 1992). Instead of an early modern focus on problems
with production and distribution of wealth and human progress through science, contemporary debates are focused on issues of risk alongside a recognition that scientific knowledge raises more questions than it can easily answer (Lupton, 1999). A person is now constructed as an individual who, with the assistance of institutional structures, is called upon to see themselves as the one who plans, acts, and designs their own life. This making of one’s life through daily choices of how to be is understood as a process based upon compulsion such that it is now constructed as a necessity of modern life to create one’s own lifestyle and ensure that this lifestyle always works with risk and the possibility of failure. Calculation is required as daily decisions must be made without the certainty of knowing the ‘right’ decision (Giddens, 1991).

Elliott (2016) argues that in living in a global age of individualism, ones’ individuality is not what is important but rather one’s capacity to instantly transform and reinvent oneself. This is enacted through practices of consumerism that promote notions of instant gratification and a “fantasy of the self’s infinite plasticity” (p43) such that people are judged not by what they have achieved but by their capacity for flexibility and speed of transformation. If people are to succeed within contemporary society they are constructed as needing to be both enterprising and flexible; able to adapt, accept defeat, tolerate frustration and be able to start again. The consequences of lifestyle become one’s own such that social problems turn into problems of the psychological disposition within the individual which therefore require personal solutions rather than changes in social structures (Beck & Beck-Gernsheim, 2002; Elliott, 2016).

With successful living in contemporary society constructed as requiring calculating individuals focused on reinvention it also constructs individuals as having the capacity to be reflexive; people with the ability to understand and respond to ever changing information in an on-going cycle and the continuous revision of how to be a person using the practiced art of self-observation (Giddens, 1991). When constructed in this way it is not just life that is the focus of an individual’s reflexivity but also their subjectivity. In a society where people are bound to each other through their individualism, the goal of life becomes constructed around how to be true to oneself (Giddens, 1991).
Reflexivity has become the way to know oneself through continuous practices of self-observation, reflection, choice and change. In contemporary society the individual is constructed as having the capacity to make choices reflexively such that “…whatever lifestyle the individual chooses to adopt, she or he cannot fail to be aware that other choices both could have been, and still could be made.” (Sweetman, 2003, p. 546).

There becomes an “experimental feel” (Elliott, 2016, p. 45) to what people do as they learn to factor in all the different possibilities for how to act. In the midst of this, expert knowledge can be turned to help relieve the decisions of how to live one’s life. While psychotherapy for example, offers a way to cope with the demands of individualization it also encourages this notion of reflexivity as a ‘natural’ way of being through the opportunity it offers to practice it. Through the process and language of psychotherapy a person constructs a narrative of who they are and what their ‘naturally’ choosing self wants for itself (Beck, 2002).

These processes of individualization in society can be seen to be tied to both neo-liberal forms of governmentality and the expertise of psychology, psychiatry and psychotherapy; what Rose (1998a) refers to as the psy-complex. With the person constructed by neo-liberal ideals as a consumer and the location of all agency in conjunction with a market forces approach to health care, the individual is positioned as active patient, choosing those services and interventions that will best meet their needs (Barnett, Clarke, Cloke, & Malpass, 2008). With health as a commodity, the consumer has the right to expect certain standards of service as they would with any purchase they make. But once again, with the right to choose comes a responsibility for the decisions taken (Brown & Baker, 2012).

Alongside an understanding of contemporary selves as flexible, adaptable and reflexive, Rose (2007) argues that identity is also being shaped by an understanding of ourselves as somatic individuals. As biological, molecular and genetic selves we have come to understand that we have an obligation to make sense of the risks our body faces and to optimise our body for the good of our own health and future generations (Rose, 2007). In this construction mental illness, like any other illness, is located in the body, and the brain in particular. People with mental illness becomes human beings with disordered neurochemicals and while they may not be responsible for their condition, they are none-the-less at risk of becoming ill and it is
this potential risk that they must make their lifestyle project (Scott & Wilson, 2011; Teghtsoonian, 2009). “Citizenship, here as elsewhere, is to be active. Thus the actual or potential patients must try to understand his or her depression, to work with his or her doctor to obtain the best program of medical care, to engage in self-techniques to speed the process of recovery – and, of course, to ask his or her doctor to prescribe Prozac by name.” (Rose & Novas, 2005, p. 448). In constructing individuality as somatic, the source of illness is primarily assumed to be within the individual’s body rather than within a social context. As a result both health and illness become a central strand of the biography a person creates for themselves, the outcome of which they alone are responsible. Within this particular construction of contemporary society, it is perhaps unsurprising that ideas of self-management of long-term health conditions should be envisioned as essential; that someone with ongoing health problems, can and should actively manage and choose how to live with them. In the words of Lorig and Holman who have been influential in the development of the Chronic Disease Self-Management Program at Stanford University; “One cannot not manage...Unless one is totally ignorant of healthful behaviours it is impossible not to manage ones’ health. The only question is how one manages.” (Lorig & Holman, 2003, p. 27).

This is not to suggest that theories of individualization in a context of risk and uncertainty are the only way to understand contemporary social life and the opportunities and challenges it presents. As Elliot (2002) argues, by placing risk as the central force shaping social life, other cultural and political forces that might be at work are not acknowledged. He draws attention to social theories that identify the increasing standardization of everyday life and how this suggests an understanding of human beings as becoming more regulated rather than more individualized. Equally, while tradition may no longer be the primary force that determines how to live, this loss does not mean that a complete vacuum exits where we are free to be whatever or whomever we choose. The language we use to think and express ourselves is full of links to past traditions; while a person may speak of the importance of concepts of independence and autonomy that does not mean that this same person is not also influenced by narratives of how duty and obligation shaped the actions of previous generations (Adams, 2003). Equally while the capacity to be
reflexive can be considered an essential element of the individualization thesis, reflexivity can also be understood as a form of cultural capital; a capacity that is reliant upon a particular cognitive and affective style that is shaped by one’s socioeconomic position and therefore not open to all (Scott & Wilson, 2011; Threadgold & Nilan, 2009). “People who cannot deploy such resources and capabilities...are likely to find themselves further disadvantaged and marginalized in a new world order of reflexive modernization” (Elliott, 2002, p. 305).

**Surveillance Medicine**

As theories of individualization suggest trends in our relationship with our selves, the concept of surveillance medicine can be used to understand trends in contemporary approaches to health and illness. Armstrong (1995) argues that over the course of the twentieth century a fundamental shift has occurred in the way illness and health are constructed. His ideas offer a way of thinking about self-management practices as an expression of a broader change in medical ideas about the nature of health and illness and our responses to them.

Armstrong (1995) describes a series of changes in the way understandings of illness and the body have changed since the early eighteenth century. Firstly there was Library Medicine in which the classical learning of the physician was more important than specific knowledge about an illness. Then came Bedside Medicine as physicians began to focus upon the illness itself by attending to categorising of symptoms and the practical management of illness. At this time illness and symptoms were understood to be one and the same; “a headache or abdominal pain was the illness” (Armstrong, 1995, p. 394). Armstrong identifies the appearance of Hospital Medicine as an important, revolutionary change in the practice of medicine when at the turn of the eighteenth century the clinical examination, the post-mortem and the segregation of ill bodies in hospitals allowed the body and illness to be conceived of as three-dimensional. The symptom presented by the patient was now linked to the sign that the physician could find by careful examination and both pointed to an underlying lesion that was the disease. While this way of understanding illness has remained dominant and still relevant, Armstrong argues that from the early twentieth century there was a further revolution in medical thought and practice with a developing
concern for measuring and overseeing the health of everyone and what he calls “the problematisation of the normal” (Armstrong, 1995, p. 395) where few people are understood to be fully healthy as everyone is constructed as being at risk of illness and potentially in need of medical intervention.

This attention to the health of the population is more conventionally understood using the term ‘public health’. What started as a focus upon reducing illness by attending to the environment through such projects as sewage disposal, provision of clean water and good housing, became a concern with the individual’s role in helping to stop the spread of illness, the role that the environment plays in illness and by the later part of the twentieth century, a recognition of the social and economic determinants of health (Dew, 2012). Details of people’s personal habits and domestic life were documented and became the focus of instruction in hygienic techniques for the maximization of health. This surveillance of the population and their habits saw the development of techniques of medical inspection, population surveys, education in domestic hygiene, registration of births, health visitors, school milk and infant welfare clinics. The child (and the mother as the primary caretaker) became one of the primary targets of surveillance and training in the health and hygiene of both body and mind (Armstrong, 1995; Rose, 1986).

Population surveys and the statistics required to analyse them provided the means by which health and illness could be measured across large groups and in doing so provided the evidence of levels of morbidity beyond what could be known in the hospital setting. Tools such as these allowed health and illness to no longer be seen in a binary, either/or relationship. Instead bodies could be seen on a continuum with health something that was relative amongst all bodies. A continuum allows spaces to be seen between people and it is in these spaces that Surveillance Medicine has made the case that health and illness is firstly calculable and then secondly “that everyone was normal, yet no-one was truly healthy…” (Armstrong, 1995, p. 397) and everyone therefore needs the “…benevolent eye of medicine” (Armstrong, 1995, p. 399). With this blurring of the distinctions between health and illness, health care has moved beyond the hospital to take on the wider population. Much of this extension of health care into the community is identified by Armstrong as happening post World War II with a transition from older techniques of hygiene into newer techniques of health
promotion. As people internalised the messages of health promotion, practices of diet, exercise and stress management became the means by which communities could monitor and surveil themselves. With health and illness on a continuum there is space for both to co-exist and for both to be worked upon.

In Hospital Medicine signs, symptoms and illness come together so that the body becomes three dimensional in which the object of the endeavour is to find the hidden illness. In Surveillance Medicine signs, symptoms and illness become re-envisioned as risk factors; the object is no longer the discovery of illness that the signs and symptoms point to but how the illness acts as a risk factor for the future potential of other illnesses in a never ending cascade. The conceptualisation of risk factors creates space for possibility and uncertainty as likely illnesses that might result are just that, likely but not definite. It is the possibility that becomes problematic with risk factors acting as “pointers to a potential, yet unformed, eventuality” (Armstrong, 1995, p. 402). Risk factors no longer live within the body alone and ideas of ‘lifestyle’ become a target for intervention. The idea of a psycho-social space within the person becomes important to the notion of risk factors as individual attitudes and beliefs become tied to the project of health promotion. As evidenced in the launch of a new medical journal in 1955 titled The Journal of Chronic Disease, it also became possible to conceptualise illness as something that could not necessarily be cured and that would remain a constant presence in a person’s life (Armstrong, 1990). Risk factors construct health and illness as potentially calculable uncertainties for everyone while chronic illness turns risk factors into actual medical problems that require a focus upon the individual.

This discussion of surveillance medicine provides just one way to consider health promotion practices and in particular does not draw attention to the social justice discourse within contemporary health promotion and its concern with addressing the social determinants of health (Dew, 2012). Despite this limitation, the notion of Surveillance Medicine allows a way of thinking about health practices as constructing particular relationships between subjectivity, illness, health and expert knowledge. The practices and ideas of Surveillance Medicine construct everyone as being at risk of illness and potentially in need of medical expertise. A culture of surveillance and monitoring becomes an unquestioned part of contemporary health care practice and
the calculation of potential risks becomes the domain of expert medical knowledge. In the process, some population groups become identified as being more problematic than others with more risk factors and higher levels of chronic illness and these groups or individuals in turn become the subject of intensified intervention.

Concepts of individualization, reflexivity, and responsibilization act as a way to make sense of contemporary notions of the self while surveillance medicine offers a way to make sense of concurrent trends in medicine towards a focus upon everyone being at risk of illness and in need of expert attention. Without duty and tradition to guide how life is to be lived, it is the individual who must choose how to live and accept the consequences for choices made. In the context of risk and uncertainty, the capacity for reflexivity becomes assumed as processes of self-monitoring, assessment and decision making in the light of ever changing information becomes an essential expressions of citizenship. Intensified by an embodied construction of individuality, maximising health and limiting the impact of illness becomes constructed as both a right and a responsibility held by an individual who is expected to recognise risks to their health and appreciate how their actions create costs for health care service who must in turn prioritise who they provide care to. Self-management thus becomes an exemplar of broader social forces of individualization, reflexivity, and the personal surveillance of one’s health in the name of risk and responsibility.

For people understood to have a mental illness these social forces would seem likely to be intensified by the regular attendance in their lives of experts in matters psychiatric as the language, ideas and practices of psychiatry are powerful; not least for their ability to compel a person to accept treatment for their illness because they are perceived as being a risk to themselves or others but also powerful in the sense of their ability to produce particular forms of subjectivity (Terkselsen, 2009; Weiner, 2011). Psychiatry relies upon both talk and medication as its technologies of practice and while it is known that medication has side effects that need to be monitored and managed, it is perhaps harder to see the side-effects of how psychiatry speaks about the objects and subjects that it claims as its own. It is to how psychiatry constructs the condition known as bipolar disorder and the place of self-management practices in its treatment that this chapter now turns.
Bipolar Disorder

Bipolar disorder is one of many conditions over which psychiatry claims to hold specialist knowledge. To determine if a person is to enter the realm of psychiatric knowledge and expertise a diagnosis must first made. Internationally there are two texts that act as the authority in determining if a diagnosis of bipolar disorder is justified; the International Classification of Diseases (ICD) published by the World Health Organisation of which the current edition is ICD-10 (World Health Organisation, 2015) and the Diagnostic and Statistical Manual of Mental Disorder (hence forth referred to as DSM) published by the American Psychiatric Association of which DSM-5 is the current edition (2013). In Aotearoa New Zealand it is the DSM (American Psychiatric Association, 2013) that dominates the process of psychiatric diagnosis (Mellsop, Banzato, Shinfuku, Nagamine, Pereira, & Dutu, 2007).

Bipolar disorder is constructed as a disorder of mood such that people are understood to experience recurrent episodes of abnormal mood and activity levels that psychiatry understands as ‘mania’, ‘depression’ and ‘hypomania’. The DSM constructs mania as episodes of “abnormally, persistently elevated, expansive or irritable mood and persistently increased activity or energy” (American Psychiatric Association, 2013, p. 124) that results in either hospitalization or marked impairment in a person’s functioning. Hypomania is constructed as a similar state to mania but is understood to be milder and of a lesser intensity such that other people do not intervene in a person’s life, either in terms of hospitalisation or stepping in to take over a person’s day to day responsibilities. Depression is constructed as periods of persistently low mood, often associated with a loss of pleasure in usual activities that causes impairment in a person’s day to day functioning. The term ‘mixed state’ is used to refer to when a person meets the diagnostic criteria for mania or hypomania at the same time as meeting diagnostic criteria for depression (American Psychiatric Association, 2013).

While bipolar disorder is understood to be made up of cyclical, episodic and abnormal mood states, the nature of the disorder is further conceptualised as having two subtypes; bipolar I and II. The primary difference between the two is that people with bipolar I are understood to have had at least one period of mania while those
with bipolar II experience hypomania i.e. a less intense version of mania. Bipolar disorder has not always been divided by these notions of I and II as it was not until 1994 that DSM-IV (American Psychiatric Association, 1994) introduced the construct of bipolar II disorder. Prior to ‘bipolar disorder’ the term used was ‘manic depression’ and it is to Emil Kraeplin and his work in the late 19th century that credit is usually given for being the first to construct different categories of insanity by conceptualising and separating ‘dementia praecox’ from ‘manic depressive insanity’ (Angst & Sellaro, 2000; Jaeger & Vieta, 2007). Also known as manic depressive psychosis, these terms were also used to think of people who experienced ‘depression’ without mania. By 1980 the DSM III (American Psychiatric Association, 1980) was using the term bipolar disorder as a means to separately categorize those people who experienced ‘depression’ from those people who experienced both ‘depression’ and ‘mania’. (Liebert, 2013c; Pichot, 1997).

Currently the DSM frames the prevalence of bipolar disorder as 1.8% of the population being likely in a 12 month period to meet the diagnostic criteria. Yet there is also concern in the scientific literature that rates of diagnosis have grown considerably, particularly in the numbers of people being diagnosed with bipolar II for which some suggest there could be a prevalence rates of 10.9% (Angst, Gamma, Benazzi, Ajdacic, Eich, & Rossler, 2003; Moreno, Laje, Blanco, Jiang, Schmidt, & Olfson, 2007). Burrows (2010) argues that rather than this being indicative of an actual epidemic of bipolar disorder, this is more an effect of how the DSM constructs mental disorder by turning to the concepts of ‘subthreshold’ symptoms (meeting modified or reduced numbers of diagnostic criteria) and the ‘spectrum’ model (mental illness and health are on a continuous scale) such that the definition of what counts as a mental illness is becoming more broad. What has changed is not people’s experiences but how they are categorised. In DSM-5 (American Psychiatric Association, 2013) this can be seen in the way diagnoses of bipolar disorder are to be accompanied by designations of severity as an indication of where on the spectrum of bipolar disorder an abnormal mood episode is to be placed; mild, moderate or severe. It can also be seen how in addition to the categories of bipolar I and II there is also ‘cyclothymic disorder’, ‘substance/medication induced bipolar and related disorder’, ‘bipolar and

1 This term would later be transformed into ‘schizophrenia’.
related disorder due to another medical condition’, ‘other specified bipolar and related disorder’ and ‘unspecified bipolar and related disorder’ (American Psychiatric Association, 2013). Cylothymia, unspecified bipolar and other specified bipolar disorder criteria are all concerned with attributing a diagnosis to experiences that would usually be considered subthreshold, or below the criteria already set out for depression, mania and hypomania. What was once named as ‘manic depressive insanity’ has become divided into a number of different categories and as a consequence potentially opened up the likelihood of a person’s experiences being deemed pathological.

As with DSM-III and IV (American Psychiatric Association, 1980, 1994), the DSM-5 continues to construct illness on the basis of categories despite recognising the limitation of such a method as people may “not fit exactly into the diagnostic boundaries of disorders” (American Psychiatric Association, 2013, p. 19). For Ian Hacking (2007) scientific categorical descriptions don’t necessarily describe something real or natural but instead they bring into being a new kind of way that a person can be conceived of; he proposes that categories ‘make up’ people which in turn has a ‘looping effect’ upon how people see themselves and respond to the category under which they have been placed. How people present thus categorized then changes the category itself. The implications of categorization for ‘making up’ people can be seen in the way that bipolar II disorder came into being in 1994. Prior to this the less intense versions of mania that lasted only briefly were not constructed as an illness and they were not routinely enquired after by clinicians. Instead people were more likely to be categorised as having ‘depression’ (Burrows, 2010). The person’s experiences haven’t changed in the intervening time but with the creation of bipolar II they can now come to see themselves as a different sort of person. Their periods of elation, busyness and productivity are now not a natural response to the relief of being free of depression, instead they are abnormal experiences which are to be viewed with wariness rather than pleasure. With the creation of hypomania as an illness category and a greater attention to the nature of these experiences in the person, the threshold for what counts as hypomania is in turn being challenged. Categories don’t just describe new ‘illnesses’, they also alter how people experience themselves and interact with others.
The notion of disability and ongoing impairment has also become an important part of the construct of bipolar disorder. Kraepelin's construction of separate entities of dementia praecox and manic-depressive insanity was based in part upon a way of thinking that saw the experiences now known as schizophrenia as resulting in an inevitable deterioration while those with manic-depressive insanity fully recovered their functional and cognitive abilities between episodes (Angst & Sellaro, 2000; Jaeger & Vieta, 2007). This more hopeful vision of manic depression in comparison to schizophrenia, what Jaeger & Vieta call “conventional psychiatric wisdom” (Jaeger & Vieta, 2007, p. 1), is now challenged with positivist research arguing that despite therapeutic advances, disability and poor outcomes are the norm for bipolar disorder (Huxley & Baldessarini, 2007). This notion is reflected in the DSM-5 construction of bipolar disorder with statements such as “...at least 15% [of people with bipolar II] continue to have some inter-episode dysfunction...” (American Psychiatric Association, 2013, p. 138) and “Individual with bipolar I disorder perform more poorly than healthy individuals on cognitive tests” (American Psychiatric Association, 2013, p. 131).

As well as being located with ideas of ongoing impairment and disability, bipolar disorder is also constructed as a condition that inevitably recurs with “more than 90% of individuals who have a single manic episode going on to have recurrent mood episodes” (American Psychiatric Association, 2013, p. 130). It is on the basis of bipolar disorder being relapsing and episodic that ideas of monitoring the person for the signs of impending relapse in order to take early and appropriate action are based. More importantly, if the person can perform this monitoring and surveillance upon themselves, then the chances of psychiatric expertise intervening even earlier in a relapse are seen to be increased (Morriss et al., 2007; Perry, Tarrier, Morriss, McCarthy, & Limb, 1999). Technologies that might aid self-surveillance are a growth area in the self-management of bipolar disorder; from digital self-tracking devices (Faurholt-Jepsen, Vinberg, Frost, Christensen, Bardram, & Kessing, 2015) to education programmes (Colom & Lam, 2005; Proudfoot, Parker, Manicavasagar, Hadzi-Pavlovic, Whitton, Nicholas, Smith, & Burckhardt, 2012), all are focussed on the early intervention of psychiatric expertise in relapse.
Of particular interest to this thesis is the use of the discursive technology of psychoeducation as a strategy to develop the self-managing capacities of people with bipolar disorder. It is understood as a structured educative process of providing people with information about their condition, teaching them the skills needed to manage their condition and promote their ability to make more informed decisions about their own treatment (Smith, Jones, & Simpson, 2010). Francesc Colom, a leading advocate of psychoeducation for bipolar disorder, describes it as a “simple” intervention (i.e. not requiring long and complex training) best thought of as “a patient’s empowerment training targeted at promoting awareness and proactivity, providing tools to manage, cope and live with a chronic condition…changing behaviours and attitudes related to the condition”…replacing “guilt [with] responsibility, helplessness [with] proactive care and denial [with] awareness” (Colom, 2011, p. 339). In a similar vein, Colom and Lam (2005) propose that psychoeducation works because of its attention to providing information about bipolar disorder that allows people to then improve their adherence to their medication regime, change their attitudes toward their illness, seek psychiatric help when they notice the early warning signs of relapse and regulate their lifestyle; all in accordance with a medical model of the disorder.

As can be seen from the earlier discussion of self-management practices, psychoeducation is explicitly based upon assumptions that position the individual as the one with the responsibility for their health and all the attendant obligations and duties that come with this position. Given the social forces at work across contemporary Western society it would seem unlikely that notions of self-management are going to quietly disappear. As health services respond to the ongoing pressure to address the costs of chronic illness (Bodenheimer, Chen, & Bennett, 2009; Meropol & Schulman, 2007; van Baal, Polder, de Wit, Hoogenveen, Feenstra, Boshuizen, Engelfriet, & Brouwer, 2008), it would seem likely that the pressure to turn people into self-managers will grow and this would seem to have implications for how people with chronic illness come to see themselves.

As a practicing mental health nurse who participates willingly in the promotion of the self-managing capacities of people understood to have bipolar disorder, it is these pressures and tensions that are of specific interest as both practitioner and
researcher. In order to explore the effects of self-management practices in a psychiatric context and focus specific attention upon its capacity to shape how a person comes to make sense of themselves, this thesis has chosen to focus upon the construct of discourse and the work of Michel Foucault. It is an analysis of discourse that uses his conceptual tools of technologies of the self, relations of power and governmentality which are now discussed in detail.

**Foucault**

Michel Foucault's work may be difficult to categorize as philosophy, social history or political science but his analyses His concern with ‘games of truth’ and technologies of power and of the self have helped us to see the relationships between the different practices that seek to know and manage human life through the ways that people make sense of themselves as ‘naturally’ endowed with certain abilities, duties and rights (Rabinow & Rose, 2003).

“What are the games of truth by which man proposes to think his own nature when he perceives himself to be mad; when he perceives himself to be ill...” (Foucault, 1990b, p. 7).

Foucault’s interest in the discourse and practices of the human sciences (biology, medicine, psychiatry and criminology in particular) demonstrates how they are discourses that are regulated by the notion of truth; that they can and indeed do, know the truth of what it means to be human. What Foucault demonstrated was that through their attention to problems of illness, madness and crime, these knowledges have shaped human beings into particular thinkable and manageable forms (Rabinow & Rose, 2003). Through his analyses Foucault also showed how power is implicated in the means by which these knowledges construct the objects of their attention; how they objectivise on the basis of dividing practices (the sick and the healthy, the mad and the sane, the criminal and the law abiding citizen) and how power is implicated in the means by which a human being turns him or herself into a subject. For Foucault, power was and is, not an object that a person holds or not, but rather it is a relation – a way of acting upon others to shape the field of their possible action, a management of the possible actions of others. Foucault also understood power to require freedom or as Petersen (2003) defines freedom; the possession of agency or
the capacity to act rather than the freedom to make unconstrained choices. Power can only be exercised over people who are faced with a range of possible responses. This conceptualisation of power makes it less about confrontation and more about how conduct is governed (Foucault, 2003f). Using Rabinow and Rose’s definition of technologies as “the intellectual and practical instruments and devices enjoined upon human beings to shape and guide their way of ‘being human’” (Rabinow & Rose, 2003, p. xxi), power becomes both a relation and a technology that acts between people to shape conduct.

In the later phase of his life and work, Foucault moved his attention from the games of truth and the role of power in objectivising the subject of the human sciences to “games of truth in the relationship of the self with the self” (Foucault, 1990b, p. 6) as a means to consider how we come to relate to ourselves as particular sorts of selves; what are the processes of subjectivization and how are they are enacted by people upon themselves through technologies of the self. Foucault understood technologies of the self as all “those intentional and voluntary actions by which men not only set themselves rules of conduct, but also seek to transform themselves” (Foucault, 1990b, p10) and it is here that the rise of professionals of health and in particular how the experts of what Rose (1998b) calls the psy-sciences (psychiatry, psychology and psychotherapy) have taken a leading role in claiming to provide the truth about human ‘nature’ and “who whisper in our ears and advise us how to act and who to be” (Rabinow & Rose, 2003, p. xi). Health care can be seen to place significant faith in techniques of self-governance whereby the conduct of individuals are regulated through their active engagement in recommended practices to recover from illness and achieve health. The problems of people with long-term health conditions and their self-managing capacities can be seen as part of this broader reliance upon technologies of the self (Petersen, 2003).

These instruments and devices for working upon the self are many and varied and found within a range of institutions beyond health including education, the prison and religious institutions. Foucault proposed that what they all have in common is that they create particular ethical regimes for living; through the aspect of the person that is the target of work, the nature of the relationship between self and authority, the techniques used to reshape the self and the type of subjectivity to which a person
is led to aspire. Arguably, our contemporary relationships with our selves turn to notions of life and health as the central means to making sense of who we are and how to act. Rose (2007) makes the case that our self-governance practices have moved from an understanding of ourselves as being inhabited by an inner psychological space as the source of our difficulties and the target of our self-governance to practices that are based upon an understanding of ourselves as neurobiological creatures whose troubles and potential both lie in the brain. This would suggest that psy-bio expertise will increasingly be turned to shape one’s relationship with one’s self. Teasing apart a technique of the self such as the self-management of long-term conditions using Foucault’s concepts allows a way to consider in more detail the sort of self being formed as an effect of self-management discourse and practices and the ethical regime of which it is part. Perhaps there are other ways to be a person than the one prescribed by self-management discourse (Foucault, 1990b; Rabinow & Rose, 2003).

As has already been noted, discussions in the literature of what self-management is and how it should be practiced can be seen to rely upon neo-liberal ideas of the patient as an active and rational decision maker. For Foucault, attention to techniques of self in modern times also has to include a consideration of the ‘arts of government’ and the role of liberal and neo-liberal styles of political thought as “the modern nation state and the modern autonomous individual co-determine each other’s emergence” (Lemke, 2001, p. 191). His analysis of the ‘arts of government’ which he named governmentality (Foucault, 2003c), brought together ideas about technologies of power and of the self in such a way that the nature and practice of government can be thought of as on a continuum that moves from an individual’s self-governance and techniques of the self through to issues of political practices aimed at governance of the nation state. As an ‘art of government’ neo-liberal rationalities are particular in their focus upon styles of government that rely upon an apparent ‘natural’ tendency of people to be autonomous and seek the freedom to choose their own life. This reduces the state’s role to one of providing the environment that enables the self-steering capacities of individual and allows the state to govern both “at a distance” and through a notion of freedom (Rose, 1999a, p. xxii). In this context citizenship comes about through enacting one’s free choice in a responsible way which positions
self-management practices as one of a number of potential mechanisms to govern at a distance and reward the often marginalized person with ‘chronic mental illness’ with another means to achieve citizenship.

Governmentality understands the conduct of conduct as processes of power and self that in contemporary society focuses upon harnessing people’s self-steering capacities such that people are governed through their own desires. This means in the context of bipolar disorder, people do not necessarily experience or express a sense of coercion. This can be seen in the studies that overtly position people with bipolar disorder as the expert on how to live and recover from the condition. When people are asked about how they live with the condition they often respond with ideas that position themselves as active individuals making a choice to get better through such actions as developing self-awareness, managing stress, recording sleep patterns, taking medications, engaging in physical activity and developing relationships with trustworthy others (not necessarily health professionals) (Rusner, Carlsson, Brunt, & Nyström, 2010; Russell & Browne, 2005; Suto, Murray, Hale, Amari, & Michalak, 2010; Veseth, Binder, Borg, & Davidson, 2012). Practices that are thought of under the rubric of self-management strategies are, in these studies, being embraced as a form of self-determination rather than a clinician determined regime of living. When viewed through a lens of governmentality, self-management practices can be understood as both technologies of power and self that allow government at a distance by acting through an individual’s sense of self-determination. This does not mean that a person who espouses the benefits of self-management has been ‘duped’ into a particular way of seeing themselves and how they should live but it is to suggest that the technologies of the human sciences are not necessarily as ‘safe’ and as ‘common sense’ as is implied by self-management discourse.

**Aims of this Discourse Analysis**

This introduction has sought to show that our many ways of thinking, speaking and acting upon and about ourselves and others are part of a historical, social and cultural climate that makes particular assumptions about the kinds of people we can and should be; that what we can think and say about ourselves is determined by social and cultural convention and practices (St Pierre, 2004) and that these conventions
position us, “...hailing us, shouting ‘hey you there’ and making us listen as a certain type of person.” (Parker, 1992, p. 9). This overview of self-management has drawn attention to how as a discourse it ‘calls’ to a person with a chronic illness as someone who can and will be a responsible health consumer, someone who turns to health professionals for guidance on how to live and recognises themselves as the centre of any process of change in how they live. But is this necessarily problematic? And what might this mean for people understood to have a disorder that is bound to the ideas and practices of the psy-sciences? The discussion thus far would suggest that given psychiatry’s dominance in shaping what is taken as the truth of the brain and mind that it will be strongly implicated in how the self in self-management of bipolar disorder can be thought of. Current constructions of bipolar disorder now routinely turn to phrases such as “a severe chronic mental illness characterized by fluctuating mood and activity patterns”, “suffering”, “frequent, current episodes”, “higher functional impairment” and “severity of symptoms is associated with a lower quality of life” (Van den Heuvel, Goossens, Terlouw, Van Achterberg, & Schoonhoven, 2015, p. 2). While these quotations are taken from the opening paragraphs of just one academic article on bipolar disorder they have none the less come to characterise how bipolar disorder is spoken of; as a “...tale of manic numbers and depressing outcomes, bipolar disorder is by-and-large depicted as leading to wide-spread and long-term disruptions, disability and danger.” (Liebert, 2013b, p. 181). This is not to suggest that bipolar disorder is not disruptive, dangerous or disabling, that it is not a real illness, or if it does exist, that it is not neurochemical in nature. Neither is it to suggest that the experiences that have come to be associated with bipolar disorder do not lead to significant distress, loss, unhappiness and chaos. Rather, it is an attempt to stand back from the assumptions that are made about what it is and begin to consider how discourse shapes how we can and cannot speak of bipolar disorder, the people who ‘have’ it and how they are to live with it. In particular it seeks to explore the effects of the discursive practices of self-management for bipolar disorder upon subjectivity and in the process re-evaluate that nature of the ‘self’ in self-management. It does this by asking:

What are the subject positions made available within a discourse of self-management of bipolar disorder?
What are the implications of these for how a person with bipolar disorder develops a regime of living?

This thesis is an explicit attempt to think differently about the ‘goodness’ or otherwise of self-management practices and consider the implications for processes of self-formation as a result of the discursive practices of self-management. In doing so, the significance of this thesis lies in its use of a Foucauldian methodology to identify the iatrogenic effects of psychiatric practice (and self-management practices specifically) in a time when psychiatry espouses the importance of constructs of empowerment and recovery (Parker, 2014; Roberts & Wolfson, 2004). By considering how we can speak about and act upon a chronic health condition such as that known as bipolar disorder, it seeks to support both those in practice who acknowledge the dilemma faced between providing care and promoting self-determination (Graham, 2006) and a broader project of a contemporary critical psychiatry (Bracken & Thomas, 2010). It takes an alternate approach to constructs of power in psychiatry where power is not just about repression but also about production and the power of self-management practices to produce a particular sort of person that one should and could be when also living with a chronic health condition. It moves the focus from assumptions of the beneficence attached to the sharing of the specialised knowledge of the psy-disciplines toward a consideration that through relations of power, the discourses and medicine and psychology are dangerous.

The intention is treat the subject matter in a dispassionate manner but with aid of the work of such people as Nikolas Rose, the work of the thesis has none-the-less promoted an unease about the implications of health care services that promote a regime of self based upon notions of choice, independence and responsibility; that in doing so “...something is lost: the ways of relating to ourselves and others that are encompassed in such terms as dependency, mutuality, fraternity, self-sacrifice and commitment to others” (Rose, 1999a, p. xiv). In light of this discussion of tone and intent, it is also important to note that when the term bipolar disorder is used in this thesis it is done so on the basis that it is a concept based upon particular social, cultural and political assumptions. It is a term used as if it has quotation marks around it so as to “trouble the naturalization” of the concept (Martens, 2008, p. 2).
the same vein, while the phrase “a person with bipolar disorder” is often used, it too seeks to assume that the naturalness of the person does not take any particular form. It would perhaps be more accurate to write “a person understood to experience the object known as ‘bipolar disorder’” but in the name of short-hand the phrase “a person with bipolar disorder” is used.

**Structure of the Thesis**

The chapters of the thesis are grouped into three sections; a) theories and concepts, b) the application of these theories to the study of self-management discourse and c) an exploration of the opportunities for thinking differently about self-management.

The first section comprises of this chapter and chapters 2, 3 and 4 and is concerned with the theories and concepts on which the analysis is based; why use discourse analysis and how it has been applied in this project to investigate self-management for bipolar disorder. This chapter has provided an overview of the theories being put to work and critically explored the notion of self-management and its relevance to contemporary health care. It has also explored how the condition named as bipolar disorder is constructed and linked it to an expectation that self-management is an integral approach in its treatment. Chapters 2 and 3 provide greater detail of the ontological and epistemological assumptions upon which this discourse analysis is based while Chapter 4 is a discussion of the methods that have been used to both obtain and analyse the data.

The second section comprises of chapters 5, 6 and 7 with each chapter building upon the other to apply discourse analysis to self-management discourse. Chapter 5 applies a discourse analysis specifically to the discourse of self-management as it is found in an expert based text on psychoeducation for bipolar disorder, the Psychoeducation Manual for Bipolar Disorder (Colom & Vieta, 2006), with a particular focus upon process of subjectification i.e. how others are governed and objectified by knowledge and power (Milchman & Rosenberg, 2009). The analysis within this chapter has formed the basis for a book chapter (Wilson & Crowe, 2016) (See appendix 4).
Chapters 6 and 7 focus upon processes of subjectivation by using interview data to analyse the use of self-management discourse by people understood to have bipolar disorder as a means to govern the self. Chapter 6 asks what subject positions are being made available through the way discourse is being drawn upon to construct bipolar disorder as an object. Analysing the discourse of self-management and the subject positions it makes available to people with bipolar disorder is the specific focus on Chapter 7.

Chapter 8 forms the final section and discusses the findings of the analysis and answers the two questions posed earlier by this thesis; what subject positions does the discourse of self-management make available to people understood to have bipolar disorder and what are the implications of this for how people with bipolar disorder come to understand themselves and a life with bipolar disorder? The structure for this discussion is created by applying Foucault’s notion of ethics and the ways in which people think and act upon the self to determine preferred ways of being. In doing so self-management practices are explored as both a technology of power and of self that is shaping how a person with bipolar disorder both determines the proper conduct of his or her life and makes sense of the nature of the self and how to be concerned with it. This discussion is then used as the inspiration to propose that the ‘problems’ of self-management are not the person with bipolar disorder, their unpredictable condition and unreliable self but instead our reliance upon a notion of subjectivity as singular, contained and independent. To do this a Māori ontology is put to work as are Julia Kristeva’s ideas about self-formation in the context of managing the abject. Chapter 8 finishes by seeking to apply these ideas to the construction of an alternate notion of psychoeducation and self-management for bipolar disorder that could be applied to mental health practice.
Chapter 2

Foucauldian Discourse Analysis: Theoretical Context

“The quality of light by which we scrutinize our lives has a direct bearing upon the product which we live, and upon the changes which we hope to bring about through those lives.” (Lorde, 1984, p. 36)

As can be seen from the introductory chapter, self-management policy and practices require a particular use of language and knowledge about people that has been shaped by a dominant medical discourse. As Foucault pointed out, the discursive practices of the human sciences are characterised by their use of notions of truth and error. To critique the discursive practices of self-management therefore requires the use of analytic tools that can treat what is ‘said’ as just one truth among many. It also requires a method of enquiry that is concerned with the relationships between knowledge, power, discourse and subjectivity and a method that is prepared to explore contradiction and complexities rather than assume simplicity of meaning in what have become common sense understandings. It is for these reasons that an approach to discourse analysis based upon post-structural concepts and the work of Foucault has been chosen to investigate the discourse of self-management for bipolar disorder (Parker, 1992, 1999a).

Willig (1999) proposes that discourse analysis that seeks to address social and/or political practice can take three forms; discourse analysis as social critique, discourse analysis as empowerment and discourse analysis as a guide to reform. It is from the latter that this thesis has sought inspiration; to use discourse analysis to explore how language produces both power relations and subjectivity in order to bring about positive change in health practices. It is the specific intention of this discourse analysis to make it more difficult to think that self-management is a necessary way to respond to bipolar disorder in order to create a space to find alternate ways to think and respond.
Discourse analysis is concerned with the close study of text and as a method of analysis it has been developed by a range of disciplines who in turn base their work upon a range of theoretical assumptions about the nature of language and the people who put it to work (Parker, 2014; Traynor, 2006). An essential element therefore of a good quality discourse analysis is that the theoretical framework on which the discourse analysis is based is clearly articulated (Crowe 2005, Cheek 2004). That is the intention of this chapter; to provide a theoretical positioning of this discourse analysis as one based upon post-structural and Foucauldian concepts of language and discourse and the relationship between discourse and power relations, history and subjectivity. This theoretical context and positioning forms the foundation and the rationale for the methods used by this discourse analysis. To this end it begins with a brief overview of the development post-structural thought before moving on to make explicit its stance on the nature of discourse and its relationship with subjectivity and power.

**Post-Structuralism**

While post-structuralist theories differ in form and focus, all share fundamental assumptions about the nature of language, meaning and subjectivity and as such challenge the notion that language can objectively reflect reality. The theories associated with post-structuralism came out of a French/Parisian intellectual movement that began in the period post World War II and were highly influenced by the May 1968 student revolt in Paris and general strike. Called post-structuralism because those involved sought to develop further the ideas of structuralists such as Saussure and Levi-Strauss, the most influential early post-structuralist theorists are Jacques Derrida, Michel Foucault and Jacques Lacan with a ‘younger generation’ of theorists, Gilles Deleuze, Felix Guattari and Jean-Francois Lyotard (Sarup, 1993). Post-structuralist theories have also been heavily influenced by the work of the nineteenth century German philosopher Friedrich Neitzsche (Mann, 2008; Sarup, 1993). While the development of post-structuralist theories are primarily attributed to male, French theorists, feminism and queer theorists have also been influential in the development of post-structural ways of thinking as each have sought approaches that can take account of the place of social and cultural practices in the production of gender (Butler, 1990; Fraser, 1989; Sawicki, 1991; Weedon, 1997).
Language and meaning

Fundamental to the post-structuralist stance that language does not and cannot represent the world is the work of Saussure and his theory of the sign (Saussure, 1960). In the early years of the twentieth century, influence the development of structuralist and then post-structuralist theories in the 1960s and 1970’s. Saussure proposed that the hidden, universal structure that explains human society is the system of signs and rules that make up the language we use in specific circumstances. In language, words are linguistic signs that are understood to be made up of two parts; the signifier which is the written mark or sound and the signified which is the concept of idea that the mark/sound represents. In Saussure's view, language does not reflect a real world as there is no intrinsic relationship between an object and the word used to name it. Instead the relationship between language and object is seen to be shaped by society and therefore completely arbitrary in nature. The meaning given to words is determined by society and changes within different social and historical contexts. In addition, the connections made by society between signifier and signified are seen by Saussure to be established from a position of difference; a person can only know what the word ‘female’ means on the basis of its difference from the word and meaning attached to ‘male’. This suggests that the process of signification, of putting signifier and signified together, is a potentially powerful process that relies on “the negating, denying or ‘forgetting’ of other signifiers” (Elliott, 2009, p. 59). In using difference to divide up and determine meaning within the world, people therefore come to ascribe to themselves and others an identity based on difference. While Saussure saw the connection between signifier and signified as arbitrary and based upon relations of difference, he also proposed that once meaning was generated by society, it then become fixed (Sarup, 1993; St Pierre, 2000; Weedon, 1997).

Saussure’s ideas have played a central role in the development of social theories that are concerned with how power and domination are at work within language. Post-structuralism takes his ideas about the lack of correspondence between word and object and argues that meaning is never fixed once and for all, rather that meaning in language shifts depending on historical and social context which results in meanings always being open to interpretation and challenge. (St Pierre, 2000; Weedon, 1997).
“Language does not point to pre-existing things and ideas but rather helps to construct them, and by extension, the world as we know it. In other words, we word the world.” (St Pierre, 2000, p. 483). When we use language to word the world we do so on the basis of socially constructed rules that determine what can and cannot be said about a particular object or idea. “…[L]anguage gathers itself together according to socially constructed rules and regularities that allow certain statements to be made and not others” (St Pierre, 2000, p. 485) and it is in this process of gathering itself together into a system of statements to construct an object that language becomes ‘discourse’ (Parker 1992).

**Discourse**

It is the work of Michel Foucault, exploring how discourses of mental illness, punishment and sexuality have been historically produced, that has had a particular influence upon post-structural theories (Foucault, 1990a, 1995, 2001; 2002). Salih (2002) provides a useful summary of Foucault’s perspective on discourse;

“ [Discourse] is not just referring to ‘speaking’ or ‘conversation’, but specifically to Foucault’s formulations of discourse as ‘large groups of statements’ governing the way we speak about and perceive a specific historical moment or moments. Foucault understands statements as repeatable events that are connected by their historical contexts...” (Salih, 2002, p. 47)

Discourse is thus a concept that looks beyond ways of thinking and speaking to the way language is tied to wider networks of social institutions, power and knowledge. As such, discourse is concerned with things said and written but also the social practices which involve discourse to which the term ‘discursive practices’ refers. To take an example of a discourse and its discursive practices; the Diagnostic and Statistical Manual of Mental Disorder (American Psychiatric Association, 2013) is the dominant text in the production of a discourse of psychiatry. It constructs and categorises particular experiences as ‘mental disorders’ and does so on the basis of the authority of medical knowledge to know the nature of a person’s internal ‘mental’ world. The Diagnostic and Statistical Manual of Mental Disorder (DSM) acts as a text that puts together particular statements about the objects understood to be ‘mental
disorders’. Through the discursive practice of a comprehensive psychiatric assessment, mental health professionals ask particular questions of the ‘patient’ in order to determine if their experiences qualify as a ‘mental disorder’ and offer a diagnosis based upon the knowledge within the DSM. This speech based investigation is then reproduced as a text by using a structured format to write a document that is then placed in the person’s medical record. This assessment will then go on to shape what can (and cannot) be said about a person’s experiences; by the person themselves, family and friends, those whom they approach for help and those other social institutions like the legal system that they may also come into contact with. For those people compelled through the law\(^2\) to use mental health services, the discourse of psychiatry has a very material effect upon their lives. The discourse of psychiatry also needs to be viewed in a historical context; what counts as ‘mental disorder’ has changed over time as each new edition of the DSM makes progressive claims about advances in psychiatric knowledge. The inclusion and then the removal of homosexuality as a psychiatric disorder and the ongoing debate about the place of gender non-conformity in latest edition of the DSM-5 illustrates this point well (Drescher, 2010).

Using the work of Foucault, Parker (1992) proposes a useful list of the characteristics of discourse:

- Discourse is made up of the system of statements (things said and written) and the practices (things done) that construct an object.
- It creates subjectivity by addressing the ‘reader’ in a particular way; to make sense of what is being said, the person must take up a particular subject position and see themselves in a particular way. In this process, power is seen to be at work, as the way a person is positioned in discourse inevitably gives certain rights in terms of what they can say and how they say it. People can resist the positions on offer but a position of some sort must be taken in response to the discourse.

\(^2\) In Aotearoa New Zealand the government legislation that permits this is the Mental Health (Compulsory Assessment and Treatment) Act 1992.
• There is a sense of coherence to a discourse which comes about as a result of the culturally available understandings we put to use to make sense of what is being said.

• All “discourses embed, entail and presuppose other discourses” as they draw on metaphors, ideas and analogies from other discourses. (Parker, 1992, p. 13). The term ‘intertextuality’ as used by Fairclough in his Critical Discourse Analysis (Fairclough, 1992, p. 84) as a way to describe how texts contain ‘echoes’ of text that have gone before and how we use other texts to shape our interpretation of a text.

• When taken as a whole, the discourse will in some way reflect upon the way it uses words.

• Discourses are historical in nature as they all refer to objects that have been constructed in the past by the same or a related discourse.

• Discourse is dynamic, changing and inherently contradictory in the way it draws on other discourses and gains its coherence.

• Discourse is intimately connected to power; discursive practices reproduce institutions, discourse often reproduces relations of power, and discourse has an ideological effect.

Using a post-structural approach, language as discourse doesn’t just describe the social world, it also brings it into being such that it becomes difficult to think otherwise. And while this does not mean that there is nothing outside of discourse, discourse can be seen to be intimately tied to power and knowledge.

**Discourse and subjectivity**

Post-structural theories have a particular concern with how language as discourse constructs subjectivity\(^3\). In opposition to both humanist and psychological discourses that assume a unique, rational, fixed and coherent ‘self’ at the centre of all human action and thought, post structural theories instead construct subjectivity as

---

\(^3\) In line with Mansfield (2000) this thesis uses the term ‘subjectivity’ rather than ‘self’, ‘identity’ or ‘individual’ as a way to think about the self as an experience rather than a thing; a discursively orientated experience that is an effect of the “social and cultural entanglement of life” (p3).
precarious and plural with discourse as a central player in processes of self-formation. When meanings in language are understood to be social and historical constructions, what it means to be human, to be ‘I’ is also understood to depend upon the discursive resources available to make sense of the self. ‘Gender’, ‘ethnicity’ and ‘personality’ all become ways of thinking the self that are objects of discourse rather than statements of an essential human nature. Rose (1998b) directs our attention to the dominance of what he calls the psy-complex and the discursive practices of psychiatry, psychology, psychoanalysis and psychotherapy as the means by which people come to know what it means to be human, to determine the boundaries around ‘abnormal’ human experience and use this knowledge to govern oneself.

The place of discourse in processes of self-formation draws particular attention to what Parker (1992) identifies as a key attribute of a discourse; that it creates subjectivity by addressing a particular sort of ‘reader’. To make sense of what is being said, the person must take up a particular subject position or way of being in the world. In this process, power is again seen to be at work as the way a person is positioned by and in discourse inevitably gives them certain rights in terms of what they can say and how they say it. People can resist the positions on offer but a position of some sort must be taken in response to the discourse.

To return to the earlier example of the discursive practices of psychiatry, the person who attends the appointment for an assessment with mental health services can occupy a variety of positions; ‘patient’, ‘client’ and ‘consumer’ are all possible options in contemporary psychiatric discourse. Each of these positions ‘calls’ a person to understand themselves (not necessarily consciously) in particular ways with particular attributes within the discursive practices of psychiatry. To take up a subject position as ‘patient’ may lead to a way of being in the world that is based upon an unquestioning acceptance of the expertise of mental health professionals while in responding to a call to be a ‘consumer’, a person may resist how it positions them as someone with choices. Discourse can be seen to be acting upon subjectivity through what St Pierre (2000) describes as “post-structuralism’s double move…a subject that exhibits agency as it constructs itself by taking up available discourses and cultural practices and a subject that, at the same time, is subjected, forced into subjectivity by those same discourses and practices” (St Pierre, 2000, p. 502).
Power, Discourse and Subjectivity

This discussion of discourse and processes of self-formation demonstrates how discourse is a concept that refers to more than ways of thinking, speaking and producing meaning; discourse is always tied to wider networks of social institutions and power relations (Weedon, 1997). It is Foucault's theories of power and the capacity of power relations through discourse to shape an individual’s relations with themselves and others that are particularly pertinent to this thesis.

Under the influence of the secular discourses of both humanism and psychology, we have developed a ‘common sense’ notion of power and freedom as universal resources which as human beings we have a right to possess. In this context they become objects that are binary in nature; we either have them or we do not and if we do not, someone else holds them instead. Foucault developed radically different ideas about the nature and location of power and the relationships between power, resistance and freedom. For him, power is not an object that could be “acquired, seized or shared” (Foucault, 1990a, p. 94) nor is it located as super-structure type object that the ruler uses to oversee the ruled. Instead he uses the metaphor of a network of relations where power operates from all angles in such a way that these relations are what holds the network together (Foucault, 1995) and as such it is a strategic rather than a juridical model of power where “...power is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategical situation in a particular society.” (Foucault, 1990a, p. 93). As a network of force relations, power is both strategic and anonymous acting indirectly upon actions, “...an action upon an action, on possible or actual future or present action” (Foucault, 2003f, p. 137).

Foucault used Bentham’s Panopticon design for a new type of prison as emblematic of a style of power relations that emerged through-out the 18th and 19th century whereby people’s self-governing capacities where developed as the means to control individuals, instead of resorting to direct coercion or violence. Bentham’s proposal to have a watchtower within a prison was designed such that each inmate was in an individual cell and always visible to the watchtower. The inmates knew they are always visible to a guard whom they in turn could not see and this permanent
visibility would induce the prisoner to discipline themselves and create “...a state of conscious and permanent visibility that assures the automatic functioning of power...where the inmates [are] caught in a power situation of which they are themselves the bearer” (Foucault, 1995, p. 201).

This metaphor of the Panoptican as a disciplinary style of power was not seen as limited to the prison but rather as being used throughout society. Schools, hospitals and workplaces could all be seen to be putting to work techniques that separated people into categories, allowed observations to be made and norms to be developed with which to further categorise. The ultimate aim of disciplinary power is normalization and the removal of irregularities so as to produce useful and docile minds and bodies (Hook, 2003). It is a style of power that can be said to have enabled the emergence of ‘human sciences’; psychology, psychiatry, pedagogy and criminology whose knowledges have been used to further refine how people are regulated and normalised (Roberts, 2005). This demonstrates the productive rather than repressive nature of power; its ability to produce certain sorts of knowledge about people and how they function as well as to produce certain types of individuals. This inter-relationship of knowledge, power and subjectivity in discourse then works to produce particular versions of reality which become assumed as true. This can be seen in the example of psychiatric discourse used earlier where the discursive social practice of a psychiatric comprehensive assessment is a relation of power whereby a discursive based examination of the person is used to determine their degree of individual deviance from the norms of how the mind is understood to function in ‘healthy’ individuals. This produces particular subject positions of the ‘patient’, the ‘professional’ and the ‘family’ which in turn shapes the range of possible actions of people thus categorised.

With this construct of power as a network of force relations, power is located everywhere and is not something from which we can escape. But this does not mean that the ‘patient’ in the psychiatric examination cannot resist the power relations at work. As power is a network, so too resistance is constructed as being located in a network which makes it always possible but inherently local and unpredictable. While power may be everywhere we are not powerless in the face of it. Instead power, resistance and freedom require each other as power can only be exercised
over people who are faced with a range of possible responses (Foucault, 2003f). Rather than freedom being constructed as an end goal to be possessed by right, in Foucault’s model of power, freedom becomes the ability to engage in a constant questioning of who and what we are as what may seem inevitable or ‘natural’ about us hardly ever is (St Pierre, 2000).

These styles of power relations which Foucault identified as emerging in the 18th and 19th century and of which the Panoptican is emblematic (i.e. the regulation of another’s conduct through processes of individualisation and normalisation) remain relevant to understanding contemporary styles of power and they continue to show themselves in a range of institutions including health care settings4. But in his later works, Foucault began to explore how technologies of power in contemporary society were being hidden within practices focused upon how individuals judged, mastered and controlled themselves and a recognition that contemporary society regulates conduct through citizen’s active engagement with recommended practices rather than the overt use of coercion (Petersen, 2003; Rose, 1999b). With power as a network, it can flow from above through authoritative others but also flow upward through how individuals work upon themselves. Indeed within contemporary society self-governance has become an imperative, for both the individual citizen and as an essential element of the governance of society as a whole (Hook, 2003). This results in notions of self and identity as one of the primary vehicles for contemporary relations of power and draws attention to contemporary styles of government based on neo-liberal ideals which make a specific place for self-regulating citizens while offering in return the withdrawal of the state from the daily life of individuals (Rabinow & Rose, 2003). It is at this point in discussions of power relations that the notion of governmentality becomes useful to this thesis.

**Governmentality**

The terms ‘government’ and ‘governmentality’ are being used here to think more broadly about all of the strategies used by both people and institutions (of which the state is just one) to manage or shape the affairs of others in a more or less calculated way (Dean, 2010; Foucault, 2003f; Rose, 1998b). Rather than a theory of how to rule

---

4 See Hook (2003) for an exploration of psychotherapy as disciplinary power.
others, these are strategies that act upon actions in the name of shaping conduct and a conceptualisation of government as having a primary focus upon regulating the choice of individuals as the means to govern society (Foucault, 2003f; Petersen, 2003). The ultimate goal of governmental power relations is the management and welfare of the population as whole. Power becomes a generative force – making things and people grow, ordering them and optimizing them (Hook, 2003). It is a concept that helps to make sense of the many diverse ways that authorities attempt to act upon others in order achieve such goals as social order, prosperity, empowerment or health (Foucault, 2003c; Rose, 1998b).

In the context of governmentality, the political ideals of neo-liberalism can be thought of as a ‘family’ of ways for thinking about the nature of government (who can govern, what and who can be governed and how) that operates on the assumption that it is the ‘natural’ tendency of people to be autonomous, and to have the freedom to choose one’s own life. On this basis neo-liberal ideals position the state’s role as creating the environment that enables these natural self-steering capacities while the individual citizen is positioned as cultivating within themselves their redisposition toward entrepreneurialism and autonomy (Binkley, 2011; Rose, 1999a). This style of power relation thus allows government to happen both at a distance and through freedom because of “…a matrix of institutions, practices and discourses that exert rule through the apparent absence of rule…” (Binkley, 2011, p. 382). In such an environment, anything that might impose limits on the freedom of an individual to develop their potential human capital is problematic; from depending on others for decisions and leaving habitual behaviours unexamined through to an apparent unwillingness to accept responsibility for the consequences of one’s own actions – all are regarded as a problem as they signal a failure of personal freedom (Binkley, 2011). Norms of contemporary human conduct that prioritise subjectivities based upon notions of choice, independence and responsibility, act as the means by which people can be governed (both by others and themselves), particularly in health care settings. For example, people who use mental health services who are deemed unwilling to take responsibility for the outcome of their own behaviour can find themselves discharged from health services, unable to access particular services, subject to legal penalties or enforced treatment (Brown & Baker, 2012). In this way a moral perspective is
brought to shaping conduct as certain behaviours are valued more than others and rewarded as such.

Contemporary social institutions embody both disciplinary and governmental styles of power and both rely on expert knowledge to achieve their aims (Hook, 2003). It is the human sciences and the psy-sciences in particular with their claims to know how and why humans think and act as they do that have come to the aid of strategies to govern both the self and others (Miller & Rose, 2008). We govern ourselves and others on the basis of what we take to be true about the nature of being human and psy-knowledge and practices have made it possible to govern people in ways that are compatible with neo-liberal ways of thinking. In keeping with the theoretical foundations of this thesis, psy-related phenomena are not understood as having being discovered by psy-sciences as proof of the innate psychological make up of individuals but that these phenomena, such as intelligence, personality, self-esteem and motivation to name but a few, are objects produced by the discursive practices of psy-science itself. They may be constructs that do or do not actually exist but it is in the process of searching for and giving shape to the object of ‘personality’ for example, that what it is comes into being. From the test in a women’s magazine to the categorization of one’s personality style as a means to become a more effective worker or manager and on to the contemporary debates between experts about how best to recognise a disordered personality – they are all practices that shape what can and cannot be said about the object named as personality. Psy-knowledge has made it possible, indeed has become essential, to understanding the qualities and capacities that people are endowed with and how best to develop these capacities in people through their own actions or the actions of others (Rose, 1998b, 1999a). The discourses of neo-liberalism and psychology can be seen to be working in tandem to produce “humans as selves with autonomy, choice, and self-responsibility, equipped with a psychology aspiring to self-fulfillment, actually or potentially running their lives as a kind of enterprise of themselves.” (Rose, 1998b, p. 33). These modern forms of power relations are not overtly oppressive but instead promote governance of self and others through ideas of choice and freedom, “...a type of regulated freedom that encouraged or required individuals to compare... what they were with what they could or should be.” (Miller & Rose, 2008, p. 9) and through which they are bound to
authoritative others who provide the knowledge and practice that provide the tools of self-governance.

Strategies of governmentality are concerned with power relations and how to conduct the conduct of others but they also frequently operate through technologies of the self so that people work upon themselves through what they perceive to be their own desires and aspirations and making their own judgments of how best to conduct themselves (Dean, 2010; Foucault, 1988; Rose, 1998b). "Power operates by convincing us of the selves we want and need to become, in order to be ‘true’ to ourselves." (Frank, 1998, p. 333). Health care relies heavily upon practices and ideas that allow “individuals to effect by their own means, or with the help of others, a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (Foucault, 2003g, p. 146). In the case of health care, it is the practices and ideas that allow people to enact the search for health. Again, these techniques are dominated by an understanding of an internal, psychologically shaped space for the self where the individual is the location of any processes of change. Any failure to engage in self-governance on the basis of these again highlights the moral nature of these endeavours, “...creating a moral hierarchy in which the ‘successful striving’ are pitted against those who ‘fail’ to reconstruct their experience adequately” (Holt & Stephenson, 2006, p. 215).

In this way the construct of governmentality acts as a foundational theoretical position for this thesis, seeing the practices and theories of self-management as an intersection of both power relations and technologies of the self; as both a micro-politics of self-governance and self-transformation and as a practice through which others are governed in the name of the health and productivity of the nation state.

**Summary**

This chapter has sought to lay out the theoretical foundations upon which this discourse analysis has been built. Using post-structural theories from the work of Michel Foucault, the nature of discourse and its relationship with and to subjectivity and power have been discussed. Conspicuous by its absence thus far is a detailed consideration of the historical nature and circumstances of discourse. This is rectified
in the next chapter by looking specifically at self-management discourse from a historical perspective. To do this the practice of psychoeducation has been taken as an example of a strategy of self-management discourse and using academic texts on the subject, an attempt is made to consider the circumstances, ideas and events that have shaped self-management discourse into what it has become today.
Chapter 3

Foucauldian Discourse Analysis: Historical Context

“The future accumulates like a weight upon the past” (Frame, 1994, p. 149)

“What counts in the things said by men is not so much what they may have thought or the extent to which these things represent their thoughts, as that which systematizes them from the outset, thus making them thereafter endlessly accessible to new discourses and open to the task of transforming them” (Foucault, 1989, p. xxii)

While discourse is tied to power relations and the ways in which people construct their sense of themselves, in a post-structuralist context discourse is also understood to have a historical nature. A central feature of a Foucauldian Discourse Analysis is to locate it as an object in time because discourses draw on and develop layers of meaning on the basis of relationships with other discourses. So too a discourse develops layers of meaning through how it connects itself to references of the past (Parker, 1992, 2015c).

This chapter further develops the theoretical stance of this discourse analysis by applying the notion of ‘conditions of possibility’ as way to think about how other discourses and circumstances over time have likely shaped self-management discourse and the subject positions within it. It does this by treating psychoeducation as a particular tactic or strategy of self-management discourse as was identified in the introductory discussion of self-management practices and their place in mental health setting. Treating psychoeducation as a historical object thus become a means to give thought to the events, circumstance and styles of thought that over time have helped to make it possible for both health professionals and those living with the condition called bipolar disorder to view self-management practices as essential and to the layers of discourse within discourse (Foucault, 1981; Hook, 2001; Parker, 2004).
This is not to suggest a notion of history as a linear construct nor the idea that history can provide a single explanation for the development of the discursive practices of self-management. Instead it is an attempt to show the multiple forces that sit behind the discourse and shape what can and cannot be said and in doing so, “enable one to think differently about the present” (Rose, 1996, p. 106). While history and its texts don’t determine what can or cannot be thought, it can be understood to shape the possible ways people can come to understand themselves. A historical perspective on self-management discourse offers a way to start thinking about the different subject positions it makes available to those living with bipolar disorder and the opportunities and constraints inherent within these. In terms of the analysis, an attention to the historical context of self-management discourse is a way to “make strange [the] everyday practices within which we are embedded in order to more clearly investigate their rules and structures” (Parker, 2015a, p. 84). As such, this historical analysis of selectively sampled literature is central to understanding the manner in which the discourse analysis was approached.

**Psychoeducation**

Psychoeducation can be broadly understood as a health professional led intervention where, by using group based education methods, people with a particular health condition (often seen as both long-term and relapsing in nature) and sometimes their families, are provided with relevant information in order that they might become more active participants in the treatment process. The person with the mental illness and their family is understood to need to go through a process of emotional and psychological adjustment to having a chronic condition and the engagement in an educative process of learning about the condition is constructed as providing both the opportunity to explore these adjustments and to learn new skills to manage and live with the condition (Haslam-Hopwood, Allen, Stein, & Bleiberg, 2006; Lukens & McFarlane, 2004; Ryglewicz, 1991).

In order to treat ‘psychoeducation’ as an historical object, a selection of journal articles that discuss psychoeducation as a health intervention were located. They covered a time period of 1975 through to 2006. While 1975 acted as the point where the first reference could be found to the term ‘psychoeducation’, all other articles
were selected on the basis that they either described the purpose of the intervention, referred to ideas and theories about how psychoeducation might work, described what the role of participants and health professionals, or discussed the limitations of psychoeducation. Each article was read with the purpose of seeking to understand the events, ideas and circumstances that over time have made it possible to speak of psychoeducation as the object it is now understood as and the implications of this for how self-management discourse constructs subjectivity.

**Psycho-education**

A common theme in the literature is the relationship psychoeducation has with both education and therapy; is educating and informing people a therapeutic endeavour or is education an essential aspect of psychotherapy? Two examples of differing views are now considered. Throughout their entire article Bauml *et al.* (2006) are explicit in their intention to persuade the reader that psychoeducation is a therapeutic endeavour; “In the following, reasons for viewing psychoeducation as an independent psychotherapeutic approach for acute and post-acute schizophrenic patients will be presented.” (Bauml *et al.*, 2006, p. 2). Hatfield’s (1988) concern about whether psychoeducation is therapy or education appears motivated by the palatability of the concept to families of people with mental illness. Therapy is for people who see themselves as ill and therefore based on a medical construct in which those providing the therapy are expected to treat or cure. Education on the other hand, “does not assume that the person to be helped has a pathological condition, but rather that he or she has a deficit in understanding or skill that is interfering with competence in living.” (Hatfield, 1988, p. 52). Seeing psychoeducation as ‘education’ and not ‘psychotherapy’ means the family will not be embarrassed about seeking help for themselves. This concern is perhaps making a silent reference to the historical idea that schizophrenia was caused by pathological family dynamics and the parenting style of mothers in particular (Harrington, 2012). Psychoeducation therefore with families of people with schizophrenia potentially walks a fine line between wanting the family to understand how their interactions with their ill family member can generate stress and therefore relapse, and not wanting families to feel they are being blamed. It is possible that Hatfield was seeking to distance psychoeducation from these ‘out of date’ notions.
When constructed as an educative rather than therapy based intervention, psychoeducation offers a way of seeing oneself as both ‘just like everyone else’ (as everyone engages in education) and as a person in need of instruction. When constructed as a therapeutic endeavour those people who participate are positioned as needing assistance to process and express the emotional experiences of living with a health condition. While the dominance of either therapy or education alters the discursive practices of a particular psychoeducation intervention, both are practices that fall under the assemblage of governmentality techniques. Both education and psychotherapy provide people with the knowledge, tools and techniques for continuous self-development in order that they might shape themselves into the person they wish to be; providing “...the means of shaping and sustaining subjects not in opposition to their personal identity but precisely in order to produce it” (Hook, 2003, p. 624). In this sense both education and psychotherapy are practices that allow the state to govern through a person’s own desire (Bondi, 2005; Brookfield, 2001; Hook, 2003).

**Self-help**

While both educational and psychotherapeutic processes are purported to be at work in psychoeducation, one of the other mechanisms by which change is understood to come about is through the notion of mutual support as psychoeducation happens most often in a group setting. “In the interviews the partners highlighted the facts that they had shared their problems with others and had gained a better understanding of the patient.” (van Gent & Zwart, 1991, p. 17). While the content of the educational aspect is based primarily on a medical discourse, group members are also understood to gain something through being able to support each other and learn from each other's experiences.

Self-help groups formed as a co-operative endeavour between people in similar circumstances in order to support and learn from one another. From the 1970’s, self-help groups were being recognised as a contemporary phenomenon of modern life (Archibald, 2007; Robinson & Henry, 1977). Three decades on the relevance of self-help ideas to everyday life remains strong (McGee, 2005). While many groups were

---

5 See Chapter 6 for a discussion of the nature of medical discourse.
formed out of a common experience of a health condition such as obesity, cerebral palsy, alcoholism, depression or manic depression, other experiences such as being a widow, an ex-prisoner, or single parent was also reason enough to draw people together. Primarily seen as a ‘grass-roots’ groups, they are constructed as forming when existing social institutions are unable to meet their needs (Robinson & Henry, 1977). This development of supportive groups separate from professional, conventional health services brought to the fore the idea that people in such groups were “trying to teach helpful attitudes and skills to each other” and this practice should be welcomed by ‘psychological practitioners’ interested in a ‘psychoeducator’ model of helping others. (Authier, Gustafson, Guerney, & Kasdorf, 1975, p. 34).

Archibald (2007) proposes that there are seven critical elements to a self-help group; a common problem that members share, mutual aid, provision of a network of social and emotional support, the production and sharing of knowledge, nominal costs, non-judgmental acceptance and equality between members. While these may remain relevant for group based self-help, with the proliferation of self-help texts there is arguably less focus currently on creating a community of support to improve the social conditions of its members and more focus upon self-help as an individualised, self-improvement practice (McGee, 2005; Rimke, 2000). In a search of the Scopus database to find contemporary academic literature about self-help, it appeared that for those people with identified health conditions, individualised guided self-help programmes, often using the internet, are now the norm rather than self-help groups.

Within the self-help literature there is a notable tension between the idea that self-help initiatives are an “alternative [to the] formal health care system” where reliance is placed upon the experiential knowledge of group members rather professionals (Borkman, 1990, p. 321) and those who critique self-help discourse by drawing attention to the central role of expert others claiming authoritative knowledge about how best to help oneself (Hazleden, 2010; Rimke, 2000). “The art of being free ironically depends upon submission to a particular class of expertise and upon a range of discourses which instruct the subject on how to be free” (Erjavec & Volčić, 2009, p. 99). This paradox of self-help – learning the art of helping oneself whilst also relying upon an expert other – is also identified as a paradox of self-management discourse (Wilson et al., 2007) and links to Paul Rabinow’s (1992) notion of
biosociality. He identified a trend in contemporary society whereby collectives of people come together in the name of particular biological ‘problems’ and on the basis of “...medical specialists, laboratories, narratives, traditions and a heavy panoply of pastoral keepers...” (Rabinow, 1992, p. 244) come to know who they are and how they should live. From this perspective self-help practices become another strategy of governmentality and governing the state through individual self-hood (Erjavec & Volčić, 2009; Rimke, 2000)

By turning to ideas of self-help and mutual aid as a mechanism of change, psychoeducation links to a history of self-help initiatives that have been about collective action to support one another and learn from each other. As such there exists the conditions of possibility for the development of subjectivity based upon a notion of the self as an active agent in relation to one’s life and as a valued member of a community. But the individualised self-improvement version of self-help that now appears more prevalent relies more upon a subject position where the self is an active agent who acts alone rather than in community with others. In addition, the linking of psychoeducation to self-help can be seen to make available a subject position that relies upon authoritative others to shape how one should understand and respond to a particular biologically based problem and to come to know oneself through these forms of knowledge.

**Shaping behaviour through rational scientific knowledge**

Throughout the literature there is a preoccupation with the need to find ways to change what people do in relation to the condition they are understood to have. Some are explicit about this concern by ensuring they include a discussion of the theory being used to understand how to change behaviour e.g. the health belief model in a group aimed at preventing the spread of HIV infection (Sorenson, London, & Morales, 1991) but mostly this preoccupation is seen in how authors describe the purpose of psychoeducation such as “…to develop strategies to use the information in a proactive fashion” (Lukens & McFarlane, 2004, p. 206), “…imparting information as well as helping participants develop coping skills (Daley, Bowler, & Cahalane, 1992, p. 163), or as “…compliance enhancement and early identification of prodromal signs...” (Colom & Lam, 2005, p. 359). To understand how best to go about
influencing behaviour, psychoeducation literature turns predominately to psychological concepts of behaviour modification, operant conditioning, cognitive-behavioural and social learning theories (Authier et al., 1975; Goldman, 1988; Hatfield, 1988; Lukens & McFarlane, 2004; Malow, West, Corrigan, Pena, & Cunningham, 1994; Sorenson et al., 1991).

These approaches base their claims to the truthfulness upon the use of techniques of rational science to justify the turn away from psychoanalytic ideas (Authier et al., 1975) and make it possible to conceive of the person’s behaviour as directly malleable through the use of appropriate incentives. Psychological theories of human behaviour have moved from a focus upon altering behaviour through simple stimulus, for example Pavlov’s dogs (Butler-Bowdon, 2010) to models that find a link between cognitions, behaviour and emotions. As a result, the way people think is now understood as a key determinant of behaviour (Beck & Weishaar, 1989; Ellis, 1989). Ellis’s (1989) and Beck’s (1989) development of cognitive behavioural theories for the treatment of psychological dysfunction can be seen as a rejection of psychoanalysis in favour of more rational approaches developed through the science of behavioural psychology. The latter half of the twentieth century has arguably seen psychological science being put to work specifically in support of Surveillance Medicine as people have drawn attention to the idea that health information on its own is not enough to get people to change what they do (Gibson, Catania, & Peterson, 1991). In the search to understand how to influence behaviour, psychological science has developed constructs such as self-efficacy (Bandura, 1977; Lorig & Holman, 2003), the Health Belief Model (Janz & Becker, 1984; Lorig, 2001) and the Transtherorectical Model of Change (Prochaska, DiClemente, & Norcross, 1992) in order to understand why and how people change what they do. It is these theories based upon the individual as the location of change that are often directly referred to as providing the justification for a particular approach to self-management including psychoeducation.

The notion of a rational psychological science providing the knowledge and the techniques that could help those with psychiatric and psychological problems can also be seen as part of a broader adoption of psychological constructs in the management of life (Rose, 1999) as exemplified by the scientific management
movement of the early twentieth century associated with the work of F.W Taylor (Taylor, 1911) and his ideas about how to transform the workplace to improve profitability. Credited with the establishment of management as a role distinct from ownership with whom full control of the process of productivity should rest, scientific management sought to increase the wealth of the nation by using scientific knowledge and rational techniques to make the most of resources, including the workforce (Abercrombie, Hill, & Turner, 2000). This meant that the labourer became the subject about whom knowledge was sought and in turn, to whom techniques were applied to improve productivity. This resulted in a range of ways to measure and standardise production from practical tools such as elaborate slide rules and adjustable scaffolds to intellectual tools; methods to study time, keep records, break down tasks into their component parts as well as standard formulae to replace the judgement of the individual worker, written instructions for each task, bonus payments to workers who complete tasks on time and methods for the scientific selection of workers (Miller & Rose, 2008; Thevenot, 1984). Just as cognitive behavioural approaches to understanding psychological dysfunction, this approach to industry and production applied ideas about science and rationality to the individual for the primary purpose of governing the behaviour of others. Psychoeducation’s adoption of constructs of psychological science as the means to explain how people can be induced to change how they act can thus been seen as another tactic in the government of people through the use of the psy-sciences in the name of increased productivity, health and wellbeing (Rose, 1998a).

What might this attention to the shaping of behaviour through rational science mean in terms of the subject positions that it brings to psychoeducation? It would seem that it positions people as creatures with rational reasons for why they act as they do such that it becomes possible to predict behaviour and calculate response. This results in people’s thoughts, attitudes and motivations all becoming possible points in which to intervene in people’s lives for their apparent good. Through scientific management people become both objects of theory and subjects of rational endeavour. As the object of scientific theory, if someone does not change their behaviour as a result of psychoeducation, the assumption could be made that there are some hidden aspects of a person’s internal psychological world yet to be worked upon and understood. As
the subject of rational endeavour the problem is not the theory, but the person; their inability to change their behaviour becomes an expression of assumed inadequacy or faulty way of being. In line with the earlier discussion of the critiques of self-management, it would seem that through the way psychoeducation draws heavily on psychological constructs, there is the potential for it to construct subjectivity on the basis of deficit and failure (Moore et al., 2015; Scott & Wilson, 2011).

**Mental hygiene**

Psychological science has worked hard to explain how and why individuals might be induced to change their health related behaviour. From the early twentieth century it has also worked hard in the guise of mental hygiene to provide knowledge about what constitutes ‘good’ mental health and how to best to educate people about these constructs for the good of society as a whole. While not named as mental hygiene, these samples of psychoeducation texts can be seen to contain traces of these ideas. Colom and Lam (2005) for example, stress the importance of education people bipolar disorder about the deleterious effect of poor attitudes upon mental health. In a similar vein, Landsverk and Kane (1998) talk about psychoeducation as a vehicle for education people with schizophrenia about the influence of stress upon mental health. For Authier *et al* (1975), Lukens and McFarlane (2004) and Haslam-Hopwood (2006), psychoeducation is an intervention to be used with all people in the name of improving mental health because of its capacity to teach “individuals and communities how to anticipate and manage periods of transition and crisis.” (Luken & McFarlane, 2004, p. 221).

Beginning in 1909 in the USA with the creation of the National Committee for Mental Hygiene by a group of reform-minded physicians, psychiatrists, academics and social workers, over the next twenty years mental hygiene became an international movement (Groves & Blanchard, 1930). In this way of thinking about people, all forms of mental disturbance, maladjustment, illness, or disorder were seen as damaging to the economic health and social order of a nation. Encouraged by the success of public health campaigns against such illnesses as tuberculosis, mental hygienists sought the same focus upon mental illness. Initially their focus was upon improving the care and treatment of those deemed ‘insane and mentally defective’
but their optimism in the ability of medical science to find the cause of mental illness meant they extended their focus to include all people and those things in life with the potential to undermine mental health. This meant “education, marriage, parenthood, industry – all the relationships of individuals to each other and to their environment” (Groves & Blanchard, 1930, p. 7) were the focus of attention.

Mental hygiene ideals were seen as progressive and reformist for their day (Crossley, 2006). Taking ideas from psychology, psychiatry, psychoanalysis and medicine, both mind and body were seen to be interconnected and directly affected by the environment. While hereditary influences upon mental disturbance were relevant, they were down played in favour of a focus upon environmental influences. People were understood to be a product of social forces which began in childhood when personality traits and behaviour were understood to develop in response to the child’s environment. If children were exposed to situations that elicited a repeating pattern of behaviour in the child, these patterns were thought to then become permanent. Maladjustment was understood as developing over time so intervening early to change habits of behaviour and emotion increased resistance to mental disturbances. Mental strain and fatigue were understood to be caused when people could not adjust to the complexities of modern life which led to emotional conflicts and a sense of failure to achieve. These emotions made then people vulnerable to mental collapse. Personality traits were understood to be important in predicting who might develop mental problems with certain traits and behaviours being linked to the development of dementia praecox (which became known as schizophrenia). The problems of mood and behaviour in manic depressive psychoses was also related to personality traits with these people having a particular temperament that was the cause of their intense variations in mood (Groves & Blanchard, 1930). By identifying these problems in personality early, treatment could begin to reduce the vulnerability of a person’s mental capacities. Their thinking, their attitudes, and their personality were all understood to be malleable.

World War I played a significant role in the development of mental hygienist ideas (Crossley, 2006). The war was seen to have had a significant impact upon both those who fought in it and the general population and there was a growing recognition that there was a psychological basis to how people responded to the experience of war.
“Now, the war, by the fatigues, the emotions, and the privation which have affected civilians as well as combatants, has created conditions favourable to the development of neuropathic states. A pressing social problem has thus arisen” (Colin, 1921, p. 460) The aftermath of the war also brought a fear of impending social collapse as criminality, alcoholism and an apparent lessening in people’s willingness to work were all understood to be on the rise (Colin, 1921). These were all signs of deteriorating mental health, therefore the mental health of the population needed to be tended to in order to improve a nation’s economy and military efficiency.

Deterioration in a person’s mental capacities was not considered inevitable so everyone needed to be educated into the workings of the mind in order to prevent mental disturbances occurring and encouraging people to seek early assistance with problems. This meant that a significant focus of mental hygiene work was upon intervening in childhood; either upon children themselves by working to identify those with a predisposition and then treating them or by educating teachers and parents about the needs of children so they could provide the best environment for the developing mind (Cohen, 1983). This focus upon training others in the ideas of mental hygiene saw the development of child guidance clinics as a means to identify and treat problem children, teach parents how to help their child and train teachers in how to identify and intervene in the conduct of problem children (Miller & Rose, 2008).

Prevention and treatment of mental disturbances was inherently moral in nature within the mental hygiene movement; there was a ‘right’ way to live in order to develop one’s mental capacities. “It is interested in environments, that they may be wholesome and exert a good influence upon the development of right mental attitudes and habits and upon the correction of wrong ones…” (Abbot cited in Forsyth, 1921, p. 508). The type of social order being promoted through mental hygiene was that espoused by the white, middle classes so degeneracy within the working classes was a central concern. The ‘right’ way to live in the name of mental health did not include excessive use of alcohol, refusing to work, poor manners nor sexual promiscuity (Crossley, 2006).
Mental hygiene’s concern with the mental abilities of people, the social implications of mental illness and a need to control social behaviour for the good of the nation can be seen as complementary to the Eugenics movement which was also a feature of the early part of the twentieth century. People constructed as lacking in intelligence were seen to be mentally defective, lacking in mental capacities and a subgroup of the mentally ill. This included women who were seen as ‘hypersexual’ and those unable to protect themselves from the sexual advances of men (Robertson, 2001). Within eugenics, mental defects were seen as primarily hereditary and degenerative in nature and the cause of social problems. Along with this, the feeble-minded were seen as more fertile than the rest of the population and growing in number. With the social upheaval that followed World War I, fears for the future of society produced a climate supportive of the idea that the best way to respond to the problem of the mentally defective who, by definition, did not therefore have the intelligence to exercise self-restraint or moral judgement, was to segregate them and control their reproductive capacities. Through the 1920’s and 1930’s New Zealand, along with other nations, considered the possibility of government legislation to enforce sterilization of those deemed unable to regulate their conduct for the good of society. Robertson (2001) suggests that the Depression made it harder for people to equate social problems with mental defects alone and that in the process of collecting data on the population, it was found that the numbers of people deemed defective was not as large as once thought. As a result, eugenics ideas lost favour.

While mental hygiene ideals are no longer directly influential, a focus upon the mental health of the nation remains important in contemporary public health campaigns. While ideas about the cause of mental illness no longer centre around defects in a person’s mental capacities or personality, other constructs of mental hygiene remain highly influential; mental health as influenced by social environment, the mental health of individuals as linked to the wellbeing of society as a whole, and an understanding that it is possible to take action to promote an individual’s ability to care for their own mental health remains an important construct in contemporary public mental health campaigns. Education programmes about the norms of mental health and how to achieve ‘good’ mental health are aimed at everyone and the expert

6 http://www.mentalhealth.org.nz/home/ways-to-wellbeing/
knowledge that shapes these ideas continues to come from the psychological sciences along with the more recent addition of the neurological sciences (Cloninger, 2006; Foresight Mental Capital and Wellbeing Project, 2008).

Mental hygiene ideas offered “to all the predisposed a regime of life suitable to their mental weakness.” (Colin, 1921, p. 461). While not using the same language of mental deficiency or weakness, present day public mental health initiatives continue to offer regimes for living with particular mental disorders. Psychoeducation acts in a similar vein, targeted at particular groups of people with identified health conditions but also with the potential to assist the general population (Haslam-Hopwood et al., 2006; Lukens & McFarlane, 2004). People with identified mental illnesses are therefore able to construct themselves as participating in a broader social project where ‘good’ mental health is a valuable social asset. Both mental hygiene and its transformation into contemporary public mental health initiatives can be seen as programmes of governmentality, where the population is governed through engineering the conduct of individuals so that people work upon themselves in the name of their own health whilst simultaneously producing the health and welfare of the nation state.

**Deinstitutionalization: Who will manage these people now?**

While the previous sections have highlighted the connections between psychoeducation and self-management to a broader social project of regimes of living that promote good mental health for all citizens, for people understood to have a mental illness, contemporary ways of living are intimately connected to a long history of institutional life. Internationally it is only over the last half of the twentieth century that questions have been asked about whether placing someone in a hospital institutional setting is the best way to treat a mental illness and if there might not be more helpful alternatives within communities (Bachrach, 1978; Durie, 1982; Scull, 1993). But in this movement away from institutional care, the problem of how to manage people with mental illness and how to influence the potentially problematic choices they might make when freed from the regime of the institution remains a

---

7 [http://depression.org.nz/]
central concern. In this context psychoeducation can be understood as a response to the problems of deinstitutionalisation.

Whether in spite of or because of the optimism of the period of lunacy reform in Britain, by the Victorian period institutions had become the standard response to the needs of the poor (the workhouse), the criminal (prisons and penal colonies) and the mentally ill (Scull, 1993; Ernst, 1991). The therapeutic optimism of the early nineteenth century did not last and asylums became associated with a sense of inevitable mental decay. In the New Zealand context, the development of asylums for the mentally ill in the new colony was based on British experiences of asylum care. With the significant growth in the settler population throughout the 1850s and 1860s, small scale lunatic asylums were established in centres of population growth but the size and quality of these institutions varied greatly (Ernst, 1991). While lay superintendents were involved in some of the first established asylums⁸, medical superintendents soon dominated asylum care with many having been trained as medical practitioners in Scotland. Despite medical control of asylums “the factual evidence about nineteenth-century pākehā asylums points to conditions of decay, neglect and lip service to reformist doctrines rather than to enlightenment and real reform.” (Ernst, 1991, p. 79). It was not until the 1950s that it became possible to consider something other than institutions as the appropriate response to the problem of mental illness (Scull, 1993). In New Zealand, psychiatric inpatient accommodation levels did not peak until 1970 (Brunton, 2001).

What made deinstitutionalisation possible after several centuries of asylum based care is open to debate. Psychiatry’s ability through ideas such as mental hygiene to intervene in the lives of all people, the development of medications to manage symptoms of psychosis (and possibly prevent manic-depressive illness), the civil rights movements, a growing awareness of the damaging effects of institutions and the growing cost of providing care in institutions that needed significant improvement; all are implicated to varying degrees (Brunton, 2001; Dew & Kirkman, 2002). While the suspicion remains that cost-containment had more of an influence than is usually acknowledged, it is claims to reform and humanitarian ideals that are

⁸ For example Edward Seagar at Sunnyside Hospital in Canterbury from 1863-1880,
constructed ultimately as motivating the change. “Deinstitutionalisation has assumed no less a task than that of humanizing mental health care – a task that would reverse the dehumanizing influences that are perceived to be part and parcel of traditional mental health care.” (Bachrach, 1978, p. 575).

In New Zealand, the move away from institutions was not initiated from central government and this led to the replication of problems experienced in other countries of underfunding and fragmentation in what was becoming known as community mental health care (Brunton, 2001; Dew & Kirkman, 2002). Internationally, in the move to community care it was those people with long-term, psychotic conditions who were most likely to lose access to services. Scull, in 1993 describes the American experience when he writes of how for the “thousands of younger psychotics discharged into the streets, it has meant a nightmare existence in blighted city centres, amidst neighbourhoods crowded with prostitutes, ex-felons, addicts, alcoholics and the other human rejects now repressively tolerated by their society. Here they eke out a precarious existence, supported by the welfare cheques that they may not even know how to cash.” (Scull, 1993, p. 391).

It is within the literature on psychoeducation for families that the connection to deinstitutionalisation can be found; with no institutions and inadequate community care it is the role of families to care for their ill family member and to do this the family are constructed as in need of education. For Hatfield (1988) this new direction of psychoeducation had limited usefulness until a clear theoretical framework for what it has to offer families was made explicit with the implication that it needs to go beyond a primary goal of training the family to act as long-term caregivers and pseudo mental health workers in an era of deinstitutionalisation and corresponding lack of residential and outpatient services. In this context, psychoeducation brings with it a history of inadequate care for people with mental illness, rather than the progressive, consumer based right to information approach put forward by others (Colom & Lam, 2005).

When it comes to psychoeducation and bipolar disorder, it is the advent of lithium clinics to which some authors refer when providing a rationale for the value of educational approaches for bipolar disorder (Colom et al., 2003a; Peet & Harvey,
and articles about lithium clinics link themselves to deinstitutionalisation (Fieve, 1975; Gitlin & Jamison, 1984). From the 1960's lithium carbonate offered a new form of pharmacological treatment for manic-depressive illness, and one that promised the possibility of preventing the illness from recurring. This in turn offered those researching its use the opportunity to run speciality treatment services which came to be known as 'lithium clinics’ “on the assumptions that specialty clinics would give sophisticated care in a highly efficient manner...” (Gitlin & Jamison, 1984, p. 363).

In a lithium clinic people were offered a specialist diagnostic service and once manic-depression was confirmed, the majority of people were placed on lithium. This specialist approach was argued as being particularly relevant in a time of deinstitutionalisation. “This problem of incorrect diagnosis leads to improper treatment of affective disorders...With improved diagnosis and treatment, the community would have less cause to fear that inadequately treated patients would be returned to society.” (Fieve, 1975, p. 1019). Once a week, usually in the morning, patients would attend the clinic, have blood levels taken and in the process have their mood evaluated. Patients attended weekly or monthly as their medication regime indicated. Non-physicians, most often nurses, were trained to use rating scales to evaluate mood so psychiatrists did not need to meet with every patient unless their blood test showed this as necessary. This model of service delivery was seen to be more efficient and importantly, less costly (Fieve, 1975; Gitlin & Jamison, 1984).

Lithium was the first psychiatric drug to require blood tests to be taken to ensure a therapeutic level and to monitor the risk of toxicity and potential damage to the kidneys. As its role was as a preventative treatment, it could appear to the person taking it that the drug was doing nothing beyond causing side effects so patients were seen to require education about the benefits and instruction in how to monitor for the potential of toxicity. Patients who did not take the drug as it was prescribed became over time a significant issue for lithium clinics (Peet & Harvey, 1991). Referred to as non-compliance, this problem was one to which education was understood to have much to offer; if people increased their knowledge and changed their attitude toward lithium then compliance with doctor’s orders was assumed to be more likely (Peet & Harvey, 1991).
Lithium clinics also create a link back to the debate about whether psychoeducation is best understood as a process of psychotherapy or education. In Fieve’s style of lithium clinic in 1975, no reference is made to educational interventions beyond the possibility that it happens within the “other services, including social work, nursing and referral” that are provided (Fieve, 1975, p. 1020). He is clear though that “our focus in the clinic is on the presence or absence of an affective episode and the staff make little attempt to deal with the interpersonal or intrapsychic problems of the patients except as they relate to mood.” (Fieve, 1975, p. 1021). In this style of lithium clinic a person might receive education but psychotherapy was explicitly not on offer.

For Gitlin & Jamison (1984) the expectation that the lithium clinic will provide both education and psychotherapy to its patients is overt, as is the opportunities offered by group interactions. “What is surprising, in retrospect, is its [psychotherapy] absence in the earlier clinics. Manic-depressive illness involves many psychological issues that lithium itself cannot treat...Many of these issues can be handled more effectively in individual therapy; however, group therapy provides a unique kind of support, as in helping facilitate compliance issues through peer rather than professional encouragement.” (Gitlin & Jamison, 1984, p. 367).

Bringing people with bipolar disorder together in groups was also seen as problematic, as suggested by Volkmar et al (1981) when laying out the background to the successful long-term group therapy they offered to people attending a lithium clinic. “These patients were thought to exhibit superficial and conventional relationships with strong underlying feelings of dependency, hostility, envy and competition. The patients’ inability to tolerate anxiety or intimacy and their use of massive denial and manipulation were seen as precluding the formation of a treatment alliance even during the euthymic phase of illness.” (Volkmar et al., 1981, p. 226). Instead Volkmar and colleagues aimed to provide a “weekly meeting that would present the members with the opportunity for interpersonal learning and support as well as providing for close follow-up of medications...Thus the focus of the group was on expression of affect, reality issues and immediate problems and concerns rather than on past history.” (Volkmar et al., 1981, p. 229). By refuting the notion that people with bipolar disorder have character flaws that cannot be worked
with, it becomes possible for both therapy and education in a group setting to be provided to people understood to have manic-depression.

Without institutions to apply the science of behaviour management to potentially problematic people or to provide the regime of daily life as they once had, families now needed to be trained to take on the role of long term caregiver. For those with manic depression now living outside of institutions, ways needed to be found to monitor their use of medication and respond to problems of non-compliance. Psychoeducation offered a way to act on these problems; a way to manage people when institutions no longer have the mandate to do so by sharing skills that used to be held exclusively by mental health professionals. In the context of deinstitutionalisation, psychoeducation draws on a long history of seeing people with mental illness from a deficit perspective, as lacking skills and personality attributes that would allow them to live like everyone else.

Psychoeducation also potentially constructs the problem of mental illness as one that can be attended to by an individual having more skills in caring for themselves rather than addressing the place in society of a group of people who have more usually been excluded rather than included. The absence of institutions also meant that new ways of surveilling those people with manic depression needed to be found and with the assistance of Lithium, it became possible to provide this. But these same services also provided a means by which the nature of manic depression and the person who has it could be challenged. For those with the condition, no longer did they have to be thought of as possessing a flaw in their personality. Instead they could be constructed as having the ability like everyone else to learn about themselves through relationships with others and that the condition itself could be thought of as creating psychological issues which needed attention.

**Moral treatment: re-learning self-control**

Contemporary psychoeducation taps into a long history of mental health as malleable; with appropriate knowledge from the sciences of psychology, psychiatry and neurology, people can intervene in their own lives to reduce those factors, most commonly stress and lifestyle related, that put people at greater risk of emotional and psychological distress. If people with mental illnesses are to live successfully outside
of institutions they need to learn knowledge and skills that were previously the
domain of mental health professionals so that they too can intervene in their own
lives. This requires the ability to see oneself firstly as the object of the science of
behaviour change and then as a subject with the capacity to change oneself. It is in the
development of moral treatment that history allows us to see early ways of thinking
about of the mind of those deemed mentally ill; that it could be managed in such a
way that the person’s self-governing capacities could be drawn upon to change
behaviour.

Moral treatment and particularly how it was practiced at The Retreat at York in
England in the nineteenth century, has come to represent the humanitarian and
progressive side to the history of psychiatry (Micale & Porter, 1994; Lilleleht, 2002).
In 1796 William Tuke, a Quaker and tea merchant, founded The Retreat as a place to
which fellow Quakers deemed to be insane could come for care and treatment as
means to try and address concerns with inadequate care for the insane. Tuke was not
alone in his concern with improving the conditions of asylums; Phillipe Pinel in
France is also credited with similar but separate developments in asylum care that
saw “the essential attribute of the mad as irrationality rather than animality” (Digby,
1985, p. 6). This was a fundamental change in the way insanity was viewed and it
allowed space for the idea that the mind could be managed rather than brutalised. It
is an approach that recognised an insane person as being temporarily without reason
and therefore having the capacity to regain it. It focused upon developing the self-
governing capacities of people using a code of moral or ‘right’ living based on a
Quaker Christian view of the person. Physical forms of ‘treatment’ were still used at
The Retreat but attention was more upon using ‘milder’, psychological means of
control rather than physical control. The ultimate goal was to develop a person’s
internal capacity for self-control and self-discipline. The human desire for the
approval of others and an aversion to fear was understood to motivate people to
behave in socially appropriate ways.

“...patients are considered capable of rational and honourable inducement;
and although we allowed fear a considerable place in the production of that
restraint, which the patient generally exerts on his entrance into a new
situation; yet the desire of esteem is considered, at the Retreat, as operating, in
general, still more powerfully. This principle in the human mind, which
doubtless influences in great degree, though often secretly, our general
manners...yet when properly cultivated, it leads many to struggle to conceal
and overcome their morbid propensities and, at least, materially assists them
in confining their deviations, within such bounds, as do not make them
obnoxious to the family. This struggle is highly beneficial to the patient, by
strengthening his mind, and conducing to a salutary habit of self-restraint; an
object which experience points out as of the greatest importance, in the cure

This meant that punishments and rewards for behaviours were all reasonable
practices but only so long as they were within the bounds of what might happen
within any family.

“The principle of fear, which is rarely decreased by insanity, is considered as
of great importance in the management of the patients. But it is not allowed to
be excited, beyond that degree which naturally arises from the necessary

Kindness and comfort were central to care, not subjugation and brutality.

“...since whatever tends to promote the happiness of the patient, is found to
increase his desire to restrain himself, by exciting the wish not to forfeit his
enjoyments...The comfort of patients is therefore considered of the highest
importance, in a curative point of view.” (Tuke, 1964, p. 177-178).

The desire for the good opinion of others and the fear of losing things that the person
enjoyed were complemented by the creation of a therapeutic environment led by the
benevolent authority of the superintendent in a familial atmosphere that allowed the
close, daily observation of patients within a philosophy of kindness (Scull, 1993).

Moral treatment as practiced at the Retreat was based on Quaker concepts of what it
meant to be human and the type of relationship that a person needed to have with
God (Stewart, 1992). For Quakers every person, regardless of class, gender or colour,
had the Light of Christ or the Inner Light within them. This Light within allowed all
people to be connected to God in the here and now and for all people to be connected
to each other. Cultivating this Inner Light could not be done through violence or force and it also required the suppression of self-centredness so that the divine could spontaneously guide a person to right action. Following the Inner Light did not come naturally; it was something that people learned to do through a process of inner discipline. Quakerism was based upon religious practices that stripped away religious tradition and valued inward reflection rather than outward ceremony. To experience God within each person, the cultivation of an inner discipline was essential. A Quaker's behaviour, speech and outward appearance were an expression of his or her beliefs and as such required simplicity and plainness. Quaker life was about learning positive habits that reflected religious belief and it is the cultivation of habits of inner self-control that moral treatment was based (Stewart, 1992). It was the systematic regulation of daily life based on a cohesive moral code that endorsed a Quaker view of the world and a person's place within it.

The work of Philippe Pinel in France and Vincenzo Chiarugi in Italy saw similar but separate developments in ideas about the humanity of the insane and their capacity to respond to gentleness and kindness, but without any of the religious doctrine. Collectively, these approaches all came to be known as moral treatment and all saw the insane person as someone how needed to relearn how to govern their inner world of emotions and thoughts (Porter, 1997). In histories of psychiatry, moral treatment often takes on a heroic and progressive character as an expression of a time when psychiatry found (and then kept) its humanity (Micale & Porter, 1994). Foucault's history of madness controversially revised such a view (Foucault, 2001) and argued that instead of liberating the mad, moral treatment created hidden and therefore more sinister, psychological chains. “The real operations are different. In fact Tuke created an asylum where he substituted for the free terror of madness the stifling anguish of responsibility; fear no longer reigned on the other side of the prison gates, it now raged under the seals of conscience.” (Foucault, 2001, p. 234).

Many have critiqued Foucault's work and its accuracy as a work of history (Gutting, 1994) but regardless of these criticisms, his ideas about moral treatment have opened up the possibility of thinking about it as more than humanitarian; that power was and is at work in practices that are concerned with teaching people to develop their internal capacity to govern thoughts, emotions and behaviour.
While not the only institution concerned with moral treatment as an approach, The Retreat had a significant influence upon ideas in both Britain and the USA about the role of asylums in the care of the insane (Lilleleht, 2002; Porter, 1997), much of it as a result of the publication by Tuke’s grandson Samuel of ‘Description of The Retreat’ in 1813 (Tuke, 1964/1813). As a result, “…what started as a local, private, sectarian experiment in charity wrought a fundamental change in the attitude to the insane in England and spread throughout the civilised world.” (Hunter & Macalpine, 1964, p. 19). While perhaps not as grand as this quote may claim, it has none the less been highly influential. Psychiatry quickly adopted these more humane approaches but without any of the religious overtones. When New Zealand asylums were being developed in the last half of the nineteenth century it was the British asylum practice of moral treatment and physician Superintendents that were adopted (Ernst, 1991). While claims to be providing moral treatment in New Zealand asylums is considered rhetoric rather than reality, in the Victorian period moral treatment was talked about as an example of enlightened psychiatric practice (Ernst, 1991). Indeed it continues to be referred to in contemporary times as an example of how psychiatry needs to return to similar practices based upon “kindness, compassion, respect and hope for recovery” as illustrated by the work of the Tukes” (Roberts & Wolfson, 2004, p. 37).

Moral treatment aided in the creation of the space for further developments in psychological interventions for the treatment of the mentally ill. It helped to open the door on ways of thinking that see both people’s emotions and behaviours as mechanisms through which people can be governed and can learn to govern themselves and in doing so it created a significant condition of possibility for self-management and psychoeducation. Through its reference to the texts of moral treatment, psychoeducation practices in psychiatry are linked back to examples of social reform and expressions of humanity and in doing so they become contemporary examples of enlightened practice. But as Foucault’s work suggests, there is power at work within practices that promote self-governance. For the person who is the target of psychoeducation there is the potential to see themselves as taking part in what could be an example of a progressive psychiatric treatment as much as it could be experienced as a coercive regime of living.
Summary

When texts on psychoeducation are treated as historical documents and a way to understand the events, ideas and circumstances that have made the development of psychoeducation practices possible, it can be seen that it is a practice that is tied tightly to the historical development of the discourse of psychology and its infiltration over the 20th century into how we understand the nature of being human (Rose, 1998b). Moral treatment's behavioural approach of rewards and punishments as the means to manage a person's emotions can be seen as part of the early development of the discourse which over time would develop further in the application of scientific constructs to how a person can be persuaded to engage in changing their attitude toward their health condition as a means to change their behaviour. These ideas converge with an assumption that it is a 'natural' state of humanness to seek autonomy, independence and to make one's own choices; to think or act otherwise is constructed as abnormal. The notion of the therapeutic potential of psychological constructs and their ability to help heal or improve a person's life can be seen in ideas about the 'proper' regimes for living promoted by both mental hygiene ideals and public health campaigns; that there is a psychological shaped space inside everyone and with education, all people can learn to optimise this space (Rose, 1998b, 1999a). Ideas about self-help and group therapy also turn to the therapeutic potential of psychology to heal; that people need the knowledge of psychology if they are to either heal themselves or turn to the healing powers of others.

The subject positions that would seem to be on offer are also infused with psychological constructs; a person who needs to learn from psy-experts in order to make the 'right' decisions about a suitable regime of living, a person with the capacity to change themselves but if they don't or can't they become positioned as lacking in psychological norms of self-confidence and self-efficacy. For the person understood to have a mental illness, they are positioned as having been freed from the oppression of institutions but in return they become someone who must now take on their own governance and regulation on the basis of psy-related expertise. It remains to be seen if these subject positions continue to make themselves available to the selves who are the focus of self-management for bipolar disorder and it is to this that
the thesis turns after first addressing the practicalities of engaging in a Foucauldian inspired discourse analysis.
Chapter 4
Method

“...every word, every phrase has the deepest roots, a lifetime of connections and associations, of sounds that ripple through words, of memories and dreams. Words, all words, are so deeply enmeshed, so implicated, it seems a wonder that we can still use them to new effect, can still pull them off ourselves like blood-fattened leeches and throw them back into the pool.” (Dugdale, 2013)

When discourse is understood as the way a system of statements come together to construct an object and as a result shape what can and cannot be said about the object/s, it becomes possible to unpick the patterns being used in discourse to produce particular understandings and show how they work to produce and reproduce ways of being a person through relations of power. Having created a theoretical position for this discourse analysis based upon the work of Foucault and having constructed a historical context for the discourse of self-management for bipolar disorder, this chapter is used to firstly position this discourse analysis within a field of other analyses concerned with critiquing the practices of health and medicine before moving on to make explicit how the key theoretical concepts of discourse, subjectivity and power are used to approach this Foucauldian discourse analysis.

Post-structural theories and Foucault’s concepts in particular have been used extensively by authors seeking to critique dominant assumptions in health and medicine. Chronic illness (Armstrong, 1990; Galvin, 2002), public health (Armstrong, 1995, 2014; Lupton, 1992; Petersen, 1996, 1997; Petersen & Lupton, 1996), primary health care (McDonald, Mead, Cheraghi-Sohi, Bower, Whalley, & Roland, 2007)), nursing (Cheek & Porter, 1997; Crowe, 1998; Gastaldo & Holmes, 1999; Holmes & Gastaldo, 2002; Lines, 2001; Manias & Street, 2000), intellectual disability (Burrell & Trip, 2011), psychotherapy (Hook, 2003; Miller & Rose, 2008; Parker, 2008), psychology (Parker, 1992, 2008, 2015a; Rose, 1998b; Willig, 2000) and psychiatry (Enoch, 2005; Hacking, 2007; Hamilton & Roper, 2006; Holmes, 2002; Philip, 2009;
Rose, 2008; Rose, 1986, 1998a; Terkselsen, 2009) have all proved fruitful areas to rethink the relationships between health care institutions and practices, medical knowledge, the recipient of health expertise and how people come to make sense of who they are. Discourse analyses based upon Foucault’s work and applied as a specific research method are to be found across the same range of health and psychology related fields. Those that have specifically found the exploration of subjectivity and governmentality within discourse analysis a useful direction have covered areas such as genetic counselling (Leontini, 2010), public health campaigns focused on smoking (Gilbert, 2008) and healthy eating (Vander Schee, 2009), contraceptive counselling (Hayter, 2006), obesity (Ruud Knutsen, Terragni, & Foss, 2011) and aging (Paulson & Willig, 2008).

**Aim**

This thesis seeks to extend how post-structural concepts are applied to health care practices by exploring a particular set of mental health practices named as self-management for bipolar disorder. Using a Foucauldian inspired discourse analysis because of its concern with “what kind of objects and subjects are constructed through discourse and what kinds of ways-of-being these objects and subjects make available to people.” [italics in original] (Willig, 2001, p. 91), this thesis explores the productive nature of self-management discourse in terms of the power relations at work within it and its ability to shape subjectivity. In doing so it aims to re-evaluate the ‘self’ in self-management by identifying the effects of the discourse of self-management for bipolar disorder upon both how a person makes sense of themselves and how they are to live.

To achieve this aim this chapter lays out the method that lies behind the discourse analysis that follows in chapters 5, 6 and 7. It starts with a discussion of the social and cultural context within which this discourse analysis has been put to work and then moves to a discussion of Ian Parker’s (1992) ‘steps’ of discourse analysis and how they were applied to this project. The chapter ends with a discussion of the methods used to produce the interview texts for analysis and a discussion of the issue of rigour in discourse analysis. While the previous two chapters detailed the theoretical position of the thesis in terms of its key concepts of discourse, subjectivity, power and
history, this chapter now lays out the methods used to approach a Foucauldian inspired discourse analysis; from data gathering through to the process of analysis.

The Social and Cultural Context of the Analysis

Contemporary Aotearoa New Zealand society acts as the often unspoken context within which much of the texts for analysis and the analysis itself has been constructed therefore any discussion of method must first start by making this explicit as it will have both knowingly and unknowingly shaped how this analyst engages with both the creation and the analysis of discourse. Aotearoa New Zealand is a society deeply shaped by colonialism. In 1840 a treaty, Te Tiriti o Waitangi (The Treaty of Waitangi) was signed between the British Crown and Māori chiefs in which a broad statement of principles was agreed on which to base a relationship between the British Crown and the indigenous people of the land. This treaty became the founding document of Aotearoa New Zealand and legitimated the arrival of British settlers. While one of the few treaties be agreed between Great Britain and an indigenous people, it is now recognised that the version documented in English was different to the one in Māori that the rangatira (chief or noble person) signed, but it was the English version that became the official document for the Crown. Needless to say the indigenous people of Aotearoa New Zealand lost out in the process, losing their land and with it their way of life, language and ultimately their wellbeing. Using Te Tiriti o Waitangi as a basis for negotiations with iwi (tribe), since the 1980’s the Crown has engaged in a process of restitution whereby they acknowledge breaches of Te Tiriti o Waitangi and provide compensation to iwi (Bidois, 2013; Network Waitangi, 2015; Salmond, 2012).

Te Tiriti o Waitangi has also become a document that influences the discursive practices of health and social services in Aotearoa New Zealand. In an effort to reconcile the contradictions between the two versions of Te Tiriti o Waitangi, non-Māori institutions have looked for principles that can guide government policy. Within health and social services the principles drawn upon are those of participation, partnership and protection (Royal Commission on Social Policy, 1988). Debates over what these principles might mean in practice has led to the development of concepts such as cultural safety (Network Waitangi, 2015; Ramsden,
1990, 2000) as way to help health professionals enact a commitment to Te Tiriti o Waitangi. Despite this, Māori health statistics indicate that there remains a significant disparity between the health and wellbeing of Māori in comparison to non-Māori (Robson & Harris, 2007).

By claiming an ethnicity of pākehā (New Zealand European), a position is claimed by the writer as someone who is non-Māori and acknowledges Te Tiriti o Waitangi as the founding document of contemporary Aotearoa New Zealand society and the obligations that it creates. In doing so Te Tiriti o Waitangi is also being constructed as an invitation to non-Māori to enter into a relationship with Māori as the indigenous people of the land and not perpetuate the colonial oppression of the past. Both the interviews and the process of analysis will therefore have been shaped by this position. As pākehā based research no authoritative claim is made to Māori knowledge but as a researcher who seeks to engage actively with a Māori worldview from a position influenced by social justice, these perspectives can be seen to have influenced the discussion of the findings in Chapter 8.

This discourse analysis is as culturally situated as the discursive resources drawn on in the texts under study and in making explicit a stance in relation to the social and cultural context of the discourse analysis, a discourse of biculturalism is being drawn upon. This is seen in the choice to refer to the nation state of Aotearoa New Zealand by both its English and Māori names, the claims made with regard to how the term ‘pākeha’ is being used and the choice to use the Māori name for the treaty. These are discursive strategies being used for the explicit purpose of, in some small way, resisting the longstanding technique of oppression by devaluing a Māori world view. But despite intentions motivated by notions of social justice and with an awareness of how oppression is maintained in language (Parker, 2015), the data has none-the-less been interpreted by an analyst ‘brought up’ within a dominant white-Western world view and this will likely have impacted upon how the texts were both generated and analysed.

---

9 Whenever Māori concepts became apparent in the data guidance was sort from appropriate Māori sources. Specifically this was my supervisor Dr Cameron Lacey (Māori and Indigenous Health Institute, University of Otago, Christchurch) and Mr Ruru Hona (Ngati Kahu, Ngaa Puhi; Pukenga Atawhai, Youth Forensic Team, Canterbury District Health Board)
‘Doing’ Discourse Analysis

Discourse analysis as a research method is perhaps best described as a sensitivity to language and its productive capacities. As such the attention is upon what discourse is doing rather than grasping at the meaning a ‘speaker’ is using language to convey (Crowe, 2005; Willig, 2001). As a means to understand how discourse can be analysed, Parker proposes twenty ‘steps’ to be worked through, though not necessarily sequentially (Parker, 1992, 1999b, 2004). These ‘steps’ are firstly described and then their application to this thesis is discussed.

1. Treat the objects of study as texts which can be put into words.
2. In a process of free association, consider the symbolic connections, different subject positions and alternate meanings that may be present for different readers of the text.

These can be seen as preliminary steps that identify the texts for analysis and any additional texts that need to be included to help make sense of the material.

3. Identify the objects that are being referred to.
4. Treat the discourse as if it were an object.

As discourse is understood as the system of statements and practices that construct objects, these need to be named, most usually by focusing on the nouns used but also by word combinations and adjectives. As with all aspects of discourse analysis, the choice of which objects to identify is an interpretive process but in the process of doing this connections and patterns in the text can begin to be identified. In treating the discourse as if it were an object, the text analyst is required to put themselves at a distance from the text in order to not get drawn into the truth claims or taken for granted assumptions at work within the text.

5. Specify the types of person being talked about in the discourse.
6. Speculate on the rights and responsibilities being expected of these people.

This process is concerned with the construction of subjectivity within the discourse, the subject positions being made available to the reader or audience of the text. What and how are they called into being, what rights to speak do they have and in what
way may they speak. This is a particularly pertinent aspect of the process of this thesis as it is concerned with subject positions available to people within a self-management discourse and the implications of this for their construction of their ethical self.

7. Map the network of relationships that are constructed, the picture of the world that this discourse presents.

8. Imagine how this picture of the world might respond if attacked or criticised.

In order for a discourse to systematically construct objects of which they speak, there is a set of cultural understandings being put to work by the reader/audience that enables them to make sense of it. These stages seek to identify what cultural understandings or picture of reality is being used to give the discourse coherence and make it make sense.

9. Identify the points of contrast between the different ways of speaking and the different objects they create in the process.

10. Identify the points where these different ways of speaking seem to speak about the ‘same’ object but in different ways.

Discourse entails the use of other discourses to explain, understand or articulate it. These questions seek to explore and identify the other discourses at work; to consider the relationships between them and make these explicit.

11. Consider how the different discourses identified at work in the previous two steps address different audiences.

12. Consider how I as the analyst have chosen to name or interpret these different discourses and the moral or political aspects of the interpretation.

This stage is interested in the reflexivity of discourse, its way of folding back on itself to reflect on its own way of speaking in order to draw attention to the contradictions and potential other discourses or ways of speaking about things that are so taken for granted that are not seen.

13. How have the discourses emerged historically.

14. How have the discourses woven in their own story of their origin.
Texts are located in time and the objects to which they refer have been written and spoken of previously in other texts and discourses that have gone before therefore a discourse analysis must include a consideration of the historical nature of discourses, the subject positions made available within them and how this “lays out a field of action” from which people can come to know themselves (Parker, 2004, p. 152).

15. What institutions are reinforced by the particular discourses identified.
16. What institutions are subverted or attacked by these same discourses.

These questions signal a move to a focus in the analytic process on the role of power in discourse. Institutions reproduce particular social practices that are sanctioned by social norms through their discursive practices. This makes consideration of the relationship between discourse and institutions one way to begin to consider how power is at work.

17. Look at which categories of people gain or lose from the identified discourses.
18. Who would promote or oppose these discourses.

In line with the earlier discussion of power’s both productive and coercive nature, this stage is concerned with the subject positions and the types of knowledge associated with them that have the most to gain or lose, and how dominant discourses might be resisted as a result. This aspect of the analytic process is another of particular relevance for this thesis with its interest in how self-management practices act as a form of self-surveillance and an enactment of governmentality.

And finally;

19. Explore how the discourses connect with other oppressive discourses.
20. Consider how the discourses allow dominant groups to justify the present.

With these final questions Parker is concerned with the ideological effects of discourse and the relationship between discourse and those manifestations of power that are interested in promoting certain sets of beliefs and ideas that are central to “the whole social order” (Eagleton, 1991, p. 8) through the means of “social domination ...in an inherently non-transparent way” (Zizek, 1994, p. 8). Discourse, discursive practices and the people that use them are both the instrument and the
result of power (Hook, 2001) therefore any analysis of discourse must include a consideration of how power is put to work.

**Applying theory to method**

In order to explore the effects of the discourse of self-management for bipolar disorder upon how a person makes sense of themselves and how to live, Parker’s (1992) ‘steps’ have been applied in the following manner.

As a precursor to the analysis and as detailed in chapter 3, the first step as to engage with the questions of how the discourse of self-management has emerged historically as a way to understand how other discourses and circumstances have, over time, come to shape self-management discourse and the subject positions it makes available. To do this a search of the literature was undertaken to collect together articles with a focus upon psychoeducation as the name given to the structured educative process of providing people with information about their condition, teaching self-management skills and promoting their ability to make more informed decisions about their own treatment (Smith et al., 2010). The first approach was to locate the earliest possible use of the term in the field. This was then broadened to articles that talked about concepts of both education and group based treatment of people understood to have bipolar disorder. In the process of reading, other articles were identified that gave an indication of the ideas shaping psychoeducation so they were also incorporated into the collection of articles. This process generated 20 articles ranging from 1975 through to 2006. A template was created to bring focus to the reading and interpretation of the articles which included identifying the type of intervention being discussed and for whom, how psychoeducation was defined (if at all), how the intervention was thought to work, and any references (both implied and explicit) to theories or authors shaping ideas. Because the authors’ intention in writing was usually not for the purposes of critique of the concept of psychoeducation, the assumptions and theories upon which they base their discussions of psychological and education interventions are implied. This means the judgements and interpretations made have required a degree of ‘reading between the lines’ in order to make sense of text through texts that have gone before.
The first foci of analysis following this was then to consider how discourse was being used to construct ‘bipolar disorder’ and ‘self-management’ as objects and then how discourses positioned people with bipolar disorder and the type of person they are ‘called’ to be. Whilst engaging in this process attention was paid to identifying the discourses of which self-management discourse itself seemed to be made up of and the implications of this for how a person may come to understand and act upon themselves. Throughout the analysis specific attention was also paid to identifying the power relations at work within discourses with a particular focus upon applying the concept of governmentality. This resulted in the concepts of subjectification (how others are governed and objectified by discourse) and subjectivation (how people govern themselves) (Milchman & Rosenberg, 2009) being used to provide a structure to both the process and write up of the analysis.

In chapter 5 the concept of subjectification is used to approach an analysis of the Psychoeducation Manual for Bipolar Disorder (Colom & Vieta, 2006) which is an expert produced text designed to educate mental health professionals about how best to promote the self-management practices of people with bipolar disorder. The approached used in this stage was to ask a number of particular questions of the text in terms of how discourse was being used to construct both object and subject. The following questions guided this stage of analysis:

How is bipolar disorder constructed as an object and on the basis of what knowledge?

What subject positions does the text make available to people with bipolar disorder?

What sort of relationship are people diagnosed with bipolar disorder expected to have with the object?

What metaphors are implied or explicit in the text that allow the statements ‘bipolar disorder is...’ and ‘a person with bipolar disorder is...’ to be completed.

In chapters 6 and 7 processes of subjectivation (Milchman & Rosenberg, 2009) - how people with bipolar disorder govern themselves and turn themselves into particular subjects – is used to analyse the transcripts of interviews with people understood to have bipolar disorder. Chapter 6 approaches the relationship between discourse and
self-formation by considering how people use discourse to construct bipolar disorder as an object and from this make an informed interpretation of what this might mean for how subjectivity is being shaped by discourse. To this end textual statements were grouped according to how they seemed to answer four questions:

How is bipolar disorder constructed as an object?

How is self-management constructed?

How is life with bipolar disorder constructed?

What discourses are being drawn upon in these processes?

Chapter 7 then approaches the relationship between discourse and self-formation by considering the subject positions that self-management discourse makes available to people with bipolar disorder and the implications of this for processes of self-formation. Using the findings detailed in Chapter 6 which explored processes of subjectification, a framework within which to understand self-management discourse is developed that identifies three particular elements to the discursive practices of self-management; 1) acceptance and recognition, 2) examine, confess and change, 3) moderate and regulate. These elements were then used to group textual statements and determine what subject positions or ways of being in the world are made available to people with bipolar disorder through self-management discourse. While these three elements create a conceptual tool for making sense of self-management discourse they also become a way to make sense of the subject positions on offer.

This focus upon processes of subjectivation seeks to take the exploration of the discursive construction of subjectivity beyond something purely descriptive and consider how people use discourse to construct themselves (Petersen, 2003; Willig, 2000). When done in conjunction with an exploration of power relations it allows this thesis to enacts its aim of exploring the productive nature of self-management discourse and practices and their ability to shape how a person with bipolar disorder makes sense of who they are and how they are to live.
Writing as analysis

This discussion of the process of analysis leaves out thus far a vital stage; that of writing in order to analyse. The grouping and categorizing of statements was just the start of a creative and interpretive process of thinking and writing. In the words of Elizabeth St Pierre “...analysis [is] the thinking that writing enables...” (St Pierre, 2011, p. 621). The act of writing allowed ideas to be developed, explored, sometimes kept, most often rejected or modified into another train of thinking and writing. The feedback of supervisors, conversations with colleagues and a continual reading and re-reading of theory then allowed further thinking and rewriting.

When interpretation is understood as “...widening the angle of vision...” rather than detective work to find the truth, the aim of analysis is “...to perceive more of what presents itself, by adding layers of meaning rather than to ‘boil things down’ to their underlying meaning” (Willig 2011, p. 267). Given the fluidity of meaning in language, this analysis is but one attempt to explain why things are as they are using some very particular assumptions about the nature of human beings and the world in which we live.

Context and Production of Interview Text

When this project was first conceived and gained ethical approval, the process to recruit and collect interviews with people living bipolar was one whereby people where to be approached via direct advertising and by mental health workers passing on information about the project. Having begun the process of recruitment by engaging with local providers of mental health services, the opportunity arose to link this project with a larger study that was interested in testing a model of care for people with bipolar disorder using psychotherapy (Interpersonal Social Rhythm Therapy) and medication management as a means to improve self-management and reduce health service use. With the permission of the Ethics Committee, the

---

10 Ethical approval for the Bipolar Clinic study was granted by the Upper South B Regional Ethics Committee, NZ. Approval no: URB/10/11/044
Ethical approval for this discourse analysis titled “Living with bipolar disorder: Using Discourse Analysis to explore the impact of self-management practices upon the self was granted by the Upper South B Regional Ethics Committee, NZ. Approval no: URB/10/02/001.
collection of text for analysis now happened as part of a semi-structured interview that research participants engaged in as part of entry to the Bipolar Clinic Study.

The Bipolar Clinic study is a Health Research Council (NZ) funded project that is investigating the clinical effectiveness of an intervention that incorporates psychotherapy and medication management in comparison to usual general practice care. The primary hypothesis is that those people randomised to the intervention will have lower rates of inpatient admission and acute assessment at 12 months than those people randomised to usual follow up care after discharge from specialist mental health services. One hundred people aged 18-64yrs with Bipolar I or II will be recruited at their point of discharge from the local specialist mental health service and following consent, will be randomised to either treatment as usual within general practice or treatment within the Bipolar Clinic. Exclusion criteria is limited to a) having a concurrent diagnosis of schizophrenia, b) having a concurrent diagnosis of severe alcohol or drug dependence or c) meeting DSM IV criteria for a depressive, manic or hypomanic episode.

The decision to use the Bipolar Clinic as a source of data was primarily a pragmatic one as the author of this thesis worked as both a mental health professional providing psychotherapy to participants and as a research fellow who completed all the baseline data gathering with participants. These roles allowed the opportunity to combine both my interviewing role and my PhD project to gather data.

The process of gathering baseline data from participants in the Bipolar Clinic study began with an audio-recorded, semi-structured interview that explored participants’ experiences of living with bipolar disorder. The interview schedule asked questions of interest to several members of the research team (including this PhD thesis) which resulted in a wide ranging conversation covering how they lived with the condition, what they thought of the notion of self-management, their experience of taking medication, their views on the helpfulness of health services and the subjective experience of different mood states. The semi-structured interview was the start of a lengthy process of data gathering using a mixture of structured, semi-structured and
self-report questionnaires. All interviews took place in the offices from which the Bipolar Clinic study operated and were held during the day at a time mutually convenient to both participant and researcher.

Choosing the transcripts for analysis

At the point of starting this discourse analysis, 69 semi-structured interviews had been completed. The first 14 interviews where transcribed and read through a number of times to ‘get a feel’ for how people spoke about self-management and to learn to read a text with a focus on discourse rather than attributing meaning. After this, interviews were chosen for transcription on the basis of a growing awareness of how discourse was being used at the time of the interview and when interviews might include moments of contradiction and ambivalence.

In line with the assumption that meaning making through language is culturally and socially situated and dependent upon the particular discursive resources available to a person, all the interviews with those people who constructed their identity as Māori were also included. As a pākehā researcher producing a discourse analysis shaped by a pākehā world view, the intention in ensuring that all interviews with Māori were included was not in order that claims could be made regarding how discourse is influenced by ethnicity but rather to ensure both due respect to the bi-cultural nature of Aotearoa New Zealand society and to gather a diversity of views about self-management. Twenty five interviews in total formed the corpus of interview-based text as at this point saturation had been reached with no new discourses or constructs presenting themselves. Six of these participants identified as Māori, sixteen as New Zealand European, one white English person, one white South African.

---

11 Structured Clinical Interview for DSM-IV Axis I Disorders (First, Spitzer, Gibbon, & Williams, 1996); Study specific demographic questionnaire; Brief Illness Perception Questionnaire (Broadbent, Petrie, Main, & Weinman, 2006); The Beliefs About Medication Questionnaire (Horne, Weinman, & Hankins, 1999); Bipolar Self-Efficacy Scale developed by Centre for Clinical Interventions 2008 Perth, Australia; External Influences on Attitudes to Bipolar Disorder and Medication Adherence, developed specifically for this study; Health Care Climate Questionnaire (Ludman, Simon, Rutter, Bauer, & Unutzer, 2002); Hopkins Symptom Checklist Revised (Derogatis, 1983; Derogatis, Lipman, & Covi, 1973); Medication Adherence Rating Scale (Thompson, Kulkarni, & Sergejew, 2000); Quality of Life Questionnaire (Michalak & Murray, 2010); Social Adjustment Scale (Weissman & Bothwell, 1976).
and one white American. Six of the transcripts were generated by males and nineteen by females.

Transcription process

To transcribe the audio recordings, a transcriber contracted to the University was used to create an initial textual account. All audio recordings were passed securely to the transcriber who then deleted any digital copies or shredded any paper copies of transcripts as per their confidentiality agreement with the University. The movement of audio to transcriber and the return of the transcript were logged by the researcher to ensure that each was completed and returned. The researcher then listened to each audio recording and checked the transcript for any errors.

Transcription conventions were kept to a minimum in order to avoid over interpretation by the transcriber of the audio material. When portions of the audio could not be heard or there was any doubt about the accuracy, the text was placed in brackets in the transcript and not used for analysis. In a similar vein, when material was omitted from the transcript (usually because of the quality of the audio), the omission was indicated by square brackets. Noises of assent or dissent were also included in the transcript.

Limitations of the data collection method

The decision to collect interview data through the Bipolar Clinic was a pragmatic one as it enabled more straightforward access to people with bipolar disorder which streamlined the recruitment process and gave access to a larger data source than might otherwise have been possible. Given the Bipolar Clinic is a trial of a psychotherapy to improve levels of wellness, it’s focus was not incompatible with this project’s interest in self-management constructs but linking to this larger study did produce limitation in terms of the nature of the interview text that was generated.

Firstly, it could be argued that participants were motivated to enact the ‘good patient’ in their interviews. While research participants often used the concept of altruism and the notion of ‘the greater good’ to explain their interest in taking part in a research project, there was also both an explicit and implied reason for participating in the study which was that of wanting to take up the opportunity it presented to
obtain psychotherapy for no fee which is a mental health service not routinely available to people with bipolar disorder in this area of Aotearoa New Zealand. This was particularly evident in the disappointment that some expressed at being randomised to the control group. For the participants then, the baseline interview process could be seen as an opportunity to perform in such a way that might somehow increase their chances of accessing something perceived to be of value, regardless of the information given prior to signing the consent form that emphasised the random nature of the allocation process.

Secondly, in seeking to understand how people with bipolar disorder use and respond to the discourse of self-management, those who express opposing, disinterested, ambivalent or supportive views are all equally valued but the context of the interview was such those people wanting to participate in the Bipolar Clinic study were those who willing used the discourse of bipolar disorder to construct their experiences. This is not to suggest that any one account by a participant can be seen as more accurate or truthful than another as in a post-structurally orientated discourse analysis it is not the intended meaning of the speaker that is the focus of analysis but rather the discourses to which they are responding. Neither is the intent to search for a variety of views so that findings can be generalised, but instead the intent is to be able to explore the range of discourses that people are engaging with; to explore the variability there is in how people respond to a particular discourse, how people are positioned by discourse and how discourse is being used to act as if it is the truth. In this discourse analysis it is likely that those who openly resist the construction of bipolar disorder as illness are not represented in textual form. Despite this a person may not overtly resist a particular construction of subjectivity or object but they can still position themselves in contradictory and diverse ways.

In response to both of these issues, the art of the research interview would seem to be in creating a space that allows contradiction and ambivalence to be spoken of so that the analysis can take into consideration what was said as much as what could have been said but was not (Hook, 2001). While the semi-structured interview format generated a wide ranging discussion, it is possible that in ensuring that all questions were asked and being mindful of the length of time taken to complete the interview,
opportunities to explore such things were not taken up as they might have been had the interviews been undertaken solely for the purposes of this thesis.

Rigour

Regardless of its theoretical underpinnings, discourse analysis is a highly interpretive process and there is a general tendency by those who use it to being averse to a recipe based approach of how to ‘do’ discourse analysis (Cheek, 2004; Crowe, 2005; Parker, 1992). That said, this does not mean that ‘anything goes’ when it comes to undertaking a discourse analysis. There can be seen to be a series of questions that good quality discourse analysis needs to be able to address. Crowe (2005) separates these questions into issues of methodological and interpretive rigour and the same structure is used here.

Methodologically it is essential that the theoretical framework on which the discourse analysis is based is clearly articulated. This includes the meaning and use of terms such as ‘discourse’ as they can mean different things in different versions of discourse analysis. Does the research question then ‘fit’ this discourse analysis and is there a clear rationale for the choice of texts that ‘fits’ with both the research question and the theoretical framework. In addition, is there a detailed description of both the data gathering and analytic processes and have these happened in a manner that is congruent with the theoretical position? Finally is the description of method detailed enough to allow readers to understand the context within which it was carried out (Crowe 2005, Cheek 2004, Parker 2015, Nixon 2007)?

In terms of interpretation, it is not the aim of discourse analysis to provide a definitive answer or way of making sense of the data. To seek closure in the interpretive process can be thought of as “to do violence to the variety of possible interpretations…” (Parker, 2015a, p. 78). That said, the interpretive process needs to be explicitly and coherently underpinned by the theoretical position of the discourse analysis. To determine interpretive rigour then, the reader needs to be satisfied that the links between discourse/s and findings have been adequately described and that the links between discourse/s and interpretation are both plausible and supported with enough detail. In addition, is there enough actual text material to support the findings and have the findings been related to existing knowledge on the subject.
By approaching rigour in this manner interpretations may vary but the process taken to get there will be reported in a way that is coherent and congruent with the theoretical stance (Cheek, 2004).

**Summary**

This chapter has sought to detail how post-structuralist concepts of discourse, power, subjectivity and history have been applied as a method to this discourse analysis. Parker’s (1992) approach to discourse analysis has been described in line with what are understood to be the key characteristics of the nature of discourse. These form the foundation for how the text materials have been approached and are used in conjunction with ideas of subjectification and subjectivation. Details of the context within which the interview texts were generated has been discussed exploring the practicalities of how the interviews came about and a broader social and cultural positioning of both the interviews and the analysis as a whole. What follows these considerations of methodology and method is the first stage of the discourse analysis and an exploration of processes by which others are governed and objectified by discourse. To do this the text under analysis is the Psychoeducation Manual for Bipolar Disorder (Colom, 2006) as an example of self-management discourse as produced by and for people positioned as expert in matters related to bipolar disorder.
Chapter 5
Analysis: Governing Through Psychoeducation

“...we should not be surprised that health has replaced salvation in our ethical systems, that the doctor has supplanted the priest, that the discourse of medicine has become saturated with questions concerning the meaning of life. For while medicine constantly reminds the inhabitants of our present of the possibilities of disease and death that they carry with them, it offers them the possibility of vanquishing the sufferings of the flesh, or at least postponing them, through the instrumentalization of life by medical criteria and procedures...” (Rose, 1994, p. 68)

The chapters thus far in this thesis have introduced the constructs of self-management and bipolar disorder and made a case for the use of Foucauldian discourse analysis as the means to explore the effects of the discursive practices of self-management upon the subjectivity of those understood to have bipolar disorder. They have also set the scene for the analysis by providing a theoretical and historical context to this discourse analysis and a detailed exploration of the methods used. As part of this process of scene setting, psychoeducation has acted as an exemplar of a specific tactic of self-management discourse which in turn has acted as a means to treat the discourse as a historical object. As made evident in chapter 3, psychological constructs can be seen to have acted in a comprehensive way over time to shape what is currently understood as self-management for people understood to have a mental illness. From moral treatment to behavioural psychology and on to contemporary public health campaigns, self-management discourse can be seen to have grown out of spheres of action based on psychological norms of what it means to be a person and the malleability of human conduct through the application of science such that the subjects of these spheres of action become people who lack skills and knowledge and are therefore in need of instruction by psy-experts.

Based upon these theoretical and historical contexts and an explicit method of approach to discourse analysis, this chapter now moves to the analysis itself and is
the first of three such chapters. This chapter starts the analysis process by focusing on processes of subjectification i.e. how people with bipolar disorder are governed and objectified by knowledge and power. To do this, the thesis once again returns to psychoeducation as a tactic of self-management discourse and analyses a book for mental health professionals, written by people understood to be experts in the field of bipolar disorder to provide detailed guidance on how to run a psychoeducation group for people with bipolar disorder. After making a case for the choice of this particular text for analysis, the chapter moves on to examine first how the text constructs bipolar disorder as an object, then how it constructs the subjectivity of those people with the condition and finish with an examination of the power relations at work within the text.

**Psychoeducation and Bipolar Disorder**

Best practice guidelines for the treatment of bipolar disorder (National Collaborating Centre for Mental Health, 2006; Royal Australian and New Zealand College of Psychiatrists CPGT for Bipolar Disorder, 2004; Yatham et al., 2013) whilst focused on medications as the primary form of treatment, now include discussion of the importance of interventions that address the psychological and social ramifications of the condition. This includes developing people's capacity to play an active role in the management of their own condition. Psychoeducation is one such psychosocial intervention for which there is now a significant amount of research that claims to support its use in mental health services for a range of conditions (Bauml et al., 2006; Bond & Anderson, 2015; Chien & Leung, 2013; Lucksted, McFarlane, Downing, & Dixon, 2012). The most prolific authors on psychoeducation for bipolar disorder have been Francesc Colom and Eduard Vieta (Colom, 2011; Colom & Vieta, 2006; Colom et al., 2003a; Colom, Vieta, Reinares, Martinez-Aran, Torrent, Goikolea, & Gasto, 2003b; Colom et al., 2009; Vieta, 2005) and they have used their research to produce a text for mental health clinicians called “Psychoeducation Manual for Bipolar Disorder” (Colom & Vieta, 2006). Henceforth referred to here as The Manual, it provides detailed instructions on how to run a psychoeducation programme for people with bipolar disorder.
The Manual was developed out of the research work of the University of Barcelona Hospital Clinic Bipolar Disorders Program where Colom is a psychologist and Vieta a psychiatrist. While other authors have produced literature reporting on their research using psychoeducation as a strategy for treating bipolar disorder (de Barros Pellegrinelli, de O. Costa, Silval, Dias, Roso, Bandeira, Colom, & Moreno, 2013; O'Connor, Gordon, Graham, Kelly, & O'Grady-Walshe, 2008; Parikh, Zaretsky, Beaulieu, Yatham, Young, Patelis-Siotis, Macqueen, Levitt, Arenovich, Cervantes, Velyvis, Kennedy, & Streiner, 2012; Poole, Simpson, & Smith, 2012), The Manual is currently the only published text that can be found that provides the level of detail needed for other clinicians to replicate the programme. This means for any clinician wanting to start a psychoeducation programme whose effectiveness is supported by research evidence, this would seem to be the most likely one to which clinicians would turn. The intention of The Manual is very explicit; to take the “common sense” clinical knowledge of the disorder that research has shown reduces relapses of the condition and encourage mental health professionals to teach “your patients how to manage their disorder better, live with it, progress with it, take their medication more effectively and understand why the medication needs to be taken.” (p. xvi) As such it is used in this project as an exemplar of a strategy of the discourse of self-management for bipolar disorder.

The Manual is broken in to three sections with the first section providing information for clinicians on the nature of bipolar disorder, how it is diagnosed and how best to treat it; all backed up by claims to scientific research. The second section addresses the theory of psychoeducation; why do it, when to do it, the mechanisms by which it is believed to work and then consideration of how to run psychoeducation in a group setting. The final and most substantial section making up 75% of the content of the Manual is a detailed breakdown of the content of a 21 session group psychoeducation programme. These 21 sessions are divided into units titled “Awareness of the disorder”, “Drug adherence”, “Avoiding substance abuse”, “Early detection of new episodes”, and finally “Regular habits and stress management”. Each of the sessions is broken down into describing the goal of the session, the procedure, useful tips, patient material and then finally an assignment to complete before the next group.
The analysis that follows begins by addressing how The Manual constructs bipolar disorder as an object and how it positions people understood to have the disorder. It considers how bipolar disorder is constructed as a brain illness and how as a result it becomes an object that must be medicated, the experiences of which can only be named as symptoms and an object that can only be known through the authority of medicine and science. As a result it positions those with bipolar disorder as ‘bipolar patients’ who are inherently reluctant to take medication and in need of psychiatry to provide a simplified version of what their disorder is and how to live with it. Bipolar patients are also positioned as problematic on the basis of their thoughts; while changing people’s attitudes is understood as central to the endeavour of self-management, in bipolar patients it is these very thoughts that must be surveilled as a sign of illness and a lack of awareness on the part of person that they are ill. Thoughts are both the problem to be addressed and the mechanism to fix the problem.

**Bipolar Disorder as an Object**

Bipolar disorder as constructed in The Manual is first and foremost a biologically based illness that is located in the brain.

> “Try to explain the bipolar disorders by focusing in particular on its biological aspects; in other words, starting by its definition as a brain disorder: the bipolar disorder is a disorder that affects the limbic system, neurotransmitters, and the endocrine system. In this case, even though this is an oversimplification, we will avoid any comment about the interaction of these causes with others, of a rather psychological or social nature, because this may add confusion.” (p. 55)

It is also an illness for which there is no known cure and it recurs or relapses episodically over a person’s life.

> “In any event, we have to make it clear to our patients that although it is true that they may relapse even if they do everything right, relapses will always be less frequent, last less time and be less intense... The term ‘incurability’ is of particular concern to patients, because many of them deduce that they are always going to be depressed or manic. So we should clarify that the disorder
is not curable in the sense that it cannot be ‘erased from the map’, but that it can be kept in check – or ‘dormant’, as some of our patients like to say – for long periods of time.” (p. 71)

The Manual is unequivocal in its belief that a medical model is the most truthful way of understanding it and while clinicians could “act as defense [spelling in original] lawyers for the medical model”, the point is made much more effectively “if it is another patient that defines the biological character of the bipolar disorder and the need for treatment...” (p. 54)

As a brain disorder, the experiences of bipolar disorder have no meaning for either patient or clinician beyond being symptoms of an illness.

“What often happens is that mystic or religious exaltation presents itself in the context of manic episode and it is nothing more than one of its symptoms, so that it goes away when the mania is treated. To explain this point easily and amicably, we usually joke about it and say that ‘we don’t have a problem with you talking to God through prayer, but we would be worried if you actually heard Him answer you’.” (p. 82)

This means all discussions of how people think or act in the group, particularly if their behaviour is indicative of a relapse, can be used as a lesson in how “to locate that symptomatology in the disorder” (p. 44).

The primary feature of bipolar disorder as an illness is the disordered way people experience their emotions and mood;

“The session can begin with this statement: ‘Bipolar disorder results from a change in the mechanisms that regulate mood’.” (p. 64)

Also important is the way people’s experience of disordered mood equates with notions of suffering;

“In this session, patients tend to ask why we consider bipolar disorder to be an illness. Our answer should be simple and clear; it is a biological change that has well-described symptoms and that causes people who have it and those around them to suffer.” (p. 67)
Suffering is constructed as a defining feature of an illness and as an illness, suffering would appear to be inevitable in bipolar disorder.

Depression is a particular experience that is associated with suffering which means any experience of suffering can act as a sign of an impending depressive episode;

“...the majority of patients usually have no difficulty in identifying depression, as the psychic suffering (sadness, anxiety, feelings of inadequacy, fatigue) acts as a messenger.” (p. 170)

Depression is also associated with notions of trauma;

“Since Session 5 was about depression it would not be surprising if its contents had worried certain patients and make them recall during the week the traumatic or unpleasant experiences of the depressive episodes.” (p. 93)

On the other hand, experiences of mania and hypomania are constructed as pleasurable;

“It is very important to obtain that our patients do not associate hypomania or mania with virtuous or extremely fun periods, especially because many of them abandon the mood stabilizing treatment seeking precisely this type of relapse...” (p. 144)

Any attempt to understand mania or hypomania as a positive or purposeful experience is a myth to be dispelled;

“During the session we should stress the pathological nature of both mania and hypomania, since many of our patients see hypomania as ‘a blessing’ or ‘a gift’. In these instances it would be useful for us to remind them that: (a) during hypomania people usually make the wrong decisions, (b) not all the symptoms of hypomania are pleasant... and (c) hypomania almost always leads to another immediate episode that involves greater suffering...” (p. 80)

In this construction of bipolar disorder, the suffering of depression has no meaning beyond its place as a sign of an illness while hypomania and mania are pleasurable states of mind which people find hard to give up. When experiences such as these can only able to be spoken of as symptoms of an illness that episodically recurs, it
becomes vital to be able to “differentiate normal emotions from pathological ones” (p. 85) so that thoughts and feelings can be scrutinized for evidence of a relapse. Conversations about what the experiences might mean for the person (instead of or as well as their role as symptoms) become impossible in this context.

As an illness, bipolar disorder must be treated by medication and psychoeducation is an intervention that reinforces to people this “fundamental aspect of their treatment: its biological nature and the need for drugs.” (p. 53). While The Manual is in the business of persuading people that psychological interventions for bipolar disorder are important, this cannot in any way be seen to be at the expense of medication. Psychological treatments “must always be combined with mood-stabilizer treatment and many times with an antidepressant.” (p. 123) and “it is absolutely necessary for the therapist to...make it clear that the medication is absolutely necessary, including writing it on the blackboard if necessary...” (p. 54)

Significant time is dedicated in the programme to medication related issues. Three sessions are given over to informing patients about mood stabilisers, anti-manic drugs, and antidepressants and another session is focused upon the role of blood tests to measure levels of the mood stabiliser drug known as lithium. A further three sessions address specific problem with taking medications. The first is about taking medications while pregnant, the second is on the efficacy of medication/ medical treatment versus alternative treatments such as “homeopathy, naturopathy, esoteric therapies, etc” provided by “parascientific professionals (clairvoyant, spiritual advisors or healers)” (p. 135) and the final session is on the problems that arise when people don’t take medications as prescribed or stop taking medications completely. Patient's non-adherence to medication regimes is constructed as a particular problem with a section of The Manual dedicated to defining forms of non-adherence, the reasons for it and how to combat it;

“Chart 1. Types of poor treatment adherence

1. Absolute poor adherence. This refers to the complete negligence of the patient in following the indications of the responsible therapist...
2. Selective partial adherence. Certain patients selectively reject a certain type of treatment but not another....
3. Intermittent adherence...Many patients do not completely abandon the treatment but neither do they take it as prescribed....

4. Late adherence...some patients show initial resistance to admitting the need to receive treatment and decides to start taking the medication prescribed after a few relapses...

5. Late poor adherence. After 2 or 3 years of good adherence, some patients start abandoning their mood stabilizers without apparent reason...

6. Abuse...Taking more medication is also a rather common form of poor adherence among bipolar patients...

7. Behavioural poor adherence. The term ‘poor adherence’...also includes aspects concerning the attitude and behaviour of the patient...obeying clinician’s instructions as to the regularity of sleep habits and other advisable behaviour that may facilitate euthymia, such as not consuming alcohol or other toxics...” (p. 105-106)

Treatment of bipolar disorder with medication is an imperative and a great deal of time and text is dedicated to making this point. Through detailing different types of non-adherence this problem becomes categorical in nature, constructing particular kinds of non-adherent people with particular characteristics that can become the focus of attention. When treatment of bipolar disorder with medication is an imperative it is perhaps not surprising that problems with people taking medications would also be responded to using a medical style categorical approach.

As a biological brain disorder it is the combination of psychiatric medicine and science that holds the authority to determine how best to understand the experiences known as bipolar and how best to treat it. It is only those with expertise in matters psychiatric who can provide “adequate treatment with drugs and the intervention of a psychologist specialised in techniques with proven efficacy [who] may guarantee a more positive evolution of the bipolar disorder” (p. 139) particularly as “the treatment of bipolar disorders has experienced a spectacular evolution in the last 15 years, and it may be foreseen that this evolution will be even more spectacular in the next 15 years.” The particular skill of the psy-sciences has been the way it has made bipolar disorder knowable, calculable and therefore able to be acted upon (Rose, 1998).
In terms of making it knowable, it is the DSM that acts as the means of diagnosis and classification and The Manual starts with a section primarily addressed at clinicians that considers the symptoms of the different “phases” of depression, mania, hypomania and mixed states. The intricacies of diagnosis and classification are discussed and the section finishes with a brief discussion of some of the debates about new ways of categorising the experience of bipolar disorder. The term “bipolar disorder” is used explicitly in preference to the term “manic-depressive psychosis” because of the concern that the latter is an inadequate representation of the experience and it is a term that is constructed as “highly stigmatized socially…” (p. 67).

Having established the boundaries between different types of phases or episodes of the disorder, The Manual makes bipolar disorder calculable through ideas of the potential to see warning signs of an impending episode. This firstly requires the patient to have a detailed understanding of their past history of episodes of illness. To achieve this patients are taught the technique of creating a graph of one’s life so that periods of illness are represented pictorially with a focus on naming the situations that appeared to cause or trigger each episode.

![Figure 2](image)

*Figure 2 “Life chart in which the patient noted the trigger, certain key treatments and facts.” Colom & Vieta (2006), p95*

Once a patient has mastered the art of inscribing their life in this way, “it allows them to appreciate with a certain perspective the evolution of their disorder, its triggers and whether, for example there are times of the year when the probability of a relapse is higher (e.g. spring, Christmas, final exams, etc.).” Having begun to appreciate the context within which their episodes happen, three further sessions are
spent teaching group members how to detect a relapse and take prompt action in
response. This requires lists of signs to be created for each type of episode and an
intimate understanding of the difference between one’s “normal mood swings and
those specific to the disorder...” (p. 168). By creating distinct boundaries between
normal and abnormal mood, developing the idea of early warning signs of impending
abnormal mood, and providing techniques of inscription, the psy-sciences make
bipolar disorder knowable, calculable and therefore able to be acted upon(Hodges,
2002; Rose, 1999a).

The authority of the psy-sciences to dictate what bipolar disorder is and how to act
upon it is intensified through the forceful way that language is used in The Manual
and how language is used to show clinicians how to conduct psychoeducation. During
psychoeducation sessions, clinicians are not to allow space for any debate about the
treatment of bipolar disorder;

“If it is absolutely necessary for the therapist to present, from the beginning of
the group sessions, both treatments not as opposed but as complementary,
and to make it clear that the medication is absolutely necessary, including
writing it on the blackboard if necessary. Otherwise, ‘an antipsychiatry’ type of
thinking may emerge...” (p. 54)

The text in The Manual often uses interdictory flavoured language when describing
the role of patients within psychoeducation; “patients are allowed to get involved
freely when they think it is necessary...” (p. 49), “we will warn them that failing to
respect some of these rules may lead to expulsion...”, “Any patient who fails to attend
five sessions will be forced to leave the group.” (p. 58) and “the mood-chart
technique, that the patient must master by the end of the session.” (p. 93).

Whenever The Manual refers to alternative views on the nature or treatment of
bipolar disorder there is often what can be read as a disparaging tone to the text;

“...the first contact between a patient and a psychological treatment can be
crucial in explaining the subsequent response to treatment. We are not now
going to digress into mysteries of other paradigms about whether or not to
shake hands with our patients and look them in the eye. In principle, they are
your hands, your patients and your eyes, so do whatever common sense tells you.” (p. 40)

And;

“Concerning homeopathy and so-called natural treatments, it must be said that, for now, it has not been demonstrated that they have any efficacy in the treatment of bipolar disorder. The main advantage of these treatments is that they produce as few side effects as a glass of water, and their main problem is that their therapeutic efficacy is also similar to a glass of water, in other words, ZERO…” (p. 139)

The overt disapproval of alternate constructions of bipolar disorder is complemented by a tone of address to patients that suggests the knowledge of the psy-sciences is necessary but complex and therefore requires simplification for patients. As an example, in the final session of psychoeducation the written advice that is suggested be given to patients states;

“If you are curious enough to read more, here are some informational books we can recommend. We do recommend that you stay away from technical books for psychiatrists, psychologists and other professionals, which often use language that is difficult for non-health-professionals to understand” (p. 200)

The apparent need to keep things simple for the patient is also exemplified in the way the fairytale of The Three Little Pigs is converted into the story of The Three Little Bipolar Pigs as a way to illustrate the biological nature of bipolar disorder and the importance of a person’s attitude toward it.

“The first one simply did not believe what his veterinarian told him and thought that bipolar disorder was an illness that had been made up by psychiatrists or was a fairytale, so he never changed the way he behaved...The second little pig in the story agreed to take the medication his psychiatrist suggested, even more so at his family’s insistence...The mistake he made was in thinking that medication alone would help keep his mood stable...The third little pig joined a psychoeducation group for little bipolar pigs. This activity...led him to take all the necessary precautions to avoid the dreaded
relapses: he took his medication and paid attention to this doctor’s orders and those of his psychologist...he tried to get enough sleep...[h]e paid attention to his wife's comments...he even learned to identify the signs of relapse in time...Out of all the little pigs in this story, he was the wisest pig of all, and there are some who say that some pigs are smarter than people.” (p. 69-70)

While the use of this story comes with a caveat that clinicians need to be able to walk a fine line between “comical and disrespectful comments” (p. 68), it is still none-the-less presented as one way to educate people about bipolar disorder and it does so in a way that uses simple, almost childlike methods to instruct. It is as if no one with bipolar disorder would have the capacity to understand the details of expert knowledge which in turn begs the question of what would happen if a clinician had bipolar disorder and attended a psychoeducation group.

It is imperative that people must recognise the importance of medicine to define and treat this biologically recurring condition so The Manual enlists a variety of discursive techniques to reinforce the authority of the psy-sciences. Within psychoeducation, techniques to inscribe people’s experiences are promoted as a means to know and act upon the disorder through identifying and acting upon the early warning signs of illness. At the same time, discussion of alternative constructions of bipolar disorder and its treatment are actively discouraged. This discouragement is aided by the use of childlike forms of instruction and a restriction of patient’s access to complex information that can only be fully understood by clinicians. If there was any uncertainty about the dominance of psy-sciences in this endeavour, The Manual uses its authority to discredit and ridicule any alternate constructions that patients may hold.

The Bipolar Patient – Constructing Subjectivity

At the same time as the object of bipolar disorder is discursively produced, so too is the nature of the person within whom it is understood to reside. As a person with an illness they come under the jurisdiction of pys-sciences and within The Manual the person becomes a “patient” and a “bipolar patient” in particular. Throughout The Manual and as exemplified in the already quoted text, a person with bipolar disorder is routinely referred to as a patient. The degree to which a person adheres (or not) to
the psy-sciences view of bipolar disorder makes no difference; everyone with bipolar disorder participating in psychoeducation is a patient. As a patient with bipolar disorder they take on unique characteristics and these next sections consider how The Manual positions the bipolar patient as someone who has difficulty regulating their own emotions, who understands their thoughts as both a sign of illness and a means to act upon themselves, who has the capacity to be highly reflexive in their self-examination and who has the ability to continually defer to experts.

**Emotional regulation**

Throughout The Manual there are textual references that construct people with bipolar disorder as having difficulty managing their emotions without the assistance of others;

“We must warn our patients that making their own life chart is an intense emotional work, which implies stirring-up things from the past, so that we ask them to abandon it immediately if they start feeling uncomfortable, and to give them an opportunity to complete it in an individual session with the therapist.” (p. 96-97)

As a result there are regular references to what clinicians need to do to help people to manage their emotional state. Sometimes this is about using humour;

“We prefer to end sessions with a funny, educational story that takes the dramatic feel out of a session’s content.” (p. 67)

Or changing the topic for discussion;

“But sometimes you might hear more serious comments like ‘they’ve done me a huge injustice, and I’m not going to forgive them for it.’ The therapist must be aware of that possibility and be able to redirect the subject matter if he detects a hostile reaction.” (p. 74)

Feelings of guilt are constructed as particularly problematic for bipolar patients so are something that clinicians should pay attention to;
“..to understand what prejudices they have in connection with the disorder, since they are often dominated by guilt.” (p. 54)

And try to act upon;

“Information about the pathological nature of depression is usually very guilt releasing, because patients have often been accused of being ‘weak’ or ‘lazy’ by the people around them while they were depressed.” (p. 88)

Difficulty regulating one's own emotional state is constructed as a norm for bipolar patients and something others, and experts in particular, need to pay attention to in order to make up for this deficit.

**Attitude, insight and intentions**

The ability to recognise both the problems and potentials associated with one’s thoughts, attitudes and intentions is an important attribute of the bipolar patient.

Thoughts are constructed as problematic due to the way they indicate the presence of actual or potential illness;

“The handling of depressive or negative cognitions, which also appear in some euthymic patients, is extremely delicate during a group psychoeducation session, because having the patients begin to sympathize with such cognitions must be avoided, especially those that have to do with the disorder (‘we’re a bunch of losers’, ‘what lousy luck – we’d be better off dead’, ‘we’ll never do anything good,’ etc.)” (p. 42)

To have an attitude that values the pleasure of hypomania is also problematic;

“Many patients tend to ‘give themselves permission’ to live through their initial hypomanic signs without taking action to abort the episode, and this happens because very often the patient has a near-addictive relationship with mania.” (p. 157)

This makes the examination of thoughts and attitudes a priority with an attitude of spontaneity towards ones thoughts also a problem;
“The first thing to bear in mind is that the majority of problems or important decisions should be taken slowly. Haste and impulsivity are poor guides.” (p. 194)

While a bipolar patient’s thoughts are important because of the way they act as a signal of illness, when thoughts are spoken they also act for others (and clinicians in particular) as an indicator of the degree of awareness that a patient holds about what is happening to them. Once again thoughts become problematic as they demonstrate in bipolar patients “high rates of lack of illness insight” (p. 53). But while constructed as a problem, they also seen to offer a way to work upon themselves;

“The attitude toward the disorder and the health beliefs of each patient play a highly significant role in the emergence of poor adherence; obviously, bipolar patients who firmly believe that they can control their mood by themselves will have a worse degree of adherence.” (p. 107)

Bipolar patients are therefore called upon to intervene in their thoughts;

“We can propose that the group debate blame vs. responsibility, by contrasting how thoughts of blame are useless and unproductive, and how useful, on the other hand, feelings of responsibility are.” (p. 74)

And change their attitude toward themselves;

“He was aware that this attitude involved scarifies [spelling mistake in original], but since he was a smart little pig, he understood that it was worthwhile to live a moderate life in exchange for something as important as his happiness and personal stability.” (p. 70)

Bipolar patients understand the importance of their thoughts and the way thinking can both act as means to measure illness, demonstrate self-awareness and as a means to bring about change in themselves.

**Reflexivity**

A crucial attribute of a bipolar patient is their capacity to examine what they think, feel and do and in the light of this examination, make changes in themselves. The first
stage in being able to do this is the ability to separate the normal for abnormal. Firstly
for hypomania and mania;

“We always recommend differentiating between hypomania and non-
pathological happiness.” (p. 80)

And then again in the next session on understanding the symptoms of depression;

“We will again insist on the need to differentiate normal emotions from
pathological ones.” (p. 85)

Then group members are expected to learn to recognise their unique version of
bipolar disorder;

“...always emphasize the need to individualize the knowledge of the disorder: I
am trying to learn not about the illness of bipolar disorder but about my
bipolar disorder.” (p. 163) [italics in original]

These skills are particularly pertinent to the process of learning to predict and
respond to signs of relapse. A patient who can individualize can take the generic
information about bipolar disorder they have been given and apply it to themselves;

“Step 2: Individualization – identification of one's own warnings or
operational warnings. The goal of this step is to individualize, that is adapt the
information from Step 1 to everyone's particular case. We try to have the
patients to identify which warning signs appear regularly in each type of
episode.” (p. 158)

A patient who can specialize can take their ability to examine themselves one step
further;

“Step 3: Specialization – prodromes of prodromes, or early warning signs...in
this step the patient claims ‘specialization’ in their own case, beyond
knowledge of their own relapse signs. The point is to identify the signals that
precede the warning signs – ‘warnings of warnings’.” (p. 159)

Each of these steps now needs to be completed for each abnormal mood state;
“Once the patient has made up a list of about 10 items for hypomania/mania, another for depression and is some cases where absolutely necessary, a third for mixed episodes...we have to work out with the patient (and if he agrees, the support person as well) how to use this list.” (p. 162)

The list is then to be used daily as a means to examine oneself and determine what needs changing:

“If after reviewing the list, you match one or one of the items, do not do anything to change behaviour.

If you match two items for 3 days in a row, you should consult with your support person.

If you match three or more items in a single day, it is time to put an emergency plan into effect.” (p. 162)

A bipolar patient becomes a prudent planner who can separate the normal from the pathological, name, list and rank symptoms by their importance, monitor themselves via their lists of warning signs and plan for the inevitable relapse.

This attribute of reflexivity also requires the capacity to examine and change one’s daily routines and habits, a subject to which a whole session is dedicated;

“Session 18

Regularity of habits.

...The goal of this session is to enter into greater depth on a point that has come up indirectly in almost all session: the need for regular habits.” (p. 182)

For bipolar patients this means paying attention to sleep habits;

“Observing how we sleep can give us information on the status of our bipolar disorder...We can use this information to help us; if we notice we are starting to feel depressed, it may be useful to reduce the number of sleep hours to improve our mood. On the other hand, a good way to head off a hypomanic decompensation is to make sure we are sleeping a good number of hours for a few days.” (p. 185)
To work habits;

“It is desirable for people suffering bipolar disorder to have a job with a strict habit schedule, hence jobs with constant shift changes, or no schedule, are not advisable.” (p. 187)

And also to eating habits;

“...many of our patients are worried about their weight gain as many of them binge when they are anxious, or are sedentary; also some psychoactive drugs affect weight. It is advisable for a bipolar patient never to go on a very strict diet which involves going hungry, and in any case it is advisable for the diet to be monitored by a dietician and a psychologist.” (p. 184)

On the other hand, habits related to physical exercise are constructed as problematic because while physical exercise is health inducing it is also seen as risky behaviour for bipolar patients;

“Doing physical exercise is highly advisable for a person suffering from bipolar disorder, but we must bear in mind that sports are highly stimulating, so it is best to practice sports during euthymia and, still better, during a depressive phase even though one does not feel like it.” (p. 187)

The level of attention that bipolar patients must give to examining their habits is significant, especially if habits are thought of as “repetitive patterns of behaviour that structure our lives and permit ordinary action of daily life to unfurl without effort of attention.” (Gray, 2014, p. 139). For the bipolar patient there would seem to be much work to do if there is any chance of their habits becoming effortless.

The bipolar patient does not always act as he or she should so this requires them to be able to recognise their mistakes and then tell others;

“Our session, and one of the previous ones, is rather propitious for confessions of poor adherence by the patients, which is very positive both for patients who speak sincerely and for their group mates. If this happens, we will try to have patients explain their reasons without being interrupted by the rest of the group and we will not adopt under any circumstances an openly
critical attitude. Our first reaction must always be to thank the patient for their sincerity and for showing us enough trust to explain such a significant problem both to (we) therapists as well as to the other members of the group.” (p. 140-141)

The importance of the admission of wrong doing and the opportunity it offers people with bipolar disorder as means to come to know, examine and change themselves is underscored by the strong directive given to clinicians about how they must act in this situation. Through the practice of confession the group member takes “the role of the self-examinatory, self-reflective subject who needs both [to] tell and recognize the truth” (Hook, 2003, p. 612) of their self.

While the capacity for reflexivity can be understood as an attribute of contemporary subjectivity for all people (Giddens, 1991) for bipolar patients it is constructed as a central attribute to be cultivated. There appears to be an intensified expectation that a bipolar patient can and will examine their thoughts, emotions and behaviours in line with the doctrine of psychiatry, confess mistakes and then adjust themselves accordingly.

**Defer to the expert**

The norms of subjectivity for a bipolar patient appear to centre on deficits in emotional regulation, the recognition of the problem and potential of thoughts and attitudes and the intensified capacity to be reflexive. All of these attributes rely upon the ability of the bipolar patient to defer to expert knowledge on what it means to have bipolar disorder.

People who defer to the experts will comply with a psy-science way of understanding what bipolar is and voice this to others;

“Participation in this group implies ‘confession’ in front of the other member’s own diagnosis, in this case bipolar disorder.” (p. 62)

Most importantly, they will take medication and encourage others to do so;

“Once again, it will be very positive if it is not the psychologist or psychiatrist who appears to be the only defender of the need to take medication, even
though obviously he would already have taken this position in front of the group; it is appropriate for patients themselves to advise [spelling in original] good adherence.” (p. 140)

If psychoeducation has been successful, they will recognise themselves as the third little pig in The Three Little Bipolar Pigs tale.

“The third little pig joined a psychoeducation group for little bipolar pigs. This activity, in addition to reasonable behaviour and being highly motivated not to relapse (he knew he enjoyed life a lot more during periods of euthymia), led him to take all the necessary precautions to avoid the dreaded relapse; he took his medication and paid attention to his doctor's order and those of this psychologist.” (p. 70)

And recognise the ability of the psy-sciences to know them;

“Patients included in a psychoeducation group on the other hand, are able to sense from our explanations about their disorder that psychiatry has already described and understood situations that they may be living through with shame, isolation or convinced that they are unique and non-transferable. The psychoeducation patient ‘knows that we know’.” (p. 28)

Deferral to experts is particularly important because of the way a bipolar patient’s thinking is prone to error;

“One of the mistaken ideas that are rather common among our bipolar patients is to believe that the bipolar disorder is a ‘lack of lithium in the blood’. This obviously a false myth, but we must explain it to all our patients because it has become quite popular among the persons who suffer from bipolar disorders and even among non-specialist professional.” (p. 113)

It is also important because bipolar patients are constructed as being susceptible to misinterpreting what they need;

“Many of our patients do not make rational use of sports and simply exercise when they feel like it – which is usually when they are starting to be hypomanic, and exercise makes things worse.” (p. 184)
This means bipolar patients need very specific instructions about how to manage themselves;

“Never try to overcome your hyperactivity and increased energy by trying to exhaust yourself, doing lots of physical exercise to tire yourself out and so get back to normal. This is like trying to put out a fire with gasoline…” (p. 177)

Those who do not defer to the expert knowledge of the psy-sciences are positioned as rebellious for which education will be the cure;

These are more ‘open’ session; in other words, sessions in which the patients are invited more to give their opinion concerning the topic discussed. The purpose of this approach is merely for us to get an idea of which beliefs and attitudes are being handled by our patients in order to find out exactly on what point we must emphasize, and to understand what prejudices they have in connection with the disorder, since they are often dominated by guilt. Certain patients react [to] explanations with resistance; in this case, the better strategy is to allow the members of the group to discuss between them the contents of the sessions rather than for us to act as defense [spelling in original] lawyers for the medical model, since if we do so quite a few patients will accuse us of having corporate-like attitudes. In exchange, if it is another patient that defines the biological character of the bipolar disorder and the need for treatment, the ‘rebel’ patient is left without weight arguments. (p. 54)

Problems of lack of understanding are constructed as part of the disorder which can in turn be rectified by psychoeducation;

Incomprehension is an opportunistic illness that exacerbates the course of psychiatric disorders...[p]atients who do not know their disorder do not know their lives... (p. 27)

For those who don’t defer to expert knowledge, their resistance is to be explained by the brain disorder that they have. They are positioned as displaying the characteristic “high rates of illness insight” (p. 53). What does not seem to be on offer to the non-conforming bipolar patient is a position as a person with multiple and conflicting...
motivations and beliefs; everything about them would seem to be explained by the disorder they are understood to have.

As a bipolar patient both their emotions and thoughts become signs of pathology and need to surveilled as such using psychiatric knowledge as the basis of their self-examination. At the same time a patient’s thoughts and attitudes also become the point of influence for psychoeducation as once a patient is able to be persuaded that what they have is bipolar disorder, that it needs to be treated with medication and an appropriate regime for living and the patient can reproduce these ideas in speech then they are understood to have good insight into their situation. When positioned in this way, for the bipolar patient it becomes a circular discursive endeavour; disordered thinking and emotions are symptoms of bipolar disorder which psychoexperts determine the existence of. To speak outside of the psy-science version of bipolar disorder is to risk being labelled as both ill and insightless. Once defined as ill or insightless a person does not have a legitimate voice and the presence of disordered thinking and emotions confirms the truth of the expert’s diagnosis.

**Absent subjectivity**

The Manual makes very explicit use of and is dominated by the use of a medical scientific discourse so it could be said that science and medicine form a significant part of the social and cultural context of the text’s creation. But there are other aspects of the social and cultural context of discursive practices within the Manual that are conspicuous by their absence, rather than overt presence, which in turn raises questions about the implications of this for issues of subjectivity.

All of the research and clinical work upon which The Manual is based has been carried out in Spain. The people taking part in the psychoeducation groups both clinician and patient alike can be assumed to most likely identify as Spanish or Catalan. No mention is made of this beyond an acknowledgement of The University of Barcelona Hospital Clinic Bipolar Disorder Program at the start of The Manual. It is as if there is no cultural context to psychoeducation. Yet there are aspects of the way language is used within the text that suggest that the cultural context has a strong influence upon how the discourse of self-management has been produced and how it might be read. Firstly, there is a strong tone of authority throughout the text with
many instructions for the way things must be done by clinician and patient alike. Words such as ‘exclude’, ‘allowed’, ‘expulsion’ and mandatory are peppered throughout The Manual. In addition there is the way humour is used explicitly by the authors to ‘lighten’ the tone of emotionally difficult conversations. The combination of these two linguistic tools allows space for a female, pākehā mental health nurse to read a patronising and patriarchal tone to the text but it could also be that this way of speaking is a reflection of the value Spanish culture places upon the authority of experts in matter of health and welfare.

Perhaps Spanish culture places a high value upon the authority of medicine and its right to dictate how things should be done and to read it as the dominating discourse of science and medicine is excessive. Perhaps the use of paternalistic styles of power relations in The Manual say more about the conditions of possibility for psychoeducation in a country with a long history of Catholic Christianity shaping the social fabric and as a result it is unwise to make a case to apply them to any other cultural context. In the gap left by these undiscussed elements it would appear that the subject positions The Manual makes available are done so in the context of the dominant white, western cultural basis of science and medicine. What this means for the subjectivity of those who position themselves as ‘non-white’ or ‘persons of colour’ is unclear.

**Power Relations**

The discourse of self-management as it is seen to operate in The Manual can be seen to construct bipolar disorder as an object of illness that must be medicated whilst also positioning those with bipolar disorder as the patient who has difficulty regulating their own emotions whilst also being able surveill their emotions, thoughts and actions against the norms of psychiatry in order to detect the presence of illness and take appropriate action. The production of both object and subject is aided by the disciplinary styles of power relations that can be seen to be at work.

Though the process of psychoeducation people are objectified and categorized on the basis of psychiatric knowledge. Clinicians examine the group members while at the same time teaching them to examine themselves and in doing so, people are called to see themselves as patients in need of the expertise of psychiatry, responsible for
choosing how to respond to their illness. The Manual is also an exemplar of what Foucault called pastoral power (Foucault, 2003e) and how pastoral power relations have acted as one of the conditions that has made it possible to think that the art of governing should become concerned with the welfare of populations (Foucault, 2003c).

As exemplified historically in the Christian clergy but with a history that takes it back to Hebrew society (Foucault, 2003d), the notion of the pastoral creates an image of the pastor who acts as shepherd in charge of a flock. He (as it was a highly gendered role historically) holds responsibility for watching over the flock as a whole while also knowing each one intimately. He acts as an intermediary between the flock and a higher power which therefore imbues him also with authority. It brings together notions of salvation, self-sacrifice, attention to the individual and the importance of knowing the individual’s inner world (Foucault, 2003f; Toll & Crumpler, 2004). In contemporary times it is a style of power relations that is seen particularly within health and welfare practices of care (Toll & Crumpler, 2004). Instead of saving the soul it is a person's physical and psychological health that is in need of saving while it is the knowledge of the psy-sciences that acts as the authority and means by which to know a person’s inner world. It is all “…those tender and beneficial forms of attention and regulation operating on the basis of the mechanism of love, or some heart-felt ‘calling’, which nonetheless serve state power-interests even whilst facilitating greater well-being.” (Hook, 2003, p. 617)

Throughout The Manual, the clinician is constructed as teacher, therapist, authority figure, and an evaluator of norms who is also firmly focussed upon on wanting the best for their patient. To this end, dedication and a certain amount of self-sacrifice is required by the clinician as it is important to make oneself available to patients at the earliest sign of trouble although “of course, I am usually busy, but I prefer to spend 5 or 10 min talking on the phone with one of you, that than not being able to talk to you and to have to hospitalize you, let’s say, 2 weeks later. This gives us much more work!” (p. 61).

In a group setting all members of the group are important but it is the individual who is the ultimate focus as each member needs to be able to apply their general
knowledge about bipolar disorder specifically to themselves. The practice of confession has already been highlighted as an important element of psychoeducation, but in the context of pastoral power it becomes the means by which the expert comes to know more of a person’s inner secrets so that both they and the individual can know and examine in more detail. The salvation on offer is the opportunity to be saved from the inevitable despair and distress of bipolar disorder as exemplified by the tale of third little bipolar pig described earlier.

Following Hook (2003) and his discussion of power relations in psychotherapy, The Manual can be seen as an expression of disciplinary power in which ‘its subjects adopt subject-positions in which reflexive, self-surveilling relationships are reinforced” (Hook, 2003, p. 611) through the objectifying work of medical science at the same time as expressing “those positive and seemingly altruistic motivations” (Hook, 2003, p. 617) to care for others in ways that requires those ‘others’ to practice forms of self-examination and self-disclosure. What on the surface appears to be an uncomplicated expression of care for others becomes emblematic of the anonymous and hidden nature of power relations as well as governmental power relations where the individualizing and normalising objectives of disciplinary power are linked with broader governmental aims of the management and welfare of the population through the work of psy-pastoral care expertise.

**Summary**

Within The Manual, bipolar disorder is constructed in an unequivocal fashion; it is an illness located in the brain that will inevitably recur over the course of someone's life and for which a person must always take medication to control it. In this context bipolar disorder is an object that must be medicated. With the aid of the DSM, it is possible to describe and categorise the experiences so normal and abnormal mood states can be separated from each other. The experiences associated with bipolar disorder are constructed as symptoms of an illness such that there is no meaning in the experience beyond its role as a sign of the presence of illness. While depression is related to suffering and trauma, mania and hypomania are constructed primarily as pleasurable states of mind which people intentionally allow to happen despite the inevitable negative consequences. Within these constructions there is no room for
disagreement or debate about nature of bipolar disorder and it is only those with expertise in matters psychiatric and psychological who can provide appropriate treatment.

As an exemplar of self-management discourse The Manual positions the person with bipolar disorder as a ‘bipolar patient’ and it is a subject position that has its own set of norms. Bipolar patients are constructed as having problems managing their emotional state on their own, they recognise their thoughts as a means to measure and bring about change in themselves, they display a high degree of reflexivity and self-surveillance which in turn requires the capacity to apply detail, effort and declarations of wrong doing and finally, bipolar patients will defer to the expert knowledge of psy-sciences when understanding who they are and how to live. This discourse analysis of The Manual demonstrates how everything about the person with bipolar disorder is interpreted in terms of the condition they are understood to have.

This analysis demonstrates the tightly regulated way the psy-sciences produce the experience of bipolar disorder and the people understood to have it. To speak outside of the psy-science version of bipolar disorder exposes them to the scrutiny of experts who determine if their speech is a symptom of a relapse of their condition for which they require treatment or alternatively if their speech shows a lack of insight which reinforces the notion that they require treatment. For the person with bipolar disorder, the notion of treatment always carries with it the possibility of being detained and given medication against their will on the basis that their thought processes demonstrate their lack of self-awareness and their inability to recognise that they are ill such that they risk becoming the “voiceless object of scientific discourse.” (Halperin, 1995, p. 39).

Given the earlier exploration of the historical conditions that make psychoeducation possible and shape its sphere of actions, it is perhaps not surprising that this analysis has demonstrated the tightly regulated way that the psy-sciences construct bipolar disorder and the people understood to have it. Psychoeducation draws on a long history of psy-shaped discourse as the means to understand how to change the thoughts and behaviour of others and how to use thoughts as the means to transform
one’s self. What this analysis demonstrates though is that while psy-science expertise strongly shapes the practices of those who exercise authority over others, in psychoeducation for bipolar disorder the psychological is used in the service of the medical. For people with bipolar disorder, psychiatric (and therefore medical) science takes priority with psychological science taking a role in support of medicine. Within self-management discourse, the different psy-sciences are not of equal status.

This discourse analysis also highlights the asymmetrical nature of power relations within The Manual’s version of psychoeducation practices for bipolar disorder. Only the psy-sciences can know what the experiences categorised as bipolar are and how to respond to them and as such people with bipolar disorder become bipolar patients with their own set of norms. Using techniques of a secular pastorate, people participating in psychoeducation are called to take on a way of understanding and caring for the self that relies only upon the authority of medical science because of its truthfulness and trustworthiness. Any attempt by people with bipolar disorder to think and speak outside of these positions them as lacking self-awareness and therefore potentially suffering a relapse and lacking insight into the true nature of their situation. There is no room to misunderstand what a ‘good’ bipolar patient looks like and the ways of being a person with bipolar disorder that are most highly valued.

Through the way The Manual uses language to sanction its view on the truth, it takes on the appearance of a rule book, a list of do’s and don’ts and as such brings with it a sense of it as a moral code – this is the only way to understand and live with bipolar disorder. As ideas of pastoral power suggest, health care practices including psychoeducation are provided from a desire to heal suffering and not exacerbate it. What this analysis suggests is that while that may be the stated intention, psychoeducation practices have the potential to cause harm through the way they act upon subjectivity. What does it mean for a person’s sense of self if they are ambivalent about psychiatry’s views on bipolar disorder? What about those who recognise themselves in the tale of the three little bipolar pigs but are not able to live to its standards? How else are they to see themselves? How can they show both themselves and others that they know right from wrong?
Those deemed successful at self-management as per The Manual get to construct themselves as responsible, thoughtful and self-aware while those who don’t “participate in this shepherd-flock game” (Toll & Crumpler, 2004, p. 397) would seem to be left with few ways to make sense of themselves beyond unruly, oppositional or resistant. The next chapter examines how people with bipolar disorder use discourse to speak about the experience of living with it, how they construct bipolar disorder as an object, and in the process how they respond to notions of self-management. It also seeks to explore processes of subjectivation and how the discourse of self-management may or may not be shaping processes of self-formation. This first stage of analysis identifies how The Manual lays out an expectation of the sort of self that is expected when living with bipolar disorder and the second stage now explores how people respond to these expectations.
Chapter 6

Analysis: Constructing Bipolar Disorder

“The mind may well be an illusion, something the brain does to entertain us while it goes about its business, whatever that business is, but it’s a gorgeous illusion and very convincing” (Greenberg, 2013, p. 345)

Having explored in the previous chapter processes of subjectification and the way others are objectified and governed through the discourse of self-management, this chapter and the next are concerned with processes of subjectivation and how individuals use the discourse of self-management to govern themselves and turn themselves into particular forms of subjects (Milchman & Rosenberg, 2009). In doing so these next two chapters seek to deepen the analysis of self-management discourse as both a technology of power and of self and to look beyond “official discourses” so as to not “overlook the messy actualities of how people respond to ‘strategies of rule’” (Petersen, 2003, p. 197-198). As the previous chapter examined how The Manual constructed the object of bipolar disorder and the subject within whom it is understood to reside, so too do these analysis chapters but using the text produced by people understood to have the condition. This chapter focuses upon how discourse is used by these people to construct bipolar disorder as an object while the final analysis will approach the relationship between discourse and self-formation by considering how a self-management discourse makes available particular subject positions for people with bipolar disorder to step in to and the implications of this for processes of self-formation.

The texts under analysis in the next two chapters are the transcripts of interviews with 25 people who live with bipolar disorder. Through a semi-structured interview process, they were asked about what bipolar is like to live with, what they think caused it, their views of medication and what they think of the idea that people can learn to manage the condition themselves. In this chapter the text is explored to consider how people with bipolar disorder use discourse to construct it as a particular sort of object and then consider how this might relate to processes of self-
This chapter approaches the relationship between discourse and self-formation by considering how people with bipolar disorder use discourse to construct it as an object and from this make an informed interpretation of what this might mean for how subjectivity is being shaped by discourse. The chapter has four sections. The first one examines how bipolar disorder is constructed as an illness object while the second considers how discourse is used to construct bipolar disorder as an unreliable mind. The tensions generated by these two constructions are examined in the third section while the final section summaries the findings and considers the implications of these for how people with bipolar disorder come to understand themselves.
Bipolar Disorder as a Brain Illness

Throughout the transcripts people turn to medical discourse as a means to construct the nature of bipolar disorder and how to respond to it. Medical discourse is understood here as all those theories, ideas and practices based within the institution of medicine that are concerned with making comprehensible bodily problems through notions of disease and illness and “…a faith in the superior scientific status of measurable information…” (Anspach, 1988, p. 372) over subjective experience. At its most simplistic the medical paradigm can be thought of as the process of deciding which organ is sick, explaining how it became sick and then determining what is to be done for the illness to end whilst taking into account both the cause of the illness and the ongoing effects of its symptoms (Foucault, 2003a).

Contemporary medical discourse can be understood as operating on the basis of some key assumptions;

- For a disease to be treated it must first be named, “…given an organization, hierarchized into families, genera and species.” (Foucault, 2003a, p. 3). This makes classification a central feature of medical practice.
- The focus is the disease or illness and not the person. Therefore in order to understand, diagnose and work upon the disease the person must be separated from their organs and tissues (Anspach, 1988; Verhaeghe, 2008). The primary concern is with the object (the physical materiality of the body and its disease) not the subject.
- The objects known as symptoms, signs and illness are in a relationship with each other and with the body. Symptoms are understood as the marker of illness as experienced by the patient and signs are the physical indicator that are found through close examination using techniques ranging from percussion, palpation, x-ray, and analysis of blood through to autopsy (Armstrong, 1995).
- The body is a biological system and as such its ‘normal’ state is understood to be one where it regulates its own function and therefore acts in an involuntary way. At the same time the body is conceptualised as made up of parts, organs
and tissues that are connected to one another so there is also a mechanistic notion to bodily function (Blackman, 2008; Harvey & Adolphs, 2012). This has a dual effect; firstly it requires those who engage in medical practices to know techniques for curing illness as well as the nature of the ‘healthy’ self-regulating body (Foucault, 2003) and secondly it assumes bodily mechanisms operate based upon ideas of cause and effect.

- The relationships between objects of illness and their treatment can be measured with the aid of scientific methods.

These collectively work to create a hierarchy of knowledge within medical discourse which places diagnostic technology as the most important form of knowledge (and the ability to interpret this technology), followed by the doctor’s observation and finally the patient’s account (Anspach, 1988).

In constructing bipolar disorder as an object, medical discourse locates it in a brain with malfunctioning brain chemicals that need chemical interventions in the form of medication. Medical discourse constructs illness as a thing of the body and therefore involuntary in nature so bipolar disorder too takes on this quality such that it is not the person’s fault that they have it, but as a condition that cannot be cured the issue becomes how they live with and respond to it.

Medical discourse acts as a resource to construct bipolar disorder as a problem located in the body which can be classified like any other disordered bodily process;

I got diagnosed with coeliac disease at the same time as being diagnosed with bipolar and it wasn’t til then that we kind of went ‘oh, that actually explains all that behaviour’. I wasn’t just an out of control teenager. I actually had an illness. (13)

More specifically, it is located in the brain as the problem is malfunctioning brain chemicals;

...as for why it happens to me I really, I do really feel like it’s just a chemical thing or neurochemical thing, you know a chemical thing in my brain. I feel some pretty distinct physical symptoms associated with the different points in
my cycle and I have a really vague idea of some of the hormones and neurotransmitters involved in that...(22)

As an illness, its presence is to be found through experiences named as symptoms;

Umm an elevated mood is umm lots of head noise real physical symptoms like I can tell when I walk if I feel like I am walking I am bouncing along...(6)

As an illness it is a bodily process and therefore involuntary in nature as it is constructed as developing outside of a person's direct control;

...but maybe the OCD and the anxiety was learnt behaviour got picked up as I was growing up from home quite possibility but the bipolar I think is more it's more of a disease it’s like...(6)

Just like other illnesses, taking medications is central to the experience of bipolar disorder;

...if its [medication] that keeps me well, it what keeps me well you know. A diabetic doesn't stop taking the daily insulin or whatever. If it's what I have to take, that’s what I have to take...(31)

As a medical intervention, medications don’t just treat a faulty brain, their ability to change the body confirms that what is being treated must be an illness;

...they decided I wasn’t responding to the medication for schizophrenia so they put me on lithium and I began to come right within two weeks so they changed the diagnosis to bipolar as it was working...(4)

A medical discourse of illness as malfunctioning bodily organs, in this case the brain, the symptoms this causes and the need to treat it with medications acts as a significant discursive resource when people with bipolar disorder describe what it is and how to respond to it. As an illness of the brain and therefore the body it becomes involuntary in nature, something outside a person's direct control. They didn't cause it so it is not their fault that they have it but as incurable illness the issue become how to live with it;
I made a conscious effort to think well how big do I want to make this and my like is it going to be this big or this big and I kinda didn't want it to be, I didn't want to have such a massive impact, I didn't know then that it would but I just didn't want I wanted to still maintain my own identity and you know, the same as somebody will treat it as having epilepsy like it doesn’t prevent you from doing stuff you know the only thing that I could do was research it and understand it and look for triggers...(10)

The discourse of self-management acts as a resource for thinking about the object of bipolar disorder such that in the face of something like ‘epilepsy’ that is of the brain and therefore outside of one’s direct control, the only thing to do is ‘research it and understand it and look for triggers’. It is the knowledge of science and medicine that must be turned to if a person is to live with a brain disorder.

This analysis demonstrates how discourse works to create objects and then also subjects. Using medicine as a discursive resource, the texts show people constructing an understanding of the object called ‘bipolar disorder’ as an illness located within an individual’s brain and as an illness, it is an object that acts of its own accord. As an illness it requires medication and then the taking of medication becomes a discursive practice that reaffirms the presence of an illness. At the same time discourse is creating subjects and in these pieces of text people are positioned by medical discourse as being subject to an illness that while not of their creation requires them to find a way to live with it. Self-management practices in the form of learning about bipolar disorder and looking for the things that ‘trigger’ the illness to manifest becomes a common sense response through the unspoken notion of personal responsibility. It is the construct that allows both the speaker and reader to bring coherence to the joining up of medicine and self-management as ‘speakers’ and ‘readers’ within societies that are governed through neo-liberal mentalities ‘know’ that people who are active in their own health care – researching it, understanding it and looking for triggers – are responsible people (Brown & Baker, 2012).
Bipolar Disorder as an Unreliable Mind

Medical discourse can be seen to be a dominant discursive resource for people with bipolar disorder when they work to make sense of experience but it is not adequate to fully explain the object of bipolar disorder. There is something different about bipolar disorder such that it is an illness that creates an unreliable mind but this bringing together of psychological and medical discourse creates significant tensions for the person with bipolar disorder to manage.

Psychological discourse is understood here as those sets of statements that cohere around the understanding of an individual’s mind as the central point from which a person’s thoughts, feelings and actions originate and an attention to how these might be altered, managed or shaped. It is a discourse concerned with using science to ask ‘how do we learn to think as we do?’ and ‘what are the connections between our thoughts, feelings and actions?’ and then engaging in practices that apply this knowledge for the therapeutic benefit of the individual. It is a discourse that is based upon the assumption that the ‘mind’ and therefore the ‘self’, is a psychologically shaped space and as such it therefore constructs the things of which it claims to speak as ‘real’ objects (Rose, 1998b). Through concepts such as ‘personality’, ‘attitude’, ‘intelligence’ and ‘self-esteem’, it acts in a normalising way to categorise and examine a person’s mind and determine the degree to which it conforms to the norm the discourse has created. In its contemporary form it is arguably a discourse that is concerned with working from the inside out; that working on one’s inside space of thoughts and feelings i.e. the mind, will transform a person’s behaviour and interactions with others. The psychological theories that inform the discourse are not necessarily a coherent set of ideas and practices (Parker, 2015b). This can be seen in the tension between more mechanical models that seek to change behaviour through systems of rewards and punishments and those concerned with ideas about the mind and its thoughts and feelings as shaped by past events that continue to effect the present. Perhaps it would be more appropriate to talk of psychological discourses in the plural as Burman (1996) does or use a notion of strands of psychological discourse as a way to think about the multitude of ideas about the mind and how it functions (Parker, 2015b).
As Rose has argued, psychological constructs have come to form the essence of the truth we hold about our nature as human beings (1998b, 1999a) so it is hardly surprising that people with bipolar disorder turn to psychological constructs to talk about how the object of bipolar disorder acts upon the person to create an experience of the mind as unreliable. What becomes evident within the analysis is the way psychological discourse works in tandem with medical discourse to position people as having an illness that by its nature is assumed as a separate entity to the person themselves, but an illness that has the power to remove awareness of oneself and that must then be managed through the skill of determining the difference between self and illness.

Psychological discourse operates on the basis of assumptions about the nature of ‘normal’ psychological functioning and in the texts, people evaluate themselves on the basis of norms of self-control and self-awareness to position themselves as abnormal. Firstly the psychologically normal person can control their own conduct and bipolar disorder interferes with this capacity;

> P...it [bipolar disorder] plays on your mind, it takes your control, it takes your control away from you yeah
> I: So that’s what makes it difficult to live with?
> P: Yeah it does and you just feel you feel a lesser person that other people a lot umm especially when something stupid happens...(2)

With the ability to exert self-control as an important psychological norm, any inability to enact this changes a person's status when measured against others. Secondly, bipolar disorder has the capacity to generate behaviour that is not in keeping with how they would usually present themselves to others;

> ...and there I was standing there like a fucking naked person statue really weird he said like he couldn’t believe it it was just like bang I went into this other persona..(11)

Using the notion of ‘persona’ this text turns to a psychological construct to try and explain how the person could demonstrate a lack of self-control such that they can act so differently from one moment to the next. Thirdly the normal person has a moment
by moment awareness of how their mind is working which bipolar disorder again interferes with;

P: Oh, bit of insight. It’d be great...
I: You can’t manage it though without insight?
P: I can’t no, because I just sort of thinks it’s just me. I just go with it, you know but also I think if I’ve got to, if I’m getting down, getting depression sort of side of things, that I have to kind of lift it up. You know and that’s what it, and that’s what it feels like as when I’m starting to feel like ‘come on, get yourself up, get yourself up, get yourself up walking’, you know…(21)

It could be that the notion of insight is being used to describe how bipolar disorder acts upon the person or that this is how the self responds to its presence – either way the mind is constructed as the centre of self-awareness and a person with bipolar disorder as unable to identify that a change has taken place in their mind.

In a similar vein, this person uses the notion of something mysterious happening within her in response to bipolar disorder’s presence;

My Mum, my Mum’s very, very supportive though and she, she knows me so well. She’ll just go, like I’ll turn up at her house and about 10 minutes later she’ll go ‘right, what’s going on? You’re either high or either low or something. ‘You know, she’ll always know and it could like the very first stage of being high and she’ll go ‘right’ or the very first stage of being low and she’ll be like ‘right’. So, um, but the other thing is I, I’ve got really good at avoiding her when I’m like that (laugh) because I don’t want her to point it out. I don’t know, it’s like a psychological, um, ah, in my head but I don’t actually realise that I’m doing it. I’m avoiding her because I don’t want her to point out that there’s something wrong with me (laugh). (13)

Thus people can be seen to be adopting psychologically based constructs to explain bipolar disorder as an object that interferes with the norms of psychological functioning.
With the mind constructed as unreliable, this person turns to her body as the means to understand her mind;

I'll play with the baby and it will be quite hyperactive play and that's when I kind of realise that ah, there is something wrong here...(13)

Habitual use of the body also becomes a way to act upon unhelpful ways of thinking;

...if I dwell on things it will eat me alive really so I just try and do, I have a really structured, routine life and that's the only way I can get my head around what I need to do...(10)

With psychological discourse being used to construct bipolar disorder as an unreliable mind, the body is constructed as offering a means to act as a conduit to the mind; a means to both know and act upon the self even when the mind is unreliable and awareness of the self is limited.

When bipolar disorder is constructed as an illness, it is done so on the basis that it is an illness that is located in the brain for which medications are therefore the most appropriate response to a presumed brain deficiency. At the same time it is an illness that effects a person's mind, limiting their capacity for self-awareness and control of how they present themselves to the world such that they might do things which are at odds with how they think of themselves. While illness may be something that everyone experiences “normal people don't have any idea about bipolar” (13) so those with it can question their status as a person;

...over the years I look at [a bipolar disorder support group] and go no I am not going to you know, sit there with a bunch of nutters you know, I have been in hospital with nutters and it’s not going to do me any good...it all depends where my head is at, you know I actually like funny enough going through this I get on quite well with nutters you know I can related to them, you know they don’t scare me you know...(9)

It is at this point that a medical discourse is expected to alleviate the stigma understood to arise from having bipolar disorder. As The Manual points out;
Place more emphasis on the medical symptoms (tiredness, fatigue, loss of appetite...) rather than on the psychiatric ones, since the latter are usually associated to the black legend they generate in the media. Nobody will be amazed or surprised if you say that, because of a disorder, you had a period when it was difficult to leave your bed...but everyone will open their eyes wide and may even look at you strangely if you say that you thought that your life was senseless and that you wanted to die (Colom & Vieta, 2006, p55).

But while a person may name their condition an illness, it doesn’t necessarily feel to the person like a proper illness because of its associations with the mind;

... the one thing that I really that did make me feel good was the fact that I actually did feel ill and confined to bed rather than some kind of undefined umm feeling of unhappiness or just not a clear mind if you like ...(8)

Bipolar disorder is constructed as lacking legitimacy as an illness because of its action upon the mind;

People get a broken arm or they even get epilepsy or diabetes but they don’t get this because it’s like, and I have seen the look on people’s faces when they know you have got it and they almost kind of, there are two looks that they get, one is confusion and the other one is pity and I try to explain that its kind a genetic thing and it’s like a chemical imbalance but it doesn’t matter it is still a mental illness ... (10)

The call to see oneself as suffering from an illness does not necessarily provide the promised antidote to a sense of oneself as a person with an unreliable mind. Using psychological norms as the basis of self-measurement, people end up positioning themselves as abnormal regardless of the potential offered by the body to act as a conduit to a mind that periodically lacks awareness of itself. In the stigma stakes, the unreliable mind ends up trumping a construction of bipolar disorder as an illness.

While psychological discourse plays an important role in how people construct their experiences and their subjectivity, it is often present in conjunction with medical
discourse. This co-joined construction of bipolar disorder as both an illness and an unreliable mind is illustrated here;

...Well, you know, I think it's pretty easy to say you're diabetic. I mean, sure, you know I'm sure a diabetic, I mean' just get it, you know, just do it' that kind of thing. No, your body requires insulin, you know your body can't produce insulin, you need to take insulin or whatever. Or you know, you've got a heart or whatever and you need to do things about it and yes, you can, everyone tries to be hard or macho or whatever but when personality, what changes is your mental illness changes your personality, you know, or your thought processes or your how you deal with something, how you manage something. It's a lot more intrinsic. It's a lot more that actually changes. It's you that starts, you know. It is you who starts to change. You aren't yourself necessarily, you're not yourself anymore. You lose that for a bit and at that point it's like, you know, shouldn't I just be able to shake myself up and change this (31)

Once again a notion of 'personality' and bipolar disorder's capacity to change it without the direct control of the person themselves is used. The mind as the location of thought and rational action is constructed as unreliable so that a person is no longer themselves. At the same time a medical discourse is used to construct 'illness' as an object characterised by its lack of interference in rational decision making and a notion of cause and effect. Using diabetes as illustrative, illness is about a deficiency in the body that is rectified by taking a medication to address the deficiency; ‘...your body requires insulin, you know your body can’t produce insulin, you need to take insulin or whatever...’ While it is an illness it is also an unreliable mind because it causes you to lose yourself and the ability to control your mind and therefore your actions such that a person can no longer ‘shake myself and change this’ as they would if it was a proper illness.

A notion of cause and effect is also drawn on here;

...I had never heard of a condition like this before, I never knew you could take a pill that would change how you feel (11)
Taking medication for an implied deficiency is constructed here as having the capacity to fix a person's faulty emotions.

As illustrated here, people use versions of psychological constructs at the same time as drawing on a medical scientific framework that uses models of illness based on ideas of cause and effect;

...it comes from unresolved pain you know...depressed people can't look at it and that's why people get into addictions and stuff like that if we've got these problems and we can get medication to help us open up and look at stuff and see what it is that we are feeling (5)

When this co-occurrence of both psychological and medical constructs is put together with the issue of bipolar disorder's lack of legitimacy as a 'proper' illness discussed earlier, it suggests that people with bipolar disorder are routinely having to find ways to manage persistent tensions between ideas of mind and body and the relationship between the two.

**Mind or Body**

The earlier discussion of the characteristics of medical discourse identified the importance of notions of the body as machine-like and the separation of the person with the disease from the disease itself. These can be seen as long-standing remnants of Cartesian thought in medicine.

Cartesianism is the name given to the movement that arose during the Enlightenment based upon the writings of the seventeenth century philosopher Rene Descartes. The main feature of this philosophical movement that remains in evidence today is Descartes' theories of the mind that place the mind or the soul as a completely separate substance from the material body within which it resides. The body is a thing in space while the soul or mind is a thing that thinks and as separate entities there is no significant interaction between the two. The inner psychological is separated from the outer physical (Bracken, Thomas, Timimi, Asen, Behr, Beuster,

---

12 While the term psychological is used here to describe the nature of the mind or self, it is done so while also not assuming that the mind or self is necessarily a psychological space.
Descartes argued that rationality was the key characteristic that defined human existence with the phrases such as “I think therefore I am” and “mind over matter” continuing to hold meaning. The mind is subject to voluntary control through the will while the body is subject to processes that do not require conscious effort and so are fixed in nature. The body becomes passive matter that operates as a machine while the mind becomes the source of action and intention (Blackman, 2008; Leder, 1992).

While it is a way of thinking that does not go unchallenged (Blackman, 2008; Bracken et al., 2012; Honderich, 2005; Turner, 1992), “modern medicine is profoundly Cartesian in spirit” (Leder, 1992, p. 21). A cartesian strand of medical discourse allows medicine to treat problems of the body with minimal reference to the mind, it creates the space for the ongoing division between health care for physical illness and mental illness, and it creates a division in forms of knowledge that ‘know’ each substance; medicine belongs the natural sciences and the mind belongs to the social sciences. It is a way of thinking that operates through processes of separation and hierarchy which are in turn supported by the scientific search for truth and error. The constraints that these ideas impose can be seen in the tensions that people are negotiating as they speak about their experiences with bipolar disorder and are perhaps best illustrated through the way bipolar disorder is constructed as a separate entity to the self;

I am often unsure of which is me and which is illness (8)

The norm of illness within a medical discourse is to construct it as an object that can and should be a separate entity from the self and this is in turn how this person constructs it.

The notion of a hierarchy of mind over body identified earlier as a feature of Cartesian thought is illustrated here;
I’ve never ever been suicidal. That is one thing about me that I just, I don’t know, I think I have enough control of my brain to not go that way. Um, I, I mean I have views of suicide and I guess that’s why, um. Like I feel that suicide’s very selfish and I wouldn’t want to do that to other people. (13)

As this person works to make sense of why she has never experienced suicidal thoughts which are understood to be part of bipolar disorder and in doing so she gives primacy to the capacity of her mind to control her actions.

But despite being an assumed norm, enacting this capacity to separate the self from the illness can be problematic. This person illustrates this by ascribing to themselves personal characteristics that can also be read as symptoms of bipolar disorder;

I have an extrovert nature anyway, people have misconstrued my extrovert nature as being manic umm which has been really difficult because I am quite bubbly and vivacious anyway and then when you are quiet and busy it’s like are you a bit depressed so there are all those context that really annoy me and I have ended up snapping at people and said if I am unwell you will be the first to know (10)

This problematic enactment of the process of separating entities is evident as this person tries to work out if her response to life events is ‘normal’ or not;

I just can’t stop crying but I don’t know if that is grief that I am still dealing with about the trauma from what happened in 2006 and also the grief and trauma over the whole relationship not working out with [husband] so I don’t really know if that is just like a normal person getting upset over a normal thing that is really upsetting or whether it’s a bipolar reaction, I don’t know… (11)

Concurrently working within the confines of psychological and medical discourse would seem to result in bipolar disorder being constructed as an object of both mind and body. The effect of this is to then position people with an imperative to work out which is which because as an illness it cannot be both. This would seem to have significant implications for how people take up practices of self-management.
But this tension can be worked with and the call to separate self from illness can be resisted. This person describes how she started with one way of thinking about what her experiences meant based on a construct of ethnic identity and then added bipolar disorder to the mix;

"...it's hard to accept the fact that I have bipolar... diagnosis because I was taken to the, what do they call them, the, the Emergency people... when my Mum was dying of the cancer so they took me up to [the mental health service] to see how, what was happening with me and cause my burden there was the fact that I killed my mother...Because I told her of my sexual abuse... Three months later she's got cancer, stomach cancer...and I told them that I believed I'd been cursed ... by my oldest birth brother because Mum would have told him what I had would have told her... but I believe he had the opportunity, the opportunity to put a mākutu\textsuperscript{13} on me so when I got back down here I told them the whole story again about why I felt my brother had put a mākutu on me and then I said to the, the Māori lady who was looking after me here, what the outcome was, what was the diagnosis and she said bipolar. I said 'oh, bipolar, oh'. This is the first of me hearing of bipolar but a Māori, coming from a Māori perspective." (M14)

While this could be read as the dominance of a psychiatric discourse in the process of meaning making, it can also be read as a resistance to a dualist way of thinking. She acknowledges the authority of the discourse of psychiatry;

I: Do you still think that way, that you triggered it?
P: No because I, I've been counselled too in that area... (M14)

She continues to retain a sense of herself through her ethnicity whilst also constructing her experiences as something psychiatric in nature;

\textsuperscript{13} In a traditional Maori world view, mākutu is a spiritual act more complex in nature than the usual western interpretations of giving someone the evil eye. It an act intended to debilitate another person but not as a form of punishment. This is not necessarily the meaning that this person places upon the term ‘mākutu’. (Personal communication, Ruru Hona 2014)
“...the first time it really confused me to be able to that’s that, bipolar with mākutu so when the people say, well if I have to say I’ve got bipolar I say ‘oh but from the Māori experience’.” (M14)

Even in the context of an interview for a research project about bipolar disorder, this person is able to resist the power of psychiatric discourse to produce bipolar disorder as purely illness whilst simultaneously becoming subject to the categorical practices of psychiatry and becoming a subject of a secular pastorate of ‘counselling’.

This analysis identifies how people use discourse to make sense of bipolar disorder as an object of illness that is a separate entity to their sense of themselves while at the same time constructing it as an object that interferes episodically with the mind’s capacity to know itself and a person’s sense of who they are. This would seem to be a significant tension for people to negotiate as they work to understand themselves and how to live with bipolar disorder.

The analysis also demonstrates how discourse operates as a productive power through both the way if forms the objects of which it speaks. In this case how discourse is acting as resource to make sense of the objects named as ‘illness’ and ‘self’ and the relationship between the two. In both the interview transcripts and the expert driven Psychoeducation Manual for Bipolar Disorder (Colom & Vieta, 2006), medical discourse is used to reinforce an apparent reality between illness and self such that they are best handled by treating them as separate entities. In so doing medical discourse is creating “a reality as coercive as gravity” (Parker, 1992, p. 8). Yet at the same time as constructing it as an illness the requirement to separate self from illness can be resisted. While power relations may be everywhere and anonymous, the discursive networks of connections and strategies always leave open the possibility of resistance (Foucault, 2003f). This is power functioning as a network of relations; flowing from both above and below with localised points of resistance at the same time as power being “actively adopted and practiced by its subjects upon themselves” (Hook, 2003,p. 619).
Summary

When it comes to constructing bipolar disorder it is medical discourse\textsuperscript{14} to which people turn when they understand themselves to have this condition. It is an illness located the brain and as with all illnesses, the body is faulty which can be rectified by the use of medications. The taking of medication can in itself become a discursive practice as the success or otherwise of medications in changing how a person thinks and feels confirms that bipolar disorder is indeed an illness located in the brain.

But medical discourse does not act alone. When combined with a silent partner of neo-liberal discourse the subject position on offer is that of prudent and responsible health consumer. With the health professional positioned by medical discourse as technically responsible for providing accurate information, it is the person who becomes ethically responsible for the choices they make about how to incorporate this knowledge into their day to day life (Helén, 2004). As a person with an incurable brain disorder, the individual is called to recognise themselves as having the ability to both exacerbate and limit the expression of bipolar disorder through their own actions. While they are not to blame for their condition, they are instead called to see themselves as accountable for how they choose to respond to the knowledge of science and medicine.

With the aid of psychological discourse bipolar disorder becomes an illness that takes away self-awareness and leaves in its place an unreliable mind. To combat its unreliability, some people construct their body as able to act as a conduit to the mind, something that a more embodied notion of bipolar disorder could arguably accommodate. Regardless, as an illness, it takes away one of the central characteristics of a proper illness; the capacity of a person to act in a rational way toward the condition. This results in a loss of legitimacy as an illness object that is not necessarily cured by medical discourse as it promises, with biological explanations offering “less refuge from guilt than one might imagine” (Martin, 2010, p. 378).

\textsuperscript{14} It could be argued that the discourse of psychiatry is conspicuous by its absence, but alternately this can be thought of as the result of psychiatry’s efforts to align itself with medical science such that psychiatric discourse simply becomes a sub-set of a more dominant discourse of medicine.
Also notable in this analysis is how medical and psychological discourse act in tandem to first construct the object of bipolar disorder as an illness that is both a separate entity from the person's concept of themselves and as an illness entity that can take away self-awareness. It then makes it an imperative to work this distinction between disorder and personal volition, self and illness such that the person becomes responsible for using their understanding of themselves as a psychological shaped being to act upon their troublesome brain and to use psychological norms of the mind in the service of medicine and the management of illness (Rose & Abi-Rached, 2013).

Medical and psychological discourses are both based upon the notion of the knowledgeable expert providing the distressed, unreliable and unknowing patient with the wisdom they need in order to live successfully. The imperative to separate self from illness can be seen as a discursive practice that bolsters the authority of both medicine and psychology by patrolling the boundaries between mind and body. In terms of processes of subjectivation and how people govern and relate to themselves, the discourses being put to work in these texts suggest that one’s relationship with one’s self is always to be mediated by psy-expertise. That how a person understands the object of bipolar disorder and responds to the unreliable mind to which it is tied is to be done by turning to the authority of medical and psychological science rather than one’s own.
Chapter 7

Analysis: Enacting Self-Management Discourse

“People know what they do; they frequently know why they do what they do; but what they don’t know is what what they do does”

(Foucault cited in Dreyfus & Rabinow, 1983, p. 187)

The overarching concern of this thesis is how the discourse of self-management operates to create particular subject positions for those people understood to have bipolar disorder and then consider the implications of this for how people with bipolar disorder come to understand and act upon themselves. The discourse analysis that has been applied to answer these questions has been done in three stages with this chapter now the final stage of analysis.

The process began with an analysis of a psychoeducation text written for mental health professionals about bipolar disorder. It identified how the discourses of psychiatry and self-management construct bipolar disorder as a brain disorder that can only be known and treated by the expertise of psychiatry. As such, taking medication for this condition is an imperative and there is no place to understand the experiences associated with bipolar disorder as anything other than symptoms that need treatment. In the process of determining what bipolar disorder is, The Manual also constructs the person with bipolar disorder such that they become first and foremost a bipolar patient whose thoughts and feelings become a site of surveillance for the presence of the disorder and then as the means to change how a bipolar patient relates to the condition. When a bipolar patient can reproduce the psychiatric construction of bipolar disorder they are understood to have insight which is an important prerequisite for any self-management practice. The bipolar patient also needs to develop their ability to be reflexive and make changes to themselves in light of their self-examination – all the while deferring to psychiatric expertise. Using techniques of a secular pastorate, processes of normalization are at work throughout The Manual as the text works to identify ‘normal’ human experience, how people with bipolar disorder deviate from these norms and then how they can regulate
themselves in line with these norms. Those people unwilling or unable to participate in these disciplinary processes are positioned by discourse as unruly and oppositional.

Chapter 6 documented the second stage of analysis by examining text produced through interviews with people understood to have bipolar disorder as a means to look deeper at the work of discourse upon subjectivity and consider how those with the condition use discourse to construct bipolar disorder as an object and what this might mean for how people come to think about and therefore govern themselves. This stage found that medical discourse dominates how bipolar disorder is constructed but it acts in conjunction with psychological, Cartesian and neo-liberal discourses. This combination would seem to make available a way of being in the world based upon a moral construct of responsibility – it is not a person’s fault that they have this illness but they are now accountable for how they take the knowledge of medicine and psychology and apply it to the management of their disordered brain and unreliable mind.

This final analysis chapter focuses specifically upon the discourse of self-management within the speech of people with bipolar disorder to consider in more detail the subject positions the discourse makes available and importantly, how people with bipolar disorder use, respond to and engage with these subject positions. What ways of being in the world does the discourse of self-management make available to those understood to have the condition? On the basis that a sense of self is constructed through the repeated performance of subject positions (Crowe, 2005), what might this mean for processes of self-formation in people understood to have bipolar disorder?

Throughout the texts there is little direct reference to the practices named by experts as self-management so in order to consider the work of the discourse of self-management, a framework for understanding the enactment of self-management has been taken from the analysis of the psychoeducation text in Chapter 5. On the basis of this work, the enactment of self-management discourse can be seen to have three distinct but at times overlapping elements to it. Firstly, to practice self-management a person must accept that what they experience is bipolar disorder and recognise it as
an object known and understood only by psychiatry. Secondly, it requires a person to undertake a reflexive process of self-examination where a person surveills themselves for signs of becoming unwell so that once found, the person can identify how their own actions contributed to this relapse so they can then commit to making changes and learn from their mistakes. The third element to practicing self-management is the capacity to moderate oneself so that excess can be guarded against. Each of these elements relies upon the person knowing and applying the knowledge of psy-expertise.

While this conceptualisation of self-management allows a way to think about the discourse of self-management and how it is enacted, the analysis has also identified that these three elements of i) accept and recognise, ii) examine, confess and change and iii) moderate and regulate also act as significant subject positions within the discourse of self-management. As well as describing a process, they are also characteristic ways of being in the world that can be understood as the effect of a discourse of self-management. As such, this stage of analysis is specifically concerned with how discourse acts to construct subjectivity; that the discursive resources available to people in particular social, cultural and historical contexts shape how it becomes possible to think about oneself. This was illustrated earlier by discussions of how psychological discourse acts as a resource for how people can think of their inner world and the nature of their self (Rose, 1998b, 1999a). But discourse does more that act as a resource as this could suggest that it is a simply a matter of choice that people make to speak in different ways about experience. Discourse also acts by requiring people to adopt particular subject positions in order to hear the messages on offer as “the discourse is hailing us, shouting ‘hey you’ and making us listen” in particular ways (Parker, 2015c, p. 158). When discourse positions a person as a subject it also grants particular rights to speak (Parker, 1992, 2015c). Again, as illustrated in the previous chapter, the discourses of medicine and psychology grant a particular authority to those with psy-expertise and while ‘lay’ people still readily access the discourse, when they do so, it positions them in a particular relationship to psy-experts such that while discourse is shaping subjectivity it is also bolstering power relations.
Acceptance and Recognition

As a person who understands themselves as having a mental disorder named and known by psychiatry, the taking up of this way of being in the world is not something that happens automatically, rather it is position that a person would seem to be drawn into. For this person, having a diagnosis that they accept allows them access to psy-experts and the potential they offer to provide relief;

I suppose the difference between then and now is that I have a diagnosis and I am on medication that is finally working for me after years of being on so many meds that just weren’t doing the trick…(6)

Rather than a desire to feel differently, this person is drawn into an acceptance of the psychiatric discourse of illness and treatment by the desire to take up the subject position of ‘good mother’;

.. it wasn’t until [son] was born, well was conceived that I really started looking at myself and questioning like when you get into a manic episode suddenly it is all focussed on what you are focused on, and like blinders on and I was scared that would affect his being raised and I was scared that it would affect you know that he wouldn’t get what he needed if I got into that… I decided that I would rather be treated at this point than risk losing [son]. (7)

As someone with bipolar disorder who is about to become a parent, her talk of her acceptance of the need for treatment draws upon both a discourse of what it means to be a good parent and a discourse of risk; that by not accepting and engaging with treatment she will put her child at risk and so come to the attention of state authorities.

The act of bringing people together with the same diagnosis to share their experiences with each other also acts as a means to draw people in to the subject position;

... I’ve heard all the other experiences that people have and they are quite different to mine, um, but then when we had like the peer support group right at the end of my stay with [the mental health service], they, um, and we talked
about a lot of experiences, I realised that some of the thoughts were, were quite similar to the others and there were a lot of similarities and I sort of accepted that, yeah, I did have a psychotic episode for this period of my life... (14)

In settings where people can meet others with the same condition as themselves, people use discourse to construct their experiences. In the process, this person recognises the way this ‘calls’ to them as a person whose experiences are best understood through the psychiatric construct of psychosis and in doing so gives up on some of their previous resistance to this position. There seems to be something particularly powerful in hearing the discourse of psychiatry out of the mouths of people who are thought of as peers.

**The active patient**

Once drawn in, it is a way of being that is active rather passive in nature;

I know that I have been on a massive learning curve with it and umm that has been the beauty of it it has been the learning, actually being in a space where I am willing and able to learn umm when I got discharged the other week [the case manager] said ‘you’ve been a model patient’ (laugh) (and like then she said that I was ready and umm so bit) you know I just plant so many seeds from them [Dr and case manager] you know [case manager], I nicknamed her the voice of reason and every little gem that she had I just grabbed hold of it and planted it and grow it and yeah I didn’t waste any of their resources I suppose you would say, I didn’t waste any of it cause I so badly wanted to get better... (6)

It is a subject position in which the person becomes a patient who defers to psychiatric knowledge and wisdom on the basis that their own ideas, their own ‘voice’, is lacking in reason. The task of the patient is then to act upon the knowledge, ‘to plant it and grow it’ and actively apply it to themselves. As a patient with an illness, ‘to get better’ means actively taking on the wisdom of psychiatry on the basis that it is superior to one’s own.
In order to take on a sense of self as an active patient, this subject position requires a person to give up aspects of their sense of self;

…it’s about like, kind of accepting and I think guys find it hard that they have to, you know, accept it that’s them and they have to listen to other people cause they don’t want to but ‘no, no, no I’m not unwell’ cause they want to be strong. But with me I accepted it, it is what it is. (35)

In order to make sense of how ideas about ‘acceptance’ and one’s gender may be linked requires both reader and speaker to draw on a culturally available narrative adopted from psychological discourse that one’s gender affects one’s capacity for emotional expression (Gray, 2012). Despite a lack of empirical evidence that biology can account for emotional expressiveness (Shields, 2013; Wester, Vogel, Pressly, & Heesacker, 2002) there remains a preoccupation in psychological science with the notion of difference between male and female (including the reproduction of the norm of human beings as either one gender or another) and it is this norm of assumed difference that this person would seem to be drawing on in order to make sense of how a person engages in self-management practices. And they do so in a way that suggests that self-management discourse requires a person to give up an idea of themselves as strong and independent. The implication is that no longer is a woman’s assumed ‘natural’ tendency to express emotion and rely upon others a failing – in self-management discourse it can become an asset.

**Obligations and responsibilities**

One way that this subject position is enacted is through the taking of medication, as medication to treat the condition is an imperative in the discourse of psychiatry and medicine;

Well she’s [family doctor] trying to help me and I think I’ve got to play my part by helping as well. I mean I’ve got no time for people that say they’ve been to the doctor but they’re not taking those pills because they won’t help. It’s like why spend, why spend the doctor’s time if you think you know it all. (M3)

But the act of deferring to the expertise of psychiatry to know and treat one’s mental distress does not necessarily make following the doctor’s orders straightforward;
I think it’s easy to know that you have got bipolar but it’s hard to follow the
treatment and the umm consistency that I think is important to achieve a level
of wellness...(8)

This suggests a moral quality to a subject position based upon acceptance and
recognition. A person may both accept and recognise themselves as a subject of the
discourse of psychiatry but also be unable to practice its requirements in a consistent
manner. This would seem to bring with it potential for a sense of self based upon
failure through not being able to live up to the notion of the ‘model patient’.

The moral quality is intensified by the way this subject position relies upon ideas of
personal responsibility. While the psychiatric discourse may bring relief by
explaining the cause of distressing events, it brings with it obligations;

Oh yeah, and I think there was after I was diagnosed there was a big sense of
relief. Well, now you know why this is, you know, why you behaved in this way
and why we’ve had these issues, um, you know... In some ways a sense of
closure but then you, there’s a new challenge. You have to monitor it. (M2)

Acceptance and recognition acts as a foundation for ideas of personal responsibility
as described by this person;

Yeah, cause if you don’t accept it then you’re always conscious, I don’t have it
and then, therefore you won’t want to do the things to prevent it coming
on...(35)

And while others may aid the process of acceptance it is ultimately something a
person does on their own;

My Dad is probably just at the moment being going to be diagnosed with it so
you can’t really talk about it with him... but he’s just absolutely refused to get
any help or refused to talk about it or acknowledge anything or, yeah. He’s not
come to the party and nobody else can, um, take him to the party...(31)

It is a way of being in the world that appears to be tied strongly to a discourse of neo-
liberalism. The individual is called to accept and recognise themselves as the subject
of psychiatric expertise and then use psychiatric knowledge to meet their obligations
as a patient with bipolar disorder to take responsibility for their health and ‘to do the things to prevent it coming on’.

People living with bipolar disorder actively engage with a subject position that values acceptance and recognition but they do so in a way that is beyond the straightforward replication of the bipolar patient that is proposed by The Manual.

In these texts it is not a way of being in the world that appears naturally or automatically, rather it is a way of being that a person appears drawn in to over time and in the context of their relationships with others. Just as in The Manual, it is a position that requires an active response on the part of the patient to plant and tend the garden that grows through the wisdom of psychiatry. In the process, it may involve for some people a giving up of ways of seeing the self based upon notions of strength and independence in favour emotional expressivity and a dependence upon others.

As in the earlier discussion that identified the place of neo-liberal and medical discourses acting collectively to shape how people construct the object of bipolar disorder as an illness object toward which they hold a responsibility, this subject position of accept and recognise is enacted using the discourse of neo-liberalism and the active and responsible health consumer (Brown & Baker, 2012). Having recognised the authority of the psychiatric discourse to name and act upon their distress as a brain based illness, the person is now responsible for how they act toward it.

**Self-Examination and Change**

The enactment of the discourse of self-management can be seen to be tied to a reflexive style of practice upon oneself; a process that entails self-examination, admission of mistakes and then changing behaviour so the mistake is not repeated. This thesis argues that through its repeated enactment, people step in to a way of being in the world that is characterised by detailed self-examination and judgement, the admission of guilt and then committing to change oneself to prevent wrong doing in the future. This reflexive relationship with oneself is performed with a level of intensity beyond what is expected of people without bipolar disorder.
Within the discourse of self-management this reflexive form of attention to the self is rigorous and detailed;

...I know myself well enough to know to know [name] would you have behaved like this normally and the answer if no ok so what do we need to do next time in order for you not to do this well the question is I need to stay well, how do you do that? Take the medication ok what are your triggers? How do you know you are becoming unwell? Loss of sleep, crazy thoughts, you know I know myself well enough to know when things are starting to go down for me so that is the key for me...(10)

It is a form of attention to the self that is constant and ongoing as there is always the risk of forgetting the lessons of the past;

... I have some hiccups every now and then because I think I have got it all sorted and then I do something...(11)

It is a way of being that requires high levels of self-awareness and, as identified in the previous chapter, a dualist way of thinking about oneself – is this me or is it not?

... so I don’t really know if that is just life a normal person getting upset over a normal thing that is really upsetting or whether it’s a bipolar reaction, I don’t know...(11)

Even the ordinary things of life, in this case becoming a parent, are subject to separation into either/or.

I kept going “ok is this because I have got a new baby or is this because I am unwell “and most of the time the answer was it’s because you have got a new baby so it was tricky differentiating and umm you know having a new baby is not easy (3)

Discourses of medicine and self-management combine in such a way that a reflexive approach to bipolar disorder requires practices of self-examination that are based upon separation of self from illness.

As well as negotiating a world of binaries, this subject position also invites a person see themselves as having an internal world that cannot be trusted;
... you know how you get these feelings in your heart and your tummy that something is not right in the early days and you are supposed to listen to them and I had all of those warnings, I had all of those bells going off but I chose to ignore them because I put it down to my bipolar and I never knew whether to trust my instincts or whether it was just me being crazy and imagining stuff and so I just ignored it...(11)

It is a subject position characterised by a rigorous and detailed form of reflexivity whilst at the same time relying upon a construction of the mind and the self as unreliable and not to be trusted. Bipolar disorder is constructed as an object that works upon the mind to make it untrustworthy and the discourse of self-management positions the person with bipolar disorder as someone who enacts reflexivity on the basis that they are indeed unreliable readers of their own mind yet also able to separate self from illness.

**Learning from experience or wrong doing?**

In the discourse of self-management of bipolar disorder, processes of self-examination and judgement are tied to the capacity to identify how one's own thoughts and actions contributed to an actual or potential relapse. This can be framed as the capacity to learn from experience;

Every episode for me is learning, I look back over the ten years since my diagnosis, the first admissions to hospital were really long, where I had no insight whatsoever, I was driving blind really so every time I have been unwell out of that has come a learning...(10)

Identifying the part one's actions played also has the potential for a person to be focused upon finding fault with themselves;

I: So do you take your medications as prescribed?
P: At least 90% of the time.
I: Ok. The other 10% what happens during those times?
P: Laziness I suppose. Depends, yeah, yeah. I think laziness, um. The laziness, this doesn’t help going in, into a medication adherence study but, um, I went to the Coast and forgot to bring back my Lithium so for
Saturday night and Sunday night and Monday night I took nothing. I didn’t tell my partner til I’d got some more off my doctor. So on Tuesday I went to the doctor and said ‘right, this is what I’ve done’... It was stupid of me to forget it but I did forget it. There was nothing I can do until, but I should of probably had a spare. (M2)

This person’s act of forgetfulness is not just described here as a mistake that they made, it takes on a critical tone as they examine their actions against the norms of what counts as responsible behaviour for a person with bipolar disorder.

For some people the reflexivity that characterises this subject position requires the ability to admit mistakes and then make amends for wrong doing;

Sometimes I,’ ah well, hello, you only live once’ but I sometimes do a little bit, push it... I have to make sure if I have a really late night, late night and drink a lot of stuff I try and make sure that that week I get good sleep and try and fix what I’ve done. (35)

A subject position based upon characteristics of reflexivity and self-examination would seem to walk a fine line between a management of the self based upon an openness to learning from the mistakes a person inevitably makes in life and a relationship with oneself based upon fault finding and making amends for wrong doing. As identified in The Manual, the discourse of self-management is easily tied to practices of confession which can be understood as illustrative of disciplinary style power relations where a person comes to know and act upon themselves on the basis that “words and rituals that govern these confessions are those prescribed by an authority, albeit one who has replaced the claims of god and religion with those of nature and the psyche.” (Rose, 1998, p. 96). This subject position characterised by reflexive self-examination and change would seem to promote a notion of ones relationship with oneself as based upon making amends for an inability to keep to the rules of living with bipolar disorder as determined by psy-sciences.

The problem and potential of thoughts

If a person is to demonstrate that they have learnt from a mistake in how they live with bipolar disorder, then they need to make changes in themselves in order to
avoid a repeat experience. It is here that a person’s thoughts present both a problem and an opportunity.

A medical discourse once again draws people into a form of self-examination built around thoughts as an expression of oneself or of one’s illness;

...and I doubt often whether or not my choices of what to do and the way I go about doing things whether or not they are actually, whether its illness or whether it’s me or where the two kinda me meet cause they do, I am not my illness but my illness does influence my thoughts, my decision, my way of deal with things in life...(8)

Both medical and self-management discourse positions thoughts as problematic. They are a symptom of an illness and so a person must judge if their thoughts are a reliable expression of themselves or if they are a sign of illness and therefore unreliable.

While thoughts are constructed as problematic in this subject position, they are also constructed as the means by which a person can bring about change in themselves;

That’s what they teach you, is just like strategies to cope with it yourself and I use that pretty much day to day, especially like the breathing and the, um, just like being aware and watching thoughts rather than being clingy to stuff and you, you just let stuff sort of go through and just go past it so long as you, um, become aware of, you know, what’s going on around you and, and say ‘ok, maybe I need to do this differently and I want to stay stable’ then it’s easily manageable. (14)

Thoughts need to be managed in order to bring about change;

That’s, that’s one that I mean I haven’t done it for probably since I got out of hospital because I’m very aware. I either go into a shop now and go ABC, action, behaviour consequences. I’ve got to, cause otherwise, honestly, I could just easily, you wouldn’t believe how easy it is to shop lift...(21)
Thoughts need to be worked upon for change to occur;

I: What is it that you most want to give other people?

P: A taste of freedom cause a lot of people are I suppose are slaves to their problems and their illnesses I guess umm

I: So what is it that you see that they need to be able to do in order to stop being a slave?

P: One thing would probably be to kick out their inner critic which seems to be a real common thing that people have with mental illness, they beat themselves up a lot you know like the coulda, woulda, shoulda hmm...like I am not without my fears like something's really you know like some things in the future kinda little bit but then I remind myself don't futurise, don't futurise...

This subject position draws attention to the tensions that exist around a person’s emotions and thoughts; they are inherently untrustworthy and unreliable yet at the same time, managing and disciplining one's thoughts is understood to be the way to bring about change in oneself.

This analysis also draws attention to the particular ‘flavour’ of reflexivity that people with bipolar disorder can engage in; a form of self-examination and self-critique that is based upon ideas of wrong-doing and a way of being that positions a person as to blame for any relapse in their condition because of things they did not do but should have. It is a way of being in the world that likely intensifies feelings of guilt and shame and a way of being in the world that is shaped by a constant state of self-critique and risk mitigation on the basis of psychiatric norms. In line with ideas that contemporary subjectivity is strongly based upon notions of reflexivity and choice in identity construction (Giddens, 1991), these people with bipolar disorder actively engage with the idea that reflexivity is central to how they operate in the world. For some, a reflexive way of being seems to have become second nature and while The Manual would construct this as a rational response to an unpredictable condition, this analysis suggests that a subject position based upon reflexivity can also be understood as an effect of the discourse of self-management and as such it is not necessarily a ‘natural’ way to be human.
Moderation and Regulation

Just as processes of reflexivity are promoted by a self-management discourse as a means to reduce relapse, so too is the ability to moderate the self. The enactment of moderation shapes subjectivity as people are called to see themselves as someone who can control and restrain their thoughts, feelings and actions and regulate themselves using the norms of psychiatry.

As with a subject position that values acceptance and recognition, this is a way of being that does not necessarily come ‘naturally’ to a person;

...I did the WRAP course but often that is, self talk doesn’t come to the fore umm like I guess you know I am slowly learning not to drink coffee after 6pm in the evening um lay off drinking alcohol on a work night and that kind of thing...(8)

It is constructed as a process of learning to enact new habits and giving up old ways of being for fear of becoming unwell;

...um, it’s quite, it’s gutting cause like, especially when I first like got bipolar, I was only 20 and I wanted to go and experience a whole lot more stuff that I know I can’t risk now. Like I wanted to be naughty, you know, try some A class cause my friends, they all are going to go, go have E. I wanted to try it out just, you know, just to see what it was like but there’s just, I just don’t want, I just don’t want to risk it now. It’s just, it’s scares me too much cause I don’t know how they would set me off...(35)

It is also a subject position that people can be drawn into on the basis of obligations to others;

Stephen Fry umm I read a book that he wrote the foreword to which was quite a good quite a funny book about bipolar umm but the single best thing you can do he said to help manage bipolar is to get a dog so I got a dog and I think there is an element of truth to it because even if you don’t have routines yourself you feel the need to help your dog to live with routines...(8)
The fear of becoming unwell and the obligations a person has to others are constructed as important motivators for this way of being;

...so everything has to be measured and everything has to be I mean everything involves thought, I just can't throw caution to the wind... it's what people do like they go out and enjoy friends company and do that stuff and now that I have learnt and as I have continued to learn that this is far more important because the consequences are too big and the consequences impact not just me but they impact on a lot of people around me so it's what I have to do...(10)

Active engagement with this subject position takes significant effort, attention to detail and persistent attention to oneself. Moderating experiences requires both action and effort;

To manage my depression I will walk or I get out and do things like I bike around Bottle Lake every weekend. I walk every night. I make sure that I get up and walk up that valley every night... the worst time for me is first thing in the morning. It’s like a nightmare cause everything comes rushing in so the longer I sit and lie in bed the worse it is so you, I just literally have to get myself out of bed. If I wake up six in the morning and can’t go back to sleep then that’s out of bed because otherwise I start manifesting all this stuff in my head and it, it takes a lot of affirmation to get me to stop doing it. Better that I get in the shower and go for a walk. (21)

It requires diligence and attention to detail;

... you know like alcohol is an issue like obviously I can’t go out and get absolutely shit faced so I have to be very monitored of that umm late nights aren’t an option for me which is big struggle for work because I work after hours, I am on call from 5.00pm until 8.00am so I can get called out so that is an issue but then I have to counteract that the next day if I do get called out that I have to sleep umm, I can’t take my medication after 8.30 otherwise I have a stupefied feeling the next day umm which limits me from going to the movies at 8.30 or going out for dinner or like people might get home at 10.30 if they are going out for a meal I can’t, I can’t do that or won’t do that like
regularly like I might do it once a fortnight but I never do it on the week night it would always have to be on a Friday or Saturday so I could sleep the next day...(10)

It requires a constant focus upon the self;

... it’s always in the back of my head like ‘if you do this could you get unwell’ which is probably a good thing, it’s always there cause it’s sort of like a safety barrier net saying, you know, ‘do you really want to do this’. (35)

These examples of active engagement with the subject position that values moderation and regulation also highlights the place of fear, and fear of becoming unwell in particular, in motivating people to take up the call to moderate themselves on the basis of psychiatric wisdom.

**Moderation through medication**

In the transcripts, moderating and regulating the self is done primarily through the use of medication and attention to ones habits of daily living. Medication is described as offering protection against a lack of self-regulation;

...I feel like the only thing keeping me really stable is the medication cause I don't think I'm eating healthy. Definitely not eating healthy and I don't have a very good sleep pattern which they said was very important but now kind of like doesn't seem to be as important. It’s just mainly keeping, um, keeping my medication stable. I think if I had a few days, few nights without sleep, stop my sleep, I would have problems...(35)

While medications may comfort and protect, they can also restrict;

Citalopram made me feel like I was wrapped in cotton wool all the time...It was quite nice. I liked it. I understand some people don’t, um, and it just, it stopped the bottom from falling out of my world really, um, and Lithium um, um, made everything kind of flat. Like I was flat. I sort of, I didn’t feel like hugely responsive to anything really. My mind seemed sort of narrow and limited. (22)
While medications may be valued, it also requires a person to manage a sense of being totally reliant upon them;

I was always worried that I would get hooked on them and I am, I guess I am hooked on them... I don't want to go without them and I think that I would actually probably panic if I didn't have them. (13)

A willingness to feel reliant upon medications may be central to the experience of taking medication but to see oneself as dependent upon something outside of oneself effects how this subject position is taken up;

...I'm willing to take Olanzepine...I don't want to do anything else...If there's any other way of doing it I'd rather exhaust every single way before I would even go there and also then it drives, it drives me a little wild and I can understand that the brain is a very sensitive thing, you know, a computer after all in some ways, um, that any medication would take a lead in time of a month or six weeks or something or two months or something like that before the levels would start working and so, um, I just didn't want to be dependent on any medication. I think dependency is the other thing. (20)

Medications can act as a sign of personal weakness;

...I haven't reached that desired confidence to not be without them just yet because I am still learning a lot about the damage, yeah the damaged impact of all those influences and that that have done and encroached upon my way of thinking yeah I haven't got that ability to be strong to cope without them not yet...(46)

A person using medications can be constructed as someone who is not strong enough to cope without them, just as a person using medication is constructed here as somehow putting themselves at risk by taking them;

I used to be absolutely anti medication, anti pills, this time I am not mucking around, it's not that I came off medication at all I just didn't want to take it because it wasn't natural to the body but you can't help it when you have got this disorder this is what works and this is what I do...(2)
Through talk about medications, the discourse of self-management can be seen to become entangled in ideas about what it means to be self-reliant;

I: What do you think of the idea that someone with bipolar disorder can learn to manage their condition?

P: Yeah, I, I’ve kind of heard about that but, um, without, without taking medication? (M2)

Medication can be experienced as central and even essential to a person’s ability to engage in regulating and moderating themselves but with it can come a sense of oneself as dependent and lacking in self-reliance. If self-management is constructed as ultimately about a demonstration of one’s capacity for self-reliance this presents a subject position infused with contradictions as a person is called to see themselves as both responsible and lacking in self-reliance at the same time. In this context ambivalence toward medications would hardly seem a surprising response to contradictions within this subject position.

**Moderation through habits**

Like medications, habits are constructed as a particular form of practice that helps a person to enact a subject position that values moderation and regulation. While the next piece of text was used earlier to demonstrate the effort of active engagement with this way of being, it also demonstrates how habits are understood to moderate mood;

To manage my depression I will walk or I get out and do things like I bike around Bottle Lake every weekend. I walk every night. I make sure that I get up and walk up that valley every night (21)

Habits are also constructed as helpful in moderating distressing feelings;

I also tend to compartmentalise stuff because otherwise it is too big and I can’t deal with it like ahh every episode I have had I try and put it somewhere like try and put it where it belongs and it’s kinda in the past cause if I dwell on things it will eat me alive really so I just try and do, I have a really structured,
routine life and that is the only way I can get my head around what I need to do… (10)

Disciplining the body through habits becomes a way to discipline the mind but the difficulties generated by this notion of the body as a conduit to an unreliable mind once again draws on psychological constructs, this time constructs of will power and self-control;

... and it's that willpower you know because sometimes we just don't have the willpower to do it and sometimes we are just blatantly stubborn, no ears type attitude… (46)

Without the ability to manage one’s will, habits are understood to remain undisciplined.

In the context of living with bipolar disorder, the experience of elevated mood presents particular difficulties to the display of willpower as the pleasurable sensations it can bring are constructed as difficult to resist;

I guess because it is hypomanic rather than full-blown manic I guess it was a really good place to be and it was always hard to finish to kind of lose that energy and then kind of hang up... Kind of like a high, kind of like you know you are taking drugs I guess. I have never taken drugs so it is not a very good comparison but, you know that would be how I imagine people feel when they take drugs they just go right up there and live to the extreme... (7)

Talk of habits incorporates ideas about the limits to self-control and the resulting sense of failure that can accompany a lack of willpower;

... an hour after I take them [medications] I have a window a thin hour window where sleep just takes over and I have to be really mindful of that because about 9.30 I get really hungry, really hungry and nine out of ten I will succumb to that I will go down and grab an apple or biscuits or a sandwich and its terrible and I know that eating at that time is not good but it's like a craving, terrible but that’s what I have to do in order to be so there is no way around that… (10)
A failure to enact the norms of willpower and self-control can generate a circle of intensification of habits to address a lack of willpower;

...sometimes I do a little bit, push it...I have to make sure if I have a really late night, late night and drink a lot of stuff I try and make sure that that week I get good sleep and try and fix what I’ve done (35)

Deficiencies of willpower result in temptation being given in to, which in turn requires an intensified focus upon habits in a way that suggests a need to make amends.

Within the discourse of self-management, habits are constructed as practices that help people moderate themselves yet they also require of people significant levels of diligence and self-control. Habits cannot be effective without displays of willpower so a person’s relationship with themselves has the potential to be based upon a self-surveillance that searches for inadequate levels of willpower and then attends to this deficit through increased conformity and rigidity. This in turn would seem to increase the likelihood that a discourse of self-management can perpetuate a sense of self as a failure and in need of making amends for one’s deficits.

**Summary**

This analysis demonstrates that a self-management discourse makes available to people understood to have the condition subject positions that are characterised by the enactment of acceptance, reflexivity and moderation. Acceptance is not an automatic or instinctive endeavour; rather people are drawn into an enactment of acceptance that then requires an active response. This subject position is tied to a neo-liberal discourse of responsibilization; once psychiatric discourse is acknowledged as having the authority to know a person’s mental distress, the person then becomes responsible for the choices they make about how to respond to expert knowledge. The person is not the cause of bipolar disorder but they are to be held accountable for how they live with it as how they live with it is constructed as a matter of choice (Miller & Rose, 2008; Rose, 1998b). It becomes a subject position that is tied to notions of success and failure; successful self-managers are those
people who believe they are suffering from an illness, and those who don’t believe are likely to fail in their attempts at self-regulation (Blackman, 2007).

A reflexive relationship with one’s self is, in this analysis, a way of being that is enacted with a level of intensity beyond ‘normal’ others and this rigorous attention to the detail of one’s internal world is performed through a lens of medical-cartesian discourse such that people are positioned as having to choose between naming experiences as either self or illness. There is no option in this version of reflexivity for it to be both. This subject position calls people to a reflexive relationship with the self that is both rigorous and detailed while also creating the conditions for a relationship with the self that is based upon fault finding, shame and making amends for wrong doing.

These are ways of being in the world that highlight some of the tensions between the discourse of self-management and how people come to understand their experiences. On the one hand a person with bipolar disorder is understood to have thoughts and feelings that are unreliable and untrustworthy as they could be an expression of illness rather than a person’s ‘real’ internal state. On the other hand, the discourse of self-management positions the person with bipolar disorder as adept at both self-surveillance and disciplining one’s thoughts in order to avoid relapse by not repeating the mistakes of the past. The demand for a reflexive way of being is intensified and it must be enacted with a diligence that recognises one's self as unreliable.

As with a subject position characterised by reflexivity, a position characterised by moderation also requires an active engagement with a persistent attention to oneself. Medications and habits form the backbone of the enactment of moderation and they are practices that are not free of side-effects. While medications can be effective aids to moderation, they can bring with them a sense of oneself as lacking in self-reliance such that a self-management discourse calls a person to see themselves as both self-reliant and dependent at the same time. A focus upon one’s habits of daily living can also be an effective practice in the name of moderating the self but ideas of habit are tied to ideas of willpower and whether one has enough will power to change one’s habits. In this process the creative potential of one’s habits run the risk of becoming
lost by a focus upon habits as an expression of conformity, rigidity and a sense of failure.

As a technology of self (Foucault, 1988), the discursive practices of self-management for bipolar disorder invite people to see and act upon the self in ways that are characterised by dividing practices and contradiction. Separated from ‘normal’ others by an unreliable self it becomes imperative that people can and should separate self from illness. At the same time as they are positioned by discourse as unreliable, people with bipolar disorder are also positioned as the responsible choice maker. In a similar fashion a person’s thoughts are constructed as both a problem to be surveilled in search of illness whilst they are also constructed as the means to bring about change in oneself; all of which would seem to leave people negotiating contradictory ways of being in the world. As a technology of power (Foucault, 1988), the self is governed through the caring ministration of psy-experts such that the discourses of medicine and psychology become the only way to make sense of one’s self. The diligence and intensity that characterises the discursive practice of self-management as a technology of self overlap with a technology of power so that the self governs the self through and by regimes of living sanctioned by authoritative others.

A note on absent constructs

In completing this analysis of how individuals use the discourse of self-management to govern themselves and turn themselves into particular forms of subjects it is important to note the absence of some particular textual themes in the analysis. Given the explicit stance taken to note the social and cultural context of both the creation of the interview text and the analysis, conspicuous by its absence or rather its very limited appearance, is the use of a Māori worldview as a discursive resource within the texts. This is not to suggest that people did not draw on concepts of self and the world taken from or inspired by a Māori worldview, but when it came specifically to the discourses being used to construct the object of bipolar disorder and the subject positions within the discourse of self-management they made a very limited appearance. This could be taken as a limitation of the study and a reflection of the analyst’s difficulty in noting discourses outside of a white-Western worldview. It
could also say much about the dominating influence of white-Western concept in the discursive resources that people draw on to make sense of who they are – regardless of how they might construct a notion of ethnicity. The reason for this limited appearance is unclear and it is an area for further study as currently no research could be located that analyses the discourses of medicine, psychiatry, or psychology with an attention to how people who name their ethnicity as Māori (or indeed any other indigenous ethnicity) draw on these discourses to construct themselves.
Chapter 8
Discussion: Re-Evaluating the Self in Self-Management

*It is often the case that an important idea is not important because it is true (in some absolute sense) still less because it is indubitable, but because it is fruitful* (Fulford, Thornton, & Graham, 2006, p628).

*There is thus no effacing the poetic dimension of the processes at hand: historical interpretation, whether of self or other, far from simply finding what is already there, immanent in the data, relies through and through on the imaginative capacities of those doing the interpreting* (Freeman, 1993, p229-230).

This thesis has sought to explore the effects of the discourse of self-management for bipolar disorder upon how a person makes sense of both themselves and how to live. In doing so, it has also sought to investigate the nature of the self in self-management discourse. After reviewing the key assumptions of language and discourse upon which this Foucauldian discourse analysis is based and summarizing the findings of the analysis, this chapter moves on to consider the implications of the findings for processes of self-formation in people understood to have bipolar disorder. It does so firstly by using Foucault’s four ethical dimensions of one’s relationship with one’s self and then uses this discussion to suggest alternate styles of relationship with one’s self using concepts of ontological pluralism and the management of the abject. The implications of both analysis and ensuing discussion are then considered in the proposal of an alternate model of psychoeducation before the chapter concludes with a discussion of the limitations of this discourse analysis.

**Language and Discourse**

This Foucauldian inspired discourse analysis based also on the work of Ian Parker (1992) has prioritised an understanding of the productive capacity of language to shape what can and cannot be said, and therefore what can and cannot be thought, about what it means to be a person with bipolar disorder. This discourse analysis has
been based upon several key assumptions about the nature of language and discourse. Firstly, that language cannot act in representational way to capture and describe the ‘real’ world. Rather people use language to construct the world and the ideas and meanings it conveys shift depending on historical and social context. Secondly, language is understood to govern how we can speak about objects through the action of discourses i.e. large sets of statements gathered together according to sets of rules that shape what can and cannot be said about particular objects. Thirdly, discourse is assumed to be historically shaped – what can be said about an object at this point in time is a reflection of what has been said in the past by the same or related discourses. Fourthly discourse shapes subjectivity through the creation of subject positions; that in order to make sense of what is being said a ‘reader’ must recognise that they are being ‘called’ to in some way and positioned as a certain sort of subject in relation to the discourse. When these assumptions are collected together, discourse is understood to act in a productive way making it possible to say certain things but not others such that it becomes difficult to think otherwise. This leads to the final assumption made here about discourse – that it is tied to wider networks of social institutions and power relations. This discourse analysis is concerned with how power works through discourse to produce particular subject positions and then how people use these to govern others and govern themselves without the need for overt coercion. To this end the concept of governmentality has been useful as a means to think about how technologies of the self shape how people govern themselves whilst also being tied to broader strategies of government aimed at the management of the nation state in the name of such things as health, welfare and productivity.

These assumptions have been applied to analysing the discourse of self-management as found in an expert based text on bipolar disorder and in the talk of those people understood to have bipolar disorder. As a result, the discursive practices of self-management have been shown to act as both a technology of power and of self; they are practices that allow people to both govern others and govern themselves based upon the knowledges of the psy-sciences that have taken on a truthful status when it comes to matters of the mind. They are practices that shape how people with bipolar disorder develop a relationship with themselves at the same time as they shape styles
of relationship between people with bipolar disorder and others, in particular mental health professionals.

**Summary of the Findings**

The first stage of the analysis detailed in Chapter 5 takes a text produced by psy-experts in the field of self-management of bipolar disorder, the Manual of Psychoeducation for Bipolar Disorder (Colom & Vieta, 2006), in order to first investigate processes of subjectification (Milchman & Rosenberg, 2009) and the ways others are governed and objectified through relations of power and knowledge. The analysis identified that the discourses of self-management and the psy-sciences tightly regulate how bipolar disorder can be understood and what a person must do in response to it. As an object, bipolar disorder is constructed as a brain disorder that will always recur so it must be treated with medication. As a technology of power, The Manual is emblematic of a secular pastorate that acts to create a space where in the name of care and concern for the good of a person’s health, the conduct of people with bipolar disorder is shaped around reflexive, self-surveilling ways of being in the world that are based upon the norms and authority of the psy-sciences. Regardless of a person’s degree of conformity to the psy-science version of their experience, everything about a person with bipolar disorder is to be explained by their brain disorder.

Both Chapter 6 and 7 approach the analysis of discourse with a concern for processes of subjectivation and how individuals use the discourse of self-management to govern themselves and turn themselves into particular forms of subjects (Milchman & Rosenberg, 2009). Chapter 6 comes to subjectivation through a focus upon how people with bipolar disorder use discourse to construct bipolar as an object and what the implications of this might be for subjectivity. Chapter 7 builds upon this by then paying specific attention to self-management discourse and the subject positions it makes available to people with bipolar disorder.

When people with bipolar disorder construct the condition they understand themselves to have, they turn predominately to medical discourse while also drawing on psychological and neo-liberal discourses to make sense of experience. First and foremost, bipolar disorder is constructed as a brain illness. As such it is not
something that they have brought on themselves but it is constructed as an object for
which they hold the responsibility for how they choose to live with it, particularly as
it is understood as something a person can exacerbate by their own actions. While
medical discourse is used to construct bipolar disorder as a brain illness,
psychological discourse is used to at the same time construct the mind as unreliable
and abnormal such that bipolar disorder is an object that marks a person as different
from ‘normal’ others because it is an illness with less legitimacy than non-mind
related illnesses. With the mind constructed as unreliable the body is able to offer a
conduit to this hidden world and a way to read the mind. An effect of medical
discourse is to place the body in a life with bipolar disorder in the more limited role
of the display of symptoms of an illness while the person with bipolar disorder is
forced to choose between understanding their experiences as either part of their
‘true’ self or as part of their illness as it cannot be both. By drawing on this
combination of medical, psychological, and neo-liberal discourses to construct the
object of bipolar disorder, the subject positions made available to people are
characterised by notions of choice, accountability, and a self that is unreliable. This
results in a relationship with oneself that is always mediated by and with the experts
of the psy-sciences. It also suggests that people with bipolar disorder are being
drawn into an intensified version of contemporary personhood whereby a person's
psychological self is to work in the service of managing a person’s neurochemical
biological self (Rose & Abi-Rached, 2013).

Self-management discourse calls people with bipolar disorder to subject positions
based upon practices of acceptance, reflexivity and moderation. While the analysed
text suggest that these are positions that people with bipolar disorder actively
reproduce, they do so in a way that identifies some of the complexities and
contradictions within them; being responsible while also unreliable, being diligent in
one’s self-governance and surveillance while also relying upon expert others, being
self-reliant while also dependent, being not at fault yet faulty, and monitoring ones
thoughts for signs of illness while also using ones thoughts as a mechanism of self-
transformation. Weiner (2011) also identifies these same tensions; how self-
management practices for bipolar disorder simultaneously require a person to
demonstrate their capacity to be rational whilst also having a "constant suspicion
toward their present thought and emotions, and distrust of an imagined future self.” (Weiner, 2011, p. 448) These are contradictions and tensions that in The Manual have a minimal presence and when they do appear, are dealt with by offering the salve of the medical model and the relief from suffering presumed to lie with knowing that one has acted responsibly.

The Ethics of a Life with Bipolar Disorder

Within health care settings neo-liberal norms of subjectivity that are based upon choice, independence and personal responsibility are particularly potent and they, in conjunction with the subject positions within a discourse of self-management bring a moral domain to self-management practices. When a person has a long-term health condition, in this case bipolar disorder, there are particular styles of living and ways of conducting oneself that are valued and rewarded more than others. Dean (2010) uses the example of that “ubiquitous exercise in self-government, the diet” (Dean, 2010, p. 26) to highlight how a person draws on expert knowledge from a range of sources to determine why and how they will go about the practice of dieting. There are many ways to be on a diet; choices need to be made about what knowledge to base our actions on, the part of ourselves we wish to work upon and who we hope to become as a result of a diet. Importantly, these multiple ways to be ‘on a diet’ are ways that are not stable in nature and inevitably come up against each other.

“Techniques of relating to oneself as a subject of unique capacities worthy of respect run up against practices of relating to oneself as the target of discipline, duty and docility.” (Rose, 1998b, p. 34). Just as in self-governance through one’s diet, in self-governance through one’s bipolar disorder there are always points of conflict and contestation about how to be in any given context, always judgements to be made about how to conduct one’s life.

It is these processes of self-formation through the ways of acting and thinking that a person uses “to monitor, test, improve and transform...” (Foucault, 1990b, p. 28) oneself, that Foucault is referring to when he uses the term ethics. Moral codes define desirable or undesirable behaviour while ethics refers to the numerous practical ways that a person determines the proper conduct of their life, the kind of selves they should or could be and the practices they might use to act upon themselves to achieve
this. (Foucault, 1990b; Rose, 1998b). Ethics in this context is focused upon the process by which the individual thinks about and then acts upon the self, the process by which people construct preferred subjectivities or ways of being. What sort of life should I lead? How am I to be concerned with my self? Is my self something that requires care, if so, what is the nature of this care? It is this practical application of ‘codes of conduct’ that this discussion now focuses on. In seeking to tease apart the nature of the relationship one is expected to have with oneself, Foucault proposed four dimensions to explore; 1) the ethical substance, 2) the mode of subjection, 3) the self-forming activities and 4) the telos. These dimensions are now used to explore how self-management practices shape how a person understood to have bipolar disorder makes sense of their self and the nature of a life with bipolar disorder.

The ethical substance: This is the part of oneself or one’s behaviour that is the focus of moral conduct, the aspect of oneself that is being singled out as the focus of moral work (Foucault, 2003d, p111).

Within a discourse of self-management for bipolar disorder the part of the self most relevant to one’s moral conduct is the unreliable mind. Neither thoughts nor feelings can be relied upon to guide a person’s behaviour because the source of those thoughts and feelings is an unreliable mind. While the brain too is implicated as the source of problems with regulating one’s conduct, within the discourse of self-management people with bipolar disorder turn to the mind and the thoughts and feelings it generates as the focus of moral conduct. By surveilling thoughts and feelings for signs of illness and working upon how one thinks, a person is seeking to act upon a mind that always has the potential to lose the ability to know itself which in turn can result in behaviour that is socially unacceptable or morally abhorrent, for example sexual promiscuity. Neither thoughts, nor intentions nor feelings can be singled out as the focus of moral conduct because of their unreliability which results in the person having to construct the whole mind as in need of close attention if a person is to demonstrate moral conduct.

Indeed because of the mind’s ability to produce conduct of dubious morality, working on one’s mind (primarily thoughts and attitudes) is constructed within a discourse of self-management as a way to compensate for or demonstrate to oneself and others
that a person really does know right from wrong regardless of how they might have behaved. In this context, feelings of shame become an important indicator of a person’s ability to know right from wrong. Shame is evidence that a person knows they have behaved in unpleasant, hurtful, or socially unacceptable way. It could be argued that shame is an essential means by which a person can construct themselves as an ethical subject, a ‘necessary evil’. But this could also be seen as a way of understanding shame as pathological, a sign of a malfunctioning individual who cannot manage their own behaviour. Shame in this context becomes unwanted; something to be avoided at all costs. While it might affirm a person’s ability to determine right from wrong, shame would seem to be more potent as a sign of being a faulty individual.

What if shame was instead constructed within a developmental frame of reference; an emotion through which human beings learn about themselves and their relationships with others, an emotion with a productive nature that allows a person to learn (Rodogno, 2008)? In this scenario shame, while still not a pleasant experience, could instead become something around which we develop rituals of redress and reconnection when someone acts in a way that creates shame. Rather than it being a sign of a faulty self (Tangney & Dearing, 2002) and something to be avoided at all costs, it becomes part of processes of self-formation through which a person learns to develop a sense of who they are in relation to others with access to social rituals to heal the connections with others that get broken as a result of shame inducing acts. By thinking and acting in this way it would seem that what could come from this is a more integrated sense of oneself where the unacceptable parts of oneself have less need to be organised around the notion of shame (Wheeler, 2003, p297).

**Mode of subjection:** On what basis are people “invited or incited to recognise their moral obligations” (Foucault, 2003d, p. 111), what authority or truth is being called upon as the reason to act. “[T]he way in which the individual establishes his relation to the rule and recognise himself as obliged to put it into practice.” (Foucault, 1990b, p. 27).
At first glance, in a discourse of self-management the mode of subjection would seem to be the authority and truth of the psy-sciences. By recognising him or herself as an object of psychiatric discourse and accepting its authority to determine what it is and how to live with it, both science and medicine are acting as the basis for determining the relationship a person has with their self. But there would also seem to be layers to this dimension, with other truths acting in conjunction with the psy-sciences to call people with bipolar disorder to recognise their moral obligations. In particular, a neo-liberal discourse that values subjectivities based upon enterprise, choice and personal responsibility adds a layer to the mode of subjection. In contemporary Western societies knowledge of what it means to be human is centred on assumptions of "humans as selves with autonomy, choice, and self-responsibility, equipped with a psychology aspiring to self-fulfilment, actually or potentially running their lives as a kind of enterprise of themselves." (Rose, 1998b, p. 33). These modern forms of power relations are not overtly oppressive but instead promote governance of self and others through ideas of choice and freedom and have in turn become very potent constructs within health care settings (Brown & Baker, 2012). Yet their potency is based upon an assumption that responsibility is what an individual person enacts by taking 'personal responsibility'. As demonstrated by Weiner (2011) in her ethnographic study of a bipolar support group, responsibility can also be shared with others in such a way as to acknowledge “the discontinuous and never entirely knowable subject” (Weiner, 2011, p. 480).

The call to see oneself as both under the jurisdiction of psy-science and as the quintessential neo-liberal citizen relies upon another layer to the mode of subjection; one of fear. Within the discourse of self-management the call to see oneself as the ideal health consumer appears less as invitation and more as incitement on the basis of fear. For people with bipolar disorder fear is an important part of their use of the discourse of self-management. Bipolar disorder is constructed as an object to be feared because of its unpredictability, the distressing emotions it can generate and its ability to produce shame inducing behaviour. Psy-experts in turn arguably exploit these fears in their use of the discourse of self-management in order to persuade people that they need to take up self-management practices in order to be free of this fear.
“...bipolar disorder is a *recurrent disorder* [italics in original] which means that many of those who suffer from it will present with future episodes. This must not frighten us, because the possibility of controlling relapses is in our hands...” (Colom & Vieta, 2006, p. 99)

As a result, the discourse of self-management can be seen to be promoting an ethic or way of living tied to choice-making and seeing oneself as responsible on the basis of the fear of the consequences of not doing so. Once again this promotes a relationship with oneself mediated by psy-experts as they are constructed as the source of salvation from fear.

While fear is a motivating force for people with bipolar disorder to take up a discourse of self-management and the subject positions within it, this fear can also be understood as arising as much from how others respond to them as from the internal experiences of altered thoughts and feelings. What if, for example the places where a person might go for assistance with their bipolar disorder e.g. inpatient mental health settings, were not in themselves objects of fear? What if the object of bipolar disorder itself was not treated in discourse as abject, abnormal and fearful but instead as part of the spectrum of human experience? Without the motivation of fear, the driving force to act upon oneself on the basis of psy-science and personal responsibility would perhaps not be quite so intense.

**Self-forming activity:** What are the techniques that one applies to oneself in order to change oneself into an ethical subject and to comply with the rules of conduct? “What are we to do, either to moderate our acts, or to decipher what we are...” (Foucault, 2003d, p. 112).

This analysis has identified subject positions that the discourse of self-management makes available to people with bipolar disorder that are characterised by practices of self-surveillance and moderation and in this context can be thought of as techniques of the self. Firstly there is a form of reflexivity characterised by intense self-surveillance, and a rigorous and diligent attention toward one's internal world whilst also making a continuous effort to determine a division of experiences between self or illness. Secondly there are the techniques to moderate the self based upon a
person’s use of medication and attention to their daily habits. These self-forming activities are then enacted within power relations based upon a secular pastorate.

**Self or illness**

As has been identified in Chapter 6, these techniques that people with bipolar disorder apply to themselves in order make sense of who they are, are all constructed on the basis of a medical-cartesian discourse so as well as being activities that require the sanction of psy-experts, they are also activities that assume a distinction can and should be made between self and illness experiences. The self being formed as an effect of the discourse of self-management is forced to choose between one or the other. But people with bipolar disorder can resist this way of thinking by the way a narrative of ethnic identity allows a person to construct themselves as both having an illness that requires the attention of psy-experts and as having experiences that demonstrate their connection to an indigenous view of the world and self.

“...the first time it really confused me to be able to that’s that, bipolar with mākutu so when the people say, well if I have to say I’ve got bipolar I say ‘oh but from the Māori experience’.” (M14)

While the discursive practices of self-management are generally dominated by a medical-cartesian discourse, this analysis suggests that this does not have to be the case when a person has other discursive resources available to them.

**Becoming a creature of habit**

Habits can be thought of as non-reflexive activities where the self is formed through training the body and mind to act in routine ways. In the context of self-management practices these routines can be understood as based on disciplinary power relations that shape the self through the regulation of conduct based on the norms of psy-science. In this scenario habits are bodily practices concerned with rigidity and conformity and the unthinking reproduction of social institutions that supports current power relations (Burkitt, 2002). The analysis of the subject positions within self-management discourse identified the importance of habits as a means to know oneself. For the psychoeducated patient of The Manual, discursive practices based on
the confessional allow the patient to reveal their mundane routines and habits (without necessarily recognising their importance) which are then interpreted and given significance by the psy-expert. In the discourse of self-management habits are constructed as both problem and liberation where ‘bad’ habits are the source of the problem (in this case relapse of one’s bipolar disorder) while attention to implementing ‘good’ habits is seen as liberating a person from the problem of ‘bad’ habits. The self being formed is one that is understood to be deficient in will power such that the only way to govern conduct in the absence of will is to increase the focus upon habit (Bennett, Dodsworth, Noble, Poovey, & Watkins, 2013).

While attention to habits can be understood as disciplinary based practice, habits can also be understood as a way to extend the creative potential of the body and of the self. Rather than something that reduces human behaviour to order and conformity, Grosz constructs habits as having “a fundamentally creative capacity that produces the possibility of stability in a universe in which change is fundamental.” (Grosz, 2013, p. 219). This creativity can be seen in the way the body alters in response to repeated patterns of behaviour, for example in the way repeated patterns of sleeping and waking at regular times interacts with the body's circadian rhythm altering hormones and the subjective experience of mood (Dallaspezia & Benedetti, 2011; Hickie, Naismith, Robillard, Scott, & Hermens, 2013; McClung, 2013). In addition, the transformative quality of habits means that behaviour can become unthinkingly regularised so that actions happen without conscious thought, arguably leaving space for other things to take one’s attention. When framed this way habits can be understood as repeated actions that allow a person to engage with a notion of self where learning and change is possible (Blackman, 2013; Grosz, 2013).

Alternatively, when constructed as a non-reflexive practice that is located on the surface of the subject, habits can be altered without rigorous self-examination such that repeated patterns of conduct can be a way of resisting the incitement to explore deeper within the psyche for truth and meaning. When habits are constructed in this way, it extends notions of biology in bipolar disorder beyond the brain. As the body, mind and brain interact to generate change, the self is offered the potential to be more than psychological and more than neurochemical (Keane, 2000; Rose, 2007).
While the discourse of self-management calls people to become creatures of habit, this does not necessarily require it to be in the name of conformity and regulation. Habits offer self-forming practices that can be both rule and opportunity, growth and stasis, as well as resistance to and reproduction of existing power relations. The self-forming activities of moderation that make up an ethical enactment of self-management discourse would seem to rely heavily upon forms of body knowledge but its value to self-management is constrained by a medical discourse of the body as the site of symptoms and a medical-cartesian discourse that seeks to separate the mind from the body. The body can be used to coerce as well as means to come to know and care for the self, it is not a choice of either/or despite what our attachment to medical discourse might suggest.

This formulation of the self-forming activities that people with bipolar disorder engage in makes a strong case for an embodied notion of bipolar disorder and its management that moves beyond the body as the location of symptoms. Using her ethnographic research with the Hearing Voices Network, Blackman (2007) explores how a person “enters into a dialogue with their experience, and how this process can change the embodied experience of voices” (Blackman, 2007, p. 16). Through discourse members of the network engage in constructing their experience of voices in ways that integrate them into their sense of who they are rather than adopting a medical discourse that requires the voices to be separated from the person symptoms of illness. Through this process people’s experiences of the voices change “such that they are embodied as rather different phenomena” (Blackman, 2007, p. 18). This discourse analysis demonstrates how a medical discourse requires particular dialogues about the separation of self and illness and the role of habits but this analysis also proposes that these dialogues can be constructed differently and result in a different relationship between one’s body and one’s self.

**Pastoral power**

As the analysis of the Psychoeducation Manual for Bipolar Disorder (Colom, 2006) identified, relationships based upon a secular pastorate form the basis for how clinicians are encouraged to enact the self-management discourse. For the person with bipolar disorder, this results in self-forming activities of surveillance and
moderation that are being shaped by the psy-expert’s need to know a person’s inner world in order to offer individualised routes to salvation. Through discursive practices of ‘confession like’ interactions, people with bipolar disorder tell a psy-expert what is within them which the expert then interprets and constructs meaning according the particular ideas which they believe reveal the truth of a person’s experience. This confessional style of interaction whereby people learn who they are through the mediation of psy-experts is a feature of contemporary health care (Mayes, 2009; O’Byrne & Holmes, 2009) but for the person with bipolar disorder this requirement to have a relationship with oneself mediated through the truth of psy-sciences and practices of confession would seem to be intensified.

Thinking about health care for people with bipolar disorder in terms of pastoral power also allows a way to think differently about the drive in contemporary mental health care towards providing recovery-orientated, patient centred care that promotes the empowerment and self-determination of people experiencing mental health problems (Davidson, Harding, & Spaniol, 2005; Lapsley, Nikora, & Black, 2002; Sterling, von Esenwein, Tucker, Fricks, & Druss, 2010). From this perspective ‘recovery’ as a policy of mental health service provision (Davidson & White, 2007; Mental Health Commission, 1998; Pilgrim, 2008) becomes less about personal self-determination and more about institutions of the state shaping how a person governs themselves in the name of health. Notions of pastoral power draw attention to the way both those people understood to have a mental disorder and those known as mental health professionals engage with each other and with themselves through a complex web of power relations that both are often blind to (Mayes, 2009). In a similar fashion it also provides a way to think about the implications of the growing call for psychotherapy as an essential adjunct to medication in the treatment of bipolar disorder (Frank, 2007; Miklowitz & Scott, 2009; Scott, 2006; Scott & Colom, 2008). While psychotherapy can be framed as a beneficial process of self-discovery facilitated by a therapist motivated by care and concern for autonomy, notions of pastoral power draw attention to how psychotherapy can also create a space for discursively produced self-formation based upon practices that valorise the revelation of one’s inner world in the context of a caring relationship that is built upon the authority of the knowing expert. Ideas about recovery and practices of
talking based therapies are concepts in mental health care that work on the basis that “...to know the truth about oneself requires them to subject oneself to examination and expert elicitation and interpretation” (Mayes, 2009, p. 488).

**The telos:** What “... is the kind of being to which we aspire when we behave in a moral way?” (Foucault, 2003d, p. 112), what sort of person is one aiming to be as a result of this ethical work.

As in the earlier discussion of the mode of subjection that identified neo-liberal discourse as one of the ways that people with bipolar disorder are called to recognise their moral obligation, it would seem that the ‘kind of being’ that people with bipolar disorder are positioned to aspire to through self-management discourse is a person who takes responsibility for the choices they make. Contemporary notions of subjectivity can be seen to be focused upon the enterprising individual which has become a way of being that is played out in a multitude of aspects of daily life; from the school, to work, to the family, people living in advanced liberal societies are called to see themselves as responsible people living their life through choice and freedom (Miller & Rose, 2008, p18). The enterprising individual is understood to work upon their life in order to maximise the worth of their existence and will do so in ways that pays particular attention to the management of risk (Galvin, 2002; Rose, 1998b). Experts, and health professionals in the context of this thesis, concurrently become focussed on the individual’s conduct in the name of helping to minimise the risks that are constructed as an inevitable part of contemporary life (Brown & Baker, 2012). In these ways the state is able to govern its population through the governance of individual subjectivity.

Aspiring to personal responsibility in relation to living with bipolar disorder appears to be tied tightly to notions of risk and its active management. The expertise of psy-sciences constructs bipolar disorder as inevitably recurring and self-management discourse constructs these recurrences as linked to predictable factors. Relapses have triggers that can be identified and most importantly, people engage in conduct that is understood to promote the likelihood of a relapse. The contemporary individual who also lives with bipolar disorder will demonstrate their enterprising nature by working hard to understand their personal risk factors of relapse and then acting
upon these by changing how they live. Once they have worked to control their conduct that is implicated in a potential relapse, the next focus is to plan in advance the actions that others should take on their behalf when they cannot actively manage the risk of lack of rationality. In aspiring to personal responsibility, people with bipolar disorder would seem to be engaging in practices that promote notions of the risky yet enterprising self (Scott & Wilson, 2011).

Aspiring toward a relationship with the self based upon personal responsibility is driven by a relationship with experts as once “the patient understands their disorder, they have the growing sensation of being understood” (Colom & Vieta, 2006, p. 27) then allows them to make the correct choices about their conduct. In seeking to operationalize concepts of self-management for people with long-term health conditions, Lorig & Holman (2003) construct all conduct as a choice such that what matters most is educating a person to ensure their choices align with the knowledge of science and medicine. Personal responsibility thus becomes about choosing one's conduct on the basis of instruction and advice and not about what a person learns about themselves, through their experiences of living.

While all people in contemporary Western societies can be understood as being called to see themselves as exercising personal responsibility, for people with bipolar disorder the call to relate to oneself in this way is both intensified and put under tension. A biological model of mental illness does not allocate blame to the individual for developing an illness in the first place but at the same time a person with a mental illness can be held accountable for how they live with it. In the name of recovery, people with a mental illness are offered self-determination while simultaneously having their conduct regulated by psy-experts through notions of choice and responsibility (Brown & Baker, 2012). But importantly, the demonstration of personal responsibility allows a person with bipolar disorder to become a citizen like everyone else; their conduct has an exchange value such that they become socially included rather than excluded. For those who are able to enact personal responsibility, aspiring to a relationship with the self based upon notions of responsibility and choice therefore has much to recommend it when conduct is traded for citizenship. But what of those people who will not or cannot conduct themselves according to the norms generated by neo-liberal thinking? What of those
people for whom the boundary between illness and personal volition is not clearly defined? Aspiring to a relationship with the self based on personal responsibility would seem likely to promote a sense of self based on failure or at worst even further marginalize and pathologize. Personal responsibility in this reading is not as benign as it may first appear which begs the question, are there alternate relationships with the self that could be aspired to through self-management practices that allow a less restricted ethic of life with bipolar disorder?

In discussing Foucault’s ideas about an ethical life\textsuperscript{15}, McNay (1994) is critical of how he privileges the notion of a relations with the self over relations with others such that his stance on ethics is lacking in any context of a life lived embedded in social relations. Taking this criticism up, what if the telos of a life with bipolar disorder was to prioritise intersubjectivity over subjectivity and to live a life whose primary objective is the maintenance and quality of one’s connectedness with others? In the context of a telos that aspires to social connectedness, opportunities are provided to think differently about important aspects of life with bipolar disorder, in particular the experience of shame and the purpose it serves. In a similar vein to Kristeva’s (Kristeva, 2002) construct of the management of the abject as a developmental process, if the telos of life with bipolar disorder was not about personal responsibility but about social connectedness then shame could become less about personal failing and more about a disruption in social connectedness. This would also suggest processes of self-formation that prioritise the nature and quality of a network of relations with others in preference to notions of individuality and independence from others.

\textbf{Ontological Pluralism}

To find alternative ways to think about the ethics of a life with bipolar disorder is not straight-forward when the nature of the ‘self’ in self-management is dominated by a notion of the ‘normal’ self as contained, singular, autonomous and rational. To privilege processes of self-formation through intersubjectivity over subjectivity

\footnotesize{\textsuperscript{15} Foucault’s work on the constructs of ethics and governmentality as the overlap of technologies of power and self were in development over what turned out to be, the end of Foucault’s life. Because of this they can be regarded as unfinished projects for Foucault.}
arguably requires a Western ontology of the nature of existence to be challenged if we are to find ways to think differently. Inspired by Salmond’s (2012, 2014) use of ontological pluralism as a way to think differently yet wary of misrepresenting or misusing indigenous Māori knowledge and practices, this thesis suggests that there is useful thinking that can come from applying a Māori relational ontology to this discussion of self-management, and in particular to consider how a telos of self-management practices could prioritise social connectedness instead of an individualised personal responsibility. This interweaving of ontologies is put forward as a way to create a foundation for alternate ways to practice self-management.

The notions of self as rational, individual and singular around which self-management is currently constructed come from a Western ontology that can be traced through different strands of thought or conditions of possibility. From the creation narrative of the Old Testament, to ideas about human superiority in the construct of the Great Chain of Being (Bennett, 2010, p87-88), from Darwin’s theories of evolution and on to rationalities based upon the concept of science and the essential role of objectivity to determine the ‘truth’ of human existence; these are ways of thinking that in each historical context have become taken for granted truths. But these ways of thinking about the nature of human existence can also be constructed as some of any number of ways to think. They have become ‘habits of mind’ (Salmond, 2014, p297) that have become so deeply entrenched that alternate views of how the world is ordered are dismissed as superstitious or primitive (Salmond, 2012). Salmond instead argues that in the context of Aotearoa New Zealand, a pluralist approach that interweaves a modern Western ontology with a Māori indigenous ontology is a more useful discursive social practice rather than operating on the basis that only one reality is possible. In Aotearoa New Zealand society Te Tiriti o Waitangi (the Treaty of Waitangi) remains a living example of two distinctly different ontological versions of the world which, through restitution processes whereby the Crown acknowledges its breaches of the Te Tiriti o Waitangi (Treaty of Waitangi) and provides recompense to iwi (tribes), we now see discursive practices that seek to bring these world views together (Office of Treaty Settlements, 2014). It is this concept of ontological plurality that this discussion seeks to be inspired by.
In a modernist, Western style ontology the world is a singular entity composed of bounded entities; nation states that are marked by boundaries and inhabited by autonomous individuals with rights and duties (Bidois, 2013; Salmond, 2012, 2014). These autonomous individuals are then divided into cultures and societies. It is an ontology built upon dualisms in which one half of the binary is always dominant; animate versus inanimate, mind versus body, human versus animal, modern versus primitive (Salmond, 2012) and “[i]t is dualism that allows for the conception of air tight boundaries, the kind of boundaries that define autonomy.” (Evens, 2012, p. 8).

From a Māori perspective the world is founded on complementary dualisms; Te Ao and Te Po (the everyday realm and the dark realm of ancestors), tane and wahine (male and female), tapu and noa (ancestral presence and absence), ora and mate (good fortune, wellbeing and illness, misfortune and death) (Salmond, 2012). These are pairings rather than binaries so that one cannot exist without the other. With no clear division between entities, everything (plants, land, people and object) is animated by hau, the wind of life. This is a relational ontology where phenomena emerge through a process of reciprocal exchange such that “the negotiations that forge and shape relations are the stuff of life.” (Salmond, 2012, p. 121). The self (ahau) is constituted by its network of connections to others, always in the context of reciprocity. “When the exchanges are in a state of balance, hau flows unimpeded and the network of relations are...in a state of ora...If reciprocity fails...[i]t is manifest as illness and misfortune, a breakdown in the balance of reciprocal exchanges.” (Salmond, 2012, p. 121).

When the self can be thought of as being formed through the nature and quality of its connections to others, experiences of shame and stigma can be thought of as processes of relational disconnection that can be healed through reciprocity; the everyday ‘stuff of life’ rather than a burden to be carried by one person alone. When it becomes possible to interweave different views of the nature of existence and what it means to be human, it also becomes possible to experience oneself as both separate from and connected to all people and things. Rather than the self needing to be rational, singular and bounded it becomes possible to speak and think of oneself as both rational and irrational, singular and multiple, bounded and uncontained (Meredith, 1999).
Managing the Abject

While Salmond comes to her ideas through anthropology, Julia Kristeva also offers a way to think differently about self-formation through her engagement with linguistics and psychoanalysis. Kristeva takes the work of Sigmund Freud and Jacques Lacan to construct her own theory of the formation of self (McSherry, Loewenthal, & Cayne, 2015). Freud’s vision of the self was as something that would ultimately reach a stable state and that mechanisms of repression allow for the creation of a clear dividing line between the conscious and unconscious, between the known and unknown aspects of the self. For Kristeva, unwanted unconscious material is always on the fringes of experience of the self such that the boundary fence of the self is never finished and the dividing line between unconscious and conscious is always blurred. The self is always a work in progress and ‘[t]he subject never feels itself to be ordered and knowable. It is always under threat, in an unresolved state that is exciting as well as dangerous...’ (Mansfield, 2000, p81).

The body is central to self-formation for Kristeva as despite all our attempts to protect ourselves from the unwanted and put a boundary around what frightens us, our body provides a constant reminder of our permeability through the physical flows of blood, sweat, urine and vomit. The contained, clean and proper body is always under threat. ‘I work hard to alienate those parts of myself that disgust me’ (Mansfield, 2000, p83) and it is in the process of pushing away the abject part of the self that the self is formed but never in a way that is finished or complete. Kristeva understands humanness as a work in progress, constantly having to work with the unease of permeable and blurred boundaries between inside and outside, self and other, mind and body.

While Kristeva uses the corpse as the ultimate manifestation of abjection because of the way it brings together life and death, love and repulsion simultaneously, the experiences named as bipolar disorder can also be thought of as a manifestation of the abject, a marker of the fragility of humanness and an entity that ‘does not respect borders, positions, rules. The in-between, the ambiguous...’ (Kristeva, 2002, p232). Bipolar disorder provokes the process of abjection, it challenges a person’s sense of who they are and it remind us of our ‘leakiness’; that our ‘natural’ state is one of
barely contained chaos. For both the person and for others, bipolar disorder makes manifest our anxiety about the crossing of boundaries and self-management practices can be thought of as a way to rein in that which does not respect boundaries and reminds us of our fragility – a way to keep in order that which is a manifestation of dis-order and death.

In Kristeva’s version of self-formation, subjectivity is a process and the management of the abject is part of a developmental process of coming to understand the self. Shame and stigma in this context are not a sign of a disordered person and therefore experiences to be avoided at all costs. Instead shame and stigma can be thought of as another way that a person tries to contain the abject within oneself and avoid the anxiety created by an awareness of ones uncontained self. Management of the abject becomes a developmental process, something to be spoken of as ‘normal’ part of self-formation.

With this reading, it is perhaps then not surprising that psychiatric discourse would focus upon the importance of separating self from illness. Thinking with Kristeva, self-management practices become about trying to repress ambiguity and contradiction, trying to create a system of order that can contain our anxiety of the abject. The constant call to separate self from illness in this context becomes more about an expression of our fear of the abject that any actual truth that self and illness are indeed separate entities. Yes, bipolar disorder may disturb one’s sense of self but when thought of as a manifestation of the abject, this disturbance becomes something to be worked with rather than repressed. Abjection is neither good nor bad; it is instead a process by which we construct and reconstruct our sense of self. It is not a process that can be prevented or avoided therefore what would seem important is how we work with the abject. Currently self-management practices evoke the abject on the basis of a fear of the abnormal and so reinforce a need to separate self from others and self from illness.

**Rethinking the Self in Bipolar Disorder**

What if the self is formed through and by one’s social connections such that the self is less individual, more collective and founded on reciprocity? What if the self does not live in a neatly contained body and is always finding ways to negotiate permeable
boundaries between self and others, time and place, the contained and the uncontained, the body and the mind? No matter what the ‘truth’ of these statements, it is in the thinking of the possibility that it becomes clear that the problematic self around which an ethos of living with bipolar disorder is centred is only problematic because people are required to understand themselves as having a singular, individual and static self that functions on the basis of binary oppositions. Rather than a person being seen as abnormal because they have a body and mind that are slippery and not easily contained, or a person being understood to have a sense of self that is disturbed by bipolar disorder (Inder, Crowe, Moor, Carter, Luty, & Joyce, 2011), it is instead our notion of the self that would seem to be the problem and the resulting limits it places upon how we can think and speak of the self.

Within alternate constructions of selfhood, self-management discourse would have no need to position people as having unreliable minds as these experiences would instead be incorporated within an understanding of how the mind works. Rather than prioritising the containment of the body that is always at risk of becoming uncontained, moderation practices might instead focus on the opportunities for creative change that one’s daily habits can make available. Rather than forcing a choice between understanding experience as either self or illness, practices of self-surveillance might instead accommodate both simultaneously. Rather than subject positions being taken up on the basis of fear, a notion of positive liberty and the capacity to exercise critical judgement could shape a more thoughtful attention to how a person is being called to understand themselves (McNay, 1994).

To think about social connectedness as the foundation for the formation of the self and a style of life requires us to give up ways of thinking based upon binaries - this or that, past or present, me or you – and find ways of speaking and thinking that engage with multiplicity and ambiguity, connection and contradiction. If the self in bipolar disorder was rethought, subjectivity could become a ‘work in progress’ and self-management practices could become about embracing ambivalence and ambiguity. Equally, to engage with ontological pluralism without labelling one as more scientific or more primitive that the other comes the opportunity to practice integrating multiple world views and multiple ways of making sense of one’s self and one’s relationship to others. While a Māori world view has been used here as an example of
a relational ontology that might act as a discursive resource for understanding the self, it has a particular relevance for mental health professionals providing health services in Aotearoa New Zealand. On a daily basis we come into contact with people who continue to experience the repercussions of colonisation upon their wellbeing, people who are exposed to discursive practices that do not easily allow them to integrate multiple worldviews. What could it mean to people if diversity and contradiction could be become the guiding norms of self-management practices rather than the current approach that is dominated by the notion of deficient self and an unending search for the contained, rational, clean and proper body?

This is not to say that engaging in practices of self-surveillance and self-regulation are unhelpful to a person living with bipolar disorder but they are currently practiced within a narrow vision of how a person should or could be. Whether or not bipolar disorder is both illness and mākutu would seem not to be the issue for debate. Rather attention needs to be given to the way the current discourse of self-management provides people with limited forms of subjectivity that all fall under the auspices of the benevolent eye of medicine and its attendant notions of deficit. Neither does this mean that the expertise and knowledge of the psy-sciences is flawed but rather that it is only one form of truth that is held in place by relations of power. If people are to make sense of a life with the object that shall, for arguments sake, be called bipolar disorder, it would seem that the role of mental health professionals is to assist people to access a range of discursive resources so that they might firstly question the ways of thinking and speaking to which they are exposed and then consider what it might mean to be a person and how to live.

**Rethinking Psychoeducation**

With an alternative conceptualization of the self the ethos of a life with bipolar disorder could look very different and the discursive practices of self-management enacted by mental health professionals in psychoeducation and psychotherapy could do much more than reproduce dominant beliefs about the nature of bipolar disorder and those who live with it. If it is through discourse that people come to understand who they are and what they might become then the discursive practices of self-management could become transformative rather than a regulative.
Changing how mental health professionals enact self-management discourse on the basis of alternate constructions of the self is a significant undertaking given the dominance of discourses of science and medicine in psychiatry. It is one thing to speculate but entirely another to resist dominant discursive social practices. In spite of this, this discussion speculates on how psychoeducation might be practiced differently in order to allow people space to create a life with bipolar disorder that is not tightly regulated by psy-expertise. Given that some people with bipolar disorder report a helpfulness from engaging with psychiatric discourse to construct the nature of their condition (Fry, 2013; Russell & Browne, 2005; Straughan & Buckenham, 2006; Suto et al., 2010), how might an approach be developed that makes use of psy-knowledge while also making space for alternate constructions? How might psychoeducation make it possible for a person to consider a range of ways of being rather than the tightly regulated version of The Manual? How might we “nourish and respect the subjective, embodied and collective expertise of people diagnosed; the meaningfulness of feelings and the ‘irrational’…approaches that move beyond illness models for engaging with madness...” (Liebert, 2013a, p. 24).

This thesis proposes an approach within mental health service provision that seeks to combine psychotherapy and education but from a critical and deconstructive perspective (Kaye, 1999; Parker, 2014), to use principles of group therapy (Yalom & Leszcz, 2005) and narrative therapy (Combs & Freedman, 2012) in conjunction with principles of critical pedagogy (Matthews, 2013; Smidt, 2014). The intent in using these approaches is that the normative and disciplinary practices of both psychotherapy and education might be made more visible and actively resisted. This makes it possible to acknowledge and address the practical dilemma of those facilitating psychoeducation groups of how to provide an optimal relational based learning environment whilst also remaining ‘on schedule’ with the curriculum (Scaturo, 2004). Arguably the term ‘psychoeducation’ becomes unhelpful given how it is linked to the dominance of psy-discourse. In the absence of something more suitable it is the term used here but with reservations.

This alternate conceptualisation of psychoeducation is founded on particular assumptions about the nature of the person. Firstly a person’s sense of themselves is understood to be constructed through discourse, language and power; the
possibilities for how the self can be thought of are dependent upon the ideas and concepts available to a person and the ease with which they can be voiced. Secondly a person’s sense of themselves is understood to be relational, performative and fluid such that how a person understands themselves cannot exist outside of their relationships with others and how others experience them. The performative nature of self means that we become ourselves through the actions we take whilst also becoming ourselves through how others respond to our actions. Fluidity refers to the changing nature of the self such that it is not stable and contained but changes depending on context and relationships with others (Combs & Freedman, 2012).

These assumptions mean that how things are spoken of, the narrative that people use to talk about themselves and their problems and how these narratives are created in dialogue with others are important tools to be used in the process of developing self-awareness. Because a person’s sense of who they are is understood to be tied up in relations of power, the task of such an approach is to develop the critical thinking of participants, unsettle the taken for granted and make space for multiple perspectives so that people can develop alternative narratives of themselves and their lives. From a critical pedagogy perspective “[d]ialogue is a moment where humans meet to reflect on their reality as they make and remake it” (Shor & Freire 1986 as cited in Smidt, 2014, p. 90) while group therapy\(^{16}\) allows a space to be created where stories of oneself can be told, reflected upon, questions asked and alternate narratives constructed about who person might be and how they might live; all within the context of relationships with others.

Such an approach to psychoeducation is working within a dual perspective; that people can understand themselves as having a condition called bipolar disorder that has problematic effects both mind and body at the same time as thinking of the problem as located outside of the person. The practice of externalizing problems (Kaye, 1999) allows a focus upon the relationship a person has with bipolar disorder, the discourses that shape that relationship and exploring if there are other ways to

---

\(^{16}\) Yalom & Leszcz (2005, p1-2) propose eleven mechanisms through which group therapy can bring about change; instillation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group, development of socialization techniques, imitative behaviour, interpersonal learning, group cohesiveness, catharsis and existential factors. How these are used depends upon the focus and purpose of the group.
speak of it that don’t pathologize identity and that make space for an alternate relationship with the object of bipolar disorder.

**Guiding principles**

These critical, narrative approaches to psychotherapy and education in conjunction with the interpersonal experience of the group context suggest some potential principles that could act as a guide for a re-visioned psychoeducation.

- The more resources in terms of concepts and ideas that a person has access to, the more choice they have about what is most useful to them. Psychiatric knowledge may have something to offer to the process of making sense of experiences known as bipolar disorder but it not the only form of knowledge that can be useful.

- Both therapy and education are processes that create and reproduce relations of power. The intent is not to try to be neutral but to name and recognise the workings of power.

- There is no ‘right’ way to have a relationship with bipolar disorder, instead the group is concerned with how a person decides for themselves what works best for them at this time in their life.

- That the group context is an opportunity to stimulate relationships based upon collaboration and collectivism rather than individualism.

- Both facilitators of the group and participants can move in and out of an expert role; everyone has something more to learn.

- Unsettling taken for granted assumptions can be uncomfortable but is still a helpful learning tool.

- The process of learning and developing self-awareness is as important as the content one learns about.
Learning through social connection

By bringing people together in groups and given time to be themselves, groups members are understood to recreate in the group their unique interpersonal universe and it is through this relational approach to learning about self and others that group therapy seeks to act (Yalom & Leszcz, 2005). Yalom & Leszcz (2005) explicitly adapt the principles of group therapy to different contexts including the use of groups for people with long-term health conditions to support adaptation, decrease social isolation and provide health related information and name this as “supportive-expressive group therapy” (Yalom & Leszcz 2005, p. 511). Using the principles of group therapy, narrative therapy and critical pedagogy the goals of the psychoeducation programme would become:

- To create a mutually supportive environment that promotes social connection;
- To provide an environment where participants feels able to consider their relationship with bipolar disorder and how they might want that to change;
- To provide an opportunity for participants to develop skills of self-reflection and critical thinking as a means to grow self-awareness; and
- To provide participants the opportunity to learn from the knowledge of science and medicine whilst also considering other forms of knowledge that might be helpful;

Foundational conversations

“We are always already embedded in a particular set of perspectives, operating from within certain positions when we try to understand ourselves and others. To be ‘critical’ then does not mean finding the correct standpoint, but it means understanding how we come to stand where we are” (Parker, 2014, p. 59). Taking Parker’s notions of critical thinking, the content of an alternate psychoeducation group would be based around two foundational conversations; firstly about discourse and power and secondly about the discursive construction of bipolar disorder.
Discourse and power

This conversation is concerned with the taken for granted assumptions that lie behind ideas of what bipolar disorder is and how to live with it. Ideas about what counts as expert knowledge would be discussed and the concept of pastoral power and the role of confession would offer a way to think about relationships between self and others, and the person with bipolar disorder and experts. Ideas about language, the stories we tell about ourselves and the nature of truth would also be explored as would a relational perspective on how we come to know who and what we are.

Constructing bipolar disorder as an object

This conversation is concerned with how a person constructs the object of bipolar disorder, what it means to them, their relationship with it and how they might want this relationship to change. Using narrative therapy concepts of externalization, dialogue would focus upon the relationships that people have with the ‘problems’ of bipolar disorder rather than thinking of people with bipolar disorder as problematic.

After these foundational conversations a list of potential other information would be offered alongside a discussion of what group participants want to get from the group experience. Possible subject matter would include:

- Exploring how psychiatry understands bipolar disorder and what might be both helpful and unhelpful about this. Are there alternate constructions that people use?
- Medications and the dilemmas they present
- Dialogue about the notion of personal responsibility and it’s place in a life with bipolar disorder
- Debating the notion that experiences are either me or my illness and what this means in relation to processes of self-stigma. Choosing between self and illness dominates ideas about self-management of bipolar disorder but is it helpful to ‘slice and dice’ oneself in this way?
- Living with shame and guilt; how to manage the unreliable self and the potential for behaving in ways which are unacceptable to one’s view of oneself.
• Generating stories of connection and healing disconnection through dialogue about the place of other people in a life with bipolar disorder, the place of peer to peer relationships, stigma, how memories of others with bipolar disorder shapes experiences.

• The role of circadian rhythms and the place of habits.

• Responding to depression, hypomania and mania.

• Relapse and crisis planning. Should one plan for the inevitable relapse? What sort of plans work?

• Mindfulness approaches to managing anxiety and stress

• How much it too much? Exploring experiences with alcohol and other drugs in relation to mood stability.

• The personal is political; discussion about how one's personal experience of bipolar disorder can be linked to broader social structures and the place of social as well as individual change; that personal attempts to find an ethos of life with bipolar disorder are also a political action.

By choosing an approach that seeks to include but not be dominated by a psy-science view of what has come to be known as bipolar disorder, this alternate psychoeducation could walk a fine line between deconstructing and reproducing the dominant discourses that shape notions of self-management of bipolar disorder. But “we will never anyway be able to arrive at something better unless the means we employ are consonant with the ends we desire” (Parker, 2014, p. 61) so it would seem more important to try something different rather than wait for the revolution that is needed in how we can think and speak about experiences understood to be bipolar disorder.

**Limitations of this Discourse Analysis**

Despite an understanding in post-structural based research that analysis and interpretations are inevitably multiple and partial in nature, there are two factors that need to be made explicit as possible limitations to this particular use of discourse analysis; the effect of dominant discourses upon interpretation and the author’s role in the co-creation of the text.
Just as this thesis has been concerned with how the discourse of self-management is being drawn on by people with bipolar disorder to shape subjectivity, as a researcher I too have had to draw upon my own set of discursive resources in order to interpret the texts which may have in turn limited my field of vision to a narrower set of possible understandings (Cheek, 2000). As a mental health nurse in clinical practice, I live daily in a world that turns to medical, psychological and scientific discourses to make sense of reality – discourses that both make particular assumptions about the nature of people and legitimate my role as an ‘expert’. While the choice of discourse analysis has been an explicit attempt on my part to find different ways to think and act, it has none the less been difficult to approach texts without searching for meaning and to give up long held beliefs about the ability of language to accurately represent authentic experience. This thesis has not explicitly challenged the notion that bipolar disorder is ‘real’ so I have arguably tried to have my cake and eat it too; to keep the door open to the possibility that something might be called bipolar disorder exists at the same time as critique the assumptions that lie behind the construct.

I have taken the role of interviewer and therefore co-generator of some of the text and also interpreter of the text and this discourse analysis has not focussed upon my discursive practices and how this will have shaped the text. The people who engaged in conversations with me about the experiences of living with bipolar disorder did so as part of requirements to enter a research project that offered the possibility of accessing psychotherapy and a psychiatrist for which no payment was required. This suggests that the texts created were part of an exchange; ‘I will tell you what I think will get me accepted into a study’. Also, the interviews happened in the context of assumptions that bipolar disorder is a condition that exists in reality and that living with it can be challenging. The interview questions did not invite people to challenge the dominant constructions of bipolar disorder. This means the interpretations are limited to the context of people who understand themselves to have the condition known as bipolar disorder which does not allow the findings to be extended to the experiences of people who actively resist the diagnosis as a way to make sense of experience.
Conclusion

This thesis has sought to explore the effects of the discourse of self-management for bipolar disorder upon how a person makes sense of both themselves and how to live. In doing so, it has also sought to investigate the nature of the self in self-management discourse. Foucauldian discourse analysis has been used to tease apart the taken for granted assumptions of self-management of bipolar disorder, not so that in the dismantling process one becomes paralyzed and unable generate change but rather to understand how we come to think and speak of it as we do so its complex nature can be made clearer. In the unsettling process of seeing from a new perspective, alternate ways of thinking that are less likely to reproduce dominant and taken for granted practices become more possible. In the process of this dismantling and rebuilding, psychiatric practices have been made more visible and questions asked about the nature of its expertise and the power relations at work in a time when ideas about psychiatric practice as empowering have come to the fore (Parker, 2014). This doesn’t mean that the practices of the psy-sciences are wholly ‘bad’ or ‘wrong’, but rather they are all “dangerous” (Foucault, 2003d, p. 104) as they act in ways upon subjectivity that are neither benign nor harmless.

People understood to have bipolar disorder can be seen to be tightly woven into discursive practices that construct them as ill and in need of the expertise of psychiatry at the same time as part of broader social structures that construct and prioritise forms of individuality based upon enterprise and choice, with a person’s health just one of the projects upon which to focus one’s enterprising nature. For those who actively engage with the discursive practices of self-management for bipolar disorder it can act as a form of capital; something they can trade for the right to be seen as a neo-liberal citizen, just like everyone else. But this appears to be at the cost of processes of self-formation that are driven by practices of intense self-surveillance, reflexivity and moderation that are motivated by fear and shame. For a person understood to have bipolar disorder one’s relationship with oneself is infused with practices based on division and contradiction that is always being mediated and regulated by psy-experts and their claims to know the truth of what it means to be human. This discussion has also drawn attention to how our notion of the nature of the ‘self’ and what it is can create its own problems in self-management practices.
Using ideas of ontological pluralism and the abject, ways of thinking about the self as something ‘naturally’ slippery and uncontained have been proposed.

In a similar vein to Wenier’s (2011) ethnographic study, this discourse analysis has identified the limitations of contemporary self-management practices. As she argues, current approaches to the management of bipolar disorder construct a paradox that both presumes and eludes rationality as “...we now have a technical means by which we can manage ourselves, but those very means also communicate the fact of our necessarily incomplete autonomy.” (Weiner, 2011, p. 480). This results in people with bipolar disorder enacting forms of responsibility that acknowledge the self as never entirely knowable or controllable. This discourse analysis supports but also aims to build upon this by arguing that what is needed is a radical rethinking of self-management practices so that they do not embed the paradox in the first place.

What this discourse analysis has not done is to consider if or how a discourse of self-management might be implicated in processes of self-formation for people who actively resist or rebel against a psy-science version of their experiences. Perhaps they are able to use the discourses of science, psychology and medicine to find helpful ways to make sense of how best to live their lives but if so at what price might this occur as those considered lacking in ‘insight’ are also likely to be the people constructed by others to be the most ‘difficult’ and ‘complex’; the group of people often most marginalized by broader social structures and institutions.

The discursive practices of self-management are not going to disappear any time soon as they are tightly connected to the dominant discourses of contemporary Western society. If anything, their perceived value will grow as technologies are sought that will reduce the escalating cost of health care. It behoves us then to understand both the strengths and weaknesses of self-management practices from a range of paradigms. A discursive approach allows us to think about how we are all positioned by the discourses available to us to make sense of who and what we are. By proposing an alternate approach to psychoeducation (for want of a better name for the practice), this thesis is seeking to respond to the discursive practices of self-management for bipolar disorder by changing how it can be spoken of. Given the dominance of medical, psychological and scientific discourses in mental health
practice this is no small undertaking, but one that none-the-less that seeks to contribute to a more liberal psychiatric practice.

“I do not think that a society can exist without power relations, if by that one means the strategies by which individuals try to direct and control the conduct of others. The problem, then, is not to try to dissolve them in the utopia of completely transparent communication but to acquire the rules of law, the management techniques, and also the morality, the ethos, the practices of self, what will allow us to play these games of power with as little domination as possible.”

(Foucault, 2003b, p. 39-40)
References


Durie, M. (1982). What is Community Mental Health? In Canterbury Association for Mental Health (Ed.), *Community Mental Health: A report of discussions organised by Canterbury Association for Mental Health* (pp. 5-14). New Zealand: Canterbury Association for Mental Health.


Evens, T. M. S. (2012). Twins are birds and a whale is a fish, a mammal, a submarine: Revisiting 'primitive mentality' as a question of ontology. *Social Analysis, 56*(3), 1-11.


Hazleden, R. (2010). ‘You have to learn these lessons sometime’: Persuasion and therapeutic power relations in bestselling relationship manuals. *Continuum, 24*(2), 291-305.


Māori Glossary

Ahau: I, self
Iwi: tribe, nation
Mākutu: incantation
Mate: illness, death, misfortune
Noa: free of ancestral presence
Ora: health, wellbeing, alive
Pākehā: New Zealand European
Rangatira: chief, noble person
Tāne: male
Tapu: scared, ancestral presence
Te Ao: daytime, the everyday
Te Po: the night, the place of ancestors
Te Tiriti o Waitangi: The Treaty of Waitangi
Wahine: female

(Salmond, 2012; Williams, 1975)
Appendix 1

DSM 5 (American Psychiatric Association, 2013) Diagnostic criteria for bipolar disorder

Diagnostic Criteria for Manic Episode (p. 124)

A. A distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least a week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behaviour:
   1. Inflated self-esteem or grandiosity
   2. Decreased need for sleep (e.g. feels rested after only 3 hours 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), as reported or observed.
   6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
   7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.
Diagnostic Criteria for Hypomanic Episode (p. 124-125)

A. A distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behaviour, 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 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), as reported or observed.
   6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
   7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging 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 individual when not symptomatic.

D. The disturbance in mood and the change in functioning are observable to others

E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).
Diagnostic Criteria for Depressive Episode (p. 125)

A. Five (or more) of the following symptoms have been present during the same 2-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.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty or hopeless) or observations made of by others (e.g., appears tearful).

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).

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.

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 as observed by others).
Appendix 2

Semi-structured interview schedule

1. What is it like to live with bipolar disorder?
2. How long did it take for a Dr to tell you, you have bipolar?
3. Tell me about some of the ideas you had when your mood was high (ie during mania)
4. How long do you think the condition will last?
5. How do you deal with it?
6. How successful do you think you’ve been at living with bipolar?
7. What do you think of the idea that someone with bipolar disorder can learn to manage their condition?
8. How much difference is there between how you live with bipolar and how other people expect you to do it? E.g. are there things you do that others think you shouldn't?
9. What do you think caused bipolar disorder in you?
10. What did your family/whanau think was the cause of your illness?
11. How do you think your bipolar will affect you in the future?
12. What do you think your bipolar medications are doing for you?
13. Do you have any worries or concerns about being on the medications?
14. What do you most want your medications to do for you?
15. What’s been your experience of using health services?
Appendix 3

Psychoeducation articles used in Chapter 4


CHAPTER SEVEN: USING DISCOURSE ANALYSIS TO INVESTIGATE HOW BIPOLAR DISORDER IS CONSTRUCTED AS AN OBJECT.

Lynere Wilson (University of Otago, Christchurch, NZ)

Marie Crowe (University of Otago, Christchurch, NZ)

<table>
<thead>
<tr>
<th>Chapter contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
</tr>
<tr>
<td>2. Bipolar disorder</td>
</tr>
<tr>
<td>3. Discourse, power and subject positions</td>
</tr>
<tr>
<td>4. Findings</td>
</tr>
<tr>
<td>5. Clinical relevance</td>
</tr>
<tr>
<td>6. Summary</td>
</tr>
<tr>
<td>7. Clinical practice highlights</td>
</tr>
<tr>
<td>8. Recommended reading and glossary</td>
</tr>
<tr>
<td>9. References</td>
</tr>
</tbody>
</table>

Introduction

The experiences now known as bipolar disorder have a long history as a focus of attention for psychiatry; from la folie circulaire (circular disorder) to manic depressive insanity to present day bipolar disorder (Goodwin & Jamison, 2007) psychiatry has worked hard to know, define and claim expertise in the treatment of the disorder. As with many other health conditions which are understood to be incurable and relapsing, in contemporary
mental health care there is an expectation that people can learn to live a life that is conducive to limiting relapse and when a relapse does happen, an expectation that the person can learn to see the early signs of impending illness and take appropriate action (Colom & Vieta, 2006; Suto, Murray, Hale, Amari, & Michalak, 2010). As part of this movement toward greater self-management by individuals with long term health conditions, mental health clinicians have led the development of psychoeducation as an intervention. Psychoeducation seeks to integrate a psychotherapeutic and educational approach to the way information is shared with people living with long-term conditions so that they learn more about the condition they are understood to have and how best to live with it (Ryglewicz, 1991). It is an intervention that is now recognised as an essential part of mental health care for people with bipolar disorder (Poole, Simpson, & Smith, 2012; Stern & Sin, 2012) to the point where it seems ‘common sense’ to expect that a person can learn to manage their own condition and to do so offers the possibility of a greater sense of control over one’s own life. Who would not want this?

As a complex set of health practices that rely upon language and specialised knowledge, mental health care is an ideal practice for discourse analysis. People who are understood to have a mental disorder become part of psychiatry’s discursive practices and as such they are called to understand themselves as a patient with an often incurable disorder. It appears that by engaging in this process, (whether with agreement, ambivalence or resistance) the subjectivity of diagnosed people is being transformed by psychiatric discourse and practices (Estroff, 1989; Terkselsen, 2009). This chapter is concerned with investigating the practice of psychoeducation for bipolar disorder as a way to ask questions of an intervention that seems to have reached the status of ‘taken for granted’ in order to consider if it might be having broader effects upon people beyond knowledge acquisition.
By applying a discourse analysis methodology based upon Parker (1992) and the writings of Michel Foucault, this chapter will investigate how the discursive practices of psychiatry produce our understanding of what bipolar disorder is and in the process, shape what it means to be a person with bipolar disorder. The Psychoeducation Manual for Bipolar Disorder (Colom & Vieta, 2006) has been chosen as the text for analysis because of its place as one of the few published, evidence based guides for clinicians that provides high levels of detail about the content of a psychoeducation programme for bipolar disorder. As such it provides an example of the psychiatric discourse about the nature of bipolar disorder and how people are expected to live with it.

After providing an introduction to the experience known as bipolar disorder we will discuss the theoretical concepts of discourse, power relations, and subject positions that are central to our approach to discourse analysis. Then, using illustrations from the chosen text, we will show how the discursive practices of psychiatry construct bipolar disorder as an illness located in the brain that only psychiatry and science have the authority to treat. When constructed as an illness, the experiences associated with it have no meaning beyond being symptoms and it is imperative that it must be treated with medication. In the text a person with bipolar disorder becomes a ‘bipolar patient’ with attributes of reflexivity and deference to experts.

**Bipolar disorder**

Bipolar disorder is constructed as a disorder of mood in which people experience recurrent episodes of moods constructed by psychiatric discourse as mania, hypomania, depression or mixed episodes. Mania is constructed as episodes of “abnormally, persistently elevated, expansive or irritable mood and persistently increased activity or energy” that results in marked impairment in functioning or hospitalisation (American Psychiatric Association,
Hypomania is constructed as a similar state but of a lesser intensity thus not requiring intervention in a person’s life, either through hospitalisation or stepping in to take over a person’s day to day responsibilities. Depression is constructed as periods of persistently low mood, often associated with a loss of pleasure in usual activities causing impairment in day to day functioning. Mixed mood episodes are constructed as occurring when a person experiences symptoms of mania or hypomania at the same time as symptoms of depression (American Psychiatric Association, 2013).

To date psychiatry has no cure for bipolar disorder so those diagnosed with it are required to learn skills to manage it over the long-term. Psychoeducation is an accepted practice to enable the person to manage their disorder and there are now a significant amount of claims to support its use in mental health services for a range of conditions (Bauml, Frobose, Kraemer, Rentrop, & Pitschel-Walz, 2006; Chien & Leung, 2013; Lucksted, McFarlane, Downing, & Dixon, 2012). The most prolific authors on psychoeducation for bipolar disorder have been Francesc Colom and Eduard Vieta (Colom & Lam, 2005; Colom et al., 2003a; Colom et al., 2003b; Colom et al., 2009; Vieta, 2005) and they have used their research to produce a text for mental health clinicians called “Psychoeducation Manual for Bipolar Disorder” (Colom & Vieta, 2006). Henceforth referred to here as The Manual, it provides detailed instructions on how to run a psychoeducation programme for people with bipolar disorder. The Manual was developed out of the research work of the University of Barcelona Hospital Clinic Bipolar Disorders Program which according to its website is “devoted to generating, disseminating and applying knowledge on outcome, treatment and prevention of bipolar disorder” (http://www.bipolarclinic.org).

The intention of The Manual is very explicit; to take the “common sense” clinical knowledge of the disorder that research has shown reduces relapses of the condition and encourage mental health professionals to teach “your patients how to manage their
disorder better, live with it, progress with it, take their medication more effectively and understand why the medication needs to be taken.” (xvi) While written for clinicians, it contains information about how psychiatry constructs the condition, how psychiatry treats it and advice written specifically for the person with the disorder about how they should conduct themselves in relation to bipolar disorder.

**Discourse, power and subject positions**

Discourse analysis is concerned with how human experience is structured by language. Rather than language being seen as able to represent reality, in discourse analysis it is assumed that how we can think about ourselves and our experience of the world is determined by the language, ideas, concepts available to us; they shape what it is possible to say or not say about a particular thing and they do so within both a social and historical context. Discourse analysis is perhaps best described as a sensitivity to language and its productive nature such that analysis of text is focused upon what is done by language rather than what is meant (Crowe, 2005) (Willig, 2001)). In this methodology language is understood as one mechanism by which people come to think and know themselves.

Our approach to discourse analysis has been shaped by Ian Parker’s work (1992), and he in turn has been influenced by the work of Michel Foucault. Discourse analysis is notorious as a research methodology without a set of ‘rules’ to follow and Parker is at pains to point out that his approach is not a step by step guide. What he does provide is a broad theoretical framework for understanding the nature of discourse and its role in human life which is then used to shape the questions that can be asked by the analysis. Foucauldian inspired discourse analysis is concerned with “what kind of objects and subjects are constructed through discourse and what kinds of ways-of-being these object and subjects make available to people.” [italics in original] (Willig, 2001, p. 91).
Discourse is understood here as “a system of statements which construct an object” [italics in original] (Parker, 1992, p. 5). This includes practices or things that are done that use discourse. For example, the discourse of psychiatry constructs the object of mental illness in particular ways. One of the ways that these ideas are reproduced and ‘put to work’ is through the text known as the Diagnostic and Statistical Manual of which DSM 5 as the most recent edition (American Psychiatric Association, 2013). Through the discursive practice of a comprehensive assessment, clinicians use this text to decide how best to make sense of a person’s difficulties and give a diagnosis. This diagnosis is then shared with the person and their family, recorded in their file for others to refer to and used to construct a letter to the person’s family doctor. Through this assemblage of processes discourse can be seen to be shaping what can and cannot be said about the person’s experience.

As well as constructing objects, discourses also make available particular ways of being in the world or subject positions (Willig, 2001). To further our example, the person who sees a clinician for a comprehensive psychiatric assessment can occupy the position of ‘patient’ or ‘client’ or ‘service user’ or ‘consumer’. Each of these terms ‘call’ to the person in a particular way, such that a person comes to understand (not necessarily consciously) that particular attributes go with each of these positions. In order to make sense of what is being ‘said’ a person must come to see themselves in a particular way (Parker, 1992) and the psychiatric discourse makes available a space for different sorts of selves to step in.

We also understand discourses as reproducing relations of power. The discourse of psychiatry dominates our contemporary understandings of what it means to be ‘mentally ill’ and people who do not use psychiatric discourse to make sense of their difficulties are often named as lacking in insight. In this sense discourse is understood to be productive as it makes things happen while at the same time people can reshape it, challenge it and resist it.
With these theoretical underpinnings in mind and the methodological steps offered by Parker (1992), the following questions acted as the starting point for analysis:

How does the text construct bipolar disorder as an object? What knowledge is used to construct bipolar disorder as an object? To finish the statement ‘bipolar disorder is...’ and ‘a person with bipolar disorder is...’ as a means to explore the use of metaphor in construction of both object and subject. What ways of being in the world does the text make available to people understood to have bipolar disorder? And what sort of relationship are people with bipolar disorder expected to have with the object?

Findings

**Bipolar disorder as an object to be medicated**

Bipolar disorder as constructed in The Manual is first and foremost a biologically based illness that is located in the brain;

“Try to explain the bipolar disorders by focusing in particular on its biological aspects; in other word, starting by its definition as a brain disorder: the bipolar disorder is a disorder that affects the limbic system, neurotransmitters, and the endocrine system. In this case, even though this is an oversimplification, we will avoid any comment about the interaction of these causes with others, or a rather psychological or social nature, because this may add confusion.” (p55)

The understanding of bipolar disorder as a brain based disorder is a necessary pre-requisite for enforcing the need for medication as the only treatment option. As a brain disorder, the experiences of bipolar disorder are constructed as having no meaning for either patient or
clinician beyond being symptoms of an illness. The psychiatric construction of the disorder is the only permitted construction within psychoeducation sessions. Alternative constructions are dismissed or derided;

“What often happens is that mystic or religious exaltation presents itself in the context of manic episode and it is nothing more than one of its symptoms, so that it goes away when the mania is treated. To explain this point easily and amicably, we usually joke about it and say that ‘we don’t have a problem with you talking to God through prayer, but we would be worried if you actually heard Him answer you’.” (p82)

Any attempt to understand mania or hypomania as a positive or purposeful experience is a myth to be dispelled;

“During the session we should stress the pathological nature of both mania and hypomania, since many of our patients see hypomania as ‘a blessing’ or ‘a gift’. In these instances it would be useful for us to remind them that: (a) during hypomania people usually make the wrong decisions, (b) not all the symptoms of hypomania are pleasant... and (c) hypomania almost always leads to another immediate episode that involves greater suffering...” (p80)

When experiences such as these can only able to be spoken of as symptoms of an illness that episodically recurs, it becomes vital to be able to “differentiate normal emotions from pathological ones” (p85) so that thoughts and feelings can be scrutinized for evidence of a
relapse. Psychiatric discourse is reproduced in psychoeducation sessions by marginalizing any alternative explanations.

As an ‘illness’, bipolar disorder must be treated by medication and psychoeducation is an intervention that reinforces to people this “fundamental aspect of their treatment: its biological nature and the need for drugs.” (p53). While The Manual is in the business of persuading people that psychological interventions for bipolar disorder are important, this cannot in any way be seen to be at the expense of medication. Psychological treatments “must always be combined with mood-stabilizer treatment and many times with an antidepressant.” (p123) and “it is absolutely necessary for the therapist to...make it clear that the medication is absolutely necessary, including writing it on the blackboard if necessary...” (p54)

Significant time is dedicated in the programme to medication related issues and the problem of non-adherence to medication regimes is addressed in a section of The Manual dedicated to defining forms of non-adherence, the reasons for it and how to combat it;

“Chart 1. Types of poor treatment adherence

8. Absolute poor adherence. This refers to the complete negligence of the patient in following the indications of the responsible therapist...

9. Selective partial adherence. Certain patients selectively reject a certain type of treatment but not another....

10. Intermittent adherence...Many patients do not completely abandon the treatment but neither do they take it as prescribed....

11. Late adherence...some patients show initial resistance to admitting the need to receive treatment and decides to
start taking the medication prescribed after a few relapses...

12. Late poor adherence. After 2 or 3 years of good adherence, some patients start abandoning their mood stabilizers without apparent reason...

13. Abuse...Taking more medication is also a rather common form of poor adherence among bipolar patients...

14. Behavioural poor adherence. The term ‘poor adherence’...also includes aspects concerning the attitude and behaviour of the patient...obeying clinician’s instructions as to the regularity of sleep habits and other advisable behaviour that may facilitate euthymia, such as not consuming alcohol or other toxics...”

(p105/106)

Treatment of bipolar disorder with medication is an imperative and a great deal of time and text is dedicated to making this point.

**The process of subject construction**

Ensuring the authority of a psychiatric discourse to know bipolar disorder and the people understood to have the condition is central to the psychoeducation practices described in The Manual. To ensure adherence to these constructions the text can be seen to use some specific discursive tactics.

Firstly, The Manual often uses interdictory flavoured language when describing the role of patients within psychoeducation; “patients are allowed to get involved freely when they think it is necessary...” (p 49), “we will warn them that failing to respect some of these rules may lead to expulsion...”, “Any patient who fails to attend five sessions will be
forced to leave the group.” (p58) and “the mood-chart technique, that the patient must master by the end of the session.” (p93).

Secondly, it makes no space for debate about the nature or treatment of bipolar disorder;

“It is absolutely necessary for the therapist to present, from the beginning of the group sessions, both treatments not as opposed but as complementary, and to make it clear that the medication is absolutely necessary, including writing it on the blackboard if necessary. Otherwise, ‘an antipsychiatry’ type of thinking may immerge...” (p54)

Thirdly, whenever The Manual does refer to alternative views on the nature or treatment of bipolar disorder there is often what can be read as a disparaging tone to the text;

“...the first contact between a patient and a psychological treatment can be crucial in explaining the subsequent response to treatment. We are not now going to digress into mysteries of other paradigms about whether or not to shake hands with our patients and look them in the eye. In principle, they are your hands, your patients and your eyes, so do whatever common sense tells you.” (p 40)

As with the process of excluding any other possible explanation for the person’s experiences, the need for medication is positioned as the only possible response.

And finally, the overt disapproval of alternate constructions of bipolar disorder are complemented by a tone of address to patients that suggests the knowledge of the psychosciences is necessary but complex and therefore requires simplification for patients. The need to keep things simple for the patient is exemplified in the way the fairytale of The
Three Little Pigs is converted into the story of The Three Little Bipolar Pigs as a way to illustrate the biological nature of bipolar disorder and the importance of a person’s attitude toward it:

“The first one simply did not believe what his veterinarian told him and thought that bipolar disorder was an illness that had been made up by psychiatrists or was a fairytale, so he never changed the way he behaved...The second little pig is the story agreed to take the medication his psychiatrist suggested, even more so at his family’s insistence...The mistake he made was in thinking that medication alone would help keep his mood stable...The third little pig joined a psychoeducation group for little bipolar pigs. This activity...led him to take all the necessary precautions to avoid the dreaded relapses: he took his medication and paid attention to this doctor’s orders and those of his psychologist...he tried to get enough sleep...[h]e paid attention to his wife’s comments...he even learned to identify the signs of relapse in time...Out of all the little pigs in this story, he was the wisest pig of all, and there are some who say that some pigs are smarter than people.” (p 69,70)

While the use of this story comes with a caveat that clinicians need to be able to walk a fine between “comical and disrespectful comments” (p 68), it is still none-the less presented as one way to educate people about bipolar disorder and it does so in way that uses simple, almost childlike methods to instruct. It is as if no one with bipolar disorder would have the capacity to understand the details of expert knowledge which in turn begs
the question of what would happen if a clinician had bipolar disorder and attended a psychoeducation group.

**Constructing the surveilling self**

At the same time as the nature of bipolar disorder is discursively produced as a recurring brain disorder that must be medicated, The Manual makes available particular subject positions or ways of being in the world for the person who is understood to have this condition. As a person under the jurisdiction of psy-sciences the person with bipolar disorder becomes a “patient” and a “bipolar patient” in particular. As a bipolar patient, they are called to be reflexive, to work upon their thoughts and defer to experts.

**Reflexivity**

A crucial attribute of a bipolar patient is their capacity to examine themselves and in the light of this examination make changes to what they do and think. The first stage in being able to do this is the ability to separate the normal for abnormal. Firstly for hypomania and mania;

“*We always recommend differentiating between hypomania and non-pathological happiness.*” (p 80)

And then again in the next session on understanding the symptoms of depression;

“*We will again insist on the need to differentiate normal emotions from pathological ones.*” (p 85)

Then group members are expected to learn to recognise their unique version of bipolar disorder:

“*...always emphasize the need to individualize the knowledge of the disorder: I am trying to learn not about the illness*
of bipolar disorder but about my bipolar disorder.” (p 163)

These skills are particularly pertinent to the process of learning to predict and respond to signs of relapse. A patient who can individualize can take the generic information about bipolar disorder they have been given and apply it to themselves;

“Step 2: Individualization – identification of one’s own warnings or operational warnings. The goal of this step is to individualize, that is adapt the information from Step 1 to everyone’s particular case. We try to have the patients to identify which warning signs appear regularly in each type of episode.” (p 158)

A patient who can specialize can take their ability to examine themselves one step further;

“Step 3: Specialization – prodromes of prodromes, or early warning signs...in this step the patient claims ‘specialization’ in their own case, beyond knowledge of their own relapse signs. The point is to identify the signals that precede the warning signs – ‘warnings of warnings’.” (p 159)

Each of these steps now needs to be completed for each abnormal mood state so that a list can be created and used daily as a means to examine oneself and determine what needs changing;

“If after reviewing the list, you match one or one of the items, do not do anything to change behaviour.
If you match two items for 3 days in a row, you should consult with your support person.

If you match three or more items in a single day, it is time to put an emergency plan into effect." (p 162)

A bipolar patient becomes a prudent planner who can separate the normal from the pathological, name, list and rank symptoms by their importance, monitor themselves via their lists of warning signs and plan for the inevitable relapse.

This self-surveilling subject position also requires the bipolar patient to recognise both the problems and potentials associated with their thoughts and attitudes. Thoughts are problematic due to the way they indicate the presence of actual or potential illness;

“The handling of depressive or negative cognitions, which also appear in some euthymic patients, is extremely delicate during a group psychoeducation session, because having the patients begin to sympathize with such cognitions must be avoided, especially those that have to do with the disorder (‘we’re a bunch of losers’, ‘what lousy luck – we’d be better off dead’, ‘we’ll never do anything good,’ etc.)” (p 42)

While thoughts are a problem, they also offer the way to bring about change in a person;

“The attitude toward the disorder and the health beliefs of each patient play a highly significant role in the emergence of poor adherence; obviously, bipolar patients who firmly believe that they can control their mood by themselves will have a worse degree of adherence.” (p 107)
Bipolar patients are therefore called upon to intervene in their thoughts;

“We can propose that the group debate blame vs. responsibility, by contrasting how thoughts of blame are useless and unproductive, and how useful, on the other hand, feelings of responsibility are.” (p 74)

And change their attitude toward themselves;

“He was aware that this attitude involved scarifies [spelling mistake in original], but since he was a smart little pig, he understood that it was worthwhile to live a moderate life in exchange for something as important as his happiness and personal stability.” (p 70)

Surveillance of one’s thoughts and attitudes is a central aspect of this subject position. The bipolar patient becomes both a prudent planner and someone who understands the way their thinking can both act as means to measure illness and as a means to bring about change in themselves. Despite this, the bipolar patient doesn’t always act as he or she should so this requires them to be able to recognise their mistakes and then tell others;

“This session, and one of the previous ones, is rather propitious for confessions of poor adherence by the patients, which is very positive both for patients who speak sincerely and for their group mates. If this happens, we will try to have patients explain their reasons without being interrupted by the rest of the group and we will not adopt under any circumstances an openly critical attitude. Our first reaction must always be to thank the patient for their sincerity and for showing us enough trust to explain
The importance of the admission of wrong doing and the opportunity it offers people with bipolar disorder to come to know, examine and change themselves is underscored by the strong directive given to clinicians about how they must act in this situation. Through the practice of confession the group member takes “the role of the self-examinatory, self-reflective subject who needs both [to] tell and recognize the truth” (Hook, 2003, p. 612) of their self.

While the capacity for reflexivity can be understood as an attribute of contemporary subjectivity for all people (Giddens, 1991), for bipolar patients it is a central attribute to be cultivated, especially if psychoeducation is to be successful. There appears to be an intensified expectation that a bipolar patient can and will examine their thoughts, emotions and behaviours in line with the doctrine of psychiatry, confess mistakes and then adjust themselves accordingly.

*Deferring to the expert*

As a bipolar patient, the person is also called to see themselves as someone who defers to expert knowledge on what it means to have bipolar disorder and there are a number of ways that this subject position can be taken up.

People who defer to the experts comply with a psy-science way of understanding what bipolar is and voice this to others;

“Participation in this group implies ‘confession’ in front of the other member’s own diagnosis, in this case bipolar disorder.” (p62)
They will take medication and encourage others to do so;

“Once again, it will be very positive if it is not the psychologist or psychiatrist who appears to be the only defender of the need to take medication, even though obviously he would already have taken this position in front of the group; it is appropriate for patients themselves to advise good adherence.” (p140)

If psychoeducation has been successful, they will recognise themselves as the third little pig in The Three Little Bipolar Pigs tale;

“The third little pig joined a psychoeducation group for little bipolar pigs. This activity, in addition to reasonable behaviour and being highly motivated not to relapse (he knew he enjoyed life a lot more during periods of euthymia), led him to take all the necessary precautions to avoid the dreaded relapse; he took his medication and paid attention to his doctor’s order and those of this psychologist.” (p70)

The bipolar patient who resists the knowledge of bipolar as a brain disorder that needs medication and therefore does not defer to psy-expertise becomes instead a rebellious patient;

These are more ‘open’ session; in other words, sessions in which the patients are invited more to give their opinion concerning the topic discussed. The purpose of this approach is merely for us to get an idea of which beliefs and
attitudes are being handled by our patients in order to find out exactly on what point we must emphasize, and to understand what prejudices they have in connection with the disorder, since they are often dominated by guilt. Certain patients react [to] explanations with resistance; in this case, the better strategy is to allow the members of the group to discuss between them the contents of the sessions rather than for us to act as defense [spelling in original] lawyers for the medical model, since if we do so quite a few patients will accuse us of having corporate-like attitudes. In exchange, if it is another patient that defines the biological character of the bipolar disorder and the need for treatment, the ‘rebel’ patient is left without weight arguments. (P54)

The rebel patient is constructed as someone who simply needs to be persuaded of the error in their thinking and psychoeducation is presented as the means by which this lack of understanding will be rectified;

Incomprehension is an opportunistic illness that exacerbates the course of psychiatric disorders...[p]atients who do not know their disorder do not know their lives... (P27)

A lack of understanding is constructed as something to be cured by medicine, just like an illness. At the same time, lack of awareness of one’s bipolar disorder is also constructed as part of the disorder itself;

Subjects suffering a manic episode do not recognize that they are ill [italics in original] and they might resist attempts at treatment. (P83)
As is a lack of trust;

...problems such as irritability or lack of trust that often arise from the psychopathology itself, which can be an obstacle to receiving proper treatment. (P26)

Everything about the non-conforming patient is to be explained by the brain disorder they are understood to have such that people who resist the knowledge of psy-experts are no longer complex creatures with multiple and conflicting motivations and beliefs, they are simply displaying the characteristic “high rates of illness insight” (p53).

**Clinical relevance**

With psychoeducation now a recognised education based psychological intervention that promotes the self-managing capacities of people with bipolar disorder, it appears to have taken on the status of common sense – who would not want to be better informed about the condition they have? But it is its taken for granted status that makes it of interest to discourse analysis which offers a means to stand back from the ideas and the language of psychoeducation and treat it as just one truth among many, held in a place of dominance by language and power (Parker 1992). In this way it is possible to reflect on what it is we do as mental health clinicians when we think and speak; from the assessment of problems understood to effect the mind through to the treatment of emotional distress, language acts as the primary technology by which mental health clinicians act upon others. The productive nature of language in combination with clinicians’ role as discursive practitioners also draws attention to the therapeutic potential in prompting people experiencing mental distress to explore the assumptions they hold about themselves and make space for new ways of constructing experience that are more enabling (Crowe, 2004; Kaye, 1999).
By focusing on a psychoeducation text for bipolar disorder we have identified how the language and practices of psychiatry tightly regulates the object known as bipolar disorder and the person with the condition. Using The Manual as our point of reference, to live successfully with bipolar disorder explicitly requires people to take on a way of thinking and acting that conforms to psychiatric assumptions of normality and engage in practices of self-governance mandated only by psychiatry. This means that any talk of a possible social or relational location for a person’s difficulties are effectively silenced, as are emotions such as trust, shame and guilt.

This discourse analysis also draws attention to how the text acts as a form of disciplinary power that Foucault called pastoral power (Foucault, 2003d). It brings together notions of salvation, self-sacrifice, attention to the individual and the importance of knowing the individual’s inner world and a style of power relations that is common in health and welfare practices of care (Foucault, 2003a; Toll & Crumpler, 2004). Instead of saving the soul it is a person’s physical and psychological health that is in need of saving while it is the knowledge of the psy-sciences that acts as the authority and means by which to know a person’s inner world. It is all “...those tender and beneficial forms of attention and regulation operating on the basis of the mechanism of love, or some heart-felt ‘calling’, which nonetheless serve state power-interests even whilst facilitating greater well-being.” (Hook, 2003, p. 617). As such it highlights the asymmetrical nature of power relations in a practice that is more usually constructed as empowering and promoting agency in the individual with bipolar disorder (Stafford & Colom, 2013; Smith, Jones, & Simpson, 2010).

Through the way The Manual uses language to sanction its view on the truth, it takes on the appearance of a rule book, a list of do’s and don’ts and as such brings with it a sense of it as a moral code – this is the only way to understand and live with bipolar disorder. As
ideas of pastoral power suggest, health care practices including psychoeducation are provided from a desire to heal suffering and not exacerbate it. What this analysis suggests is that while that may be the stated intention, psychoeducation practices may also be acting upon subjectivity in ways that are undesirable.

**Summary**

Using a Foucauldian inspired discourse analysis we have shown how in a psychiatric discourse everything about the person with bipolar disorder is interpreted in terms of the condition they are understood to have and how the psy-sciences have a tightly regulated way of constructing what bipolar disorder is and an equally all-encompassing approach to understanding the person who is understood to have the condition. This discourse analysis also demonstrates the productive capacity of discourse and the way it makes it possible to think in certain ways and exclude others. Psychiatric and scientific discourse makes particular things thinkable and understandable (Parker, 2004; Rose, 1999a) and in doing so creates a particular space to play out one’s life on the basis of knowledge that stakes out the boundaries of those things are permissible and those that break the rules. Using techniques of a secular pastorate, psychoeducation calls people called to take on a way of understanding and caring for the self that relies only upon the authority of medical science because of its truthfulness and trustworthiness. Any attempt by people with bipolar disorder to think and speak outside of these positions them as lacking self awareness which for psychiatry makes them potentially suffering a relapse.

But what does it mean for a person’s sense of self if they are ambivalent about psychiatry’s views on bipolar disorder? What about those who recognise themselves in the tale of the three little bipolar pigs but are not able to live to its standards? Those deemed successful at self-management get to construct themselves as responsible, thoughtful and self aware
while those who don’t or can’t would seem to be left with few ways to make sense of themselves beyond unruly, oppositional or resistant.

<table>
<thead>
<tr>
<th>Clinical practice highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Psychiatric discourse dominates how bipolar disorder can be understood and in the process provides a limited vision of how a person can live with it successfully.</td>
</tr>
<tr>
<td>2. Engaging in practices of self-management enters people into relations of power that are not necessarily empowering in nature.</td>
</tr>
<tr>
<td>3. Discourse analysis provides one way for mental health clinicians to step back from the way they use language, consider the effect it has upon subjectivity and change how they use words as a result.</td>
</tr>
<tr>
<td>4. Mental health clinicians are ideally positioned to develop ways of working with people that allows space to explore assumptions about self and others and find ways of constructing experience that are enabling.</td>
</tr>
</tbody>
</table>

**Recommended reading and glossary**


Euthymia: Ordinary or ‘normal’ mood; neither depressed or euphoric

Interdictory flavoured language: An authoritative way of using language that emphasises what can or cannot be done.

Psy-science: A term used by Nikolas Rose (Rose, 1998) to refer to the disciplines of psychology, psychiatry and their descendant psycho based sciences because of their significant role over the last 200 years in bringing into existence a new ways of understanding what it means to be human.

DSM: Diagnostic and Statistical Manual of Mental Disorders

References


Lucksted, A., McFarlane, W., Downing, D., & Dixon, L. (2012). Recent Developments in Family Psychoeducation as an Evidence-Based Practice. *Journal of Marital and Family Therapy, 38*(1), 101-121.


