

AND THERE WAS DIAGNOSIS: A PSYCHOANALYTIC INQUIRY INTO
INDIVIDUALS' INTERPRETATIONS OF THEIR BIPOLAR DISORDER
DIAGNOSIS

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DIAGNOSIS**

submitted by **MERİÇ MANKA** in partial fulfillment of the requirements for the degree of **Master of Science in Clinical Psychology, the Graduate School of Social Sciences of Middle East Technical University** by,

Prof. Dr. Sadettin KİRAZCI
Dean
Graduate School of Social Sciences, METU

Prof. Dr. Bengi ÖNER ÖZKAN
Head of Department
Department of Psychology, METU

Prof. Dr. Faruk GENÇÖZ
Supervisor
Department of Psychology, METU

Assist. Prof. Dr. Fazilet CANBOLAT
Co-Supervisor
Department of Psychology, Çankaya University

Examining Committee Members:

Prof. Dr. Bahar ÖZ (Head of the Examining Committee)
Department of Psychology, METU

Prof. Dr. Faruk GENÇÖZ (Supervisor)
Department of Psychology, METU

Assist. Prof. Dr. Tuğba UYAR SUIÇMEZ
Department of Psychology, Başkent University

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

Name, Last Name: Meriç MANKA

Signature:

ABSTRACT

AND THERE WAS DIAGNOSIS: A PSYCHOANALYTIC INQUIRY INTO INDIVIDUALS' INTERPRETATIONS OF THEIR BIPOLAR DISORDER DIAGNOSIS

MANKA, Meriç

M.S., Department of Psychology, Clinical Psychology

Supervisor: Prof. Dr. Faruk GENÇÖZ

Co-supervisor: Assist. Prof. Dr. Fazilet CANBOLAT

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The present study examines individuals' interpretations regarding their bipolar disorder diagnosis, and the function of this diagnosis for the individuals from a psychoanalytic point of view. In this respect, the research question of the study was constructed as "How do individuals diagnosed with bipolar disorder interpret this diagnosis?". A qualitative research method was adopted in the study, and the data was analyzed through thematic analysis. Semi-structured interviews were carried out with six individuals who were diagnosed with bipolar disorder. As a result of the analysis, five main themes were identified, which can be demonstrated as "*I Can See Clearly Now: The Diagnosis as an Identity*", "*Surrender Your Guilt Be Free: Being Diagnosed and Being Relieved from Responsibility*", "*With or Without You: Experiences Before and After the Diagnosis*", "*To Be or Not to Be Recognized, That Is the Question*", "*Mirror Mirror on the Other*". The findings of the study were discussed in the light of psychoanalytic theory and literature.

Keywords: Bipolar Disorder, Diagnosis, Lacanian Psychoanalysis, Qualitative Research, Thematic Analysis

ÖZ

VE TANI VARDI: BİPOLAR BOZUKLUK TANISI ALMIŞ KİŞİLERİN BU TANIYA DAİR YORUMLARI HAKKINDA PSİKANALİTİK BİR ÇALIŞMA

MANKA, Meriç

Yüksek Lisans Psikoloji Ana Bilim Dalı, Klinik Psikoloji Bölümü

Tez Yöneticisi: Prof. Dr. Faruk GENÇÖZ

Ortak Tez Yöneticisi: Dr. Öğr. Üyesi Fazilet CANBOLAT

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Bu çalışma, kişilerin bipolar bozukluk tanısı hakkındaki yorumlarını ve bu tanının kişiler için işlevini psikanalitik açıdan incelemektedir. Bu bağlamda çalışmanın araştırma sorusu “Bipolar bozukluk tanısı almış kişiler bu tanıyı nasıl yorumlamaktadırlar?” şeklinde oluşturulmuştur. Çalışmada nitel araştırma yöntemi benimsenmiş ve veriler tematik analiz yoluyla incelenmiştir. Bu kapsamda bipolar bozukluk tanısı almış altı kişi ile yarı yapılandırılmış görüşmeler yapılmıştır. Analiz sonucunda oluşturulan beş ana tema, “*Artık Net Görebiliyorum: Bir Kimlik Olarak Tanı*”, “*Suçluluğunu Bırak Özgür Ol: Tanı Almak, Sorumluluktan Kurtulmak*”, “*Senden Önce Senden Sonra: Tanı Almakla Birlikte Değişen Deneyimler*”, “*Tanınmak ya da Tanınmamak, İşte Bütün Mesele Bu*” ve “*Ayna Ayna Söyle Bana*” olarak belirlenmiştir. Çalışmanın bulguları psikanalitik teori ve literatür ışığında tartışılmıştır.

Anahtar Kelimeler: Bipolar Bozukluk, Tanı, Lacanyen Psikanaliz, Nitel Araştırma, Tematik Analiz

To the journey

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CHAPTER 1

INTRODUCTION

1.1. An Overview of the Present Question and the Study

Bipolar disorder is a mental disorder that is characterized by recurrent and circular episodes of depression and mania or hypomania that impacts a person's mood, energy, activities, and thought processes (World Health Organization [WHO], 2025). According to the statistics provided by World Health Organization (2025), bipolar disorder affects approximately 1 in 200 persons worldwide, or 37 million people in general. In addition to being a chronic and recurring disease, the fact that it causes significant limitations and difficulties in people's lives have resulted in bipolar disorder to become a widely recognized and well-known illness. However, problems of misdiagnosis together with overdiagnosis have been addressed frequently in terms of bipolar disorder (Bradford et al., 2024; Ghouse, 2013), in addition to criticisms regarding the reliability and validity of the DSM and diagnostic criteria of bipolar disorder (Allsopp et al., 2019; Bradford et al., 2024; Ghaemi, 2013; Ghaemi et al., 2022; Ghouse, 2013; Hyman, 2010; Jablensky, 2016; Vieta & Phillips, 2007).

The notion of diagnosis of bipolar disorder and the experiences related to receiving this diagnosis has also been a subject of research. Bipolar disorder diagnosis has been associated with concepts such as "label" and "stigma" (Baltacı et al., 2023; Dyga, 2019; Hayne, 2003; Inder et al., 2008, Inder et al., 2011; Lane, 2024, Pallesen et al., 2020, Proudfoot et al., 2009; Russell & Moss, 2013), but also with "recognition" and "legitimization" (Baltacı et al., 2023; Hayne, 2003; Lane, 2024; Pallesen et al., 2020; Proudfoot et al., 2009), and has often been discussed in conjunction with the notion of identity (Dyga, 2019; Inder et al., 2008; Inder et al., 2011; Ironside et al., 2018; Proudfoot et al., 2009; Russell & Moss, 2013). In addition

to that, bipolar disorder diagnosis has also been addressed from a psychoanalytic point of view by Rabaey (2023), who discussed the role of diagnosis in bipolar disorder in terms of the double mirror model of Lacan.

Literature review revealed that studies conducted on this subject are insufficient and limited, or addressing the topic only superficially. Furthermore, it was concluded that the findings obtained are not sufficiently diverse and are contradictory. Moreover, the concepts of diagnosis in general and bipolar disorder have not been extensively studied and examined within the framework of psychoanalytic theory. Therefore, in the light of this information, it has been concluded that a more comprehensive and in-depth inquiry is needed regarding where this diagnosis fits in relation to both individuals' experiences with the disorder and their own sense of selves.

Therefore, this study has been conceptualized in order to examine individuals' subjective interpretations and their relations to their diagnosis of bipolar disorder in-depth within the framework of psychoanalysis with the aid of thematic analysis method.

To begin with, at the first chapter of this thesis, an introduction will be made. First of all, general information about bipolar disorder will be provided. Later, criticisms regarding the diagnosis of bipolar disorder will be presented. Next, studies regarding the bipolar disorder diagnosis in the literature will be given. This general introduction will be followed by psychoanalytic literature concerning bipolar disorder, concept of diagnosis, and diagnosis of bipolar disorder in specific, respectively. At the second chapter of this thesis, methodology of the study will be introduced. In addition, participants of the study besides the process and the procedure of the study will be exhibited. At the third chapter, results of the thematic analysis, main and subordinate themes generated along with extractions from the interviews will be presented. At the fourth chapter, the findings of the study will be discussed particularly in terms of Lacanian psychoanalysis. The fifth and the last chapter of the thesis will be the conclusion, which will include clinical implications, strengths and limitations of the study, and suggestions for further research.

1.2. A General Introduction to Bipolar Disorder

Bipolar disorder is a mental disorder, which is classified as one of the mood disorders, and can be described as a condition in which a person's mood fluctuates between the two extremes, which are defined as mania and depression (Nierenberg et al., 2023). The history of bipolar disorder dates back to ancient Greece. It was first recorded by Hippocrates, who separated it from temperament and considered it as a mental disorder (Mason et al., 2016). However, it wasn't until the 19th century that these two states started to be regarded as periodic cycles, until then, they were considered as independent from each other. The first person to assert these two states as a cycle was Jean-Pierre Falret in 1851, who demonstrated this as a cycle between mania and depression and an interval between them without any symptom present, and referred to it as "circular madness" (Angst & Sellaro, 2000). After that, Emil Kraepelin, based on the nosology of Karl Kahlbaum, and driven from the conceptualization of Falret, came up with his own classification, in which he divided states of psychosis, mania and depression into two, which he named as "manic-depressive insanity" and "dementia praecox" (Mason et al., 2016). This category consisted of both unipolar depression and mania, and circular episodes of depression and mania (Angst & Sellaro, 2000).

Bipolar disorder was included in the first edition of the DSM in 1952 as manic-depressive reactions, and was considered as a psychotic disorder, and consisted of three types which were depressed, manic, and other (APA, 1952). In the second edition of DSM, it was categorized as an affective disorder and was described as alternating mood states and divided into three as depressed, manic, and circular (APA, 1968). At the third edition, bipolar depression was separated from unipolar depression, while emphasizing the polarity of the disorder. In this edition, it was now established that presence of mania was sufficient for a diagnosis of bipolar disorder (APA, 1980). At the fourth edition of the DSM (APA, 1994), bipolar disorder was divided into two as bipolar I and bipolar II disorders, in which while an episode of mania was necessary for the diagnosis of bipolar I, an episode of hypomania was necessary for a diagnosis of bipolar II disorder. Thus, hypomania, which is considered as a milder form of mania, was introduced in DSM-IV (Goes, 2023).

When it comes to the fifth and the latest edition of DSM (APA, 2013), bipolar disorder is included as “Bipolar and Related Disorders” and consists of bipolar I disorder, bipolar II disorder, cyclothymic disorder, substance/medication-induced bipolar and related disorder, bipolar and related disorder due to another medical condition, other specified bipolar and related disorder, unspecified bipolar and related disorder, and specifiers for bipolar and related disorders. According to DSM-V (APA, 2013), in order for a diagnosis of bipolar I disorder to be made, criteria of a manic episode should be met. A manic episode is defined as a definite time frame during which there is an unusually high level of energy or activity and a constantly elevated, expansive, or irritated mood, showing up for the majority of the day, almost every day, and lasting at least one week, or any period of time if hospitalization is required. During this episode, at least three of the symptoms of mania should be seen, which are defined as increase in self-esteem, needing less sleep, talking more than usual without being able to stop, a feeling of racing of thoughts or flight of ideas, being distracted and inattention, an elevation on activities either goal directed or non-goal directed, engaging in risky and potentially dangerous behavior. These changes in mood should be severe enough to restrict or impair functionality and may result in hospitalization and should not be caused by any other medical conditions or substances (APA, 2013). On the other hand, criteria for an episode of hypomania were defined in DSM-V as showing the same symptoms but for a duration of at least four days, and functionality of the individual should not be severely impaired or restricted during that time frame. A presence of psychosis should also not be applicable as it would be an indication of mania. A major depressive episode in DSM-V was characterized by feeling depressed for most of the day and almost every day accompanied by feelings of sadness, emptiness or hopelessness, a significant decrease in pleasure and interest, eating too little or too much, sleeping too much or not being able to sleep, feelings of tiredness, feelings of guilt or worthlessness, lack of concentration and not being able to decide, thinking of death or suicide or attempts or plans of suicide. At least five of these symptoms should be present for a period of two weeks and should limit the functioning of the individual and result in distress. Again, these symptoms should not be explained by another condition or a substance. An episode of hypomania and a major depressive episode is required for a diagnosis of bipolar II disorder. Additionally, a diagnosis of bipolar disorder with

mixed features can be made if at least three symptoms of depression is present during an episode of mania or hypomania, or if at least three symptoms of mania or hypomania is present during a depressive episode (APA, 2013).

Prevalence of bipolar disorder was found as 1% for bipolar I disorder and 1.1% for bipolar II disorder when criteria of DSM-IV was utilized (Goes, 2023). While the age of onset for bipolar disorder was reported as between 28 to 33 in earlier studies, it is now suggested that symptoms of the disorder first manifest themselves during adolescence and the first manic episode occurs around early 20s (Angst & Sellaro, 2000). The exact cause of bipolar disorder is not known, and causes are attributed to a variable and complex interaction of various factors such as genetics, psychological predispositions and environmental factors. However, genetic studies showed that bipolar disorder was hereditary to a large extent as an individual with a first degree relative with bipolar disorder was eight times more likely to develop the disorder, and the estimates of heritability was found to be between 60 to 80% for bipolar I disorder and 46% for bipolar II disorder (Goes, 2023). In terms of gender differences, it was demonstrated that while women tended to experience more depressive episodes, more comorbidities with eating disorders, and disturbances of sleep and weight changes, men were more likely to experience manic episodes, developing substance abuse and gambling addictions. In addition to that, incidence rates for women were higher for bipolar I disorder during their adulthoods (Treuer & Tohen, 2010). Furthermore, while bipolar disorder manifested itself in a more episodic and circular manner for men, women were more likely to experience depressive episodes, while pure manic or mixed episodes were observed equally for both genders (Angst & Sellaro, 2000).

Bipolar disorder is a chronic, recurrent, and progressive disorder, associated with a poor prognosis (Angst & Sellaro, 2000). Bipolar I disorder was demonstrated as having an acute onset and had an episodic course which included psychotic features and more manic characteristics. Meanwhile, bipolar II disorder seemed to have an insidious onset that was more likely to go unnoticed, a course which was more recurrent and chronic with depressive characteristics (Brancati et al., 2023). Bipolar I individuals were more likely to experience major manic episodes, possible psychotic

symptoms, and a tendency to alternate between manic and depressive episodes, all of which increased their functional impairment and hospitalization risk. Higher frequency and length of depressive episodes that substantially impair everyday functioning and quality of life were more typical for bipolar II (Nierenberg et al., 2023). Early onset, rapid cycles, manic, mixed and psychotic characteristics and comorbidities with other disorders or illnesses were more strongly associated with poorer outcomes, more impairments in functionality and higher hospitalization rates (Treuer & Tohen, 2010). Additionally, bipolar disorder was related to premature mortality and high suicide rates. It was established that while almost 34% of bipolar individuals attempt suicide, the rate of death by suicide was 15 to 20%. This rate was 30 to 60 times as much as the population in general (Nierenberg et al., 2023). Suicide rates were higher for individuals with bipolar II disorder. The prevalence of mixed depression among suicide attempters was significantly higher than that of nonsuicidal bipolar II and unipolar depressed individuals, indicating that the majority of suicide attempters were bipolar II patients (Treuer & Tohen, 2010). Bipolar disorder was illustrated to have high comorbidity rates with both other mental disorders and physiological conditions, such as anxiety disorders, attention deficit/hyperactivity disorders, personality disorders, especially borderline personality disorder, psychotic disorders, substance abuse and addictions, cardiovascular diseases, heart conditions, hypertension, diabetes, dementia, hypercholesterolemia, and hyperlipidemia (Nierenberg et al., 2023).

Regulating manic, mixed, or depressed episodes and subsequently preventing future episodes from recurring have been the main goals of bipolar disorder treatment. As bipolar disorder is a recurrent and chronic disorder, maintenance and continuity is essential in treatment (Nierenberg et al., 2023). Although it is more common for individuals to seek help and treatment during episodes of depression and to stop treatment during manic episodes, as mania comes with an impairment in functionality and judgement, and risky and dangerous behaviors might accompany this state, treatment of mania is regarded as an emergency and sometimes should involve hospitalization (Goes, 2023). When treating bipolar disorder, the primary approach is pharmacological. Medication used in bipolar disorder can be divided into four categories, which are lithium, anticonvulsants, antipsychotics, and

antidepressants. Mood stabilizers are essential in treatment of bipolar disorder in order to prevent episodes or reduce their number and to provide a more stable mode. Both lithium and anticonvulsants are mood stabilizers. While lithium is the most widely used mood stabilizer, anticonvulsants such as carbamazepine, lamotrigine, and valproate can also be prescribed. Antipsychotic medications are also commonly used in treating both manic and depressive episodes, and to ensure maintenance. Some of the antipsychotic medications used can be listed as risperidone, olanzapine, aripiprazole, quetiapine, and haloperidol. Even though antidepressant prescriptions are not the first choice in treatment of bipolar disorder as they might induce a manic episode, they can still be prescribed during depressive episodes, especially for bipolar II disorder. Some of these antidepressants can be illustrated as paroxetine, citalopram, and agomelatine (Nierenberg et al., 2023). Along with psychopharmacological treatment, psychotherapeutic approaches can also be beneficial for individuals with bipolar disorder. Psychotherapy can especially be helpful during depressive states, besides being helpful in noticing and managing symptoms, and improving cognition and functionality of individuals. Furthermore, alternative treatment methods such as neurostimulation can be utilized for patients who are unresponsive or intolerant to mainstream treatments. Some of the neurostimulation approaches that were found to be effective in treatment of bipolar disorder are electroconvulsive therapy and repetitive transcranial magnetic stimulation (Goes, 2023).

1.3. Criticisms Regarding the Diagnosis of Bipolar Disorder

Despite being widely utilized in making a diagnosis, reliability and validity of DSM have been highly scrutinized (Allsopp et al., 2019; Ghaemi, 2013; Ghaemi et al., 2022; Ghose, 2013; Hyman, 2010; Jablensky, 2016; Vieta & Phillips, 2007). In addition to that, its categorical rather than dimensional approach has also been heavily criticized. While it is asserted that a categorical approach ensures more reliable outcomes, as a consequence, it also results in highly invalid outcomes (Vieta & Phillips, 2007). According to Ghaemi, since DSM categories are largely unscientific, they should not serve as the foundation for scientific studies (2013). In addition to that, as the boundaries between categories are unclear, symptoms of

different categories overlap and results in high comorbidities. This situation either leads to the emergence of new categories or cause people to fall outside existing categories; thus, leading to an infinite number of categories (Allsopp et al., 2019).

Some researchers argued that DSM emphasizes the provision of a pragmatic classification for clinicians, rather than a valid one. Instead of relying on empirical research, it depends on judgement (Ghaemi et al., 2022). Medical classifications are made primarily to address practical requirements for identifying and treating patients who are unwell; therefore, it is understood by professionals that diagnostic classifications are constructions that are only supported by their ability to offer a practical framework for structuring clinical experience and forecasting results and treatment outcomes (Jablensky, 2016). Although DSM offers a classification of distinct, uniform illnesses, it also recognizes that because diagnostic categories overlap, this framework is not always applicable; hence, becomes inconsistent internally. A large portion of the variation within the manual stems from practical considerations for using it in clinical settings. This permission for interpretation enables the clinician with flexibility, allowing them to classify unnecessary symptoms that do not neatly fit into a diagnosis or to label behaviors or experiences as disruptive or distressing for others even though they may not be distressing for the person being evaluated. A clinician is free to use a single diagnosis in a variety of ways to accommodate distinct manifestations and circumstances within the diagnostic criteria. Emphasizing utility rather than theoretical consistency, in fact, contradicts what it is supposedly trying to do (Allsopp et al., 2019). In addition, the fact that diagnostic instructions depend on subjective experiences and reports instead of biological or clinical research or focusing on the etiology of the disorder raises questions concerning the validity and scientificity of DSM (Jablensky, 2016).

In their study, Vieta and Phillips investigated the validity of DSM by deconstructing it. They reviewed DSM in terms of content, concurrent, discriminant, and predictive validity (2007). They argued that as the prerequisite of diagnosing bipolar disorder is the presence of at least one episode of mania or hypomania, and the fact that psychotic symptoms are deducted from the definition has compromised the content validity of the DSM. Additionally, in DSM, bipolar depression and unipolar

depression are not differentiated, which causes problems in terms of predictive validity. Furthermore, as the current diagnostic system does not rely on any scientific data, such as genetic or biological studies, or do not include biomarkers to support the diagnosis, concurrent validity of DSM cannot be mentioned. Moreover, discriminant validity is far from optimal in any classification when no etiological classification is present. In psychiatry, a great deal of overlap in symptoms is present, and the distinctions between disorders depends on quantitative methods rather than qualitative methods. Certain issues cannot be addressed as a result of the current classification. A large number of patients do not fall into any category because boundaries between them are too artificial, or they fall into multiple categories as they meet the criteria for multiple conditions due to an overlay of symptoms. Along with these, even though they experience similar outcomes with individuals who fulfill the conditions of the diagnosis, a large number of patients who do not experience symptoms severe enough or long enough are considered not fit for diagnosis (Vieta & Phillips, 2007).

In addition to criticisms directed at DSM in general, diagnostic criteria of bipolar disorder has also been subjected to critiques (Bradford et al., 2024; Ghaemi, 2013; Ghaemi et al., 2022; Ghose, 2013; Vieta & Phillips, 2007). Between the two most widely used manuals when making a diagnosis, which are Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Statistical Classification of Diseases and Related Health Problems (ICD), significant disparities concerning the diagnostic criteria were found, which seriously damage the construct validity of bipolar disorder (Russell & Moss, 2013). Another issue that can be mentioned is that in order to preserve specific mental diagnostic definitions and prevent overdiagnosis, the bipolar spectrum has been left out of the DSM, resulting in superficial and narrow categories (Ghaemi, 2013). However, the issue of overdiagnosis is still persistent (Ghose, 2013). In fact, documented rates of incidence of bipolar disorder have increased alarmingly since the 1950s and more quickly in recent years. According to one critic, as a matter, this might have been relevant to pharmaceutical corporations' investments in bipolar illness medications, which would once again call into question the legitimacy of the diagnosis (Russell & Moss, 2013). In their review, Ghose and her colleagues found the rates of overdiagnosis to be between 4.8 to

67%, in addition to evidence suggesting a considerable amount of misdiagnosis (2013). Some of the factors that could have an impact in this situation were addressed as possible comorbidities with other disorders such as personality disorders, attention-deficit hyperactivity disorders, substance abuse, and shortcomings of diagnostic manuals (Ghouse, 2013). Bradford and her colleagues also referred to some problems encountered when diagnosing bipolar disorder in their review (2024). Since depression usually preceded mania or hypomania and at least one episode of mania or hypomania was necessary in order to be diagnosed with a bipolar disorder, most patients were first diagnosed with major depressive disorder. At the same time, as patients were not inclined to seek treatment during mania, chances of diagnosing these individuals might have been missed. Lastly, they conveyed the possibility of misdiagnosing bipolar disorder as a psychotic disorder at first (Bradford et al., 2024). To conclude, studies support the possibility of misdiagnosing, over diagnosing, or underdiagnosing bipolar disorder. Some factors leading to this occurrence can be put forward as the invalidity of the diagnostic manuals, categorical approach to diagnosis, too wide or too narrow categories, overlapping symptoms, unclear boundaries, the ambiguities arising from the nature of the disorder, the vague definition of the disorder, and certain requirements for a diagnostic criterion to be met.

1.4. Studies on Diagnosis of Bipolar Disorder in the Literature

Studies on the current literature mostly discussed bipolar disorder diagnosis in terms of the suffering and distress it brought for the individuals experiencing it, and associated it with outcomes such as low life qualities, self-harming behaviors, and high rates of suicide attempts (Russell & Moss, 2013). Furthermore, some studies also suggested that diagnosis was linked to noncompliance with medicine and psychological therapies, which was thought to have a detrimental effect on the prognosis (Proudfoot et al., 2009). Another drawback of diagnosis was suggested as being refused outreach to services, which can end up in individuals being unwilling to engage in some services, that hinder their recovery process in turn (Pallesen et al., 2020). Being diagnosed was also associated with feelings of loss, such as

occupational and social functioning, or future dreams and hopes (Inder et al., 2011; Russell & Moss, 2013).

The concepts most frequently associated with diagnosis in the literature were “label” and “stigma” (Baltacı et al., 2023; Dyga, 2019; Hayne, 2003; Inder et al., 2008, Inder et al., 2011; Lane, 2024; Pallesen et al.; 2020, Proudfoot et al., 2009; Russell & Moss, 2013). Diagnosis meant a person to be announced as mentally ill, which would result in either real or experienced stigmatization by both self and society, and would bring feelings of being misunderstood, or being inferior to healthy people for the individual (Dyga, 2019). The stigma and labeling that accompanied the diagnosis was reported by a vast majority of individuals across studies. In their meta-review, Russell & Moss (2013) found the strongest mutuality as being exposed to stigmatization between studies, which resulted in them being isolated from the community. This experience of stigmatization could also lead to discrimination, and in turn, people becoming more reluctant in sharing their diagnosis (Pallesen et al., 2020). However, it is also noteworthy that in their qualitative study, Pallesen and his colleagues stated that almost none of their participants actually talked about experiences regarding stigma (2020).

In her review, Baltacı and her colleagues (2023) discussed that even though diagnosis was mostly associated in the literature with discrimination, prejudice, and labelling resulting in people being more inclined to conceal their diagnosis, studies in recent years suggested that individuals experience a kind of recognition and legitimization when such problems are specifically labeled with a medical diagnosis. In contrast to being stigmatized by a diagnosis, people tended to label themselves as “sick” and used a medical discourse when talking about their diagnosis and disorder, which contributed to the legitimization of the diagnosis (Baltacı et al., 2023). According to research and clinical experience, receiving a diagnosis lent significance to an individual's sometimes unclear and complex experiences of illness, and validated the condition for both the individual and the larger social community (Proudfoot et al., 2009). Other qualitative research has also supported these findings. For example, the study conducted by Hayne have demonstrated that diagnosis by making what was previously invisible visible and what was unknown known, have

provided individuals with a recognition, affirmation, and justification regarding their symptoms and experiences; hence, enabling them to legitimize their disorder (2003). The study carried out by Pallesen and his colleagues have reached parallel findings, which showed that being diagnosed not only occupied a place of legitimization for the individuals, but also reserved a practical position for them (2020). Participants reported finding it useful both in terms of an internal comprehension of their challenges and the explanatory value of it when sharing it with friends, family, and coworkers (Pallesen et al., 2020). In addition, another aspect of diagnosis of bipolar disorder that was reported which should be taken into consideration is the fact that the validity of the diagnosis not being questioned because bipolar disorder was typically apparent, and its impacts can easily be seen by others, in contrast to many physical disorders and some mental illnesses (Proudfoot et al., 2009). In line with this, Lane talked about a “moral hierarchy” of diagnosis, which stands for different levels of status attributed to medical diagnosis (2024). Bipolar disorder was considered to have a high status compared to some other diagnoses of mental disorders within the system of mental health. Some of the factors that can be related to this were addressed as the validation given to the disorder by the culture, the place it occupies in the media, and its causes and symptoms being associated with biology, hormones, chemicals or genetics. All these factors combined made bipolar disorder a serious and legitimate disorder, and resulted in more people identifying with the diagnosis, possessing the diagnosis, embracing it as an identity and organize around it as a group, which was referred to as “strategic essentialism” (Lane, 2024). As a result, the diagnosis became an entity that normalized and justified behaviors which otherwise would seem as problematic (Proudfoot et al., 2009).

Another concept frequently examined alongside the diagnosis of bipolar disorder was identity. Resulting from the nature of the disorder, threats it brought to a person’s sense of self and identity were mostly reported in the current literature (Dyga, 2019; Inder et al., 2008; Inder et al., 2011; Ironside et al., 2018; Proudfoot et al, 2009; Russell & Moss, 2013). As bipolar disorder is characterized by cycling between depression and mania and constant changes in mood, it would inevitably affect one’s experiences of cohesion and continuity, and damage constructing and maintaining a stable sense of identity (Dyga, 2019). In their meta review, Russell &

Moss (2013) have found that almost all studies reported challenges with identity regarding a diagnosis of bipolar disorder. One of the main defining characteristics that caused the creation of distinct, and occasionally conflicting identities were based on mood or state of illness. Furthermore, individuals had trouble telling the difference between their "real self" and the illness, which led to confusion. These elements worked together to create a lack of internalized consistency and, as a result, damaged their sense of self (Inder et al., 2008; 2011). Individuals expressed uncertainty about the reality of their experiences and a lack of confidence in themselves (Proudfoot et al, 2009). Furthermore, being diagnosed also introduced a new identity for the person, which resulted in them comparing their past and present experiences, and wondering about which behaviors were actually caused by being ill, and which was their real self. It also brought challenges concerning whether to accept and internalize this new identity or not (Dyga, 2019). Studies illustrated that individuals related to their diagnosis in different ways. Some people believed it to be an essential component of who they are, while others distanced themselves from the label, and some believed it to have a detrimental influence on identity, while others claimed it had a neutral or positive effect (Ironside et al., 2018). Some individuals accepted this diagnosis as an identity (Russell & Moss, 2013). Still, other people discussed the process of accepting or facing their bipolar disorder diagnosis. Patients' ability to stay well has been demonstrated to be influenced by their acceptance of the diagnosis. Those who accepted their diagnosis were more adept at recognizing triggers or early warning indicators before an episode, and they were more likely to adhere to elective treatment plans (Proudfoot et al., 2009). On the other hand, non-adherence to medicine has been linked to refusal to accept diagnosis. Research asserted that accepting the diagnosis paved the way of a more integrated sense of self (Dyga, 2019; Inder et al., 2008). Dyga also conveyed in her study that as a consequence of the diagnosis, people adopted a new identity as a patient which became a central part of their identity (2019). A new narrative emerged after being diagnosed, a narrative of illness, or a bipolar narrative, which involved individuals' stories concerning their disorder and their experiences (Dyga, 2019).

Some positive effects of receiving a diagnosis have also been reported (Hayne, 2003; Lane, 2024; Pallesen et al., 2020; Proudfoot et al., 2009; Russell & Moss, 2013;

Warwick et al., 2018). For some individuals, getting diagnosed led to receiving both social and practical support, access to services, and guidance (Warwick et al., 2018). In addition to that, it stood for an answer, explanation and recognition (Hayne, 2003; Pallesen et al., 2020; Proudfoot et al., 2009; Warwick et al., 2018). For some individuals, diagnosis was a confirmation of their preexisting suspicions, while for others, this process happened gradually. Individuals talked about "making sense" of their experiences or aligning with what they already knew about the disease (Pallesen et al., 2020). Getting a diagnosis was also associated with relief as it finally put a name to the experiences (Proudfoot et al., 2009). Through understanding the cause and the problem, individuals conveyed that they were now able to notice the triggers or warnings and could better control and manage their symptoms (Proudfoot et al., 2009; Warwick et al., 2018). In addition, being diagnosed was also associated with a sense of agency, empowerment, and control, generating solutions, feelings of hope about the future, accepting the self and appreciating life, establishing boundaries, finding balance, and constructing a routine (Pallesen et al., 2020; Warwick et al., 2018). Getting a diagnosis also meant receiving the right treatment and made recovery possible (Hayne, 2003) Lastly, as was mentioned before, diagnosis served as a legitimization and justification. In her study, Lane discussed usage of diagnosis of bipolar disorder in explaining unacceptable or unpleasant behavior and its utility in diverting the blame (2024). Possessing and identifying with the diagnosis enabled people to gather around a specific category, form groups and establish cohesion in a way (Lane, 2024).

1.5. Bipolar Disorder in the Psychoanalytic Literature

From a psychoanalytic view, bipolar disorder has mostly been discussed in terms of melancholia rather than mania by considering mania is introduced as a defense against melancholia (Rabaey, 2023). In *Mourning and Melancholia*, Freud described melancholia as a situation in which object libido is withdrawn from the lost object (1917). An identification with this object takes place, and as a consequence, the ego undergoes a state of melancholia when this object is lost. What this lost object is or what is lost with it is ambiguous. According to Freud (1917), mania occurs as a victory against melancholia. While melancholia is described as a defeat of the ego,

mania is characterized as a victory of it (Freud, 1917). Later, he indicated that it is the ego ideal that ego gains victory over, and said that when these two overlap, a feeling of victory arise (Freud, 1921). Freud referred to ego ideal as the culmination of all the restrictions that the ego must accept and asserted that the fusion of these two results in a state without restriction and criticism (1921). Therefore, mania can be understood as a resistance shown by the ego before the ego ideal. Freud suggested that the ego briefly merges with the ego ideal due to the withdrawal of the ego ideal's directives and prohibitions, which causes the manic sensation of glory and freedom (Freud, 1921). After that, Freud talked about mania being a defense against the persecution of the super ego, which is driven by the death instinct during the state of melancholia, and leading the ego into its death (1923). Klein (1935) then used the term of manic defense when defining certain ways of preserving the ego against the anxieties of depression and paranoia, and stated that this defense includes omnipotence, denial, and idealization (as cited in Moncayo, 2021).

Despite not directly addressing bipolar disorder, Lacan discussed depression, melancholia, and mania separately. In Television, Lacan declared depression as a “moral failing” and said, “Moral weakness, which is, ultimately, located only to thought; that is, in the duty to be well-spoken, to find one’s way in dealing with the unconscious.” (1974/1990, p. 22). What is meant by well-spoken is every individual having an ethical duty of discovering their unconscious and questioning themselves by coming through their passion for ignorance, which can only be possible with entering into analysis (Swales, 2023). In addition to that, depression can also be a result of renouncing one’ desire or not pursuing it. This wavering of desire and pushing for jouissance over desire would in turn end up in depression (Swales, 2023). Desire is unconscious, the essence and driving force of the subject, it is a relation to the fundamental lack and not to an object; therefore, can never be fulfilled. It is also a defense against jouissance. Jouissance, in turn, can be described as a paradox, enjoyment within pain and pain within enjoyment (Evans, 2006). Hook & Vanheule also discussed depression as failing to utilize language when addressing to the Other (2023). The Other represents the symbolic, it is the radical alterity equated to language and law (Evans, 2006). When the Other’s position as an entity that structures the symbolic order becomes inoperative, jouissance can no longer be

moderated in speech. In Lacanian psychoanalysis, depression is regarded as a symptom that can manifest itself in all structures, and it is not a structure itself. From another perspective, Verhaeghe (2008) associated depression with a reversal of acquisition of an identity, deriving from the fact that depression is characterized by feelings of loss and emptiness. In the face of a loss of the stabilizing identification, the process of acquiring an identity can be reversed. Identification, according to Lacan, is the change a person undergoes when he adopts an image. When someone assumes an image, they accept it as themselves and recognize themselves in it. Identifications also form the basis of identity formation (Evans, 2006). On the other hand, Vanheule (2023), by drawing attention to the fact that depression is an affective situation, indicated that depressed feelings should be examined in terms of the interaction, or conflict, between the body and speech, just like any other affective condition. The body is impacted by speech, and speech by body. Lacan also positioned inhibition at the level of the body and described it as a situation when the subject chooses not to see, and paralyzes himself, which prevents articulation. Likewise, emotions arise when one is faced with a task or circumstance that they are unsure how to handle, cannot come up with a signifier to guide him, and fails in articulation (Vanheule, 2023). It can be said that in depression, what is at question is a failure of articulation. Coming back to Lacan's point on depression being a moral failing resulting from avoiding true speech and neglecting the unconscious, the resolution of depression would be through engaging in articulation and exploration of unconscious and reestablishing a relationship with the Other (Hook & Vanheule, 2023).

On the other hand, Lacanian theorists separated melancholia from depression and stated that melancholia shares the same mechanism as psychosis, which is foreclosure (Grigg, 2015; Hook & Vanheule, 2023; Leader, 2023). Psychosis is one of the three structures introduced by Lacan, namely, neurosis, perversion, and psychosis. These structures define the position taken by the subject in front of the Other, the lack, and desire, and they are all characterized by a fundamental operation taken at the face of the master signifier, which is the Name-of-the-father. These operations are classified as repression for neurosis, disavowal for perversion, and foreclosure for psychosis. As a result of the foreclosure of the fundamental metaphor,

the symbolic order cannot be introduced in the psychotic structure. As a consequence of the paternal metaphor not signifying the mother's desire, separation between the mother and the infant cannot occur, resulting in continuation of the state of unity between the infant and the Other (Evans, 2006). While neurotic depression is a result of division and conflict, melancholia, like psychosis, is characterized by a failure of language in managing the inburst of jouissance. In addition to that, unconscious is considered as a force coming from within in neurosis, whereas in psychosis, it is a force felt from without in contrary; therefore, they cannot receive the same assistance from language when regulating the drives. In order to address psychotic types of depression and mitigate the effects of foreclosure, further techniques to balance jouissance are required (Hook & Vanheule, 2023).

Melancholia was discussed as the presence of the object in contrast to its absence by Grigg (2015). For the melancholic subject, the object in question is a much more difficult object to understand. This object is defined as "obscured, veiled, and masked", and is called the object *a* (Brenner, 2023). The object *a*, also called as the *objet petit a*, is described as the object of desire, the object that can never be reached, rather it is the cause of desire, it is the object that sets desire in motion. It also represents the partial objects that demonstrates the drives. The goal of the drives is not to reach this *objet petit a*, but they revolve around it. This object *a* also stands for the reserve of libido that could not be reduced, and it is the object of anxiety (Evans, 2006). This object is experienced as toxic in melancholia, and the subject is left defenseless against it. This object remains suspended in the real order, which is out of comprehension and articulation. Throughout his work, Lacan has frequently referenced the three orders, which he introduced as the symbolic, the imaginary, and the real. The symbolic order is the realm of language, the Other, desire, unconscious and law. Whereas the imaginary is the realm of images, ego, imagination and deception, as it promises unity and autonomy. Both symbolic and imaginary orders are entities of language, as symbolic order is built upon the signifier, while imaginary order consists of the signified and signification. On the other hand, the real order is what cannot be apprehended by language and withstands symbolization; therefore, out of human reach completely (Evans, 2006). Resisting to be mediated and processed, this "object" is also traumatic, it is an overwhelming thing that has the

potential to flood the subject with explosive jouissance. This uncovered object imposes an excessive proximity, resulting in subject not being able to separate from it. For the neurotic, separation is only possible through the Other, limiting and regulating the excessive jouissance by the regulation and mediation of language. As this is not the case in psychosis, this excessive jouissance takes over the subject, which is also true for the case of melancholia. Not being able to separate from the object, the subject ends up being exposed to the traumatic nature of the real order, being defenseless in the face of it, and becoming a piece of it (Grigg, 2015). Hook (2023) conceptualized melancholia as the subject not being able to mediate the distance between themselves and the Other, who is considered as too excessive, in parallel with the excessiveness of the object *a*. The inability to manage the harmful jouissance emitted by the object in the Other and issues of symbolic placement together make it difficult for the subject to establish a secure posture in relation to the Other's desire. Stated differently, the issue is not solely with the symbolic relationship to the Other. The problem of the object within the Other that has approached too closely is another crisis in melancholia. The reason for this is excessive closeness is the fact that melancholic subject not having the necessary tools of symbolic mediation to defend himself against it (Hook, 2023). Brenner (2023) drew attention to another aspect of melancholy, which is the narcissistic identification between the subject and the object *a*. However, object *a* is an object that unlike others, escapes from being a product of the identification with the specular object; therefore, it is not a part of the ideal ego. Ideal ego is formed as a consequence of the identification between the subject and his specular image and stands for all the ideal images attributed by the subject to his image (Vanheule, 2011). Absence of the veil of the image makes the object *a* inconsistent, renders identification impossible. When identification with the object becomes impossible, ego is degraded to the level of the ego ideal (Brenner, 2023). Ego ideal is another feature of the ego together with the ideal ego. The ego ideal is the symbolic perspective through which the individual comes to understand how others see them or how they acquire their place in society (Vanheule, 2011). When the object *a* confronts the ego ideal, the only way to lessen the threat is to defend the ideal ego. At this point, refusal of the ideal ego would also result in losing access to the ego ideal. Consequently, in melancholia, identification with the object *a* reflects a state in

which the ego, in both of its forms, falls short in compensating for the absence of the object *a*. It involves a shift from the imaginary and symbolic to the real, from loss to lack, and from the ideal ego to the object *a*. A world of desired objects without the motivation to desire them is what defines melancholia rather than a desire that has lost its object (Brenner, 2023).

When it comes to mania, Lacan said the following “Let’s specify right away that what is at issue in mania is the non-function of *a* and not simply its misrecognition. No *a* comes to ballast the subject and this delivers him, in a way without any possibility of freedom, to the sheer infinite and ludic metonymy of the signifying chain.” (2004/2014, p. 336). Signifying chain is defined as a chain that is formed by signifiers connecting to each other. A signifier is described by Lacan as a thing representing a subject for another signifier (1964/1998), in other words, there is one signifier that represents the subject for all the rest of the signifiers, which is the master signifier. But still, the subject cannot be signified by any signifier. Therefore, signifiers form a continuous chain, in which a signifier signifying another signifier and so on, and all signifiers are linked to each other, which continues infinitely (Evans, 2006). Signifying chain is metonymic in nature, since it continues indefinitely. Metonymy can be characterized as a trope where a phrase is used to indicate a thing that it is intimately associated with but does not actually refer to. The sequence between the signifiers constitutes the metonymy in the signifying chain, and it is a horizontal occurrence. Lacan suggested that desire is also a metonymy, as it is infinite and continuous, if it is reached, then it is no longer desired, and turns to another object (Evans, 2006). On the other hand, metaphor is described by Lacan as a substitution of one signifier for another (1996/2006). In order for meaning to be constructed, there has to be a metaphor which enables signification. Metaphor, in turn, is a vertical occurrence. In addition to that, Lacan also asserted the Name-of-the-father as the paternal metaphor, the fundamental metaphor that makes all other metaphors possible. Through formation of the metaphors, signifieds and signifiers are knotted together, and creating anchoring, or quilting points, which Lacan named as “point de capiton”. Points of captions are essential for meaning to be constructed. At the same time, Lacan associated metonymy with displacement while linking metaphor to condensation, because metaphor is based on similarity, and metonymy

on proximity and contiguity. Process of signification can only be made possible through metaphor and metonymy working together (Evans, 2006). Later, Lacan connected mania with the return of the language in the real order and considered mania as a derailment in the signifying chain, corresponding to the metonymy (Lacan, 1974/1990).

Deriving from his arguments, it can be suggested that Lacan positioned mania as a condition existing at the level of language (Rabaey, 2023). As a result of the destructing effect of mania has on language, the subject becomes a captive of this deranged language. Language is also responsible for the formation of subjectivity, it is formed as a result of utilizing language and arises in speech. Language, according to Lacan, is not just a tool for communication but rather a virtually independent entity and domain that functions through individuals and has the consequence of simultaneously creating subjectivity and meaning. In fact, he conveyed that “We believe we want to say what we want but...We are spoken.” (Lacan, 2005/2016, p.142). Therefore, when the language fails, subjectivity is also seized. This failure in language can be explained as a detachment between the object *a* and the signifying chain. Object *a* can be regarded as what anchors the language, and when it no longer functions, it results in a derailment in metonymic aspect of language, in other words, signifiers start to slip. This loss of function of the language also has consequences in terms of jouissance (Rabaey, 2023). Through castration and entry into the symbolic order, that is the realm of language, jouissance starts to be regulated by language (Evans, 2006). However, there is always a leftover, a remainder that cannot be grasped by language, which is the object *a*. Object *a* also stands for the reserve of libido that cannot be reduced (Vanheule & Verhaeghe, 2009). This leftover, object *a*, is the basis of the metonymy of desire, the cause of desire, working as an anchor for the subject, which the drives circle around (Evans, 2006). Therefore, the non-function of object *a* would mean both jouissance and drives to be no longer weight down by this anchor and manifesting themselves as agitations and excitations in the body; thus, causing the elevation felt in mania. A metonymy no longer anchored by object *a* and not quilted by metaphors would result in flight of signifiers, without any meaning, and hence the manic language. This would conclude in the subject falling under the control of language, and losing their subjectivity in turn (Rabaey, 2023).

Lacan's arguments were later expanded upon and debated by subsequent Lacanian theorists. One of the theorists who has thoroughly explored this topic is Leader. He asserted that Lacan's remarks on mania raises more questions than it answers. While discussing the theory of Lacan on mania and the non-function of object *a*, he argued that the point made concerning the infinite signifying chain is not reasonable as mania comes to an end eventually (Leader, 2023). In addition, he conveyed that the idea about the non-functioning of *a* rises certain questions such as how free intervals between the episodes can take place, and whether the *a* starts to function again. He questioned how can *a* stop functioning or then start functioning again and asked how manic episodes come to an end. He replied to this question by bringing forward the role of persecutory ideas, and the fact that they act as a stabilizer, and mentioned that manic periods are often followed by repetitive persecutory ideas. Then, Leader talked about the three types of psychosis from a Lacanian point of view, which are paranoia, melancholia and schizophrenia (2023). He asserted that even though all three types of psychosis are based on the process of foreclosure, they differ in ways of how they manage excitation, create meaning, localize the libido, and relate to the Other. In terms of paranoid psychosis, the distance to the Other is regulated through the aid of delusions. Through locating the libido in the Other and announcing himself as innocent and the Other guilty, he succeeds in separating the Other from himself. On the other hand, meaning cannot be established in schizophrenia. The issue of meaning is nonetheless unresolved in spite of the attempts of making sense of it through constructing delusions. Libido returns in the subject's body and thoughts, rather than being restricted to the Other. The schizophrenic is frequently committed to the lifelong mission of attempting to uphold the distinction among his self and the Other in any manner imaginable, even though these boundaries may be unclear and unreliable. When it comes to melancholia, meaning is formed through attribution of the guilt to the subject himself, leading them to blame and degrade themselves (Leader, 2023). However, for mania, delusions are not always present, only consistency among them being the belief that the Other is in danger, and it should be saved and protected. While the Other must be restored in terms of mania, it should be condemned in paranoia. However, this raises the question of who is responsible for the aggression, the subject or the Other? In mania, the Other should be kept away and protected from guilt, whereas it is the Other who is guilty in paranoia and the

subject in melancholia. This situation results in the alternation of the guilt between the subject and the Other in the case of manic depression. Leader (2023) suggested that this also provides an explanation to the ambivalence related to the sense of self and identity in manic depression. The inability of distinguishing the illness and themselves, highs and lows, mania and depression may be a reflection of the underlying ambiguity around who is responsible. They are never fully at blame because of their over-identification with the Other, to put it in a different way, the “I” going back and forward between them and the Other, which implies that the fault is shared by both of them. Again, Leader pointed out that the manic-depressive and schizophrenic both experience libido in their bodies, but it is also evident in their language (2023). In terms of the distance taken against the Other, the manic subject is united with the world, and strongly involved with the Other in a harmony, at least at the beginning of the episode. In manic depression, there is a belief that they are included and trusted by the Other, and they strive to protect and save it. Likewise, the strength of identifications and promotion of a chosen individual to a state of authority is common in manic depression. Lastly, Leader claimed that mania cannot be directly addressed as a product of foreclosure, rather it holds a position of restoration for the subject. However, he discussed that likewise in schizophrenia, the mechanism of manic depression lies in establishing a relationship with the Other, and the mediation techniques used in this regard. In order to support his claim, he reminded Lacan's criticism of the notions of persecution at the start and finish of manic episodes and said that these persecutory ideas can be understood as efforts to strengthen the line separating the self from the Other, which is constantly in danger (Leader, 2023).

1.6. Diagnosis from a Psychoanalytic Perspective

The DSM has also been extensively researched by psychoanalytically oriented researchers, and its reliability and validity have frequently been the subject of debate (Baltacı, 2019; Baltacı et al., 2023; Guéguen, 2013; Moncayo, 2021; Rodríguez, 2004; Vanheule, 2014; 2017; Verhaeghe, 2008). In addition to reaching the conclusion that DSM is invalid and unreliable from a scientific point of view (Vanheule, 2014; 2017), its sign-based approach to diagnosis has also been subject of

criticism (Baltacı, 2019; Moncayo, 2021; Vanheule, 2014; 2017; Verhaeghe, 2008). Deriving from the work of Saussure, Lacan identified sign as a thing representing something for someone (1964/1998). In a DSM based diagnosis, symptoms are regarded as signs, having a fixed meaning for everyone showing that symptom, pointing to a fixed diagnosis, and can be generalized (Verhaeghe, 2008). On the other hand, from a psychoanalytic point of view, symptoms are regarded as signifiers; thus, what is at question considering the symptom from a psychoanalytic point is that they cannot have a fixed meaning as signifiers will always be subject to change and shift meaning, and since everyone's chain of meaning will be unique, the origin of the symptom will be different for everyone (Verhaeghe, 2008). Hence, examining symptoms in the same way for everyone and making generalizations is contrary to psychoanalytic principles. Addressing all symptoms in the same manner for everyone means discarding the subjectivity and uniqueness of that person, and reducing people to symptoms and disorders (Guéguen, 2013). At this point, Verhaeghe separated medical diagnostics and clinical psychodiagnostics and asserted that while medical diagnosis heads toward the general while starting from the symptom, the aim is to reach the particular starting from the general, by following the signifying chain in clinical psychodiagnostics, which are opposite to each other (2008). It can be suggested that while medical doctors are busy reading signs, psychoanalyst occupies in interpreting signifiers (Moncayo, 2021).

Another criticism offered in a psychoanalytic sense is against the positivist position that psychology has begun to adopt. Lacan conceptualized this as analysts beginning to put themselves in the position of “the subject supposed to know” (1964/1998), which can be considered as a position of the master, and not the analyst (Baltacı, 2019). Illich (1995) drew a comparison between the position of a medical doctor in society and that of a judge or a clergyman. According to him, a judge is in a position to determine what is legal and who is guilty; a priest is in a position to determine what is sacred and what is profane and heretical. Regarding medicine, he used the following statements: “In every society, medicine, like laws and religion, determines what is normal, appropriate, or desirable. Medicine has the authority to label a person's complaint as a legitimate illness, to declare a person sick even if they are not.” (as cited in Baltacı et al., 2023). Furthermore Foucault, in his works “The Birth

of the Clinic” (1963/2003) and “Madness and Civilization” (1961/2006), revealed how professionals such as doctors, psychiatrists, and criminologists increased their authority with the rise of new discourses. Based on this, it is possible to evaluate the concept of ‘legitimization’ within the framework of the medical institution being the provider of the recognition of the individual's illness, and, through this, the subject, by society (as cited in Baltacı et al., 2023). Meanwhile, according to Parker et al. (1995), “mental illness” has historically been positioned within the field of psychiatry, and the effects of psychiatrists traditionally having the right to diagnose disorders, prescribe medication, and decide what is considered abnormal (as cited in Baltacı et al., 2023). In his work, Verhaeghe discussed this as a collision between the discourses of the master and the hysteric, only resulting in strengthening the master’s position (2008). Discourse of the master to be accepted in psychiatry would inevitably lead to a power relationship between the clinician and the patient. Which would, in turn, indicate an acceptance of the diagnosis only because it was pronounced by an authority, and not based on its accuracy (Verhaeghe, 2008). In this manner, the clinician, by situating himself in the position of the master, reduces the patient to a position that forces them to rely on his knowledge. However, all discourses are marked by an impossibility. It will never be possible for the message sent by the agent to reach the other in the intended manner, meaning communication is doomed to fail each time, which is also applicable to psychodiagnostics (Verhaeghe, 2008). Another point to be considered according to this argument is the fact that the position of the agent is fueled by his own lack, his self-division. Applied to the psychodiagnostics, it would mean that the diagnostician is also marked by lack. There rises the question, who is he to diagnose (Verhaeghe, 2008)?

An additional point made by Verhaeghe (2008) is the fact that a better diagnosis does not indicate a better treatment. In fact, diagnosis itself is the treatment. According to Hyman, diagnosis can be regarded as a reification, which can be described as nominalization being sufficient for an explanation (2010). The appearance of mastery and control over something always accompanies when something is named. Once named, it becomes manageable, and soothes the anxiety which rises from the unknown, which is an indication of the power of nominalization. Also called as mentalization, or verbalization, might be regarded as one of the crucial aspects of

psychotherapy. The patient demands an answer from the clinician, attempting to avoid facing his lack, calls for the master discourse, and the clinician replies by diagnosing, bringing the master signifier, which also coincides the process of assuming an identity, through the authority figure. Receiving a diagnosis might bring a temporary relief by the power of mentalization, in this sense, Verhaeghe referred to this as “band-aid therapy” (2008).

Throughout his seminars, Lacan has declared the following: “The unconscious is structured like a language.” (1955-56/1993, p.167), “The unconscious is the Other’s discourse.” (1966/2006, p.10), “The symptom is itself structured like language.” (1966/2006, p.223). His quotes present that symptom cannot be thought separately and independently from the language and the Other, it takes shape around them and manifest itself in relation to them. Lacan considered symptom in different ways throughout his work. First of all, he conceptualized the symptom as a signifier and conveyed that a symptom forms in relation to the history of that person (1966/2006). Later, he talked about it as a process of signification (1954-55/1988). After, he defined symptom as a metaphor (1966/2006). Lastly, he described symptom as a message, addressed to the Other (1960-61/2015). Based on these, symptoms should be interpreted and worked in regard to the subject’s relation to the Other, by the means of language (Verhaeghe, 2008). DSM, by reducing the subject to a position of an object, a symptom, ignores the subject’s own interpretation, and reflexive relation to their symptom (Vanheule, 2014). It is the individual who make sense of their problems, and only through interpreting their distress and evaluating the meaning they attach to their suffering, they can come to a conclusion whether it conveys a problem for them or not. Symptoms take shape around the subjective experiences. In this manner, symptoms are personal constructs and cannot be interpreted by anyone but them. And this interpretation can only be possible through the agency of language. Only through signification meaning can be constructed, and the clinician can only gather information by following the signifying chain through the speech of the patient (Vanheule, 2014). By utilizing signifiers, subjects can function in the realm of the symbolic, which is one the three registers introduced by Lacan. Symbolic refers to the realm of the language, and the Other. The imaginary corresponds to the register of the images, ideas, and signifieds. The third register, the

real, on the other hand, is inaccessible to language, something that cannot be represented, and outside comprehension (Evans, 2006). There will always be residues beyond the reach of language, and cannot be signified, which will correspond to the realm of the real. And how a person relates to the realm of the real will also be a dimension taken into account from a Lacanian approach to diagnosis (Vanheule, 2014).

Lacanian practice discusses psychopathology in terms of clinical structures, which are neurosis, perversion, and psychosis, and diagnosis in Lacanian terms stands for detecting the structure of the subject (Fink, 1997). However, these structures do not refer to illnesses, and they are not clusters of symptoms. But rather, they determine how a subject relates to the Other, lack and desire. It is a position taken by the subject. Instead of being dimensional, structures are categorical, and a subject can only coincide to a single structure. At the same time, all structures are differentiated by the operations they are subjected to, which are repression, disavowal, and foreclosure for neurosis, perversion, and psychosis respectively (Evans, 2006). These structures can be considered as ways that establish how signifiers are utilized by the person when signifying themselves, which ultimately results in a specific position for the subject. It is this signification process that should be the center of the psychoanalytic work. Through following this process of signification, the singular meaning of the symptom can be interpreted (Vanheule, 2014). As Lacan himself conveyed, “It is already quite clear that symptoms can be entirely resolved in an analysis of language, because a symptom is itself structured like a language: a symptom is language from which speech must be delivered.” (1996/2006, p. 223).

1.7. Diagnosis of Bipolar Disorder from a Psychoanalytic Perspective

Only one study directly examining bipolar disorder diagnosis has been reached in the psychoanalytic literature. In his study, Rabaey (2023) examined individuals’ experiences of mania in terms of Lacanian theory of identification.

Rabaey (2023) conveyed that from a Lacanian point of view, it is an interaction of the drives, ego, language and the Other that forms the basis of subjectivity and

identifications, and he sought assistance of Lacan's double mirror model when discussing bipolar disorder diagnosis from this perspective. Given the supposition that during manic episodes, drive impulses overpower the ego and impair language function, Rabaey (2023) asserted this model as especially pertinent to researching the subjective experience of the effect that mania has on a person's sense of self. Rabaey relayed that although challenges with identity were an apparent situation in bipolar disorder, how individuals eventually integrate their experiences to their identities has not been widely investigated (2023). In order to examine this process from a Lacanian perspective, he conducted thematic analysis and came up with six themes demonstrating this process. His analysis illustrated that at first, while individuals experienced mania as something that disrupted their sense of control and caused them to feel ashamed and led them to question their identities, getting diagnosed made them feel relieved, and it served as a way of describing and understanding themselves. After that, by identifying with the diagnosis, individuals started to form a narrative, in which they attributed their past experiences to bipolar disorder, and started to acquire knowledge about the disorder. Later, they began to take responsibility for their symptoms and kept themselves in check and under surveillance. Finally, they constructed their own narratives by attributing a personal significance to their experiences (Rabaey, 2023).

Rabaey (2023) discussed his findings on the basis of Lacan's double-mirror theory, which is illustrated in Figure 1. This model demonstrates the formation of the ego, ego ideal, and ideal ego through identification via mediation of language. (Vanheule, 2011). Lacan proposed that language serves as a mirror for individuals to discover their identities through others. Self-experiences, which are fragmented at the beginning, are integrated with the aid of identifications, relying on language. Drives arising from the body results in individuals perceiving themselves in contradictory ways. Creating mental images enable them to get over this fragmented experience and work toward creating a comparatively consistent self-image, or ego. Ego is a fictional and expected wholeness that is constantly under threat from drives. Beginning with his prior theory of the mirror stage, which discusses the integrative and constitutive implications of identifying with an image, which is an act of misrecognition, Lacan's double mirror model introduces that language serves as the

primary mirror through which people see and misrecognize themselves (Rabaey, 2023).

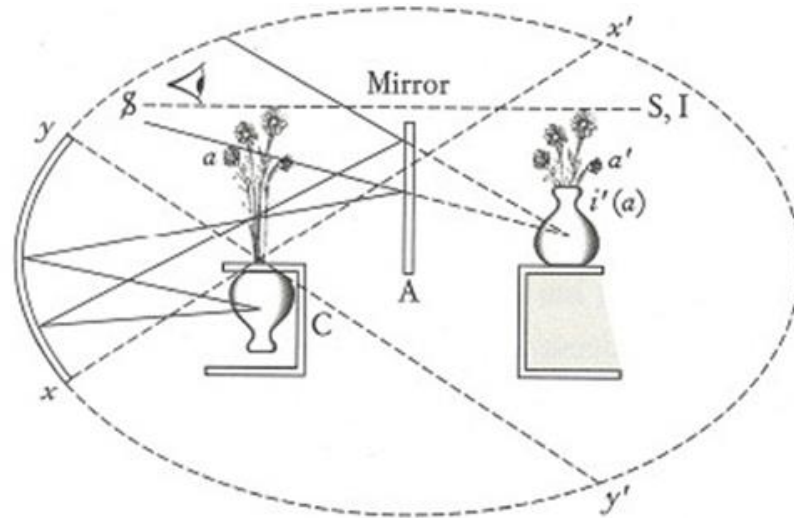


Figure 1. Lacan's double-mirror device (Lacan, 1996/2006)

At the left side of the model, the symbol $\$$ stands for the divided subject. According to Lacan, language can never adequately capture subjects, rather it would produce a lack, in which the subjectivity will arise. Subjectivity is originated from signifiers, and how an individual utilizes it. While this lack is situated in the realm of the symbolic, at the imaginary realm, individuals attempt to see themselves, via creating images about their ego, which is represented by the eye in the device. A, which demonstrates the language and discourse, is shown by the plane mirror and stands for the Other. According to the theory, people project an image of themselves by utilizing this mirror of language in an attempt to see themselves, that is a misrecognition of subjective division. At this point, narratives take a central part, they are ways for people to form mental representations of themselves and make sense of who they are. Drives are illustrated by the flowers in the model. According to Lacan, drives are bodily experiences about which there is insufficient innate knowledge. Drives are initially perceived as uncontrollable chaos rather than being absorbed or regulated at all. At the right side, what is seen by the eye in the mirror of language is shown. While $i'(a)$ represents the ideal ego, ego ideal is depicted by I. Self-observation happens by merging dispersed images into a total one, for this reason, lack will be misrecognized and idealization will be involved (Vanheule,

2011). Lacan argued that while ideal ego is origin of an imaginary projection, ego ideal is a symbolic introjection. The ideal ego takes shape around the specular image in the mirror, it is on the level of the imaginary and is a fiction of unity upon which the ego is based, and it points towards the possibility of a future unification. Whereas the ego ideal is situated in the symbolic order and is based on an ideal signifier, it is an internalization of the law and acts as a guide that shapes the individuals' position in the symbolic order. Ideal ego represents the primary identification, but it is still the root of all secondary identifications, while ego ideal is a product of secondary identification (Evans, 2006). Mirror of language is held by the ego ideal in a vertical position as they are the foundations of idealized versions. Driven by the conflict between the ideal ego and the ego ideal on the one hand, and the drive and the divided subject on the other, the ego is always subject to integration, misrecognition, and identification. However, Lacan later puts forward that drives can be represented in language up to a point, as the object *a* can never be reflected in language (Rabaey, 2023).

When describing mania, Lacan asserted that “What is at issue in mania is the non-function of *a* and not simply its misrecognition.” (2004/2014, p. 336). Based on this statement, it can be proposed that what is at question is the hinderance of the mirroring of the drive in mania. When the language fails, lack cannot be promoted in terms of the drives, resulting in difficulties faced with subjective experiences (Rabaey, 2023). At this point, forming a bipolar narrative was introduced as a way of mastering mania and a method of controlling and restraining the drives. In mania, when the drives attacked language and restricted its function of representation, subjects were reduced to a position of an audience, being unable to control their impulses. At that point, diagnosis enabled a way of acquiring mania through language and provides a recognition in the mirror of the Other for the subject. When defining the ego dystonic drives that dominate the ego and language use, diagnosis served as a clarifying mirror image for the individuals and began the process of constructing narratives. Narratives regarding bipolarity were used to develop the first designation of the bipolar condition, which led to a comparison of accessible narratives with one's own experiences. Through this process of identification, people rewrote their story of identity and, consequently, their ego. The importance of peers

and significant others recognizing and validating this new identity was also addressed by the participants. In turn, a new ego as “bipolar” was built with the help of this narrative. Comparing themselves with other bipolars which represents the norm and the ego ideal and trying to be like them stood for the ideal ego. An image of agency and being in control was adopted at this point. Observations and external representations served as a way for them to determine their condition. Through building a fantasy of control and mastery, they constructed an ideal ego for themselves and separated themselves from other bipolars. To conclude, the study revealed that receiving a diagnosis functioned as a way of representing the impulses and ego dystonic experiences through language that was previously neutralized by the overwhelming drives in mania. Through identifying with the diagnosis, constructing a narrative about bipolarity and forming a new “bipolar ego”, individuals gained a sense of controlling and capturing mania, and they fell into the illusion of control and agency (Rabaey, 2023).

1.8. Aim and Scope of the Study

Based on the information provided above, it can be concluded that diagnosis plays an important role in individuals' experiences of bipolar disorder. However, it is argued that the answer to the question of what this diagnosis means and signifies for individuals remains unclear. Therefore, it is thought that more research is needed on what diagnosis means for individuals and why it is important.

This study was conceptualized in order to investigate questions such as what receiving a bipolar disorder diagnosis meant for individuals, where it stood in their experiences, and why it was important, in addition to examining how individuals related to this diagnosis, how they talked about it, and their own subjective interpretations of it in-depth.

In light of these questions, the research question for this study was constructed as “How do individuals diagnosed with bipolar disorder interpret this diagnosis?”. This study was conducted within the framework of psychoanalytic theory, in particular,

Lacanian psychoanalysis. In this regard, the subtext and manifestations of the unconscious in people's statements have been of great importance in this study.

A qualitative research method was chosen to enable a detailed and in-depth examination of individuals' statements. As the researcher of this study is psychoanalytically oriented and wished to utilize this theory in her work, thematic analysis method was chosen since it is a method that provides this flexibility.

CHAPTER 2

METHODOLOGY

2.1. Qualitative Research and Psychoanalysis

Denzin and Lincoln remarked that there can be no specific definition of qualitative research (2011). Similarly, there is also no particular method that dictates how qualitative research is carried out. Rather, it contains various practices and approaches in itself (Snape & Spencer, 2003). The method of the study would depend on the decisions and the background of the researcher, driven from the purpose and the settings of the research (Patton, 2002). Different from quantitative research, the data on hand could be on writing or in drawing, instead of being numerical (Silverman, 2011). Therefore, the focus of the study would not be on quantity but will aim to answer questions such as “how”, “what” or “why” (Ormston et al., 2014). As a result, the hypotheses will be formed on the basis of the data and not at the beginning of the study (Silverman, 2011).

Unlike quantitative research, qualitative research aim at arriving at a complex and in-depth data. In line with their purpose, their methods can vary on how to reach this data, and qualitative research provides the researcher the necessary freedom and flexibility on doing so (Denzin & Lincoln, 2011). Some of the most important factors on deciding the method and the procedure of the research will depend on the ontology and the epistemology, the aim of the study, the research question, the sample, and the researchers themselves (Ormston et al., 2014). The concept of ontology engages in the characteristics of the reality and depends on the question that if the world can be understood in a similar way by all individuals, or if it is perceived differently by each individual, depending on their interpretations. There are two positions that answer this question, which are realism and idealism. Realism answers

this question by proposing that regardless of people's knowledge or views, there is a mutual outside reality. On the other hand, idealism asserts that no outside reality can exist that is not shaped by people's perceptions and opinions (Snape & Spencer, 2003). Overall, the key ontological question is whether the world is similar for all individuals or is it fundamentally different as it is prone to subjective interpretation. Since the aim of qualitative research is investigating and comprehending the world via participants' own perspectives and explanations, interpretivism is closely linked to qualitative research (Ormston et al., 2014). In the meantime, epistemology is involved with how the information about reality can be acquired and the foundation of this information. Two ways of reaching this information arises as a result of this question, which are described as bottom-up and top-down processes (Snape & Spencer, 2003). In a bottom-up process, also called as induction, conclusions are driven from observations, while in a top-down process, also named as deduction, observations are used to test previously constructed propositions. In other words, hypothesis formed beforehand in deductive processes while they are formed in the aftermath of the analysis in inductive processes (Ormston et al., 2014). In this manner, although qualitative research seems closer to an inductive process, some researchers suggested that no clear distinction as an inductive or deductive process can be made, and qualitative research can involve and benefit from both processes (Blaike, 2007). The interaction between the researcher and the researched, and how it affects the results is a second important epistemological issue in social research (Snape & Spencer, 2003). According to one approach, these concepts are unrelated to each other, and the results are not affected by the researcher. Another approach holds that the relationship between the researched and the researcher cannot be dissociated, and the process would be inevitably affected by this interaction. At this point, reflexivity will gain significant importance when carrying out qualitative research (Ormston et al., 2014).

Psychoanalysis locates subjectivity in its center, and what is examined is the individual's language and discourse, and through them, their unconscious. Correspondingly, empirical and positivist approaches occupied with numerical data and aims at confirming hypothesis or generalize the results to the population does not coincide with what psychoanalysis tries to achieve. However, like all practices,

research is also crucial for psychoanalysis (Dreher, 2000). In her words, Dreher (2000) referred to this as follows: “Psychoanalytic (empirical) practice without psychoanalytic concepts is blind, psychoanalytic concepts without psychoanalytic (empirical) practice are empty.” (p. 7). Looking at the history of psychoanalysis, it appears that the studies that were conducted were carried out as case studies. On the other hand, Vanheule highlighted the benefits of qualitative research provides psychoanalytically oriented researcher with (2002). First of all, the context and the richness of the data can be preserved in qualitative research. Furthermore, the primary objective of qualitative research is to construct and develop a theory, which can be used to broaden the scope of substantial theories like psychoanalysis at the same time (Vanheule, 2002). Another advantage of this method is that as the data will not be gathered from an analytic situation, this “extra-clinical data” will be made use of establishing psychoanalysis a scientific standing (Dreher, 2002). This application of psychoanalysis to data acquired from outside of a clinical setting will also make it possible to reach individuals who are not undergoing analysis and enable a systematic questioning that cannot be valid for a clinical setting as it is the free associations of the patient that is followed in psychoanalysis (Vanheule, 2002). A further point where psychoanalysis and qualitative research methods are compatible is that qualitative research methods also emphasize individuals' subjectivity and their own interpretations, and do not ignore the researcher's position and actions (Ormston et al., 2014). Overall, it can be concluded that applied psychoanalysis can benefit from qualitative research methods as they can ensure them with necessary opportunity and freedom to center subjectivity and interpretation while exploring unconscious and language, meanwhile providing psychoanalytically oriented researchers with a channel for utilizing psychoanalysis in conducting research and systematic studies.

2.2. Design of the Study: Thematic Analysis

Thematic analysis was defined as “a method for identifying, analyzing, and reporting patterns (themes) within data” by Braun & Clarke (2006). Thematic analysis contains a variety of methods within itself, their common purpose being developing themes from qualitative data (Finlay, 2021). Differently from other analysis methods in

qualitative research, thematic analysis is more of a method rather than a methodology. These two concepts differ in the respect that a methodology dictates the implementation of a theoretical frame and not only an analytic method to pursue. Thematic analysis only provides the researcher with the second and enables the researcher with the freedom of utilizing the theoretical frame of their own choosing (Braun et al., 2022). Qualitative research can be divided into two positions as small q and Big Q orientations. While small q approximations adopt a positivist attitude, Big Q approximation comprises both technique and philosophy. Braun & Clark talked about three approaches to thematic analysis, which are described as coding reliability, reflexive, and codebook (2019). In coding reliability approach, the process starts with developing themes, and codes are developed by multiple researchers so that coherence can be ensured (Braun & Clarke, 2019). Reflexive thematic analysis is a method of analyzing qualitative data while placing an emphasis on the active participation of researchers during the process. It recognizes that the identification and interpretation of themes are influenced by the subjectivity and the theoretical framework of the researcher (Finlay, 2021). In reflexive thematic analysis, codes emerge gradually as the research proceeds, and they are open to change and improvement (McLeod, 2024). Lastly, codebook approach unites both methods. Although it uses systematic coding techniques similar to coding reliability, it gives qualitative research criteria like reflexivity priority (McLeod, 2024).

In their article published in 2019, Braun & Clarke placed their method of thematic analysis in Big Q and codebook approaches; however, they also stated that they now favored identifying their approach as reflexive thematic analysis. What distinguishes this approach is that it centers the researchers own role during the whole process. It emphasizes the fact that researchers take an active role throughout the research, and the importance of them to be conscious of their role (Finlay, 2021). In reflexive thematic analysis, the researcher aims to be aware of their own standing and background that is guiding their analysis and be transparent about it. They argued that codes or themes do not appear out of the data on their own, but it is the researcher who decides how to code, or whether a chunk of information to become a theme or not, it is a process of creation rather than discovery (Braun & Clarke, 2019). Through transparency and communication about the possible ways of their

expectations or presumptions might be shaping the process, reflexivity provides the researcher with a quality control (Braun et al., 2022). In other words, thematic analysis provides researchers with the freedom to integrate their choice of theory into their work while also ensures the trustworthiness of the study through reflexivity (Finlay, 2021).

When deciding on how to design a thematic analysis, there are a few things to be considered. Some of these can be listed as the aim of the study and accordingly, its research question, the content and the size of the sample, and the data itself. In addition to that, researcher's ontological and epistemological standing would be among the most crucial factors when designing a study (Braun et al, 2022). A thematic analysis can be either experiential or critical. An experientially oriented thematic analysis would put the participants' world views and perceptions in its center and would try not to deviate from it. On the other hand, a thematic analysis with a critical direction takes a more critical approach when interpreting meaning, which also applies to inquiries concerning the already existing meanings as well as their potential consequences (Finlay, 2021). From an epistemological point of view, the research can either adopt a realist or a constructionist approximation. A realist approach assumes a direct, one-way relationship between meaning, experience, and language. On the contrary, meaning and experience are constructed and recreated socially, rather than being intrinsic in people, according to a constructionist perspective (Braun & Clarke, 2006). In thematic analysis, when generating themes, there can be two possible routes, which are inductive and deductive analysis. An inductive process would refer to themes emerging from the data and not being affected by the researcher's theoretical background. At the same time, in a deductive, also referred to as theoretical, approach, researcher's theoretical standing and curiosity would influence the development of the themes. In other words, while the themes in an inductive analysis would be derived from the data, they would be driven by the researcher in a deductive approach (Braun et al., 2022). However, a thematic analysis can employ and benefit from both methods, as according to Braun & Clarke (2006), it is unlikely that the researcher's standing and background to not to influence the development of the themes. Lastly, another aspect to be taken into account will be the level of the interpretations. Interpretations can be either made

from a latent or a semantic level (Braun et al., 2022). When a semantic method is employed, the themes arise from the data's surface or explicit implications, and the analyst does not look for anything that extends beyond what participants have written or stated. At the latent level, on the contrary, analysis goes further than the semantic content of the data and tries to discover or investigate what is being said beyond the surface level, and what might be the factors that shape it (Braun & Clarke, 2006).

The current study was carried out by a researcher with a psychoanalytic orientation. One of the strengths of thematic analysis is that it provides the researcher with flexibility in employing their theory of choice. Additionally, its focus on subjectivity, interpretation, and reflexivity makes it a good fit to be used with a psychoanalytic approach. It can be said that the study held a more critical point of view, because the aim was to explore the unconscious materials beyond what was being said at the conscious level, and consequently, interrogating participants' own interpretations and discourses. Additionally, a constructionist approach was adopted in this research, as from a psychoanalytic point of view, meaning and language cannot be formed independent of O/others. Both inductive and deductive analysis was utilized in the study. At the beginning of the study, even when deciding on the topic and the research question, the researcher had a specific vision and curiosity and had some psychoanalytic concepts in mind that might have been relevant to this topic. Her background in psychoanalysis influenced her questions, her interviews, her initial codes and eventually, her themes. At the same time, the data also provided her with unexpected information, which generated a considerable amount of the codes and the themes of the research. Lastly, a latent level of analysis was applied in the present research, because, again in accordance with psychoanalysis, the aim of the researcher was to by scraping the surface level, to search for the traces of the unconscious and try revealing them.

2.3. Sampling Method and Participants

Purposive sampling is a method where participants are specifically chosen based on their personal attributes. It is a nonrandom method that doesn't require a predetermined number of participants or underlying ideas (Etikan et al., 2016). When

choosing which units to study, purposive sampling depends on the researcher's judgment (Rai & Thapa, 2015). In other words, the researcher determines what information is required and then searches for individuals who possess the knowledge or experience necessary to deliver it. In qualitative research, it is usually employed to find and choose the instances which provides the most information so that the resources are used as efficiently as possible (Etikan et al., 2016). Morrow stressed that unlike quantitative studies, while conducting a qualitative study, recruiting participants always comes with a purpose of selecting the individuals that meet the criteria and can give the relevant information in line with the research question (2005). The sample under investigation is typically rather small, particularly in contrast to probability sampling methods. Purposive sampling's primary objective is to concentrate on specific demographic features that are of interest and can best assist in addressing research concerns. The population is not represented by the sample under study (Rai & Thapa, 2015). In line with this information, purposive sampling method was utilized in the present study in order to reach the most suitable sample that was compatible with the research question of the study.

The research question of the study was “How do individuals diagnosed with bipolar disorder interpret this diagnosis?”. On the basis of the research question, the only inclusion criteria of the study was “being diagnosed with bipolar disorder”. No additional inclusion criteria were identified as the goal of the study was to explore individuals’ interpretations of their diagnosis; therefore, it was sufficient that they have received a diagnosis regardless of the specifics of the diagnosis, such as bipolar I or bipolar II disorder. As a result, the sample of the study included participants diagnosed with different types of bipolar disorder. In addition to this, participants’ genders, ages, age at diagnosis, and time since diagnosis also varied.

When deciding the sample size in thematic analysis, data saturation is one of the most widely used application. Saturation can be defined as the stage that occurs when no new information, codes, or themes emerge from data, and it is simply described as information redundancy (Braun & Clarke, 2019). However, in their article, Braun & Clarke argue that the concept of saturation is a method applied blindly and without question (2019). According to them, as an analysis that is based

on reflexivity and interpretation, a clear-cut application such as saturation cannot be suitable for thematic analysis. Since it is a fluid and organic process, the codes can always be changed and new meanings and interpretations can be generated; thus, “no new data” in thematic analysis cannot be a valid status (Braun & Clarke, 2019). Low also stated that the dynamic process of analysis can never be finished, and it is the researcher who decides on where to stop or when to proceed (2019). She put forward the idea of pragmatic saturation that suggested what might be considered as "saturation" depends on the analysis's objectives and aim (Low, 2019). Likewise, Braun & Clarke also pointed out that in qualitative studies, choosing the right sample size is a practical task and that it is critical to acknowledge that research is almost always a pragmatic endeavor, defined and limited by the researcher's time and resources (2019). Furthermore, when considering reasons for sample size in thematic analysis, the idea of information power, that was proposed by Maltreud et al., suggested that the more pertinent information a sample provides, the fewer participants are needed (2016). Lastly, Morrow pointed out that rather than the sample size, what gains significant importance is the sampling method, length and quality of the interviews and the data, and diversity of the information (2005). For the current study, after conducting 6 interviews, it was determined that a sufficiently rich, varied, and relevant information was reached. Hence, at that point, it was decided by the researcher to stop the data collection process.

Participants' descriptive information containing their pseudonyms, gender, diagnosis, age at diagnosis and time since diagnosis are shown in Table 1. A total of 6 participants were included in the data analysis. 2 of these 6 participants were men and 4 were women. Of these 6 participants, 3 were diagnosed with bipolar II disorder, 1 with bipolar I disorder, 1 with bipolar I disorder with psychotic features, and lastly 1 with bipolar I disorder with psychotic and mixed features. Participants' ages at diagnosis ranged between 16 to 27 and time since diagnosis varied from 4 to 21. Two participants who were interviewed were not included in the data analysis as it was found out that one of these participants did not actually receive a bipolar disorder diagnosis, and the other participant was considered not to have made a meaningful contribution to the data set.

Table 1. Descriptive information of the participants

Participants	Gender	Diagnosis	Age at Diagnosis	Time Since Diagnosis
Feray	Woman	Bipolar II	19	4
Bilge	Woman	Bipolar II	19	11
Ceyhun	Man	Bipolar I with psychotic features	18	10
Ekin	Woman	Bipolar II	27	10
Cenk	Man	Bipolar I with mixed and psychotic features	19	21
Neslihan	Woman	Bipolar I	16	9

2.4. Procedure

Ethical approval for the research was obtained from the Middle East Technical University Human Research Ethics Committee with the Protocol Number of 0055-ODTUİAEK-2025. Following the approval of the committee, the study was announced through various social media platforms, such as Instagram, LinkedIn, and Facebook. On the announcement, the sampling criteria, which was being diagnosed with bipolar disorder, was indicated, and included the researcher's email for those who would like to participate in the study to make contact. After that, participants who reached the researcher were informed with the terms and conditions of the study and a time for the interview was set with those who accepted the terms. The participants were informed that the interviews would be recorded and transcribed, their demographic information would be changed in order to ensure anonymity, and that they were free to leave the interview whenever they wanted. Informed consents were taken both in writing and verbally before each interview. All the interviews were conducted online through meeting platforms such as Google Meet or Microsoft Teams. Semi-structured interviews were realized with each participant. All the participants were interviewed once. At the end of the interviews, the participants were told that they can reach the researcher for further questions, and they were given the information of the METU AYNA Clinical Psychology Support Unit. The

interviews lasted between 68 to 112 minutes. Interviews were audio recorded, and they were later transcribed and coded.

2.5. Data Collection and Data Analysis

Braun & Clarke presented researchers who is planning to carry out a thematic analysis with a six-step framework (2006). However, these six steps do not have to be a linear process, and researchers can adapt these stages to their own needs and preferences (Finlay, 2021). The first step introduced by Braun & Clarke is familiarization with the data (2006). At this phase, researcher gets to know the data by reading or listening to it repeatedly. During this stage, sometimes information that had gone unnoticed previously might be discovered and new meanings, ideas, or even questions can arise (Braun et al., 2022). Transcribing the data is also an essential part of this step. Later, the first codes can begin to be developed. Researcher searches for meanings in the data in relation to the research question. Codes can be developed depending on whether the researcher place greater emphasis on the data or the theory. A code may contain various meanings, and they can change or combined with others at later stages (Braun & Clarke, 2006). After extracting the initial codes, the primary themes can be formed based on these codes. When generating themes, instead of merely classifying data, the goal will be to create significant patterns. The codes should be investigated in a way that they could group together to provide a cohesive narrative about a pattern of meaning (Braun et al, 2022). After constructing the preliminary themes, next step would be to review them so that they would be as comprehensive and targeted as possible. Some themes can be deducted, united or enhanced at this point in a way that would best reflect the data. By the end of this stage, researcher develops an adequate understanding of the themes, their connections to each other and to the overall narrative (Braun and Clarke, 2006). Next, themes can be named. When naming the themes, it is crucial for the names to fully express the main idea of the theme to the reader. A definition of each theme can be written at this phase. At the end, themes should not be hollow or overly comprehensive, they should address the research question, and collectively tell a story (Braun and Clarke, 2006). Braun and her colleagues warned researchers not to generate themes as summaries of the data, but to be creative, as a theme would

revolve around a common meaning and would reflect the interpretation of the researcher on that meaning (2022). Last step of the analysis would be writing the report. The report would have to persuade the reader of the credibility and the value of the analysis by presenting the complex story of the data. Braun et al. resembles the researcher to a storyteller and emphasizes the fact that it is the researcher's task to give voice to the data, as the data would not stand for much independent of the researcher (2022).

At the present study, analysis process started with listening to audio recordings of the interviews following conducting the meetings. Later, all the interviews were transcribed and read repeatedly by the researcher. Listening and reading the interviews aroused new questions and curiosities on her mind, and gradually, some ideas and similarities began to emerge. Based on the previous meeting, topics that could be asked or noted in the next meeting were recorded. After finishing the interview process and listening to and reading each interview multiple times, initial codes started to be created. Coding was done by utilizing MAXQDA 2024 (VERBI Software, 2024). Before starting to generate themes, these codes were reviewed, combined or divided, changed or developed. Next, prototypes of the themes were created, and a mind map was drawn up showing some of the keywords of each code. Themes were attempted to be created by considering the similarities between the codes and taking into account the distinctiveness of these codes. Keywords, particularly notable quotations and summaries were extracted for all themes considered capable of forming a subtheme. When certain subthemes began to emerge, they were gathered under the main themes. However, as the process progressed and all themes and codes were reviewed repeatedly, subthemes and main themes changed many times; some subthemes were removed, some were merged or placed under another main theme. At this stage, themes were discussed with peers and was reorganized accordingly with their suggestions. When themes were developed to a certain extent, they were discussed with the supervisor. Based on the supervisor's feedback, certain themes were removed, subthemes that showed similarities were combined with each other, themes that did not reflect the main theme or contradicted with each other were adjusted, and themes were largely simplified. In addition, names of the themes were also largely altered and

reorganized to better reflect the theme. Although the researcher tried to include the essential material from the interviews in the study to a large extent and not to overlook important information, some themes were eliminated during the process or addressed in a way that was parallel to the research question in order not to deviate from the research question of the study. For example, the theme regarding individuals' experiences with bipolar disorder initially included their separate experiences with depression, mania, or hypomania. Later, this theme was revised in order to focus more on the impact of the diagnosis on individuals' experiences. Another example to this situation was to decide examining individuals' relationships with their social environment not in an individual manner, but within the framework of concepts such as recognition, gaze, and image. As a result, while finalizing the themes, research question was kept central, ensuring that themes were relevant to this question. In addition, themes were tried to be created as simple and precise as possible.

2.6. Trustworthiness of the Study

Ensuring trustworthiness in qualitative research differs from quantitative research as it focuses on a different kind of data rather than a statistical one. Accordingly, terms that are valid for quantitative data such as reliability, validity, generalizability, or objectivity would no longer be eligible (Morrow, 2005). While conducting qualitative research, some aspects that would have to be considered will be that the data will not be generalizable because of using a small sample and not utilizing a statistical data, and the fact that qualitative research cannot be an objective process as it involves the researcher to assume an active and inclusive role during all stages of the research (Gasson, 2004). Therefore, new methods to obtain trustworthiness would have to emerge when conducting qualitative research.

When discussing reliability in qualitative research, the key concepts that emerge can be considered as subjectivity and reflexivity. In his work, Patton talked about the importance of researchers accepting and reconciling with their subjectivity and even taking advantage from it (2002). Likewise, reflexivity, which stands for both being aware of oneself and putting this awareness into action, can serve as a way for the

researcher to gain insight on how their experiences and perceptions impact the process. Moreover, researcher's blending of their own practice and theoretical background, comprehension, and singularity is also highlighted (Patton, 2002). One way of providing subjectivity was defined as "bracketing", which corresponds to explaining on ways of recognizing one's preconceptions and biases and putting them aside so that they would have no negative impact on the research (Husserl, 1931). But since there will be numerous factors affecting the process, this approach would hardly be possible. At this point, reflexivity, in which the researcher accepts and embraces their own role, is introduced. Reflexivity is also at the core of Braun & Clarke's thematic analysis method (2019). Every step of the research, from start to finish, depends on the researcher's curiosity, purpose, theoretical stance, and decisions. Research does not shape itself, but rather, it is the researcher who shapes and creates it. That is why it holds a vital importance for the researcher to be aware of their own role and subjectivity throughout the research, to embrace it, and even to transform it into material (Braun & Clarke, 2019). While conducting their research, even though researchers do not aim to be objective, they are still obligated to ensure the reliability of the research, which is the point where reflexivity comes into play (Finlay, 2021). Reflexivity may be achieved through various ways, such as keeping a research diary, where the researcher writes down their feelings, thoughts, and experiences. Along with this, getting debriefs and comments from peers or colleagues, and receiving supervision from advisors can be ways of maintaining reflexivity (Morrow, 2005).

Vanheule also stressed the importance of taking validation of the study into consideration while conducting psychoanalytic research (2002). He emphasizes the significance of the researchers being aware of personal factors that contribute to their interest in a subject, or the potentially biased impact of their "desire to know". Looking at it from a psychoanalytic perspective, there is always a chance that the researcher's "desire to know" might lead the researcher to arrive at imaginary conclusions (Vanheule, 2002). Reed (1985) also pointed out that in order for something to be accounted as psychoanalytic, it should look further than the manifest content and engage in the latent content. Valid results can only be reached through following signifiers, and their connections to each other. In clearer terms, meaning

should be constructed based on the data at hand, and not from the researcher's own interpretations or expectations (Vanheule, 2002).

The following section will explore the researcher's experiences, thoughts, and conflicts throughout this process. Writing this thesis has been a difficult process for me from the start. I can say that I have experienced a resistance at every stage without exception. No matter how much I think about or talk about this difficulty I have experienced, I can't fully grasp its implications. I believe it touched on some core issues for me. This process has made me work psychoanalytically as well as academically. I've discovered many things about myself during this process. For a long time, I couldn't decide what I wanted to study. My indecisiveness, being unable to maintain a confident stance was also clearly observable to my supervisors. I was in a state of utter indecision and panic. I changed my topic repeatedly during the process. Some of the topics I chose were too far-fetched, too scattered to be researched, some were too close to me, which is why I couldn't move forward, and some were topics I wasn't really interested in. I now think that the topic I ultimately chose was in a way paralleled my own issues. Just as getting a diagnosis would mean making sense of the chaos and turning on a light in the darkness, for me, choosing a topic would mean ending the confusion and panic I was experiencing, and indeed, it did. At the same time, both personally as someone who received a psychiatric diagnosis in adolescence and based on my observations as a clinician, I was curious about what did receiving a diagnosis mean for people. In my sessions, I encountered patients asking me, "Do you think I have ...?" or perhaps even directly, "Do you think I am ...?" I have often witnessed patients self-diagnosing or embracing their diagnosis. "Why do people want to get a diagnosis?" "Why do people embrace their diagnosis so much?" "What does a diagnosis mean for people?" "What does diagnosis stand for them?" These questions still intrigue me. The basis for my decision to study bipolar disorder lies in my childhood. During my childhood, I had the opportunity to observe this illness, or rather, to listen to it. There were members in my family with this disorder, and I heard about it partly from them, and partly from my family. In fact, it may have been the first psychiatric disorder I had ever heard of. I was young, and what I heard surprised me. At the time, I couldn't quite make sense of it, I only realized how much this disorder impacted both their own

lives and the lives of people around them. In college, people with bipolar disorder entered my life as well. I think at this point, I became more interested in how people used this diagnosis in their lives rather than in what this disorder actually is. Since I started conducting interviews, I have become more and more intrigued with this topic, and my curiosity continues to grow, sparking many questions and ideas for future research. During the process of writing this thesis, I felt that my own emotional state fluctuated between the two polars as well. The process of deciding on a topic was very difficult for me; during this period, I went through a difficult phase, which has corresponded to a depressive state. While writing the thesis, however, I was in a more manic phase, so to speak, a period when I felt very energetic and happy. When I finished my thesis, I entered another period of depression, it was hard for me to part with this thesis. I realize that I have put a lot of myself into this thesis, especially with the names of the themes. When deciding on the names of the themes, I can say that my associations guided me; in a way, the names found me. These names come from songs, books, films, and aphorisms, so I can say they directly reflect my style. It was my way of expressing my own subjectivity and adding something from myself, as if signing my own name. I also realize that throughout my research and writing, it was always the manic aspect that has fascinated me the most. Perhaps I didn't want to see the depressive side of the illness, as well as my own during this time, so I focused on the manic side. It was difficult for me to separate "myself" from this thesis, in both senses. This situation became more apparent to me when my professors pointed it out. Even after I have finished and defended it, I am still thinking about it and still have questions. This process has been long and challenging for me from many aspects. But it has pushed me just as hard. Not only in relation to my thesis, but also in relation to myself. Still, my journey continues. I recognize I have a long way to go. But as the saying goes, "it is not the destination but the journey". This thesis has been a part of my journey.

CHAPTER 3

RESULTS

This chapter will illustrate the results of the analysis. As a result of both inductive and deductive thematic analysis, five super-ordinate themes were constituted. Themes were formed on the basis of the research question of the study, which was “How do individuals diagnosed with bipolar disorder interpret this diagnosis?” The theoretical approach that shaped the creation of themes was Lacanian Psychoanalysis. The five super-ordinate themes were determined as (1) *I Can See Clearly Now: The Diagnosis as an Identity*, (2) *Surrender Your Guilt Be Free: Being Diagnosed and Being Relieved from Responsibility*, (3) *With or Without You: Experiences Before and After the Diagnosis*, (4) *To Be or Not to Be Recognized, That Is the Question*, (5) *Mirror Mirror on the Other*. Table 2 shows the main and the subordinate themes. Although there might appear to be commonalities and similarities between some themes, each theme actually represents a part of the story and has been examined theoretically within different conceptual frameworks. This chapter includes the descriptions of the main and subordinate themes and presents extractions from the interviews.

Table 2. Main and subordinate themes of the study

1. I Can See Clearly Now: The Diagnosis as an Identity
1.1. I Know Therefore I Am: Diagnosis as a Way of Signification
1.2. Who Am I, Really?: Alienating Effect of the Diagnosis
1.3. I Equals Bipolar: Identification with the Diagnosis
1.4. Not Normal, Bipolar: Being Bipolar as a Distinguishing Factor
2. Surrender Your Guilt Be Free: Being Diagnosed and Being Relieved from Responsibility
2.1. It Wasn't Me It Was Bipolar: Being Cleared of Guilt by Dissociating the Disorder from the Self
2.2. Just Like Diabetes: Biologizing the Disorder

Table 2. (continued)

3. With or Without You: Experiences Before and After the Diagnosis
3.1. Livin' on the Edge: The Two Polars
3.2. Know Thyself: Transformations in Experiences Through Receiving a Diagnosis
4. To Be or Not to Be Recognized, That Is the Question
4.1. Doctor! Doctor!: Being Recognized by the Doctor
4.2. Now You See Me Now You Don't: Striving to be Recognized
5. Mirror Mirror on the Other
5.1. The Cool, The Mad and The Rotten: How Is Bipolar Disorder Perceived by Others?
5.2. You Never Can Tell: How Am I Perceived by Others?

3.1. I Can See Clearly Now: The Diagnosis as an Identity

This main theme discusses how do individuals perceive their bipolar disorder diagnosis. This main theme is directly related to the research question “How do individuals diagnosed with bipolar disorder interpret this diagnosis?” as it was demonstrated that individuals who were diagnosed with bipolar disorder regarded their diagnosis as a part of their identity, as something that makes them who they are. They referred to the disorder as a “part of them”, and also in their discourse, the disorder and their selves were intertwined. When talking about the disorder, they used the verb “being”, and they used statements such as “my illness”, or “my bipolar”, which is discussed as a sign of them introjecting and identifying with the diagnosis. The subordinate themes of this main theme almost follow the steps of “mirror stage” proposed by Lacan. Mirror stage is essential in Lacanian psychoanalysis as it is the first time the infant sees himself in the mirror and recognizes his image, perceives himself as a whole and united being. This moment brings an awareness for the infant as it contradicts the previous perception of a fragmented and chaotic being. However, as a result of the contradiction between the way the infant experiences his body, which is still disorganized, fragmented and out of his control; and the united image he sees in the mirror, rises a feeling of alienation. Through a Big Other who recognizes and names this image by pointing out to the image and says, “This is you”, an identification can occur. The infant identifies with this image he sees in the mirror and assumes an image, and consequently, forms an ego. Therefore, the role of naming, and in this way, signification, is also essential in

this process. In this main theme, stages of forming and accepting a bipolar identity is demonstrated.

This main theme is composed of four subordinate themes; all indicating a different aspect of how individuals related to their diagnosis. Together, they represent a formation of identification between the individuals and their diagnosis and shows individuals assuming and accepting their diagnosis as a part of their identity. The first subordinate theme illustrates the function of diagnosis as a signification for the individuals. The second subordinate theme demonstrates the alienating feeling that comes with receiving a diagnosis. The third subordinate theme shows the individuals' identifications with their diagnosis, and how they consider the diagnosis as a part of themselves. The last subordinate theme discusses how the diagnosis distinguishes the individuals diagnosed with bipolar disorder from "normal" or "non-bipolar" people.

3.1.1. I Know Therefore I Am: Diagnosis as a Way of Signification

This subtheme illustrates the role that diagnosis plays as a way of "signification" for the individuals. Almost all participants described the period before the diagnosis as an unknown and dark period. At that point, receiving a diagnosis, and putting a name to the previously unknown, acted as a way of signification, and through signification, individuals could start making sense of it. This phase also corresponds to the naming and signifying stage in the mirror stage. Through a Big Other who points out to the image in the mirror and says "Look, this is you!", a groundwork for identification and forming an ego is laid for the infant. In this manner, diagnosis works as a way of stapling individuals as "bipolar" and paves the way of them forming a bipolar image, bipolar narrative and identity for themselves.

This stage is characterized by the participants as an "explanation" or a "meaning", and they also talked about "being afraid of what you don't know" or getting a diagnosis as a process of "domestication". They stated that after getting a diagnosis, they looked back at their past experiences and what they could not understand or make sense of back then has suddenly gained meaning, and they described this

period as “the stones falling into place”. In addition to that, after being diagnosed, they conveyed researching and gaining knowledge about the disorder and said what they learned really coincided with and resembled their own experiences.

In line with this, Cenk described that once he accepted his diagnosis, what he previously experienced and could not make sense of back then suddenly started to gain a meaning for him, and he could now explain it with a bipolar disorder diagnosis. He also demonstrated this process as “everything clicking into place for him”.

Cenk: Well, after the acceptance process, after I said to myself, “Okay, I really do have bipolar disorder, I have to accept that now.” it was like everything just **clicked into place** for me. I could finally **make sense** of a lot of things. Like the bike thing, I don't know, the night music thing and so on. I could **understand** them a bit more now. At least they made sense to me. I guess you could say that.

Original:

Cenk: *Valla işte kabul sürecinden sonra, yani “Ya ben hakikaten bipolar bozukluk hastasıyım bunu artık kabul etmeliyim.” dedikten sonra biraz da böyle şak şak şak **bütün taşların yerine oturması** dönemi oldu bende. İşte artık **birçok şeyi anlamlandırabilmişim**. İşte bisiklet olayı, ne bileyim gece müzik olayı vesaire falan gibi. Artık onları daha biraz anlayabiliyordum. Hiç olmazsa **bir anlama kavuşmuştu** yani öyle söyleyebilirim.*

Likewise, Ekin also said that in order to understand, a diagnosis is necessary. She resembled the period before the diagnosis to “dark ages” and stated that everything started with the diagnosis for her. She compared getting a diagnosis to “learning to read the hieroglyphics”, and said only once you learn to read them, you can attain information.

Ekin: For me, **it all started with the diagnosis**, so most things are like the **dark ages before the diagnosis**, you've lived through them, but you don't know what they were like. Were they beautiful? They were beautiful, absolutely beautiful, but they were very difficult, and that's why they were difficult. So, there's something there, but **you don't know it**. For example, right now, when someone tells me I'm very energetic, I get scared, wondering, “Am I really like that?”

Researcher: You used the analogy of a dark age here.

Ekin: Hieroglyphics! You look at them and there's something like this, like, really? You know, after you learn to read hieroglyphics, you start to learn about that place. Well, with this thing, when I look back at the past with the knowledge I gained during that 10-year period, I say, “Oh, yes, it was like that...” It's like looking back at the past through those **glasses** and reusing the information there to understand the present. The reason I call it the dark ages is that **you need that diagnosis to understand it.**

Original:

Ekin: Benim için tanıyla başladı o yüzden çoğu şey. Ya tanıdan öncesi şey gibi karanlık çağ. Ha yaşamışsınız ama ne olduğunu bilmiyorsunuz. Ha güzel miydi güzeldi kesinlikle çok güzeldi ama çok zordu ve zor olmasının nedeni de buydu. Yani bir şey var ama bilmiyorsunuz. Ya mesela şu an bana biri çok enerjiksın dediğinde korkuyorum ilk gerçekten öyle miyim acaba falan diye.

Araştırmacı: Karanlık çağ benzetmesi yaptınız burada.

Ekin: Hiyeroglifler! Bakıyorsunuz böyle “A böyle bir şey varmış”. O yani şey gibi ya gerçekten öyle hani hiyeroglifleri okumayı öğrendikten sonra orası ile ilgili bilgi edinmeye başlarsınız ya. Ben de bu şeyde ya o 10 yıllık süreçte edindiğim bilgilerle geçmişe bakınca “A evet ya böyleydi” falan diyorum. O **gözlükle geçmişe bakıp oradaki bilgileri şimdiki anlamak için tekrar kullanmak gibi. Karanlık çağ dememin nedeni o **anlamanız için o teşhise ihtiyacınız var.****

In line with these quotations, Neslihan described getting diagnosed as “waking up from a dream”. What was previously blurry and obscure to her suddenly reached a meaning, and through it, she could reinterpret her past. It is also noteworthy that while participants described the pre-diagnosis period as “a dream” or “dark ages”, they resembled the diagnosis to reflective surfaces, such as glasses or camera lenses, just like a mirror.

These quotations clearly demonstrate where does the diagnosis stands for the individuals. Diagnosis works as a “signification”, a way of making sense and understanding. It is the first step of identification. By learning the name, individuals can start to assume it as a part of them and adopt it as an identity. Another striking point is the fact that diagnosis also works as a reflective surface, like a mirror that reflects the image of the individuals and shows them how they look or how they are.

3.1.2. Who Am I, Really?: Alienating Effect of the Diagnosis

This subtheme demonstrates the alienating effect of the diagnosis and the alienation that comes with receiving a diagnosis for the individuals. Although almost all of

them eventually identified with the diagnosis and assumed it as a part of themselves and adopted it as a part of their identity, they stumbled at first and got confused on how to process it. They conveyed the confusion on how to separate their own identities and selves from what the disorder brings, especially with mania.

For instance, Neslihan talked about not being able to separate the mania from herself and her own wishes or thoughts and said that she could not decide whether it is her or is it mania that is on the wheel. This brought a confusion for her and caused her to criticize herself.

Neslihan: So, for example, even before I was diagnosed, there were some things I wanted in life. Like traveling the world and so on, the kind of dreams anyone might have. After getting diagnosed, even if it was just a distant plan, or even a close plan, but even if it was a distant plan, whenever I did something, I would always criticize myself, thinking, “**Do you really want this because you are you, or do you want it because you're manic?**”.

Original:

*Neslihan: Yani, ya mesela aslında tanı almadan önce de istediğim bazı şeyler vardı hayatta. Hani atıyorum dünyayı gezmek vesaire, herkesin olabilecek hayalleri. Tanı aldıktan sonra bununla ilgili herhangi bir uzak plan bile olsa, ya yani yakın plan da olabilir, ama uzak plan bile olsa yapsam, hep kendi kendime, “Yani bunu **sen gerçekten sen olduğun için mi istiyorsun yoksa manik olduğun için mi istiyorsun?**”, gibi her kararında kendimi eleştiriyordum.*

Ekin, on the other hand, asserted that when she was first diagnosed, she felt like she had no character. She conveyed she could not distinguish her own identity from the disorder and asked whether everything she is is because of her illness, and if there is something to her beyond the disorder. She questioned who she would be without this illness by saying “if they took this illness away from her” or “if she woke up to a day that she was not bipolar”.

Ekin: I remember it very clearly. Afterwards, I felt like that, and for a while I felt like **I had no character**. Like, **is everything I have right now actually because I'm bipolar? If they took this illness away from me, who would I be?** Am I a cheerful person? Am I an energetic person? Am I a happy person? Do I actually laugh a lot? **What am I**, you know? This, for example, weighed heavily on me.

Original:

Ekin: *Ben şeyi çok net hatırlıyorum. Sonrasında ben böyle şey gibi hissetmişim, bir süre acaba **karactersiz hissetmişim** kendimi. Hani şu an **sahip olduğum bütün her şey aslında bipolar olduğum için mi, yani bu hastalığı benden alsalar ben kim olacağım.** Ben neşeli bir insan mıyım? Ben enerjik bir insan mıyım? Ben mutlu bir insan mıyım? Ben aslında gerçekten çok mu gülüyorum? **Ben neyim** hani? Bu, bu mesela bana çok ağır gelmişti.*

Ceyhun also talked about his confusion concerning the bipolar disorder diagnosis. However, it should be noted that Ceyhun was also diagnosed with psychosis, and his discourse was significantly different than other participants. Unlike the others, his speech was much more disorganized, and it is thought that he showed no indication of an identification with the diagnosis, and he talked about the diagnosis not as something that integrated him, but rather as something that disintegrated him. He stated that with being diagnosed, he lost his sense of self.

Ceyhun: Is my life a NASA project or a mental hospital? Or being an unemployed student or medical school? Do you understand? So, being on one extreme or the other is like this. It prevents you from making plans for the future, do you understand? I said losing your sense of self. You're constantly in shock. **Am I this or am I that?** Do you understand? I mean, I got into Bilkent Civil Engineering years ago. But now I'm barely managing to get through open education, do you understand? It's confusing, **which one of me am I?**

Original:

Ceyhun: *Hayatım acaba NASA'nın projesi mi yoksa akıl hastanesi mi? Veya işsiz güçsüz öğrenci mi yoksa tıp fakültesi mi? Anlatabildim mi? Yani işte iki uçlu olmak veya diğer iki uçlu olmak bu şekilde işte. Geleceğe dair plan yapmanızı engelliyor, anlatabildim mi? Benlik algısını kaybetmek dedim ya. Sürekli bir şok yaşıyorsunuz. **Ben o muyum ben bu muyum?** Anlatabildim mi? Ya Bilkent İnşaat Mühendisliğini kazanmıştım yıllar önce. Ama şu an açık öğretilimi zar zor okuyorum, anlatabildim mi? Bu da insanı şaşırtıyor, **ben acaba hangi benim** gibi.*

As does the quotations suggest, being diagnosed came with certain questions concerning their identity for the individuals. Diagnosis made them question who they were, where did this diagnosis correspond in their identities or if there was a part of them that existed independently from this disorder. They also stated that at first, they struggled in processing this information. For example, Ekin reported that when her doctor told her, "You are bipolar two.", she responded to this by asking him, "Are

you sure I am really that?’. However, the speech of the participants also demonstrated that their diagnosis and their identity were so intertwined that they could not distinguish between the two in their discourse. They talked about the bipolar disorder by using the verb “being” and could not separate bipolar disorder from their selves.

What has been described by the participants resembled alienation. During the mirror stage, identifying with the image seen in the mirror brings a feeling of alienation. For the infant, assuming an image outside of himself, who is him yet a stranger at the same time, would cause him to alienate from himself. There can never be a complete overlap between him and this extraneous image. Like the mirror image, the diagnosis is considered as a part of the individuals, but still, it is exterior.

3.1.3. I Equals Bipolar: Identification with the Diagnosis

In this subtheme, participants’ expressions that exemplifies their identification with the diagnosis will be demonstrated. Based on the reflections of the participants, it was inferred that individuals considered this diagnosis as a part of themselves and even matched the disorder directly with themselves. Some of the statements that was used by the participants when talking about their diagnosis which were thought to be illustrations of this identification can be illustrated as “I equals bipolar”, “this is me”, “it is directly me”, “what makes me who I am is my illness”, “I’m glad I am bipolar”, and “my bipolar”.

Neslihan directly talked about bipolar disorder as a “part of her” and compared the disorder to her body parts such as her hair or her arm. When it was highlighted that she described bipolar disorder as a part of her, she stated that it is not like an arm as she can go on without it, but she cannot go on without being bipolar.

Neslihan: So, **this is part of me** right now. Just like **my hair** is wavy, I think I have this kind of situation mentally. And I try to use this situation in the most compatible and productive way for myself.

Researcher: You described bipolar disorder as a part of you.

Neslihan: Yes, it's actually **directly me**. It could be called one of my characteristics, because it's not like **an arm**. Maybe **I could lose my arm, I could continue without it, but bipolar disorder is no longer like that for me**.

Original:

Neslihan: Yani, bu benim için şu an **benim bir parçam**. Hani nasıl ki **saçlarım** dalgalıysa zihnen de böyle bir durumum var diye düşünüyorum. Ve bu durumu kendim için en uyumlu en verimli şekilde kullanmaya çalışıyorum.

Araştırmacı: Bipolar bozukluğu da bir parçanız gibi tanımladınız.

Neslihan: Evet, **yani direkt benim aslında**. Benim bir özelliğim de denebilir yani, çünkü **kolum** gibi bir şey değil. **Belki sakat kalabilirim, onsuz devam ederim, ama bipolarlık artık öyle bir şey değil benim için**.

Ekin once again talked about the diagnosis as glasses. She expressed that for her, what is called life is the diagnosis, as almost everything about her happened by receiving the diagnosis.

Ekin: So, actually, for me, **this thing called life is that diagnosis**. Seriously, I think **most things related to me happened with that diagnosis**. Because now you look at the past through those **glasses**. Or you look at people through those glasses. Getting diagnosed changed that for me.

Original:

Ekin: Yani, aslında şöyle benim için, **hayat denilen şey o tanı**. Yani şöyle cidden, ya bence, **benle alakalı çoğu şey o tanıyla beraber oldu** gibi. Çünkü ben şeyle geçmişe de o **gözlükle** bakıyorsunuz artık. Ya da insanlara da o gözlükle bakıyorsunuz. Tanı almak onu değiştirdi bende.

Ekin also stated that the illness will always be with her, and she likened the disorder to a “shadow”, which will always be near her, go wherever she goes, and compared being bipolar to “always living with her shadow”.

Almost all participants described bipolar disorder as a part of them. It was also striking that when talking about the disorder, they said, “my illness” or even “my bipolar” in a possessive manner and used the verb “having” when they talked about their diagnosis. This discourse was addressed as an indication of an internalization of the diagnosis for the individuals.

What was also considerable was the fact that participants talked about the disorder in connection with their bodies, like Neslihan who compared the disorder to her hair or

arm, and Ekin who associated it with her shadow. On the other hand, in contrast to these, Ceyhun likened the diagnosis to living with a knee replacement or a bullet in the head, which are external and foreign objects unlike the previous examples. This again brings the mirror stage in mind in the sense that whether it would be possible or not for the individual to internalize their external image. Based on their discourses, it can be argued that while most of the participants were able to internalize and identify with the diagnosis, Ceyhun was not.

3.1.4. Not Normal, Bipolar: Being Bipolar as a Distinguishing Factor

This subtheme discusses how individuals diagnosed with bipolar disorder positioned their diagnosis as something that distinguished them from other people. Individuals with a bipolar disorder diagnosis made a distinction between “bipolar individuals” and “non-bipolar individuals” and separated themselves from what they call as “normal people”.

Neslihan referred to this by saying while someone who is not bipolar continues in a monotonous, singular way, she believes that she has the capacity to change all the time. Although she also stated no one is that monotonous, it was clear that she distinguished herself from non-bipolar individuals and placed herself in a different position. From her speech, it can also be concluded that she regarded her potential of changing constantly as a positive situation that separates her from others.

Neslihan: Well, how can I explain it, it's like **someone who isn't bipolar** just keeps going in a monotonous way- though no one is that monotonous, really- but for me, independent of my surroundings, independent of what's happening around me, **I feel like I have the potential to constantly change.**

Original:

Neslihan: *Yani, nasıl anlatırım, sanki mesela **bipolar olmayan biri** tek haliyle hep monoton devam ediyorken- gerçi kimse o kadar monoton değil ama- kendim için çevremden, yani çevremden yaşanan şeylerden bağımsız, sürekli bir **değişkenlik gösterebilme potansiyeline sahip hissediyorum.***

Ekin, on the other hand, addressed a bipolar identity by saying only another bipolar can understand a bipolar person and indicated that until meeting another bipolar

person, they are alone. By emphasizing the difficulty of the illness, she argued no one would be able to comprehend it unless they have also suffered from it. She also imagined a hypothetical situation in which she would meet another bipolar individual and share her diagnosis with them. She almost referred to a bipolar community by separating the bipolar individuals from others and placing bipolar disorder beyond their comprehension.

Ekin: So, I think **only someone with bipolar disorder can understand another person with bipolar disorder.** Everyone else can offer support. That's all there is to it. For example, if someone said to me, "I have bipolar disorder." I wouldn't hide it—I mean, I don't go around waving flags saying, "I have bipolar disorder." But let's say, for example, at the place I just started working, someone says, "My brother was diagnosed with bipolar disorder." I'd say, "I'm bipolar too, you don't need to be scared." Because, you know, it's not like that. The difficulties you go through with those medications, everything you go through with the doctor, **only someone who's already been through it can understand.** That's why it's a lonely illness, you know? **You're really alone until you meet another bipolar person.**

Original:

Ekin: Yani şöyle, **bir bipoları bir bipolar anlayabilir** bence. Geriye kalan herkes destek verebilir. Onun dışında şey değil. Ya mesela şöyle, biri bana hani "Ben işte bipolarım." dese ben kendimi- şey ya bu arada ben saklamıyorum da kendimi- ama öyle bayrakları açıp "Ben de bipolarım." diye de gezmiyorum. Ama atıyorum, mesela şu an çalışmaya başladığım yerde biri dese ki "Ya benim kardeşime bipolar teşhisi kondu.", ben söylerim, "Ben de bipolarım korkmana gerek yok o kadar." diye. Hani çünkü şey değil, gerçekten o ilaçlarda yaşadığım zorluk, doktorla yaşadığı her şeyi **sadece daha önce bunları zaten yaşamış olan biri anlayabiliyor.** O yüzden yalnız bir hastalık hani, **sen gerçekten başka bipolarla tanışana kadar yalnızsın.**

Feray directly talked about the benefits and positive aspects of the disorder by saying because she does not need much sleep during hypomania, she can make use of those times. She also pointed out the fact that she has experienced a level of happiness that healthy people could never do. She differentiated herself from healthy or normal individuals and positioned herself in a privileged position.

Feray: If I had a choice, of course I wouldn't want to have this condition. But I think there are positive aspects to it too. For example, if I can make productive use of the days I spend sleepless, it adds a lot to my life. **I can accomplish things in a short period that some people couldn't do,** because I don't spend time sleeping. Or it has this effect, **I've experienced a level of**

happiness that healthy individuals might never experience in their entire lives. So, I don't know if I would want to die without experiencing that level of happiness. Because it's one of the most beautiful things in the world. I mean, how can I put it, it's such an amazing feeling that sometimes, instead of focusing on depression, I can be grateful just for being able to experience that feeling. It's really a very different feeling.

Original:

*Feray: Hiç seçim şansım olsaydı tabii ki bu rahatsızlığa sahip olmak istemezdim. Ama şöyle olumlu yanları da var bence, uykusuz geçirebildiğim günleri eğer verimli bir şekilde geçebilirsem bana çok şey katıyor mesela. Bazı insanların yapamayacağı şeyleri de yapabilmiş oluyorum kısa bir süreçte, çünkü uykuya zaman ayırmıyorum. Ya da şöyle bir etkisi var, **sağlıklı bireylerin yaşayamayacağı belki de ömrü boyunca yaşayamayacağı mutluluk seviyesini yaşamı yaşadım yaşıyorum.** Yani o mutluluk seviyesini yani yaşamadan ölmek ister miydim bilmiyorum. Çünkü dünyanın en güzel şeylerinden biri. Yani hani gerçekten nasıl söylesem, o kadar harika bir his ki bazen hani depresyona odaklanmaktansa o hissi yaşayabildiğim için bile şükredebiliyorum. Yani gerçekten çok farklı bir his.*

At the same time, most of the participants indicated that they have always known that they were different. Even though they talked about the difficulties that the disorder brings, or their sufferings, the disorder also held a place that made them “unique” and differentiated them from other individuals. By making a distinction between the “healthy” and “bipolar” people, they held themselves as different individuals. Also, by referencing other bipolars, they positioned themselves as a group, separate from the normal people. They mentioned some of the advantages and positive aspects of the illness, which are unattainable by the healthy individuals. To conclude, adopting a “bipolar identity” also functioned as a way of elevating them to a privileged and unique position at the same time.

3.2. Surrender Your Guilt Be Free: Being Diagnosed and Being Relieved from Responsibility

In this main theme, another aspect of the diagnosis for the individuals is discussed. Discourse of the participants showed that receiving a bipolar disorder diagnosis played a role in relieving them from their guilt, and their responsibilities. It was striking that during the interviews, when the participants were asked how they felt or what did they think when they were first diagnosed, almost all participants replied by

saying they were “relieved”. Although they also connected this relief with finally learning the reason behind their feelings or their acts and putting a name to it, their speech also revealed a feeling of “guilt”, and getting a diagnosis also helped them to be freed of this guilt. This feeling of guilt disclosed itself in different contexts, for instance, some stated that they were not at fault for having this illness, some reported feeling less accusatory towards themselves as they created a reason for their behaviors, and some conveyed that just as a diabetic patient does not blame themselves for being sick, they also did not have to blame themselves for being sick. Expressions like “fault”, “accusation”, or “blame” were notable in their speech. However, when they were asked about this guilt and its origin, they could not provide a significant answer. For example, when Feray, who mentioned feeling guilty, was asked why she might be feeling guilty, she responded that she also did not know and suggested it might be a condition related to her brain. Another example of this situation was when Cenk was asked why he might be referring to it as a “fault”, who reported that it was not his fault when he was talking about his illness, he responded to this question by saying “Yes, I think so too, why should it be a fault?”. However, along with this, participants stated that after receiving a diagnosis, they no longer felt guilty and talked about the diagnosis as something that “lessened their guilt”. By using their diagnosis as a legitimization, or even sometimes as an excuse, they said the diagnosis provided them with a legitimate reason or a justification, created a valid excuse for their behaviors, and they expressed this in their speech as “I did it because I am bipolar”, “It was because of the mania”, “As I attribute everything to my illness”, or “It is normal for it to be like this”. In a sense, they dissociated the disorder from themselves and absolved themselves of guilt and responsibility by placing the blame on the illness.

A discourse of medicine and illness was also very prominent in individuals’ statements. As referring to bipolar disorder as “Just like any other illness”, they attributed it to biology, physiology, or their brain, and they biologized their disorder. In addition to that, they also reported the disorder being “a scientific fact”, and something that was acknowledged and accepted by the “specialists”, and therefore, by everyone else. They shifted the disorder from being a subjective experience into a generally accepted biological fact. Through attributing the disorder to science or the

experts, they have again legitimized it in a way. However, along with this, by overlooking the subjective part of the disorder, they again attributed the responsibility to their brains and hormones.

This main theme is divided into two. First subordinate theme demonstrates extractions from participants regarding their feelings of guilt and responsibility and discusses how does getting diagnosed affects individuals in managing their guilt and its part in shifting the blame. The second subordinate theme illustrates how they compare their disorder to other illnesses and biologize their disorder.

3.2.1. It Wasn't Me It Was Bipolar: Being Cleared of Guilt by Dissociating the Disorder from the Self

In this subordinate theme, individuals' feelings of guilt and the role that diagnosis plays in being cleared from this guilt is illustrated. Participants talked about some behaviors or situations that they blamed themselves for or made them feel guilty at the time. They stated that receiving a diagnosis stood for a legitimate excuse and justification for their behaviors; thus, they stopped blaming themselves. They referred to this occurrence as "It was because of my illness", "I did it because I am bipolar", or talked about "Putting forward the diagnosis as the cause". Even though they have also indicated that they do not defend themselves for what they did or do not hide behind the diagnosis, they positioned themselves as "sick" and asserted that it was normal for them to be like this.

Neslihan reported that after being diagnosed, she rethought her past. She reconsidered some of her behaviors that she blamed herself for at the time, but was actually caused by her disorder, and reached the conclusion that she was not at fault. This resulted in her shifting the blame from herself to bipolar disorder. In a way, it sounded like she described the disorder as a kind of entity that was separate from herself, as if it were an external formation independent of herself.

Neslihan: So, after receiving the diagnosis, I revisited my past. **I thought about my behaviors that could have been caused by bipolar disorder,**

things I blamed myself for at the time, but actually didn't need to blame myself for, the things I could call my illness.

Original:

Neslihan: *Yani tanı aldıktan sonra biraz geçmişimi tekrar düşündüm. Bipolardan kaynaklı olabilecek davranışlarımı, kendimi zamanında suçladığım, ama aslında suçlamama gerek olmayan, hastalığım diyebileceğim şeyleri tekrar düşündüm.*

Feray, by directly referring the diagnosis as a valid reason, indicated that she felt relieved as she believed there was a legitimate justification for her thoughts or behaviors. She said that when she does something that is contrary to society, she told herself that she did it because she is bipolar and that she did not need to blame herself. It was also noteworthy that she brought up “excuse” when talking about her disorder.

Feray: Yes, at least I felt more **relieved** because I believed there was a **valid reason** for the situation I was experiencing or the things I was thinking, the actions I was taking, and so on. I never **consciously did anything and then used it as an excuse, saying, “I did this because I'm bipolar.”** But, for example, let's say I did something considered deviant by society. Even if I didn't realize it at the time, or even if I realized it after the fact, I could say, **“I did it because I'm bipolar, so I don't need to blame myself.”** Or spending too much money, spending beyond my means, for example. After that period, instead of saying things like, “Why did you spend so much money? Why did you do that? Are you thoughtless? Don't you have any sense?”, I can tell myself that it was something specific to that period.

Original:

Feray: *Evet, en azından hani bu yaşadığım durumun ya da düşündüğüm şeylerin, yaptığım hareketlerin vesaire, geçerli bir sebebi olduğuna inandığım için daha da rahatlamış hissetmişim. Hani bunu hiçbir zaman böyle bilerek bir şey yapıp da “Ben bipolar olduğum için böyle yapıyorum.” deyip bahane etmedim. Ama mesela aykırı diyeyim, toplum tarafından, hani toplum tarafından aykırı bir davranış yapıyorsam, aslında bunu o an fark etmesem de o dönem geçtikten sonra fark etsem de “Bipolar olduğum için yapmışım kendimi suçlamama gerek yok.” diyebiliyorum. Ya da çok fazla para harcamak, kendi ekonomik durumumun üstünde bir para harcamak hani. O dönemden sonra hani “Neden bu kadar para harcadın? Bunu neden yaptın? Sen işte düşüncesiz misin? Aklın yok mu?” gibi cümleler kurmak yerine kendime hani o döneme özgü bir şey diyebiliyorum.*

As the extractions of the participants suggests, for individuals, bipolar disorder diagnosis played a part in relieving them from their responsibilities and guilt. It

provided them with a valid basis for their thoughts and behaviors. In this way, they could attribute some of their actions to being bipolar which would otherwise be problematic and questionable and would cause them to feel guilty. Because the diagnosis created a legitimate reason for their behaviors, it ensured that they do not overburden themselves. But while doing this, they also dissociated the disorder from themselves and almost talked about it as something extraneous with its own free will. While separating the disorder from their selves, they put the blame on “bipolar”.

3.2.2. Just Like Diabetes: Biologizing the Disorder

When discussing their disorder, the medical discourse that the participants used was very distinct. Again, they referred to the diagnosis being a “valid explanation” and as something that was “accepted by everyone”. By arguing it was not a subjective condition but rather an objective one, they referred to the “experts”, talking about the disorder as an uninterpretable, clear-cut, and a consistent condition.

Cenk made references to diseases such as cancer or diabetes, and said people have to face them and do what they can in spite of them.

Cenk: That's life. **Some people have cancer, some have severe diabetes,** some have this and that, some can't even breathe. People have to do what they can, to the best of their ability, and face up to it.

Original:

Cenk: *Bu hayat işte. Kiminin kanser hastalığı var, kiminin işte ağır şeker hastalığı var, kiminin şusu var busu var, kimisi nefes bile alamıyor. Hani insanlar gücü yettiği ölçüde ölçüsünce şey yapmak zorunda, yüzleşmek zorunda.*

Bilge also compared bipolar disorder to other illnesses such as diabetes or a heart condition and likened the disorder to any other chronic physiological diseases. She added that the only difference between them was bipolar disorder being a brain disorder. She also associated this kind of thinking with relief.

Bilge: For me, as I said, **it's a disease like a chronic physical illness,** frankly speaking. **Like diabetes or heart disease.** It's just a disease in my **brain.** Actually, when you think about it like that, it's a bit of a **relief.**

Original:

Bilge: Benim için, yani dediğim gibi, o yani **fiziksel süreğen hastalıklar gibi bir hastalık** yani açıkçası artık. Yani **şeker kalp gibi bir hastalık**. Yani sadece hani **beynimde** olan bir hastalık, Yani aslında böyle düşününce hani, biraz insanı **rahatlatıyor** yani.

Likewise, Feray referenced physical health and made a comparison with diabetes or a headache, and she asserted that as it was normal to use medication for them, it was also normal to use medication for mental health.

Feray: Just as it is used for **physical health**, for example, **for headaches, diabetes**, and so on, it seems perfectly normal to use it for **mental health** as well.

Original:

Feray: Fizyolojik sağlık olarak mesela nasıl kullanılıyorsa, işte **baş ağrısı için, ne bileyim şeker hastalığı için vesaire, ruh sağlığı olarak da kullanılması da gayet de çok normal geliyor**.

When talking about bipolar disorder, participants referred to biological or physiological aspects of it, explaining it with hormones or chemicals. They reported that providing a scientific explanation for their experiences relieved them. All participants compared bipolar disorder with other illnesses, and Neslihan likened her medicine to “magnesium” or “vitamin c”. Participant’s tendency to biologize their disorder and by dismissing the subjective aspects, transforming their disorder to an objective construct was regarded as an attempt to absolve themselves of responsibility.

In addition, one of the most striking aspects of this discourse was the fact that every single participant without exception compared bipolar disorder to diabetes. At this point, it should be noted that the Turkish word for diabetes stands for “candy.” In other words, all participants likened bipolar disorder to “candy”.

3.3. With or Without You: Experiences Before and After the Diagnosis

This main theme demonstrates the impact of receiving a diagnosis on individuals’ experiences of the disorder and the role it plays in the transformation of these experiences.

To begin with, almost all participants reported that they have always felt different, and they have always known something was wrong with them. For example, Neslihan stated that when she thought about it now, she realized that she had already experienced life in different periods before, and she might have seen its effects even in middle school. Likewise, Cenk also indicated that even when he was little, around five years of age, he was someone who complained to his elders that he had a strange feeling inside of him, and years later, when the doctors told him, he understood that these were signs from back then. Ekin said she has been this way since high school, and if she was asked when she first thought she might be bipolar, she would say high school. In line with these, Feray expressed that she first started to realize that her situation was unhealthy in high school because she began noticing that other people were not experiencing these cycles as she did, and that she was experiencing them at extreme levels. The common point of these statements was that all participants conveyed once they were diagnosed, they revisited their past and searched for signs of the disorder and reinterpreted their experiences. Once they were diagnosed, their previously unexplainable and uninterpretable experiences suddenly gained meaning. Another point of these statements that is worth considering is the emphasis of “being different” from others.

Participants mentioned that the diagnosis had a stabilizing effect on them. One reason for this was proposed by one of the participants as beginning treatment after being diagnosed. However, it is argued that the diagnosis by serving as a staple, classified them under the name of “bipolar disorder” and stapled them to the image of “being bipolar”. As they assumed an image of “being bipolar”, they started to form a “bipolar narrative” and started to live as “bipolar people should live”. After that point, participants stated that their experiences have “transformed” or “evolved” into something more sustainable.

This main theme is divided into two subordinate themes. The first subordinate theme includes participants’ expressions concerning their experiences of bipolar disorder and their back-and-forth between the two ends. The later subordinate theme illustrates the transformation of their experiences as they get their diagnosis and start “knowing themselves”.

3.3.1. Livin' on the Edge: The Two Polars

Participants used the phrases of “cycle”, “period”, “extremes”, “rise and fall”, “tide”, and “change” when talking about their experiences regarding bipolar disorder. They talked about the magnitude of this change from one end to the other, and how exhausting it was for them. For instance, Cenk conveyed that for him, after periods of escalation, when it started to decline, it got very bad, and he also defined this as losing his “productivity”. He described this change as a “revolutionary” change for himself.

Neslihan talked about a “danger from both sides”. She reported that she would sometimes reach a point where she loses her sense of reality during episodes of mania, and a depression always follows mania for her, and her depression is so intense that it results in her throwing away everything she might have acquired during mania. Because of that, she described it as a “danger” and said it made more sense for her to try staying stable.

Neslihan: So, there's **danger from both sides**. One is that even if I think I'm fine when I'm manic, I can actually reach an unrealistic point, and on the other hand, I've seen that **mania is always followed by depression** for me, and my depressive periods are so deep that I throw away everything I achieved during the mania. So, in that sense, it's a danger. That's why it seemed more reasonable to try to stay **stable**.

Original:

Neslihan: Yani, *iki iki yönden de tehlike var*. Biri, manik olduğum zaman iyi olduğumu düşünsem bile aslında gerçekçi olmayan bir noktaya da gelebileceğim için, bir yandan da **maninin sonrasında hep bir depresyonun devam ettiğini** benim için gördüğümünden, ve depresyon dönemlerim o manide elde ettiğim her şeyi çöpe atacağım kadar benim için derin gerçekleşiyordu. Yani bu anlamda bir tehlike. O nedenle **stabil kalmaya çalışmak daha mantıklı gelmişti**.

Bilge on the other hand, asserted that ever since she has known herself, she has always been a depressive person. But during the period she was studying for the university exam, she observed a dramatic change in herself. She said that she came out of her depressive state completely, and turned into a social, talkative, energetic person, knowing that she is not that kind of a person. She began to spend her days

without sleeping or eating. At that time, she could not make sense of it and thought that her medicine was working.

Bilge: About two months before the exam, I started to **change dramatically**. I had been depressed all year, going back and forth between the prep school and home, and I didn't even have a social life that year, except for seeing my friends from high school. But suddenly, two months before the exam, I **changed completely**. I **completely came out of that depressive state** and became extremely talkative, extremely social, and there were periods when I didn't sleep at all, didn't eat properly. There were times when I didn't sleep for two days, three days, almost three days. I felt incredibly energetic, like I had this endless energy in my body. It didn't seem strange to me at the time. I guess I thought the medication was working. Then I stopped the treatment, meaning I stopped going to that doctor. Then I stopped taking the medication.

Original:

Bilge: *Sınava az bir süre kala, böyle bir iki ay kala falan, bende çok ciddi değişiklik olmaya başladı. Bütün sene depresif geçirdim, yani dep şeye gidiyordum dersane ev arasıydı hayatım, ama sadece işte liseden kalan arkadaşım arkadaşarımla görüşüyordum yani sosyal hayatım bile yoktu o sene. Ama birden o iki ay kala sınava bende çok büyük bir değişiklik oldu. Yani o depresif halden tamamen çıktım ve aşırı konuşkan, aşırı böyle sosyal, böyle hiç uyumadığım, hiç doğru düzgün yemek yemediğim dönemler oluyordu. Yani böyle iki gün falan, üç gün falan, üç güne yakın uyumadığım zamanlar oluyordu. Kendimi çok enerjik hissediyordum böyle inanılmaz bir enerji. Ama yani hani e bitip tükenmek bilmeyen bir enerji hissediyordum vücudumda. Yani bana garip gelmiyordu o dönem. Bilmiyorum ilaçlar işe yarıyor diye düşünüyordum herhalde. Ondan sonra tedaviyi sonra bıraktım, yani gitmemeye başladım o doktora. Sonra ilaçları falan bıraktım.*

Like Bilge, Feray also stated that she had mostly been a depressed person, and that she has had intense depressive states back in high school. She also reported that she had some suicide attempts in which she tried to commit suicide by cutting her wrists or taking pills; however, she failed each time. One time, she began thinking that as her previous suicide attempts have always failed, the surest way of committing suicide would be throwing herself from a tall building. With that thought, she indicated entering a very high phase, without any depression. During that state, she reported feeling very confident and powerful, like everything was in her control.

Feray: During the period we call hypomania, I would say things very definitively, like, “My suicide attempts always failed; the surest solution would be to throw myself off a tall building.” I would close my eyes and

imagine myself jumping off a tall building, without thinking about it, without changing my mind, suddenly stepping out and letting myself fall with a very sudden decision. This time, I was absolutely convinced I could commit suicide, absolutely convinced I could kill myself. And shortly after that thought, **without any depression accompanying it, I entered a very high phase.** I felt like everything was in my hands, that I was very powerful and confident. I never convinced myself that I was like a god or a divine being, but I felt like them, I felt like all the power was in me.

Original:

Feray: *Hipomani dediğimiz döneme de, böyle çok kesin bir şekilde şey diyordum “İntihar girişimlerim hep başarısız oldu, en garanti çözüm kendimi yüksek binadan atmak olacak.”. Gözlerimi kapatmışım ve yüksek bir binadan atladığımı, hiçbir şey düşünmeden karar değiştirmemek adına, hiçbir şey düşünmeden aniden çıkıp çok ani bir kararla kendimi bıraktığımı falan hayal etmişim. Bu sefer intihar edebileceğime kesin olarak inanmışım, kendimi öldürülebileceğime kesin olarak inanmışım. Ve o düşünceden biraz sonra, hani hiçbir zaman o depresyon eşlik etmedi, çok yüksek bir döneme girdim. Her şeyin benim elimde olduğuna dair, çok güçlü ve özgüvenli olduğuma dair. Yani hiçbir zaman böyle kendimi tanrıymış gibi ya da ilahi bir varlıkmiş gibi inandırmadım, ama onlar gibi hissediyordum yani, bütün gücün bende olduğunu hissediyordum.*

The experiences of individuals with bipolar disorder were characterized by dramatic changes between the two polars, depression and mania. The extremity of this change, intensity of both ends, and continuous cycles made them feel very tired, confused, and ended up in them losing their efficiency and productivity. Some of the participants also expressed that they could not recognize themselves during those cycles, became someone completely different from themselves and conveyed that they could not make sense of it.

3.3.2. Know Thyself: Transformations in Experiences Through Receiving a Diagnosis

Almost all participants reflected that they no longer experienced major shifts in their modes, and they were much more stable for some time. They expressed this as becoming “stabilized” or “got on track”. Getting diagnosed played a significant role in this transformation. First of all, individuals reported that as they got diagnosed, they started treatment, using medication, and settled on a doctor. Furthermore, they indicated that they began to understand themselves better and began noticing the

changes in their mood. They also talked about accepting their diagnosis and starting to live accordingly.

Neslihan conveyed that she no longer experiences major shifts in her mood, and rather she overcomes the process with minor fluctuations. She also talked about making use of her mania to do things she would normally have trouble in doing and giving herself space when she is depressed. She remarked that as she knows herself better now, she tries not to make important decisions during manic phases and reminds herself that depressive periods are temporary.

Neslihan: For quite some time now, about two or three years, **I haven't been experiencing extreme highs and lows.** I think it's called hypomania or hypodepression, I experience minor episodes like that. But before that, as I mentioned, I was much more confident, fast-paced, and felt like I could make all the decisions I wanted in my life and do everything at once. During my depressive periods, I felt extremely unproductive, like I was sick, and sometimes everything became so meaningless that I lost all motivation to continue anything, to the point where I thought ending my life would be more meaningful. Right now, **it's much milder.** Sometimes I feel more energetic, and I still try to **make use of this** then. But I try **not to make any major decisions.** When I'm depressed, **I keep reminding myself** that it's temporary and continue doing whatever I'm doing.

Original:

Neslihan: Uzun bir süredir, yaklaşık iki üç yıldır, çok yük yani **çok keskin yükselme alçalmalar yaşıyorum.** Daha sanırım hipomani hipodepresyon mu denir, o şekilde küçük şeyler yaşıyorum. Ama öncesinde yaşadığım manikken dediğim gibi, çok daha öz güvenli, hızlı, hayatımda almak istediğim bütün kararları alıp her şeyi bir kerede yapabiliyormuşum gibiydi. Depresif dönemlerimse hem aşırı derecede verimsiz, hasta gibi hissettiğim, hem de bazen her şey o kadar anlamsızlaşıyordu ki, hiçbir şeye devam edecek motivasyonum kalmayıp, yani hayatımı sonlandırmanın daha anlamlı olduğunu düşünmeye kadar varabiliyordu. Şu an için **çok daha yumuşak geçiyor.** Yani bazen daha hareketli hissediyorum, yani o zamanlar yine **değerlendiriyorum.** Ama mesela çok **önemli kararlar almamaya çalışıyorum.** Depresifken de geçici olduğunu sürekli **kendime hatırlatarak** ne yapıyorsam yapmaya devam ediyorum.

Similarly, Cenk said that he is now much more stabilized and on track, and that his episodes are much less intense and they extinguished quickly. He also reported that he is much more efficient now in controlling his fluctuations. He expressed that getting diagnosed helped him in putting himself together.

Cenk: Well, I can say it's finally **on track**. I mean, minor fluctuations are quickly dampened, so to speak. When you strike a spark, it doesn't burn intensely but rather glows briefly and then fades away. That was the most important thing at first.

Original:

Cenk: Şöyle artık, benim belli başlı **rayına girdi** diyebilirim. Yani küçük dalgalanmalar bir defa çabuk sönümleniyor, yani öyle söyleyeyim. Yani kıvılcımı çaktığınız zaman artağan bir şekilde değil de, biraz parlayıp tekrar böyle düşüşe geçen bir hale bürünmesi, o önemli oldu en başta.

Ekin stated that with getting diagnosed, she now knows herself better. She expressed that she began to listen to herself and became much more honest and compassionate towards herself. She even said she started to love herself more after being diagnosed.

Ekin: Of course, I mean, **I know myself better now**. I was that, you know, but now I think I'm honest and compassionate towards myself. **Before the diagnosis**, I wasn't compassionate, but that has changed a lot for me. When I say compassionate towards myself, I mean I really listen to myself, like what to do and what not to do, like, "Look, you don't have to do this right now, let it go." That feeling of compassion developed in me after the illness. Because, you know, the medications are so exhausting. And like I said, it's such a lonely illness that I had to show that compassion to myself first.

Original:

Ekin: Tabii ya, yani şey, daha **kendimi tanıyorum**. Ben o şeydim, yani böyle, hani gerçekten kendime karşı dürüst ve merhametli davranıyorum bence. **Tanıdan önce** merhametli davranmıyordum, o bende çok değişti. Hani kendime merhamet darken, gerçekten kendimi dinliyorum, neyi yapıp neyi, yani şey gibi, "Ya bak bunu şu an yapmak zorunda değilsin bırak", gibi. O merhamet duygusu bende hastalıktan sonra gelişti. Çünkü şey, o kadar yorucu ki ilaçlar. Ve dediğim gibi, o kadar yalnız bir hastalık ki, o merhameti önce kendime göstermem gerekiyor benim.

Individuals talked about some of the positive aspects of the disorder as well. For example, Neslihan asserted using mania to her advantage, such as waking up early and doing sports. She also said she sometimes uses mania as a spark, and as a source that enabled her to do things she could not normally do. Likewise, Feray indicated if she can make use of the time she spent sleepless, she would be able to do things she could not do under normal circumstances. Some participants also said that they started to like their lives and themselves more following getting diagnosed. For example, Ekin stated that she thinks getting diagnosed is very valuable and that she is "glad she got diagnosed".

Participants exemplified the transformations in themselves and in their experiences as starting to know themselves better, being more experienced, observing the changes in their moods, and noticing them more quickly. They attributed this transformation to being diagnosed and getting treatment and medication. By being diagnosed, what was previously unknown became known for them. After being diagnosed, they mentioned beginning to organize their lives accordingly, taking care of themselves, start creating a routine, or finding some goals and purposes for themselves, in other words, learning to live with bipolar disorder and as bipolars.

3.4. To Be or Not to Be Recognized, That Is the Question

While beginning to discuss this main theme, it is considered essential to mention that the Turkish word for diagnosis also stands for “recognition”. All participants talked about the importance of and the need for being recognized either consciously or unconsciously. They shared instances where they were recognized and acknowledged by others, or where they were not recognized. They referred being recognized by their families, their friends or romantic partners, their colleagues or teachers, and their doctors. While being recognized as bipolar individuals made them feel valued and supported, situations in which they were not recognized has made them feel frustrated and alone, feeling belittled, and resulted in them thinking no one could understand them and they would have to go through it all by themselves. Some of the situations that they have described suggested the idea that they might also be acting out in order to be seen. In addition, although some participants stated that they did not share their diagnosis with anyone other than their closest relations, some of the things they described or the examples they gave suggested that they might find themselves in situations where they would have to share their diagnosis or allow others to hear and know about it. For example, some of the participants talked about leaving their medication in places other people would be able to see, or the possibility of engaging in certain behaviors that could lead to people asking them about their illness. Being recognized and being seen as “bipolar individuals” has resulted in them feeling accepted by others as a bipolar person, and by helping to reinforce their bipolar images, has also contributed them in assuming a bipolar identity.

This main theme contains two subordinate themes. First subordinate theme illustrates participants' extractions regarding their doctors, and the importance they attach to being recognized by them. The latter subordinate theme involves their instances of being recognized or not, or how they are recognized or not, in other words, some of the actions they take in order to be seen.

3.4.1. Doctor! Doctor!: Being Recognized by the Doctor

In participants' discourses, doctors occupied a very essential and prominent place. As the doctor is the "subject supposed to know", and the only person who is able to make a diagnosis, being recognized by their doctors was of utmost importance for the individuals.

All of them touched upon the importance of the doctor in the illness as he is the one making the diagnosis, who listens and attends to them, and the person administering the treatment. Therefore, they preferred settling with a doctor who made them feel recognized and cared for. For example, Neslihan mentioned some doctors who used more general patterns when talking to her rather than thinking enough about the patient, and as she believed she could not make much progress with them, she continued with doctors whom she found more sympathetic. From her statement, it was inferred that she did not want to proceed with a doctor who reduced her to a regular patient by disregarding her own subjectivity. Cenk reported when he first started going to a doctor, he always dropped out of treatment at some point and changed doctors repeatedly. But once he found a doctor whom in his words "warmed up to", he settled with him and made much progress with his treatment.

Ekin indicated that his doctor played an important part in her treatment. Around the time when she was first diagnosed, she could reach him anytime and talked about anything, asked him any question she liked. She even talked about her doctor understanding her without her even asking. She said being with a doctor such as him was very lucky for her. When asked her thoughts about the significance of the doctors in this disorder, she replied by saying "the doctor is everything".

Ekin: I think my doctor had a huge impact on this. My doctor, or, like I said, **I could reach him whenever I wanted, and I could talk about anything.** So, maybe **he understood some things without me even asking,** but I don't remember that time so well now. If I had another doctor, hadn't had a good doctor, I would have been, I mean, I would have been really bad, I know that. I had a very good doctor. It was lucky for me.

Researcher: What role do you think the doctor plays in this disorder, what importance does he have?

Ekin: I think, **I think the doctor is everything.**

Original:

Ekin: *Bence doktorumun çok büyük etkisi var bunda. Ya ben doktorumu, ya dediğim gibi, her istediğim her zaman ulaşabiliyordum ve her şeyi de konuşabiliyordum. O yüzden şey, belki de o bazı şeyleri ben sormadan anlıyordu, şimdi o kadar eski zamanı hatırlamıyorum ama. Hani başka bir doktorda, iyi bir doktorda olmasaydım ben şey olurdu, daha yani, ben gerçekten kötü olurdu, onu biliyorum. Çok iyi bir doktordaydım. Benim açımdan şanslı yani o.*

Araştırmacı: *Doktorun nasıl bir yeri oluyor sizce bu hastalıkta, nasıl bir önemi oluyor?*

Ekin: *Bence ya, bence her şey doktor demek.*

Bilge talked about her negative experiences with doctors. She reported switching many doctors during the years. She stated that she was treated with disrespect by some or disregarded by others when she wanted to make an appointment and could not. She told this by saying her situation was critical, and she left a message to the clinic saying that she had to see her doctor, despite this, her doctor never reached her back. Before going to her last doctor, she had lost her hope in doctors; however, for the first time, she met a doctor who treated her with respect and took her seriously.

Bilge: Before going to Mrs. Melis, I told myself that if it didn't work out this time either, I would just take the medication and give up on therapy. Fortunately, it didn't turn out as I expected. We made a lot of progress with Mrs. Melis. I felt that she was a doctor who really wanted to **help me.** For the first time, I felt that I had a doctor who **cared about me and took me seriously.**

Original:

Bilge: *Melis Hanım'a gitmeden önce, kendime böyle demiştim, yani eğer bu sefer de olmazsa ben sadece ilaçları kullanırım, terapi kısmına artık bırakacağım demiştim. Neyse ki umduğum gibi olmadı. Melis Hanım'la bayağı bir ilerleme kaydettik. Yani bugüne kadar gerçekten bana **yardımcı olmak isteyen** bir doktor olduğunu hissettim. İlk defa ya **beni önemseyen, ciddiye alan** bir doktor olduğunu hissettim ilk defa karşımda.*

Without exception, every participant addressed the role and importance of doctors. They reported continuing with doctors who recognized them not just as patients, but as individuals. Doctors played a crucial role in this disorder since they were the ones with the power to diagnose. Individuals placed them in the position of “subject supposed to know” and attributed them with knowledge. In a way, it can be asserted that doctors almost play the role of the Big Other during the mirror stage. By showing them their image in the mirror and saying, “This is you”, they recognized and accepted their image. In doing so, they also paved the way of individuals to recognize this image as themselves and assume it as a part of their identity. In this regard, doctors enabled individuals to develop a bipolar identity by identifying with their diagnosis by telling them, “You are bipolar.”.

3.4.2. Now You See Me Now You Don’t: Striving to be Recognized

This subordinate theme demonstrates extractions of participants considering their efforts to be seen, and to be recognized by O/others. Being recognized and accepted by people around them, especially their families, friends and partners, held an important place for the individuals. While some participants reported sharing their diagnosis more comfortably, some reported that they did not share it except for people closest to them. For example, Neslihan said that everyone knew about her diagnosis because for her, it was better for people to know so that they could better accept and understand her behaviors when she was on a depressive or manic episode. On the other hand, Bilge conveyed that she no longer shared her diagnosis with anyone as once when she told her friends about her diagnosis, they belittled her by saying people had much more important troubles and worries and that she should be thankful that her arms and legs are intact. After this incident where she was not recognized by others, Bilge indicated that she stopped telling people about her diagnosis, as she fears she again might not be understood. However, in addition to all this, some of their statements also suggested that they might be engaging in various actions to be seen by those around them.

Ekin expressed that she told her close friends as soon as she was diagnosed. She talked about a time when she went to Germany and was forgetting to take her

medicine, so she put her lithium bottle on the table. After that, her friends at the office came and thanked her and congratulated her for being so open and trusting. She then added she did not put it there on her first day.

Ekin: Share, well, I share like this, my very close friends already know, **I told them directly that I was like this, I told them as soon as I was diagnosed.** After that, who knows, I just told another friend, for example, that I have this condition. I went to Germany, and at the time, I was forgetting to take my medication, so **I just took it out and put the lithium bottle on the table.** And my friends- I had two office friends- said, “We've never seen anyone so comfortable, so open about themselves, so we did, we congratulate you, we thank you for trusting us. I mean, by doing this thing, you're trusting us in a way.” Well, of course, **I didn't put it there on the first day.**

Original:

Ekin: *Paylaş, ya şöyle paylaşıyorum, zaten çok yakın arkadaşlarım biliyor yani, direkt söylemişim onlara ben böyleymişim diye, tanı alır almaz söylemişim. Ondan sonra kim biliyor, başka mesela bir arkadaşıma yeni söyledim, böyle böyle benim bir durumum var diye. Almanya'ya gitmişim, o zaman mesela ilaçlarımı kullanmayı unutuyordum, ve o yüzden direkt çıkartıp lityum şişesini masanın üzerine koymuştum. Ve arkadaşlarım- iki ofis arkadaşım vardı- ve şey demişlerdi, “Hani bu kadar rahat bir şekilde kendini rahat bu kadar ya kendini açan birini görmemiştik, o yüzden hani şey yaptık, seni ya tebrik ederiz bize güven aslında bize güvendiğin için de teşekkür ederiz. Hani sonuçta şey de yapıyorsun, hani bize de bir şekilde güvenle de bu aslında.” diye. Ya **tabii ilk gün koymamıştım.***

Ekin also mentioned that she regularly asked, “Do you notice a change in me?” to her friends and family, and requested them to tell her as soon as they noticed a difference in her state. In line with this, in her story about her putting her lithium bottle at the table, her friends came to ask her if there was anything they should know or something that they could do about her condition. From her expressions, it was inferred that through her actions or questions, she somehow made people around her to see or to hear about her disorder, or she reminded them in a way.

Bilge talked about not getting a treatment for a long time back when she was at high school. She was very depressed but did not go to a doctor. She regularly attempted suicide by cutting herself. She stated that as her situation worsened and her cuts got deeper, her parents also started to realize the intensity of her situation, but she still did not receive a serious treatment. In a way, her suicide attempts could be regarded

as a call to her parents, her way of showing them how serious her condition was. However, it can be inferred that her parents still did not recognize her illness.

Bilge: So, I cut my arms with a razor blade, creating cuts. Some of them were quite serious. When that happened, **my mom and dad started to realize how serious the situation was.** But I still didn't receive any serious treatment while I was in high school.

Original:

Bilge: *Yani jiletle bıçakla kollarımda kesik yapı yani kesikler yaratıyorum. Öyle hani bazıları ciddi kesikler oluyordu. Öyle hani öyle olunca hani annemle babam da biraz hani durumun ciddiyetinin farkına varmaya başladı. Ama yine de çok ciddi bir tedavi görmedim lisedeyken.*

Similar to what Bilge told, Feray also talked about her parents not recognizing her condition. She reported being depressed when she was at high school, and that she did not leave her bed for a very long time. She stated that even though her parents realized her situation was unhealthy, they still did not prefer taking her to a doctor. She conveyed that she has attempted suicide many times by cutting her wrists or taking pills, which were prescribed for her disorder. During her depressive states, she took pills and when she started feeling dizzy and numb, went to her parents saying she took pills and they should take her to a doctor, and then they went to the emergency room together.

Feray: My suicide attempts were only wrist-cutting when the illness first started. I was always trying to cut my wrists, trying to cut them deeply, but no matter what, I couldn't succeed. Actually, maybe I don't didn't want to succeed. Later, when I started taking medication, and the doctors prescribed antipsychotics and such, even though I continued to take them regularly during certain periods, when I fell into depression, I started taking quite a lot of those drugs. But every time, when I took those pills, I took a lot, at least 20 or so, I can say. I don't remember the doses at the time, but the doses were high. I felt like I had heart palpitations, like my brain was numb, like I had consumed a very high amount of alcohol. I couldn't walk, and my head was spinning. As soon as the symptoms started, **I would tell my family, "I took pills, take me to the doctor."** and we would go to the emergency room. They would do stomach pumping and such. **I don't know if I really wanted to die, but I always made attempts like that.**

Original:

Feray: *İntihar girişimlerim hastalığın ilk başladığı zamanlarda sadece bilek kesme olardı. Hep bileklerimi kesmeye çalışıyordum, derin bir şekilde kesmeye çalışıyordum, ama ne olursa olsun başarılı olamıyordum. Aslında*

*belki de ben başarılı olmak istemiyorum istemiyordum. Sonradan ilaç içmeye, doktorlar da antipsikotik falan yazdıkça, belli dönemlerde hani düzenli kullanmaya devam ettiğim halde depresyona girdiğim zamanlarda o ilaçlardan bayağı bir çok içmeye başladım. Ama her seferinde şey oluyordu, ben o ilaçları içtiğim zaman bayağı bir çok içiyordum, en az 20 tane falan diyebilirim, dozları da hatırlamıyorum o zamanki dozları, ama dozları da hani yüksekti. Kalp çarpıntısı gibi, böyle beynimin uyuşması gibi, böyle hani çok yüksek miktarda alkol almış gibi hissediyordum, yürüyememeye falan başlıyordum, başım dönüyordu. Belirtiler başladığı anda bu şekil ben **aileme hani “İlaç içtim beni doktora götürün.” diyordum, acile gidiyorduk. O şekilde mide yıkama vesaire oluyordu. Yani gerçekten ölmek istiyor muydum bilmiyorum, ama bu tarz girişimlerim hep oluyordu.***

Feray conveyed that after some time, she asked her parents again how they could not take her to a doctor back then and how could they let her stay that way, almost calling them to account. She said that her parents replied by saying they were afraid that she might have become addicted to drugs, admitted to a hospital, and it could have affected her future career. She also expressed that her parents did not accept her diagnosis as well, and did not want her to take medication, and blamed her doctor for misdiagnosing her. She indicated that she wished her parents has accepted her diagnosis and supported her. It was also striking that she tried committing suicide by her medication for bipolar disorder, and then made her parents take her to the emergency room, making her suicide attempt known and seen by them. Her remark about not actually wanting to die was also noteworthy. Based on her discourse, it can be asserted that what she wanted was not to die, but to be recognized and to be seen by her parents.

3.5. Mirror Mirror on the Other

This main theme presents participants' references regarding how they thought they were being seen by others, and their concern about their “image”. When talking about the diagnosis, they mentioned how “stigmatizing” it was, the prejudices concerning the disorder, and how it was perceived by the society. They compared bipolar disorder with schizophrenia, referenced movies with scenes of madness, electroshock, and argued this was how bipolar disorder was being perceived by others. However, it was noteworthy that while they were talking about how stigmatizing the diagnosis is, when they were asked if they have encountered such a

situation themselves, most of them said no. For this reason, it has been thought that they formed this opinion not based on their own experiences, but by trying to see things through the eyes of others, creating a hypothetical situation.

They have also referred to certain restrictive aspects of the diagnosis. They stated that diagnosis labelled them as “sick”, “disabled”, or as a “restricted person”. For example, Cenk expressed that he was exempted from military service by being classified as a restricted individual. Ceyhun also stated that he was considered disabled by 40 percent and described the diagnosis as a “loss of license”. Interestingly, Feray indicated that she had to take a medical report from her psychiatrist in order to take her driver license.

While participants talked about how bipolar disorder was being seen by others, they also spoke about how they thought they were being seen as “bipolars”. They questioned how they appeared to others. For instance, Feray asked this in her words as “Do I look different than I see myself?”. Individuals also compared themselves with other bipolar individuals, and some indicated that people were surprised to find out that they had bipolar disorder as they do not “look like it”.

Participants conducted inquiries into how bipolar disorder was perceived by others and how they themselves were perceived by others, comparing the two. It was concluded from individuals' statements that their image held an important place for them. However, it was also asserted that having others confirm this image was also very important.

This main theme includes two subordinate themes. The first subordinate theme illustrates participants' statements regarding how they think bipolar disorder was being seen by others, while the second subordinate theme will demonstrate their remarks on how they were being seen as bipolar individuals.

3.5.1. The Cool, The Mad and The Rotten: How Is Bipolar Disorder Perceived by Others?

Participants touched upon how bipolar disorder was being perceived by society, and how individuals with bipolar disorder appeared to others. Some of them shared their

own experiences regarding this situation; however, most of them made speculations and predictions about this matter. They talked about people's prejudices in this manner and asserted that they think individuals with bipolar disorder were being seen as "mad", "defective", "rotten", "limited", "inadequate", "unqualified", "sick", "unhealthy", "disabled", and "abnormal" by others. They also compared bipolar disorder to schizophrenia and referred to movie scenes with electroshocks or medication.

Participants also had different ideas about how bipolar disorder was being perceived in various contexts, such as at school, at work, or at social environments. For example, Ceyhun talked about academics not welcoming people with psychological disorders being in medical school or in the psychology department. Ekin mentioned being an employee with bipolar disorder by saying they wouldn't fire an official because they were bipolar, but they could fire an employee because they were bipolar, and if she was to share her diagnosis, she could not be sure about getting positive reactions by her employers, so she would not take that risk unless she must. On the other hand, Cenk expressed that when he shared his diagnosis with the opposite sex, he encountered some reactions in which he was told they could not be with him. He questioned their reactions by asking what difference did sharing his diagnosis make as he is the same person he was five minutes ago.

When asked what kind of reactions he encountered with when he shared his diagnosis, Cenk stated that there were several kinds of reactions. He explained that the one kind of reaction was people describing it as an "artists disease" and considering it "cool". Another reaction was telling him that they could not be with him because he could do anything at any time. One other reaction was considering it as an illness and as a serious situation.

Cenk: I get a few different reactions from people around. One is, like, "Oh, **artist's disease**, I don't know, **you're so cool with this disease**." which I've heard mostly from younger people, and I think it's very wrong, but it's not that common. Another reaction is, "Well, **you have this disease, so you can do anything**, I can't be with you." which is more of a reaction from the opposite sex that I'm trying to approach. Then there are friends who view it as an **illness**, telling me, "**This needs to be fought, it's serious, it needs to be**

addressed, it's not something to be mocked, because mocking it can have very serious consequences.”.

Original:

Cenk: Çevremden şimdi şöyle birkaç çeşit tepki var. Bir tanesi, işte “Vay sanatçı hastalığı, işte bilmem hani, çok cool adamsın bu hastalıkla.” falan gibi daha çok yaşı genç insanların böyle söylediğini çok yanlış olarak şahit oldum, ama bu sayıca çok değildir. Bir diğer tepki de “Zaten işte **sen bu hastalığa sahipsin, o nedenle ne yapsan yeridir, ben seninle olamam.**”, bu daha çok şeylerden, işte yaklaştırmaya çalıştığım karşı cinsten gelen tepki. Bir de olayı işte hastalık olarak değerlendirip, yani “**Bu mücadele edilmesi gerekir, ciddidir, şey olması gerekir, üstüne durulması gerekir, ve alaya alınacak bir durum değildir, çünkü alaya alındığında sonuçları çok ağır olabilir.**” diye bana söyleyen arkadaşlarım oldu.

Ekin stated that she thought it was not perceived in a positive manner. By specifying it as a psychiatric disorder, she said people always first thought about what they see in movies or in society before thinking it in a reasonable way.

Researcher: So how do you think people see this, how is it in people's minds?

Ekin: I don't think it's a good thing. I mean, I think **psychiatric disorders are always seen as very bad things in people's minds**, because we always see those **crazy scenes in movies, the drugs, the electroconvulsive therapy**, all that stuff. I mean, before we think logically, the things we see in society or in movies come to mind, and that's how it seems to me.

Original:

Araştırmacı: Peki insanların insanların nasıl gördüğünü düşünüyorsunuz bunu, insanların kafasında nasıl bir şey sizce?

Ekin: Bence iyi bir şey değil. Ya bence **psikiyatrik rahatsızlıklar insanların kafasında hep çok kötü şeyler** yani, çünkü hep o **filmlerdeki deli sahneleri, ilaçlar şunlar bunlar, elektroşoklar**. Hep böyle bir diyorum ya, hani bir mantıklı düşünmeden önce o toplumda gördüğümüz ya da daha işte ne biliyim, filmlerle gördüğümüz şeyler aklımıza geliyor ya, onun gibi geliyor bana.

Likewise, when Ceyhun was asked how he thought people saw this diagnosis, he replied by saying he thought people saw it as good for nothing and damaged.

Researcher: How do you think people perceive this diagnosis?

Ceyhun: I think it's perceived as **rotten and worn out**.

Original:

Araştırmacı: Nasıl algılandığını düşünüyorsunuz insanlar tarafından bu tanının?

Ceyhan: Çürük çarık şeklinde algılandığını düşünüyorum.

Feray also mentioned two possible ways of how people might react if she were to share her diagnosis. First of all, she indicated some people might not mind her diagnosis as she is a person who lives in the society. On the other hand, she said that some others might question her medication. By referring to her profession, she speculated that as a healthcare worker, people will not tolerate her using medication or going to therapy.

Researcher: So how do you think people will react to this, how do you think they will respond?

Feray: Well, I can say there are two possibilities. As an individual living in a normal society, they might not care much. A certain group of people won't care much, while another group might care a lot and ask questions like, "Are you taking medication?" Another possibility is that, for example, in a few months I will have finished nursing school, and I know that once people find out I'm a nurse, they will say things like, "**She's a nurse, but she can't help herself, she's on medication, she's going to therapy.**" I still see people around me who would say, "**How can a nurse be on medication?**".

Original:

Araştırmacı: *Peki insanların bunu nasıl karşılayacağını düşünürsünüz mesela, nasıl tepki vereceklerini düşünürsünüz?*

Feray: *Şimdi iki ihtimal olarak söyleyebilirim. Normal toplumda yaşayan bir birey olarak belki de çok fazla takılmayabilirler. Belli bir kesim çok fazla takılmayacaktır, belli bir kesim de tam tersi "A falan ilaç mı kullanıyorsun?" falan diye çok fazla takılabilir. Diğer ihtimal olarak da seçenek olarak da mesela şimdi birkaç ay sonra hemşirelik bölümünü bitirmiş olacağım ve insanlar hemşire olduğumu bildikten sonra "**Hemşire ama kendisine hayrı yok, ilaç kullanıyor, terapiye gidiyor.**" falan diyeceklerini biliyorum. Hala da hani "**İlaç kullanan hemşire mi olur!**" gözüyle bakan insanlar gördüm yani çevremden.*

It can be asserted that participants mostly had negative ideas concerning perceptions of bipolar disorder by the society.

What was surprising was that these reflections were mostly not based on their own experiences. Rather, they mostly speculated or referenced other people or movies. When they were asked about their opinions, they created various hypothetical scenarios on what they might encounter or how others might react.

3.5.2. You Never Can Tell: How Am I Perceived by Others?

In addition to talking about the image of “bipolar disorder”, individuals also talked about their own image as a “bipolar person”. They compared and contrasted the two images. It was considered that while they had more negative attributions regarding the image of bipolar disorder, they had more positive attitudes towards their own image as a bipolar person. Some even stated that they do not “look like a bipolar person”.

Neslihan expressed that people’s expectations from a bipolar person were different; therefore, they were surprised to hear that she is bipolar. She added that in her office, everyone knew that she is bipolar. However, as they forgot she is bipolar, they sometimes made jokes about bipolar disorder, and then they apologized to her by saying they forgot as she did not behave like one. When asked what she meant by expectations, she replied by saying people nowadays encountered other bipolars as well who are unstable, impulsive and disorganized, so they were surprised by the fact that she is bipolar.

Neslihan: So generally, actually, at least lately, **people are surprised that I’m bipolar because their expectations are different.** For example, everyone at the office where I work now knows I’m bipolar, but they often forget and make jokes about it. Then they say, “**Sorry, we forgot you are bipolar because you don’t act like it.**” for example.

Researcher: You said people are surprised and that their expectations are different, what do you mean by expectations here?

Neslihan: From what I’ve seen, people now know more than one person with bipolar disorder in their lives, and people who met someone with bipolar disorder before me always say that those people are very unstable, that they can’t get their lives in order, that they could do anything at any moment. That’s why they say they’re surprised by me.

Original:

Neslihan: *Yani genelde, aslında şu, yani en azından son zamanlarda insanlar bipolar olduğuma şaşırıyor çünkü beklentileri daha farklı oluyor. Mesela şu an çalıştığım ofiste herkes biliyor bipolar olduğumu, ama çoğu zaman unutup bipolarlıkla alakalı bir şaka yapabiliyorlar. Sonra diyorlar ki, “Kusura bakma hani **senin öyle bir bipolar olduğunu unuttuk çünkü hiç öyle davranmıyorsun.**” diyorlar mesela yani.*

Araştırmacı: *İnsanların şaşırıldığını beklentilerinin daha farklı olduğunu söylediniz, beklentiden kastınız nedir burada?*

***Neslihan:** Gördüğüm kadarıyla artık insanların hayatlarında tanıdıkları birden fazla bipolar insan var, ve benden önce bir bipolarla tanışmış kişiler hep o kişilerin çok dengesiz, işte hayatlarını bir türlü düzgün şeye oturtamamış insanlar olduğunu söylüyorlar, her an ne yapsa yeridir şeklinde anlatıyorlar. Ya o nedenle bana şaşırdıklarını söylüyorlar.*

Cenk conveyed that people around him promote and praise by saying he fought such a dangerous and risky illness, and at the same time he passed the civil service exam and became a government official. He stated that he agreed with them when he thought about what they said. He said if he could do it in spite of his illness, he can also do it in the future, which was a positive aspect of the illness for him.

Cenk: People around me said this, our family friends said this. They said things like, **“You fought such an important, dangerous and risky illness, and then you took the KPSS exam and so on, you got a government job.”** like that. Of course, when I thought about what they said, I agreed with them. I thought, “If I can do it despite this, and I can do it later too.” So, there was a positive side to it, too.

Original:

***Cenk:** Çevremden de bunu söyleyenler oldu, aile dostlarımızdan söyleyenler oldu. “**Sen hem bu kadar önemli, bu kadar tehlikeli riskler barındıran bir hastalıkla mücadele ettin, hem de işte KPSS’ye girdin, bilmem ne yaptın, işte memuriyeti kazandın.**” falan gibi şeyler söylediler. Tabii onların bu sözünü düşününce ben de hak verdim yani. Demek ki dedim, “Buna rağmen yapabiliyorum, daha sonrasında da yapabilirim.”, diye düşündüm. Böyle bir hani olumlu yönü de olmadı değil.*

Cenk also questioned what could have been noticed about his disorder that would lead to the question “Do you have this kind of illness?”. He mentioned that he had been to various cities, schools and worked in different jobs and have been in several environments, and he has rarely encountered such a question. He expressed this by saying that when he mentioned his diagnosis if it came up in a conversation, he encountered the response “You are the most standard person I have ever seen.”

Whether their disorder was visible to others and how did they seem to others was a subject of curiosity for the individuals. They mostly conveyed their thoughts in this manner by stating no one would be able tell that they are bipolar from the outside unless they said so.

It was suggested that individuals evaluated themselves differently by separating themselves from what they believed to be the bipolar image perceived by the society. For example, they said they do not look like a bipolar person, no one would be able to tell, or they are “functional and successful” bipolars, unlike bipolars who are dysfunctional, unstable, or cannot not put their lives in order. In other words, they isolated themselves from the bipolar image which they characterized as “mad”, “disqualified” and “disabled”, and elevated themselves to the level of "functional bipolar individuals". In this context, it was also very crucial for them that their beliefs and thoughts about their own image as a bipolar individual to be accepted and approved by those around them.

CHAPTER 4

DISCUSSION

The aim of the present study was to examine how individuals who were diagnosed with bipolar disorder interpreted this diagnosis from a psychoanalytic point of view. Therefore, the only research question of the study was constructed as “How do individuals diagnosed with bipolar disorder interpret this diagnosis?”. In addition to the fundamental research question of the study, questions such as how individuals related to their diagnosis, what this diagnosis signified for individuals, and where this diagnosis fit into people's experiences with their disorder were also included in the scope of the study. In line with the research question and the theoretical background of the study, qualitative research was carried out, and the data was analyzed through utilizing thematic analysis method. Semi structured interviews were conducted with six individuals who were diagnosed with bipolar disorder. The data were analyzed with thematic analysis. Five main themes were generated as a result of the analysis. The first theme of the study, “I Can See Clearly Now: The Diagnosis as an Identity” indicated the aspect of the diagnosis becoming an identity for the individuals. The second theme, “Surrender Your Guilt Be Free: Being Diagnosed and Being Relieved from Responsibility” demonstrated the diagnosis functioning as a way of being relieved from guilt and responsibility for the individuals. The third theme, “With or Without You: Experiences Before and After the Diagnosis” covered the effect of diagnosis on individuals’ experiences of the disorder. The fourth theme, “To Be or Not to Be Recognized, That Is the Question” showed the importance of being recognized as bipolars by either the Big Other, or small others. The last theme of the study, “Mirror Mirror on the Other” addressed how individuals thought bipolar disorder was being perceived, and how they thought they were being perceived by O/others. Deriving from a psychoanalytic framework, the findings of the study were analyzed by embracing a critical perspective, in which the unconscious material

surfacing in speech, latent meanings, and discourse of the participants were tried to be discovered. In this section, the findings of the study will be discussed especially within the framework of psychoanalysis and Lacanian theory in particular.

Before starting to discuss the initial findings of the study, it has been considered essential to explain Lacan's theory of the construction of the subject and identity, and consequently his mirror stage theory. Lacan's mirror stage describes the process of identity formation through a mirror image that the subject first experiences as the image of an "other" and then accepts as its own (Lacan, 1949/2007). Lacan first conceptualized his theory of the mirror stage in his work called "The Mirror Stage as Formative of the Function of the I as Revealed in Psychoanalytic Experience" (1949/2007). Over time, Lacan expanded and developed his theory by adding to it. He states that human beings born prematurely and completely depend on another, in particular, the mother, who is mostly the primary caregiver, to survive. When the infant is first born, he cannot perceive himself as a separate being and thinks that he is a limb of the mother, and they are a whole together. The mother also feels as though the infant is a narcissistic extension of her. The state of being one with the mother and being in a fusion together involves an excessive amount of *jouissance*. In this stage, there is only the real order, which can be defined as beyond our reach, which cannot be imagined or symbolized through language (Evans, 2006). The mother fulfills the infant's needs and keeps him alive. For a time, the infant can only see himself as a fragmented being, such as legs or arms, and there are only independent body parts for him, there is no sense of unity. Approximately around six months of age, the mirror stage comes when the infant sees himself in the mirror as an unfragmented, united, whole being and realizes that he is a separate being from his mother. This moment brings a jubilation, a moment of victory for the infant. In this moment, the infant identifies with this unfragmented image in the mirror, leading to the formation of the ego. Adopting this exterior image of the body that is the foundation of the construction of the ego is called as "mirroring" (Vanheule & Verhaeghe, 2009). The ego stands for "I", a sense of unity and completeness. Through the sense of control over the body and illusion of unity, ideal ego is formed. Ideal ego represents all the ideal images attributed to this image acknowledged as "I". However, this sense of control or mastery over the body is an illusion and is in

fact impossible, this is why Lacan regards this as a “méconnaissance”, a misrecognition, and the ego is a result of this misrecognition (Vanheule, 2011). This identification with the specular image also brings a feeling of alienation with it, because the infant identifies with something that is outside of itself. This identification is also the cause of such concepts as aggression, narcissism, or paranoia as the infant sees its reflection in the mirror as a wholeness, in contrast with the incoordination in the real body, this contrast is experienced as an aggressive tension between the specular image and the real body, since the wholeness of the image seems to threaten the body with disintegration and fragmentation (Özcan, 2023). The mirror stage also represents the introduction to the imaginary order, which is the realm of image and imagination, deception and lure. The principal illusions of the imaginary are those of wholeness, synthesis, autonomy, duality and, above all, similarity (Evans, 2006). Therefore, it can be concluded that both ego and ideal ego belong to the imaginary order. However, seeing his image on the mirror is not enough on itself for the infant to identify with this specular image. The presence of an other, more precisely the Big Other, who is mostly the mother that is the first Other for the infant, is necessary for this identification to take place (Özcan, 2023). The mother also sees the image of the infant in the mirror and by recognizing this image, presents this image to the infant by saying “This is you!”. Through this recognition and naming, the mother also assigns a signifier to this image. The infant sees her mother’s hopes and dreams, ideals or plans for him through her gaze, which also represents the gaze of the Other, that results in the formation of the ego ideal. The mother, by her gaze and by assigning him a signifier, gives a place to the infant in the symbolic order. Hence, it can be said that mirror stage also paves the way of the constitution of the symbolic order. Symbolic order is the realm of the Big Other, unconscious, desire, law, culture, and language. While the imaginary order is characterized by dual relations, symbolic order is characterized by triadic structures (Evans, 2006). At this point, the mother's reactions also function as a mirror, reflecting the world the infant was born into on both concrete and abstract levels. The infant also perceives how he and the world appear from a reference point outside of himself. From the moment the mother, or the primary caregiver, attributes and fixes the image in the mirror to the infant during the mirror stage, the infant begins to recognize other people as separate from itself. He then realizes that he is also

someone else to other people and begins to build its sense of identity based on this image. This also lays the foundation for identity formation (Vanheule, 2011).

The process of being diagnosed described by the participants is thought to be directly coinciding with Lacan's mirror stage. Before getting diagnosed, individuals talked about their chaotic experiences, which they could not make sense of or understand what was going on and what was happening to them. They referred to this state as "There is something, but you don't know what it is." (*Bir şey var ama bilmiyorsunuz*) or "You fear what you don't know." (*Bilmediğin şeyden korkarsın*). At that point, receiving a diagnosis was associated with "relief" for almost all participants, and they evaluated the diagnosis as "an explanation", "to make sense", "to domesticate", "the stones falling into place", "to coincide", or "an interpretation". In that manner, it can be argued that diagnosis functions as a "signification". Through nominalization, a process of interpretation begins. Just as the Big Other points out the specular image in the mirror and says, "This is you!", in this case, the doctor says, "You are bipolar!", and thus, initiates the process of identification. Likewise, the state before this signification was regarded as a dark and unknown period by the participants, for example, Ekin referred to this period as "the dark ages" while she compared getting diagnosed to "learning to read the hieroglyphics", in which diagnosis acting as something that enables the process of gaining knowledge or making sense. Neslihan likened getting diagnosed to "waking up from a dream" and thereby referring to the period before as something obscure and cannot be fully grasped. Therefore, it can be argued that the period before the diagnosis corresponds to the stage in which the infant perceives himself as a fragmented and uncontrollable being while being diagnosed is just like seeing oneself in the mirror for the first time as a whole and united being, which gives the illusion of control and mastery. Being diagnosed somehow even reminds the feeling of victory and jubilation that the infant feels when he sees himself in the mirror. Ekin's statement "You need that diagnosis to understand." (*Anlamanız için o teşhise ihtiyacınız var.*) almost sounds like "You need that diagnosis to create an identity.", just like a name is needed for an identity. The doctor's role in this process as the diagnostician can be likened to the Big Other in the mirror stage, who is the primary caregiver, the parent. The only difference here being the doctor pointing to the DSM rather than the mirror

when saying “You are bipolar!”. Ekin’s expression provides a good example here. When the fact that she associated the diagnosis with gaining knowledge was highlighted, she said “Yes, it all starts once the doctor says you are bipolar.” (*Evet, sonuçta sen bipolarsın dedikten sonra başlıyor her şey*). This “all” seems to refer to the identity construction, a new identity as a “bipolar person”. She also conveyed that when her doctor said, “You are bipolar two.” (*Sen bipolar ikisin.*), she replied to him by saying “Why I am bipolar two and not bipolar?” (*Neden bipolar iki, neden bipolar değilim de bipolar ikiyim?*). Hence, it can be said that the doctor’s role here is crucial, he is the Big Other who names and recognizes the individual as bipolar and initiates all subsequent installations. As was mentioned before, assuming an image as “I” is the first step of forming an identity. Identification takes place when an image is assumed. However, identification with this image cannot be possible without the presence of a Big Other who also recognizes this image. In order to be able to identify with the diagnosis, a doctor who recognizes this diagnosis is necessary.

Identifying with something brings along a feeling of alienation. At the mirror stage, identifying with the specular image means identifying with something that is not a part of the self, something exterior and foreign (Özcan, 2023). Building one's identity on this foreign image also brings a sense of paranoia with it. Likewise, the diagnosis is also something foreign to the self, something external. Some participants mentioned the confusion being diagnosed caused at first, and how they struggled to process it. This confusion was mostly caused by not being able to differentiate their characteristics with what the disorder brings. However, their statements also suggested a great deal of overlap between their selves and the disorder, so much that they could not differentiate the two, they were intertwined. For instance, Ekin conveyed that she felt like she had no character and talked about her confusion by saying “Is everything I have right now actually because I am bipolar?” (*Sahip olduğum bütün her şey aslında bipolar olduğum için mi?*). Yet, her statement “If they took this illness away from me, who would I be?” (*Bu hastalığı benden alsalar ben kim olacağım?*) illustrates the fact that she already considered this disorder as a part of her. Besides this, it also carries the meaning that she felt as though if the diagnosis was taken away, nothing would remain of her. In other words, just as the

specular image is a part of the self even though it is alien, the diagnosis is also a part of the identity although it is still exterior, hence the feeling of alienation that accompanies it.

Participants' expressions such as "I equals bipolar", "this is me", "it is directly me", "what makes me who I am is my illness" were thought to be direct indications of an identification with the diagnosis. They equated themselves with the disorder or talked about it as a part of themselves. For instance, Ekin equated her life with the diagnosis by saying "This thing called life is that diagnosis." (*Hayat denilen şey o tanı.*). It was also striking that they used the verb "being" when talking about bipolar, or "having" when talking about the disorder. For example, Bilge referred to her disorder as "my bipolar". It was thought that individuals talked about their disorder from a possessive standpoint, almost all participants used the expression "to have the disorder", which also stands for "to possess" or "to own" in Turkish. These statements were regarded as signs of an internalization of the disorder as well as identification with it. Another interesting point was the fact that some participants talked about the disorder by comparing it to body parts. Neslihan stated that the disorder is a part of her by comparing it to her hair and then said "It's not like an arm. Maybe I could lose my arm, I could continue without it, but bipolar disorder is no longer like that for me." (*Kolum gibi bir şey değil. Belki sakat kalabilirim, onsuz devam ederim, ama bipolarlık artık öyle bir şey değil benim için.*). The remarkable point of this statement was that she positioned the disorder as something she could not live without. Similarly, Ekin likened the disorder to her shadow and remarked that it will always be with her wherever she goes. These references to the body also bring the experiences of a fragmented body before identifying with the united specular image to mind. Deriving from this, it was thought that diagnosis corresponds to the united image in the mirror, something that unifies and integrates the previously chaotic and fragmented experience. Without the diagnosis, this unity disintegrates. At this point, it seems as though identification with the diagnosis has been completed.

It was noteworthy that participants likened the diagnosis to reflective surfaces, such as glasses or camera lenses. It is thought that these analogies are not coincidences.

Individuals regarded diagnosis as something that enabled them to see themselves clearer, working just like a mirror. The diagnosis provided them with a space in which they could mirror themselves.

After identifying with the diagnosis and accepting it as an identity, it became something that separated them from “normal people”. Although this distinction may seem like they are classifying themselves as sick or abnormal, it also places them in a special and different position in a sense. Being diagnosed has also resulted in a retrospective interpretation for them, after getting diagnosed, they reported that they looked back on their pasts and looked for clues that could be related to the disorder, and this resulted in them declaring “I have always known I was different.”. By separating themselves from other people, who are referred to as normal or healthy, they have also highlighted some of the advantages of the disorder, for example Neslihan talked about her potential of change while she described non-bipolar people as monotonous, and Feray expressed that the disorder enabled her to do some things other people could not do or feel. Certain benefits or advantages of the disorder were mentioned by the participants throughout the interviews, which may also reinforce their perception of being different or special at some points. This separation between bipolar people and non-bipolar people has also led to the formation of a sort of group or community of bipolars, even though some have never met any other bipolars, they have frequently referenced to other bipolars. Accepting this identity has also showed them that they were not alone and helped them in overcoming their sense of loneliness. For instance, Cenk, when talking about being diagnosed, said “It was good for me, as before that it was like, ‘Something is happening, am I completely alone?’ Just like a child saying, ‘Am I the only one in the world doing this?’, like a child wondering.” (*Benim için iyi olmuştu, yoksa onun öncesinde durum şuydu, ‘Ya bir şeyler oluyor acaba hani tamamen mi yalnızım?’ Tıpkı şey diyen bir çocuk gibi yani ‘Acaba bu hareketi yapan dünyada bir tek ben miyim?’ diye merak eden bir çocuk gibi.*). They have also said that normal people could never understand this illness, and only bipolars could understand each other. Ekin stated “You are alone until you meet another bipolar person.” (*Sen gerçekten başka bipolarlarla tanışana kadar yalnızsın.*). Participants describing themselves as bipolars, distinguishing themselves from non-bipolars and referencing other bipolars were regarded as ways

of reinforcing the bipolar identity. At the same time, these quotes also suggest another aspect of identification, identification with small others, or counterparts. The specular image in the mirror, which is an “other” in a way, is identical to the images of the little others the infant encounters in daily life, people who resemble him but are also rivals, in terms of their strangeness and imaginary qualities (Özcan, 2023). These small others, with both their similarities and their simultaneous strangeness, also offer a space for identification for the individuals. Vanheule & Verhaeghe (2009) pointed out the fact that identity is a construct that emerges in relation to the other, it is not an inherent experience, and subjects form their identities in respect to resemblance and similarity with the others. From a Lacanian point of view, people are agents who deliberately identify with aspects of other people by viewing them as reflections of themselves. Because of this, the perception of subjective identity is inherently alienated and made up of foreign components that are drawn from the other. From another perspective, Lane (2018, 2024) also discussed this aspect of diagnosis in her work and stated that people who identify with and group themselves around a particular category, such as a diagnosis, can use the formation of group identities to encourage social change or critique, like fighting against discrimination or stigma, advocate for better services, or participate in political activism. Therefore, it can be concluded that identifying with the diagnosis paves the way of forming a group identity and coherence at the same time.

As was explained before, the process of identification cannot be realized independently of the presence of a Big Other. The ideal ego, which corresponds to the primary identification, and the ego ideal which represents the secondary identification, can occur through the gaze of the Other. The child identifies with its reflection in the mirror and defines itself as a gestalt, a complete form, an ideal, which corresponds to the concept of the ideal ego. However, the infant can only own and embrace this ideal ego from the gaze of the Other who confirms that this image belongs to him. In other words, the ideal ego is imposed on the infant from outside by the Other (Özcan, 2023). This primary identification with the image and the construction of the ideal ego is the source of all the secondary identifications. While the primary identifications are narcissistic and imaginary in its nature, the secondary identifications are conceptualized as a development towards normalization and

symbolic, as they include identifying with signifiers, and positions defined and generalized by social standards. The infant first sees the image of the ego ideal in the form of the parent holding it up to the mirror and becomes captivated by that gaze. Thus, only through the gaze of the Other, and his confirmation and recognition through this gaze, can the ideal ego and ego ideal, and also the identity, can be formed. According to Lacan, the “identification” mechanism is what establishes the sense of identity (Vanheule & Verhaeghe, 2009).

Only through the recognition of a Big Other can individuals recognize themselves, which also applies to being recognized as bipolar. An identity as a “bipolar person” can be formed only if there is an Other who accepts and confirms this identity. A point worth mentioning here is the fact that the word “diagnosis” is equivalent to “recognition” in Turkish. Hence, it can be asserted that being diagnosed is a direct way of being recognized. References to be recognized and to be seen by the Others were prominent in the discourse of the participants. Doctors, who are also positioned as “subject supposed to know” were frequently mentioned, as well as parents. As was discussed before, doctors held the place of the first Big Other, the one who assigns the signifier “bipolar”. Without their recognition, the process of identity formation would not be applicable in the first place. They were also regarded as the “subject supposed to know”, meaning the position to which the information and knowledge is attributed (Evans, 2006). Additionally, doctors are, in a sense, the authority figures who determine a person's fate, that is, their diagnosis. Participants referred to their doctors either with respect or with anger or contempt, but the common point among all was they only continued with the doctors who recognized them, and stopped seeing the ones who did not. Neslihan said she only continued seeing the doctors who recognized her as an individual patient. On the other hand, Ekin conveyed that she could reach her doctor anytime she wanted, and she could talk to him about anything. Bilge talked about switching a lot of doctors, and she could not find a doctor who could understand her for some time and mentioned feeling worthless and insignificant when she could not reach her doctor when she needed her. She also asserted that her last doctor finally made her feel like she was being taken seriously and respected and said, “Mrs. Melis is, thanks to her, very good at keeping track of me, so if something comes up, I can reach her by email, for

example, and she responds immediately, very quickly. That's very important to me.” (*Melis Hanım da, sağ olsun, beni takip etmek konusunda iyi, ya bir şey olduğunda ona mail yoluyla ulaşabiliyorum mesela, ve yani anında cevap veriyor çok hızlı cevap veriyor mesela. O çok önemli bir şey benim için.*) As can be understood from these examples, participants attributed much importance to be able to reach their doctors, talk to them freely, and also to be taken into consideration and be valued by them. Ekin’s expression “The doctor is everything.” (*Doktor her şey demek.*) summarizes this point, but at the same time, it also sounds like a reference to the omnipotence of the doctor, the all-knowing and the all-powerful.

To be seen and to be recognized not just as individuals, but as bipolars by their parents, the first Big Others, also occupied an important place. The confirmation and acceptance of their diagnoses and bipolar identities by their families held a crucial position. Cenk even described that because of his diagnosis, he is considered different in his family and referred to his family’s standing with the analogy “Do not give the water to me, give it to Cenk.” (*Suyu bana verme Cenk’e ver.*). This situation can also be regarded as a secondary gain of the disorder. On the other hand, some participants conveyed that their parents ignored their suffering or preferred not to see. Bilge reported that even though her situation was getting worse and her parents were aware of it, she still did not receive an adequate treatment. Likewise, Feray talked about spending a lot of her time being depressed and in bed, but her parents preferred not to take her to a doctor. She even mentioned she later asked her parents how they could not take her to a doctor back then. One striking commonality between these two participants were that they both attempted suicide several times and using the same method, by taking pills prescribed for the disorder or cutting themselves. This situation can be interpreted as them forcing the Other to see them when the Other refused to see. This effort brings the concept of acting out to mind. Acting out can be described as a way of conveying a message. When the subject fails to convey his message to the Other by means of language and articulation, he tries to express it by his actions (Evans, 2006). Suicide attempts, as well as self-harm can be considered as acting out. As a result of the failure of the symbolic function, actions may manifest themselves as a way of communication. In addition, especially the visible kinds of self-harm such as cutting, as it leaves scars or marks, are attempts to

be seen. This unconscious message is sent to the Other in the form of an action (Gündoğan, 2024). Both Bilge and Feray reported cutting themselves, and as a result, they convey wearing bandages, or long sleeves to cover the scars. Feray's expression, "I would tell my family, 'I took medication, take me to the doctor.' and we would go to the emergency room." (*Aileme hani "ilaç içtim beni doktora götürün" diyordum, acile gidiyorduk.*) was especially striking as it could be inferred from her example that she also directly disclosed her action to her parents, and made them hear and see her suicide attempt. Another aspect of acting out is that as there is an unconscious message relayed to the Other, there is still a symbolic aspect of the action, and a scene, unlike passage to the act, which involves going beyond the symbolic to the real (Canbolat, 2018). In line with this, Feray's statement "I don't know if I really wanted to die, but I always made attempts like that." (*Gerçekten ölmek istiyor muydum bilmiyorum, ama bu tarz girişimlerim hep oluyordu.*) gave away her underlying motivation in a way. She indicated that her goal is not to die, but to be seen. She also talked about her disappointment about her parents not accepting her diagnosis and supporting her. These examples illustrate that when individuals think that they are not being recognized, they engage in certain maneuvers to be seen, such as acting out.

Besides Big Others, the recognition and acceptance of small others, such as friends, peers, romantic partners or social circles in general, were also crucial for the participants. Although some participants reported that they do not prefer to share their diagnosis with people, deriving from the subtext of their speech, it was thought that they somehow made their diagnosis known or heard by others, either by their acts or by saying or doing things that will lead to such a question being asked. Ekin stated that she told her friends as soon as she was diagnosed. She also shared that one time, when she was in a foreign country, as she was forgetting to take her medication, she put the lithium bottle at the table. Her behavior resulted in her friends at the office coming and asking her if there was anything they should know or could do about her condition, even congratulating and thanking her for being so forthcoming. In other words, she made her illness public and visible to others by putting the lithium bottle at the table, which lithium is a direct indication of bipolar disorder as it the most widely used treatment for it. Additionally, she also conveyed

asking people around her such as her parents, husband, or friends frequently whether they observe a change in her mood. Her expressions suggested that she made her disorder seen and heard, and she often reminded it to people around her by asking them to monitor her behaviors or mood. Likewise, Feray also mentioned people in her dorm saw her medication and asked her questions about it. She also stated that when she was not feeling good, she told people that it was normal for her to be that way as she was taking medication. Neslihan asserted that everyone in her office knew that she is bipolar and reflected that they should know about it in order to understand and embrace her behaviors better. Whereas Cenk said that he normally did not share his diagnosis with everyone, but if a question aroused as a result of his behaviors or attitudes, he preferred to share his diagnosis rather than to lie. On the other hand, Bilge conveyed that she did not share her diagnosis with people as once when she shared it with her friends, they told her that people had much greater troubles and she should not be concerned about this and be grateful that her arms and legs are intact. This occasion suggested that the reason for her not sharing her diagnosis was because she was afraid that she would not be recognized, as the situation she described was a moment her disorder was not recognized and respected. Therefore, it was concluded that individuals either directly shared their diagnosis with people around them, or they engaged in certain acts or maneuvers, or created certain circumstances that their diagnosis would be heard or seen, or somehow made people ask about it. The ones who reported not sharing their diagnosis feared that their disorder would be underestimated. Being acknowledged as bipolar and for their diagnosis to be verified by the people around them was thought to be significant for the individuals. In contrast, not to be recognized or to be belittled as bipolars caused them to feel frustrated and to become resentful.

In his study in which he discussed the process of being diagnosed with Lacan's double-mirror device, Rabaey (2023) illustrated how language acts as a way for individuals to integrate their experiences of fragmentation through identification. Language by working as mirror, can enable individuals to reflect their image to O/others, and gain recognition and acceptance through it. He also highlighted the importance of narratives at this stage, as they are a part of the self-image which helps people to form an identity and also to convey this identity to O/others. In his study,

he asserted how construction of a “bipolar narrative” and consequently a “bipolar ego” aided individuals to gather their fragmented experiences and achieve a sense of mastery and control over them. The findings of the present study were also in parallel with his findings. Participants described their experiences related to the disorder before getting diagnosed as “dangerous” or “extreme”. They also talked about the time when the disorder first appeared as a “dramatic change” in their sense of selves. For instance, both Bilge and Feray stated being depressed most of their lives, and when they first experienced hypomania, they experienced it as a complete and unfathomable change in themselves, and they could not recognize or make sense of this aspect of themselves as it was highly incompatible with their own identity perception. At this point, receiving a diagnosis provides a new reference point for all chaotic and unexplainable experiences or thoughts to be centered around, and enables integration. Rabaey (2023) also regarded diagnosis as a moment of being recognized in the mirror of the Other that facilitates the process of giving meaning and understanding the experiences through the aid of language. Being diagnosed marks the beginning of construction of narratives of the self and the disorder, which also includes gaining knowledge about the disorder and comparing the existing narratives with their own experiences. Thus, this narrative of “being bipolar” starts serving as a new ego, an image of the self that offers comprehension and control. As a result of this new ego, ideal ego and ego ideal in line with this ego is also formed. In this manner, he conceptualized the ego ideal as evaluating oneself against what is considered as the norm and the standard, and constantly trying to live up to it, which corresponds to the ideal ego. This would mean embracing an image of control and agency and taking charge of the symptoms and allege accountability. However, Rabaey (2023) also pointed out the fictional and imaginary characteristic of this situation. He stated that even though diagnosis paved the way of construction of a narrative and functioned as an anchor for individuals to make sense of their experiences and to gain control over it, it was indeed far from being a final destination or a true comprehension. As much as diagnosis is connected to the symbolic order due to its function as an anchor, since identification is something that takes place in the imaginary order, narratives that are constructed on the basis of this diagnosis will inevitably remain at the imaginary level.

Participants of the present study reported that their experiences related to the disorder has changed over time and evolved and transformed into something more controllable and manageable, and they stated this change by using expressions such as “get on track” or “stabilized”. They attributed this change to receiving a diagnosis, as it enabled them to “know themselves”. For instance, Cenk expressed this by saying “Getting a diagnosis helped me get a handle on things.” (*Tanı almak bence biraz topladı olayı.*) while Ekin stated that with the diagnosis, she now knows herself and said “I am glad I got diagnosed. I think getting a diagnosis is a very valuable thing.” (*İyi ki tanı almışım diyorum. Tanı almanın çok kıymetli bir şey olduğunu düşünüyorum.*). After getting diagnosed, they started to gain knowledge about and gain experience with the disorder, and with time, they reported knowing how to control or to pass the episodes, discovering what is good or bad for them, and even to use it to their advantage. Bilge mentioned this by saying “After a while, I am starting to realize the situation I am in, and that I am not doing well.” (*İçinde bulunduğum durumu zaten artık bir süre sonra fark etmeye başlıyorum, ben iyi değilim diye.*) and she also reported she now discovered trying to find a new purpose and goal in life helps with managing her disorder. Likewise, Feray said “Yes, at first, I didn't notice it at all, but now I know I am in hypomania. Still, I can tell myself to stay calm, that I need to sit down, rest, sleep, and things like that.” (*Evet, ilk zamanlar hiç fark edemiyordum, ama şimdi hipomanide olduğumu biliyorum. Ama yine de sakin ol, şu an oturman gerek, dinlenmen gerek, uyuman gerek gibi şeyler söyleyebiliyorum.*) and that she provides herself with the space to get better and to rest rather than judging herself. She also indicated that at first, the episodes had a negative effect on her but in her current circumstances, it has a more positive effect as she feels better about herself because of the things that she has achieved and succeeded in. Therefore, it can be suggested by based on the statements of the participants, while being bipolar individuals who are self-controlled, successful, stable, and responsible corresponded to the ego ideal, their self-images and beliefs in achieving stabilization, being on control and gaining mastery over the disorder, and knowing themselves stood for the ideal ego. This image of being on control also resembles the state during the mirror stage when the infant who perceives himself as fragmented and has limited control over his body sees the united image in the mirror and identifies with it while also falling on an illusion of control. Just like the ideal

ego during the mirror stage represents the unity and mastery over the body, the ideal ego in this case represents controlling and overcoming the disorder. However, both images are products of misrecognition, and thus, they are an illusion. It is also thought that these findings demonstrated similar characteristics to what Rabaey (2023) asserted about narratives about the disorder being fictional and imaginary.

Participants referred to bipolar disorder as a “very serious” and “very difficult” illness and talked about “fighting” or “struggling” with it. They spoke of themselves as people who are struggling and fighting against such a difficult and serious illness. From these statements, it seemed that they believed they achieved a kind of victory over this disease and overcame it. This also became a situation that set them apart from others and placed them in a position of a fighter. Based on their statements about the disorder and themselves, it was suggested that they have idealized the disorder in a way. Another striking point was that all participants without an exception compared bipolar disorder to diabetes, which stands for “candy disease” in Turkish. Hence, by likening it to “candy”, by attributing characteristics as “important” or “significant” to it, bipolar disorder turned into something which differentiated them from other people. However, here a contradiction has appeared as they have also spoke about it as a “label” or “stigma” and talked about how badly it was perceived by society. When talking about how they thought the disorder was being perceived by the society, they talked about the society’s prejudices, compared the disorder with schizophrenia and madness, referred to scenes with electroshock in the movies, and declared people with bipolar disorder was being seen as “defective”, “rotten”, “unqualified”, “limited”, “disabled”, “abnormal”, or “sick”. This resulted in a conflict between how they saw it and how the society saw it. On the other hand, one of the most striking points concerning this situation was although they talked a great deal about how discriminating and stigmatizing the diagnosis was, when asked whether they have encountered such a situation themselves, they all reported that they have not, which implied that what they described and told were hypothetical and imaginary situations. When asked what kind of reaction they thought they might get if they shared this, they mentioned various possibilities. For example, Cenk reported people can either see it as an artist’s disease and cool, or something serious and something to be fought, while Feray speculated that while some people might not

care so much, others might judge her medication. At this point, it is argued that in order to regulate this conflict, when they were talking about how they thought they were being perceived by the society, they either separated themselves from other bipolar people, or alleged that no one would be able to understand that they are bipolar if they do not share it themselves. For instance, Neslihan mentioned people are surprised to learn that she is bipolar as they have different expectations and added that even though everyone at the office knows her condition, they forget and make jokes about bipolarity, and then say “Sorry, we forgot you were bipolar because you never act like it.” (*Kusura bakma hani senin öyle bir bipolar olduğunu unuttuk çünkü hiç öyle davranmıyorsun.*). When asked what she meant by expectations, she responded by saying that people told her that other bipolar individuals they knew were unstable, unable to get their lives in order, and capable of doing anything at any moment, so they were surprised that she was not like that. Her statement suggested that she separated herself from other bipolars who are unstable and disorganized, and considered herself as “not like other bipolars”. Cenk talked about people around him congratulating him for “fighting such an important, dangerous and risky illness” while at the same time “taking the KPSS exam and getting a government job” and stated he agreed with them when he thought about it. Additionally, he also expressed that when he shared his diagnosis with people, he encountered the response of “You are the most standard person I have ever seen.” (*Gördüğüm en standart bir kişisin.*). Meanwhile, Ekin asserted that no one would be able to tell if someone is bipolar unless they say so themselves. Thus, considering these statements, it can be derived that when what they have idealized do not match with what they believed to be the perceptions of the others, they have regulated their own perceptions of themselves. In order to do that, they either separated themselves from others bipolars whom they described as “unstable”, “disorganized”, or “abnormal” while classifying themselves as “functional”, “successful”, and “stable” and positioning themselves as “not like other bipolars”, or they declared that they “do not look like bipolars” and suddenly attributed not looking like a bipolar as a positive situation. Therefore, it can be concluded that when the ideal egos of the individuals did not match with the ego ideals, they tried to arrange their ideal egos in a way that would be compatible with their ego ideals. In order to do that, they adopted the characteristics and qualities that they thought would best match with their ideal images.

One interesting point that emerged during the interviews was the sense of guilt conveyed by the individuals. They touched upon a feeling of guilt and reported feeling guilty. However, when the origin of this guilt was investigated, they could not provide a clear answer to this and replied by saying they did not know. For instance, when Feray, who frequently referred to guilt and feeling guilty during the interviews, was asked what the reason or origin of this feeling might be, answered by saying she did not know and attributed this feeling to her brain. Likewise, Cenk stated that he was not at fault for having this disorder, and when he was asked why he referred to this as a fault, he said “Yes, I think so too, why should it be a fault?” (*Evet ben de öyle düşünüyorum neden suç olsun ki?*) but did not answer the question. Just like Cenk, Bilge also reported that she is not at fault for having this illness by saying “This is an illness, and it did not happen at my request either, I am not at fault for having this illness.” (*Bu hastalık yani, ve benim isteğimle de olmadı, yani benim hiçbir suçum yok bu hastalığın bende olmasında.*). Still, why they portrayed bipolar disorder as a “fault” and why they felt the need to defend themselves for having this illness, was unclear.

The concept of guilt is conceptualized as a universal and an integral part of existence by Freud (1913, 1930). He argued that the origin of the culture is law, which prohibits killing and incest. And this law derives from a repressed desire, such as the desire to kill the father, in which he asserted in Totem and Taboo (Freud, 1913). In Totem and Taboo, he told the story of the tribe in which the sons gathered and killed the omnipotent father and ate him. Following this murder, they felt guilty and thus the law came into being, which said not to kill and not to engage in incest. Therefore, the law is also the reminder of the crime. Culture, law, and morality have evolved from crime (Freud, 1930). In certain ways, this also resembles the idea of “original sin” in Christianity, in which there is a trace of guilt in human nature, and guilt is an innate notion in humanity. Freud also discussed the concept of guilt in terms of his notions of ego, id and superego. While he linked guilt with the pressure of superego, he conveyed that the subject experiences an internal sense of punishment as a result of the aggressive impulses seeping into consciousness. The superego constantly judges the subject. In other words, guilt can be described as the punitive voice of the superego that opposes the id’s desires (Freud, 1923). Freud declared that society

maintains order by imposing guilt on the individual through the superego, and hence, guilt is related to submitting to the law (1930). On the other hand, Lacan offered a different perspective to the notion of guilt and proposed that guilt arises not from prohibition, but it is present apart from prohibition, and no transgression is needed for guilt to arise either (Soler, 2015). Soler proposed that guilt is induced by people's perceptions of their own wrongdoing in regard to the Other, the Other's ideals, and the Other's prescriptions (2015). She put this as a type of guilt that is founded on "alienation" and pointed out that it is related to subjects becoming subjected to the discourse of the Other, more especially to the Other's demand. Lacan also linked guilt with the real and associated it with the terms "ex-sistence" and *jouissance*, which he conceptualized as out of the symbolic's reach. The term "ex-sistence" is used by Lacan to discuss "an existence which stands apart from". It is something "extimate" rather than intimate, and it persists as if from the outside. So, what "ex-sists" is that which stands at the edge or outside of the structure yet still defines it. He conceptualized real as what "ex-sists" and not exists. Real "ex-sists", it is located outside the symbolic order, but at its edge. This "being-outside" affects the entire structure of the subject, because the subject is constituted precisely around that unrepresentable void. Lacan talked about two kinds of sins, which are existing and *jouissance*. Sin of existing refers to the absence of a reason for existing, which is directed to the Other as a question, who is positioned as someone who is able to answer this question, nevertheless, he cannot. Therefore, the sin is attributed to the inadequate Other who fails to provide an answer (Soler, 2015). When it comes to the sin of *jouissance*, once humans begin to speak, they can no longer experience pure *jouissance*. Language forecloses this pleasure, leaving behind only a fragmented, divided form of pleasure. Lacan called this "the *jouissance* that should not be", because this *jouissance* lies beyond the limits of language and law. By asking the question, "Whose fault is it then?", he drew attention to the nature of language, which both makes them human and leaves them incomplete. He answered to this question by saying, "But since the Other doesn't exist, all that's left for me is to place the blame on 'I', that is, to believe in what experience leads us all to, Freud at the head of the list: original sin." (Lacan, 2006, p. 820, as cited in Soler, 2015). By this, he meant that there is no Other that is complete, consistent, and provides full meaning. The language system is incomplete, the law is contradictory, meaning

cannot be completed. Therefore, the subject can never find complete meaning or satisfaction. If the Big Other does not truly exist, that is, if there is no ultimate order or meaning-giving law in the universe, then there is no one left to blame for subjects own lack. Here by referring to Freud's concept of the original sin, he asserted that if subjects cannot attribute their lack to an external law, they will have no choice but to direct it towards their own selves, which will give rise to guilt. To conclude, if the Other does not exist, there will be no ultimate meaning; thus, the guilt will fall upon the subject, in which, the subject will bear responsibility for the inability to produce meaning. This would correspond to the idea of the original sin which proposes that existence itself is marked by guilt. Thus, subject would feel guilty even when he is not subjected to limitations, which would also be evident in clinical outcomes. The subject who holds himself accountable for the real that "ex-sists" in relation to the Other, the only one who can take responsibility for it, will be guilty (Soler, 2015).

Another concept related is shame. Shame can be established as a primary affect in regard to the Other. It is distinguished from guilt in this manner. Miller (2006) claimed that guilt is the result of a judging Other, which is consequently an Other that possesses the principles that the subject is accused of violating. On the other hand, shame is associated with an Other, who is a primordial Other, one that sees or allows to be seen, prior to the Other who judges. Hence, while guilt can be associated with desire, shame can be linked to jouissance (Miller, 2026). The presence of an Other is necessary in terms of shame, shame arises when the subject's being is suddenly unveiled through the gaze of another. In shame, what is at question is the unveiling of the "extimate" of the subject, which is kept veiled. When this veil is lifted, it is as though one is ashamed in place of the other as a result of identifying with the unveiled other (Soler, 2015). Green and Vanheule (2024) considered shame as serving as an indicator of the fundamental lack of the divided subject being exposed to the observing other. The subject is divided by the signifier of the Other when he becomes a subject of language; thus, he is marked by loss and lack, whereas the only thing left from this division being the object *a*. When the subject is confronted with this fundamental lack in the face of an other who witness this exposure also, shame arise. Yet, from a Lacanian point of view, it is nothing but the object *a* who is the witnessing other in this scenario. This object *a* who witnesses this

exposure from within is the partial objects of gaze and voice which corresponds to the partial drives of scopic and invocatory drives respectively. In other words, while it is the gaze that sees and notices the lack of the subject, it is the voice which marks and mocks the lack, which explains how shame can be felt independently from the presence of an other. The subject comes up with ways to fill or hide this lack by assuming certain ego identities. Ego identities function as imaginary veils created to mask the lack. But once the subject is faced with this constitutive lack, he only ends up in discovering that there is nothing but emptiness behind the veil of identity. Thus, these attempts can never be successful, and when these ego identities are scattered, the lack is once again laid before the gaze and the voice, resulting in shame. When the subject experiences shame, he turns to adapting his ego identities in a way which he believes that would reflect the Other's desire. These attempts in regulating the identity could manifest themselves in the therapeutic setting by the numerous contradictions, inconsistencies, and ambiguities in the patient's narratives, which are signs of subjective division (Green & Vanheule, 2024).

Affects of guilt and shame can also be regarded as closely associated with the notion of melancholia. According to Leader (2008), what is at question in melancholia is the subject declaring himself as guilty. In melancholia, subject is guilty simply for being existing (Leader, 2008). From a Freudian point of view, in melancholia, ego identifies with the lost object, and as a result, when the object is lost, the self is also lost. In melancholia, what is empty and meaningless is the self rather than life. Therefore, the melancholic subject devalues himself, placing himself in a position where he deserves punishment (Özkan & Baltacı, 2020). Additionally, in melancholia, the aggression and hate that is felt towards that object is directed to the ego. Furthermore, superego also displays an extremely oppressive and sadistic attitude toward the subject in melancholia; thus, feelings of self-blame and self-depreciation seen in melancholia can also be considered as results of the superego's directives (Freud, 1917). On the other hand, shame is experienced when the subject's lack is revealed under the gaze of an observing Other (Green & Vanheule, 2024). When the subject becomes aware of the gap between their ideal ego and ego, shame arises. As a result of the melancholic subject positioning himself as guilty, deficient, and unsuccessful under the gaze of the Other, a persistent feeling of shame occurs.

Thus, melancholia can be considered as a notion in which guilt and shame are intertwined, and as a position in which the subject turns against his own existence (Leader, 2008).

Both affects of guilt and shame were thought to be present in the discourse of the participants. While talking about an innate sense of guilt which they could not substantiate of trace, they also talked about feeling ashamed and guilty for some things that they have done that would normally be contrary to society and norms. For instance, Feray reported blaming herself by saying “Or spending too much money, spending money beyond my means, and then after that period, saying things like, ‘Why did you spend so much money? Why did you do that? Are you thoughtless? Don't you have any sense?’” (*Ya da çok fazla para harcamak, kendi ekonomik durumunun üstünde bir para harcamak hani. O dönemden sonra hani “Neden bu kadar para harcadın, bunu neden yaptın, sen işte düşüncesiz misin, aklın yok mu?” gibi cümleler kurmak.*). Feray's words illustrate that a person does not need the presence of an Other to feel guilt and shame, and that they can feel these emotions through the Other they have internalized. It is also thought that these affects of guilt and shame were mostly associated with the melancholic state, and not the manic state. It was observed that the examples given by the participants were experienced during periods of melancholia and were more specific to that state. Similarly, Leader (2023) proposed that asking “What have I done?” after a manic episode was a very characteristic situation encountered in manic depression. The period following a manic episode usually corresponds to a melancholic phase for individuals. Therefore, it can be said that this phase is a period in which individuals question themselves due to their actions during the manic phase and consequently feel shame and guilt. Feray's quote above also conveyed an example to this. Furthermore, the innate sense of guilt described by the individuals were considered to be parallel with what Leader (2008) stated about the melancholic subject feeling guilty only for existing.

These feelings of guilt and shame consequently led the individuals to come up with ways to regulate these affects. It is suggested that at that moment, being bipolar came into the picture, and the diagnosis functioned as a way of “legitimization”. Participants expressed that after getting diagnosed, they realized that they were not at

fault, and it was because that they were bipolar. For example, Neslihan talked about this by saying, “I thought about my behaviors that could have been caused by bipolar disorder, things I blamed myself for at the time, but actually didn't need to blame myself for, the things I could call my illness.” (*Bipolardan kaynaklı olabilecek davranışlarımı, kendimi zamanında suçladığım, ama aslında suçlamama gerek olmayan, hastalığım diyebileceğim şeyleri tekrar düşündüm.*). She also stated that thinking what she was doing could actually be due to her emotional state helped her not to be too hard on herself. On the other hand, Ekin reported “I am what I am, and honestly when saying that, sometimes I might be late with things or not deliver at all. I'm not hiding behind that, but that's why it happens. I'm not saying, ‘Oh, I'm bipolar, that's why I didn't do it.’, but the reason I don't do it is usually because I'm going through a manic episode or something like that.” (*Ben böyle böyleyim diye, ve açıkçası söylerken de sadece şey, bazen bir şeyleri geç verebilirim ya da hiç vermem. Bu, bunun arkasına saklanmıyorum ama bundan ötürü oluyor. Hani ben böyle, ‘Ay ben bipolarım da ondan yapmadım.’ demiyorum, ama yapmama nedenim genelde bu, bunun atak geçiriyor olma zamanlarım falan diye.*). Meanwhile, Bilge stated “I definitely don't defend everything I've done because of an illness, of course, but I don't think they understood that I was sick.” (*Ben kesinlikle hani bunların bir hastalık sebebiyle, yani hep bir yaptıklarımı savunmuyorum tabii ki, ama hani bunların ya benim hasta olduğumu anlamadı bence o.*). Likewise, Feray said that the reason for what she did was the fact that she was bipolar, and there was nothing wrong with her. She expressed that as she created a justification for her behaviors, she now feels less judgmental and blaming towards herself. Additionally, she indicated that as she posited the diagnosis as the cause, it seemed more convincing. She also reported “I never consciously did anything and then used it as an excuse, saying, ‘I did this because I'm bipolar.’ But, for example, let's say I did something considered deviant by society. Even if I didn't realize it at the time, or even if I realized it after the fact, I could say, ‘I did it because I'm bipolar, so I don't need to blame myself.’” (*Hani bunu hiçbir zaman böyle bilerek bir şey yapıp da “Ben bipolar olduğum için böyle yapıyorum.” deyip bahane etmedim. Ama mesela aykırı diyeyim, toplum tarafından, hani toplum tarafından aykırı bir davranış yapıyorsam, aslında bunu o an fark etmesem de o dönem geçtikten sonra fark etsem de “Bipolar olduğum için yapmışım kendimi suçlamama gerek yok.” diyebiliyorum.*). These

quotes clearly suggest that participants were able to regulate and escape from their sense of guilt and shame by attributing the blame to “being bipolar”. This almost sounded like saying, “I’m only bipolar after all, don’t put the blame on me.” Bipolar diagnosis provided a legitimate and valid cause for them to shift the blame on for all the problematic behaviors. In her study regarding bipolar disorder, Lane (2018) also concluded that people who have been diagnosed with bipolar disorder typically identified with the diagnosis strongly, and resorted to it to interact with others, obtain assistance, and to explain their behaviors. Bipolar disorder diagnosis appeared to have the capacity to validate the distressing and otherwise problematic behaviors of individuals, which in turn, ended up in the diagnosis being sought by the individuals. Lane (2018) also drew attention to the fact that a vicious cycle results when diagnoses are utilized to explain behaviors, with the disorder being used to justify the problematic behaviors and the problematic behaviors being used to demonstrate the existence of the disorder. Likewise, in her study concerning obsessive compulsive disorder, Baltacı (2019) claimed that adopting a diagnosis guaranteed for individuals that their suffering would be validated. That is, as a secondary benefit, participants who maintained on using the term "diagnosis" received relief and affirmation. Therefore, through nominalization, person’s suffering was justified and recognized (Baltacı, 2019). Hence, it can be concluded that apart from the disorder, diagnosis functions as a way of legitimization and justification for the individual.

The diagnosis also clarifies the question of responsibility, as was put by Leader (2023). As was mentioned before, he discussed types of psychosis in terms of how they relate to the Other and position the guilt. In paranoia, guilt is attributed to the Other. In melancholia, guilt is attributed to self. While in mania, it is believed that the Other should be saved and protected from guilt. As a result, the following question arises: Who is responsible? Leader (2023) proposed that what is at question in manic depression is the guilt going back and forth between the subject and the Other. This state of confusion stood for an explanation of the ambivalence concerning the identity and the self in bipolar disorder (Leader, 2023). From another perspective, adaptations of various identities were ways of regulating the feelings of shame. However, regulations between identities also resulted in ambiguities, inconsistencies, and contradictions in self-narratives (Green & Vanheule, 2024). This

situation was also in question in the present study. Participants' discourses reflected contradictions. While at some points, they regarded the disorder as a part of themselves and formed their identity around this diagnosis, at some points, they dissociated it from their selves. As in the case with guilt and shame, by attributing the fault and responsibility entirely to the disorder, they treated the disorder as an entity independent of themselves. In this case, diagnosis provided an answer to the question of who is responsible: It is the disorder that is responsible, and not the individual.

One other significant point in individuals' speech was the medicalization discourse that they have adopted when talking about their disorder. According to Parker, it is discourse that organizes a subject's speech, which he conceptualized as representations and images of the world and the self (2005). All participants referred to other conditions and compared bipolar disorder with them during the interviews. Likewise, they talked about the diagnosis as a "description" and a "valid explanation", and as something "accepted", "consistent", "not subjective", with "clear lines", by referring to "experts". By stating bipolar disorder is a "biological", "physiological", "chemical or "hormonal" condition, they likened it to "diabetes", "heart condition", or "cancer". These statements can also be discussed as a way of intellectualizing the disorder. Intellectualization is a defense mechanism that enables isolating the affect from the intellect, functioning as a way of coping and regulating the overload of emotions (McWilliams, 2011). Neslihan talked about taking medication for bipolar disorder as, "Everyone may need supplements. Just as taking magnesium and vitamin C helps us make up for our deficiencies, I think the same applies here." (*Herkesin takviye bir şeylere ihtiyacı olabilir. Nasıl magnezyum almak, C vitamini almak eksiklerimizi kapatıyorsa bunda da benzer şekilde düşünüyorum.*) and added that she saw it as a way of balancing out chemicals in her body that may not be functioning as it should. Similarly, Cenk described bipolar disorder as, "I just have this complicated thing going on in my brain related to hormones, you know, something experts know about and have given a name to, and I have it." (*Benim sadece işte beynimde hormonlarla ilgili böyle bir karmaşık bir olay var işte uzmanların bildiği, ve buna bir isim verilmiş ve bu bende var.*). Meanwhile, Bilge talked about just as a diabetic must not skip their insulin as if they do their

blood sugar will spike, her chances of having an attack would increase if she skipped her treatment. She also expressed that thinking it like any other chronic physical illness but as an illness in her brain comforted her. On the other hand, Feray said, “What I mean by valid is that it's not a subjective opinion, it's a scientific fact that has been accepted by everyone, and it's not something said by someone who is not an expert in the field, but rather by experts who have developed themselves in this field, who have received training, professors, and so on. Ultimately, they are the ones saying this, and for me, this is something valuable.” (*Geçerli demekten kastım, hani öznel bir düşünce değil bu. Bir hani bilimsel bir şey ve herkes tarafından kabul almış alınan bir şey. Ve hani bunu bu alanda uzman olmayan bir kişi söylemiyor yani. Bu alanda kendini geliştirmiş, eğitimini almış, uzmanlar, profesörler vesaire sonuçta bunu söylüyor. Ve bu benim için hani değerli bir şey.*) when referring to the diagnosis. Her statement is a very good example that explains medicine, and the clinician placed in the position of the master, has the power to declare something as “legitimate”, and consequently, for it to be recognized by the society also (Baltacı et al., 2023).

Treating bipolar disorder as a neurobiological condition was also reported in the literature (Lane, 2018). According to the findings, bipolar disorder was shown to lead to especially somatic notions of identity and self-management. By conceptualizing the illness as an essentialized and reified category with a neurological cause, it was made possible for patients as well as clinicians to justify psychiatric symptoms. Patients were reported to prefer biogenetic and neuroscientific explanations as they are less blaming, which is consistent with this propensity to emphasize biomedical explanations. Since they enabled bypassing the self, somatic explanations were found more comforting by the individuals. In addition to that, bipolar disorder diagnosis made it possible for the individuals to separate themselves from the illness (Lane, 2018). Furthermore, the tendency to embrace a discourse of medicalization was found to be applicable for other disorders as well, such as obsessive-compulsive disorder, depression, bulimia, or psychosis (Baltacı, 2019). However, this situation also serves as a function of being relieved from the responsibility, this time by attributing the blame on the brain, chemicals, or hormones. Biologizing the disorder and grounding it on science almost works as a

way of validating the validation. Yet, it appears as though adopting a medicalization discourse dissociates the individuals even more from their subjectivity and their subjective experiences, and results in generalizing or objectifying the disorder up to a point that “everyone has an illness”. Adopting a scientific tone, dissociating their subjectivity from the disorder, positioning the disorder as a neurobiological entity thus allows individuals to distance themselves from the responsibility that comes with it.

Although it does not fall within the scope of this study, the question of whether bipolar disorder falls under the structure of psychosis, which is a controversial topic in psychoanalytic literature, will try to be briefly discussed with the information at hand. First of all, bipolar I and bipolar II should be separated at this point since there is no full-blown mania in bipolar II disorder. The most significant distinction between bipolar I and bipolar II in the DSM is that hypomania, and not mania, is observed in bipolar II, and, in particular, a presence of psychosis should not be applicable in bipolar II disorder as it would directly be an indication of bipolar I disorder (APA, 2013). From a psychoanalytic point of view, psychosis is not conceptualized in terms of symptoms but rather with the mechanism of foreclosure. And as it is mania that is discussed within the context of the operation of foreclosure, only bipolar I disorder will be included in the present discussion. In terms of psychosis, it is possible for an individual with a psychotic structure can live his life without being triggered, while presence of delusions and hallucinations would point to a triggered psychosis. Mechanism of foreclosure stands for the foreclosure of the paternal metaphor, in other words, the fundamental metaphor of Name-of-the-Father not signifying the mother’s desire; therefore, not being included into the system of the subject (Evans, 2006). And as it is this fundamental metaphor that initiates the process of metaphorization in language and the formation of quilting points, psychosis is considered as a language phenomenon in psychoanalysis. According to Lacan, an individual can said to be psychotic if there are language disturbances (Fink, 1997). Lacan suggested a detailed examination of the phenomena of language in psychosis and stated that when looking at the use of words by an individual with a psychotic structure, whether the person has entered into language is a subject of discussion (1955-56/1993). In his seminar *Psychoses*, Lacan declared, “If for the

neurotic the subject masters language, for the psychotic it is language that masters the subject - he is spoken, rather than speaking.” (1955-56/1993, p. 250), and reflected that in psychosis, “the subject is spoken by language”. An example to language disturbances seen in psychosis can be given as the tendency to use neologisms. Neologisms are defined as invented or redefined words (Fink, 1997). The fundamental point to focus on regarding the use of neologisms by individuals with a psychotic structure is not so much that these words are newly produced, but rather that they have no connection to another signifier. From this perspective, neologisms independently refer only to themselves. The severing of connections between signifiers is a common occurrence in psychosis. The formation of neologisms is like a radical form of this situation. Neologisms can be regarded as signs of delusions that have not yet emerged (Necef, 2020). Additionally, disjointed, incomplete, or repetitive expressions may also appear in the speech of a psychotic individual (Bilik, 2021).

However, although from a Lacanian point of view, mania is regarded as the non-function of object *a* and conceptualized with the mechanism of foreclosure, there is still the question of what happens to object *a* during the periods of remission, as was put by Leader (2023). Leader questioned this by asking whether the object *a* starts to function again during the periods of remission (2023). This brings out the question of which structure does bipolar disorder fall under? In Lacanian theory, a structure of a person is fixed, it does not change over time or there is no transition between the structures. In other words, a neurotic subject cannot become psychotic, and a psychotic cannot be made neurotic (Fink, 1997). Therefore, if bipolar disorder follows a course similar to neurosis during remission periods and only exhibits psychotic features during the episodes, could it still be conceptualized as psychosis? Moreover, if language impairments, which are one of the most prominent signs of psychosis, are not observed in a person diagnosed with bipolar I disorder, how can it be possible to determine which structure does the bipolar disorder corresponds to? The questions concerning which structure does the bipolar disorder coincides with or its origin and mechanism are not fully explained in the psychoanalytic literature.

In the present study, three of the participants, Neslihan, Cenk, and Ceyhun, reported experiencing full-blown mania, and were diagnosed with bipolar I disorder. Neslihan

described her manic period as “Going everywhere barefoot, going to school barefoot, walking around the streets singing loudly, then easily going up to strangers on the street, talking to them, and becoming friends.” (*Çıplak ayakla her yere gitmek, okula, her yere çıplak ayakla gitmek olabilir, yüksek sesle şarkı söyleyerek sokakta dolanmak olabilir, sonra sokakta hiç tanımadığı insanlarla rahatlıkla gidip konuşup arkadaş olmak olabilir.*). Cenk characterized his manic episodes as “happiness pump”, “heaven and beyond”, or making “pantomime-like movements”. Ceyhun talked about his manic episode as, “For about a month, I lived on the streets for about 15-20 days, slept in parks, and so on. Do you understand? I stayed at the Presidential Library and various libraries in Ankara. I had no home, no money. I collected food from trash cans and ate it, and so on. I think it was a typical manic episode.” (*Mesela bir ay kadar işte 15-20 gün kadar sokakta yaşadım işte parkta yattım vesaire. Anlatabildim mi? Cumhurbaşkanlığı Kütüphanesinde işte Ankara’da çeşitli kütüphanelerde falan kaldım. Hiç evim yoktu, parasızdım, işte çöplerden yemek topladım yedim vesaire. Bir tipik bir manik ataktı sanıyorum.*). Two of these participants, Cenk and Ceyhun, were diagnosed with psychosis. Meanwhile, all of them reported experiencing paranoia. Neslihan indicated when she was first hospitalized, she believed they might have been keeping her for other reasons, she did not trust them, and she tried not to take the medication. She also mentioned doctors first suspected she might have schizophrenia as she was talking very confidently without caring at all about what kind of authority the person in front of her was, and because of her long monologues. Cenk described that one time, he went into a bank, and as soon as he entered, he felt like an electric shock and thought everyone in the bank was looking and making facial expressions at him, and their gaze felt like arrows. Ceyhun reported that before his brother was going to have surgery, he overreacted to prevent him from having the surgery, he identified it as an unnecessary loss of trust, and that was how he was diagnosed with psychosis. This brings to mind the suggestion that paranoia may have a restorative effect during mania (Leader, 20203). However, it was thought that only Ceyhun’s utilization of language resembled psychosis while no such situation was observed for Neslihan and Cenk, whose discourses were organized and did not differ from the discourse of a neurotic subject. What lead to this perception was the fact that Ceyhun used the phrase “Do you understand?” excessively, could only explain things by giving

examples from books or movies rather than from his own experience, and was unable to explain what he meant when asked to do so. For example, he used the phrase “his sense of identity being wounded” frequently during the interview, but when he was asked to clarify what he meant by that, he said he read it in a book once but could not remember. Lacan (1956-56/1993) mentioned how individuals with a psychotic structure acquire conformist identifications that enable them to answer the question “Who am I?” by providing them with images and he discussed these identifications with the phenomenon of “as-if”. These individuals might exhibit a passive and uncreative stance by copying certain behaviors from the outside world and incorporating these behaviors into their own attitudes and have a tendency of identification. They seem to repeat a certain prototype and lack of originality who mimic others and are always ready to establish identifications. However, these identifications help stabilize the psychotic individual and bring them into balance. For example, they can embrace others' narratives about how to maintain a certain way of life. These narratives provide the individual with a template that guides them in social life and offers something they can rely on (Necef, 2020). The fact that Ceyhun answered questions posed to him by citing examples from characters in books or films, or referencing various authors or theories, and describing himself through these individuals or theories can be given as an example to this.

Another difference between Ceyhun and the other participants was the fact that while for all individuals, the diagnosis was regarded as something that integrated and united their experiences and their sense of selves, it was thought that this situation did not apply to Ceyhun. While other participants by identifying with the diagnosis, established a new ego and constructed a new narrative, this was not the case for Ceyhun. He referred to this as “I was diagnosed and I lost control.” (*Tanı aldım kontrolü kaybettim.*). When asked what did getting diagnosed changed for him, he replied, “Maybe if I hadn’t been diagnosed, do you understand, I don’t know, if I had been in an African tribe, I might have lived 30-40 years, maybe a lifetime, without ever seeing a mental health professional. Do you understand? But once I was diagnosed, I lost control at some point.” (*Ya belki de tanı almasaydım, anlatabildim mi, ne bileyim Afrika’nın bir kabilesinde olsaydım, hiç işte ruh sağlığı uzmanı görmeden işte 30-40 sene, belki bir ömür yaşayacaktım, anlatabildim mi? Ama tanı*

alınca ben de bir noktada kontrolü kaybettim.). This occasion might be discussed in relation to mirror stage. Under normal circumstances, imaginary identifications are followed by symbolic identifications, in other words, identifying with the image is followed by identifying with the signifier. However, the symbolic function is not inscribed in psychosis; thus, the symbolic order does not follow the imaginary order, and symbolic identification does not take place. In this case, the inability to internalize the diagnosis may also be due to the symbolic order not functioning adequately. The inability to transition from the imaginary order to the symbolic order also contributes to the failure of successfully completing the mirror stage in psychosis. The effects of this formation are reflected in people's perceptions of identity. As was demonstrated before, mirror stage is when the subject's ego and correspondingly his sense of identity is formed through identifications. A disruption at this stage would also mean for the individual to not be able to develop a stable and consistent sense of identity. Likewise, while all participants came to accept and identify with the diagnosis even though they might have felt an alienation at first, Ceyhun frequently referred to "his sense of identity being wounded" and expressed, "My sense of self, my sense of identity was wounded. Do you understand? There's a saying that people don't know what they've lost, but what they've lost is actually themselves. That's what happened to me at some point, around 19 or 20 years old. I lost myself. Do you understand?" (*Kendilik algım, benlik algım yara aldı, anlatabildim mi? Yani insan neyi kaybettiğini bilmez kaybettiği şeyi aslında kendisidir diye bir söz var. Bende de öyle oldu, bir noktada işte 19-20 yaş gibi kendimi kaybettim, anlatabildim mi?*). A more concrete result of a disruption experienced during the mirror phase can be depicted as body image remaining unstable and inconsistent because it is not established with a symbolic identification. The fear of fragmentation in psychosis is also explained by the fragmented perception of the body in the period before the mirror stage (Bilik, 2021). During the interviews, bipolar disorder diagnosis was likened to body parts such as arms or legs or hair by some participants, while Ceyhun compared it to "people living with a bullet in their head" and "people living with a platinum in their knees". Both of these examples included foreign objects that are not normally part of the body. Both a bullet and a platinum are external objects that disrupts the integrity of the body. Thus, it can be concluded that while for the other participants, the diagnosis was

regarded as an integral part of the body and the self, for Ceyhun, it was considered as external and foreign.

The last topic of this discussion will address the concept of repetition and how it could be related to bipolar disorder from a psychoanalytic point of view. Bipolar disorder can be described as a repetition of an alternation between the episodes of mania and depression. This would imply that it is related to the concept of repetition by its very nature. For Freud, repetition is the return of the repressed. When the subject is faced with a traumatic event, even if he is able to repress it, he would relive the same scene repeatedly at an unconscious level, in an attempt to resolve it (1920). On the other hand, Lacan proposed that what is repeated is not the same scene, but rather, it is the return of the missed encounter (1964/1998). As was put by Soler, “repetition is repetition of the failed encounter with the Other” (2015, p.78). According to Lacan, the Other does not exist, as it is marked by a lack also. Therefore, the subject can never experience a “complete encounter” with the Other, the definitive meaning, fulfillment, recognition, or love always remains elusive. Hence, the subject repeatedly encircles something it has never truly encountered, and even when the subject thinks he is experiencing the same thing, he is actually always chasing the trace of that missing encounter. Failed encounter means that the subject is always structurally positioned in relation to a lack. But it is precisely that lack, and that failure, which gives rise to desire. And the cause of this desire is the object *a*. Therefore, the object *a* is the engine of repetition. When the subject enters language, and thus the symbolic, he has to renounce an amount of jouissance, and this loss remains in the real. The subject spends his life trying to regain what he has lost but fails at every attempt. This is why every experience is in fact a repetition in which the subject always tries to reenact that missed encounter. Still, it would be the lack, the gap that structures desire that would be repeated each time. (Lacan, 1964/1998). In terms of bipolar disorder, the mechanism of repetition can be approached in a few ways. It can be possible to say that while manic episode symbolizes the quest for regaining the lost jouissance, depressive episode can be regarded as facing the impossibility of it. Or the repetition of alternating between the two polars can be explained as the opposite positions taken by the subject while circling around the object *a*, such as moving away or moving towards it. Repetition may also be a result

of not being able to regulate the distance from the Other. As a result of the uncertain boundaries between the subject and the Other, repetition might be an attempt to regulate the distance, and to establish a relationship with the Other. Yet, as repetition is marked by a failure of encounter, it will continue indefinitely.

CHAPTER 5

CONCLUSION

The aim of the present study was to investigate the position and function of the bipolar disorder diagnosis for individuals from a psychoanalytic point of view. The research question of the study was determined as “How do individuals diagnosed with bipolar disorder interpret this diagnosis?”. For this purpose, a qualitative analysis was conducted, semi-structured interviews were carried out with six individuals who were diagnosed with bipolar disorder, and the data was analyzed through thematic analysis. Deriving from a psychoanalytic approach, the latent meanings and unconscious materials in the speech of the individuals gained importance in this study, rather than the semantic meanings. Thus, a more critical orientation was adopted throughout analysis and discussion of the study. As a result of the analysis, five main themes were generated, which can be given as “I Can See Clearly Now: The Diagnosis as an Identity”, “Surrender Your Guilt Be Free: Being Diagnosed and Being Relieved from Responsibility”, “With or Without You: Experiences Before and After the Diagnosis”, “To Be or Not to Be Recognized, That Is the Question”, “Mirror Mirror on the Other”. The findings of the study suggested that individuals interpreted the diagnosis as a part of their identity and as a way of giving meaning to their experiences and actions. In addition, diagnosis functioned as a way of gaining recognition by the O/others, as a legitimization and as a means of being relieved from responsibility and being freed from affects of guilt and shame for the individuals. In this section of the study, clinical implications of the study, strengths and limitations of the study, and suggestions for future research will be presented.

To begin with, the most prominent finding of the study was the revelation of the identification established by individuals with the diagnosis. It was argued that

through identifying with the diagnosis and assuming this image, individuals constructed a new “bipolar ego”, corresponding ideal egos and ego ideals, and formed a “bipolar narrative”. These novel constructs started to function as a new identity for the individuals. Even though the diagnosis was considered as a good thing by them, which enabled them to know themselves better and to take control, and it seemed as though it had an integrating effect for the individuals, deriving from the findings of the study, it is asserted that it also had a dissociating effect. In other words, identification, and the ego that is created through identification, is a product of misrecognition. That is, it contains an alienation within, as it is always something foreign, an external image that is the object of identification. Ego belongs to the imaginary order, which is deceptive in nature (Vanheule & Verhaeghe, 2009). Thus, it is suggested that clinging to the diagnosis will only result in becoming even more alienated from oneself for the subjects, and to move further away from the core of subjectivity, which is desire. Talking about the diagnosis, striving for recognition through this diagnosis, embracing the image of a bipolar person and shaping one's personality around this diagnosis will only function in strengthening the identification and the ego. On the other hand, what is at issue in psychoanalysis is not the ego, but the unconscious (Fink, 1997). And unconscious manifests itself only through speech. In Lacanian terms, what is worked in psychoanalysis is the speech. Speech can be conceptualized as full speech and empty speech. Full speech, also called as the true speech, refers to the symbolic aspect of the language. Empty speech can be regarded as the ego's speech; hence, it corresponds to the imaginary aspect of the language. While full speech makes one closer to the truth of his desire, in empty speech, one is alienated from it. Empty speech and full speech are not opposites of each other, but rather they are a continuum, and they are both present during speech. In analysis, analysts' mission is trying to capture the points when the full speech manifests itself. Although reaching the whole truth of desire is not possible, it can only be approached through speech (Evans, 2006). In this manner, the speech concerning the disorder or the diagnosis is thought to be corresponding to empty speech, a speech that only works in strengthening the ego. In order to get closer to the truth of desire, the full speech, which is the door to the unconscious, should be at focus. And only through working with signifiers, slips of tongues, parapraxes, or with metaphors can the unconscious, and therefore, subjectivity can be worked

through (Fink, 2007). In this context, it is thought that the discourse of medicine, diagnosis and disorder that is embraced by the individuals results in gathering them under a collective bipolar image and distances them from their subjectivities and alienates them from their desires. Additionally, even though all individuals are diagnosed with the same disorder, the origin, function, or position of the disorder will be different for each, just as their interpretations of the diagnosis will differ. That is why in Lacanian psychoanalysis symptoms are regarded as signifiers, and they should be analyzed individually (Vanheule, 2014). In psychoanalysis, the aim is to explore individuals' subjectivity and their relations with their desire and lack. Diagnosis, however, seems to stand in a position that covers the individuals' lack. When adapted to the psychoanalytic approach, in clinical practice, by questioning the imaginary identifications made with the diagnosis, the adopted and embraced bipolar image and ego should be transcended, and the individuals should be given the opportunity to discover their subjectivity and to work on their own desires.

The current study has some strengths and limitations. As was reported, there are not many studies in the literature that examines bipolar disorder diagnosis from a psychoanalytic point of view. Furthermore, studies in the literature mostly discusses bipolar disorder diagnosis mostly as a label or stigma. There are few studies that go beyond this view and offer a different perspective regarding the diagnosis of bipolar disorder. Additionally, there no studies conducted in Turkey that directly address the diagnosis of bipolar disorder. Therefore, this study has brought an innovative and exploratory perspective to the literature. Through qualitative analysis and thematic analysis method, an in-dept and comprehensive insight into the concept of diagnosis in bipolar disorder has been provided in the current study. Furthermore, even though the notion of diagnosis has been examined and criticized in the psychoanalytic literature, there are a very limited number of empirical studies present regarding this topic. Thus, this study has also contributed to the understanding of diagnosis in general, and bipolar disorder diagnosis in specific, from a psychoanalytic perspective.

It is also thought that the heterogenous sample has provided the study with a rich and variable data. It demonstrated that even though the diagnosis changed, the function

of the diagnosis, and individuals' interpretations of it remained relatively the same. Deriving from this point, it might be a good idea to conduct a study with more diverse diagnoses in order to discover whether the function of diagnosis remains similar across disorders. However, as the sample included in the study was heterogeneous, specific categories, such as bipolar I, bipolar II, or bipolar disorder with psychotic or mixed features, could not be investigated in-depth. Therefore, studies examining each category in detail can be carried out. Likewise, case studies can also provide more detail and depth into the concept, as they might also provide more information regarding the origin and mechanism of the disorder. The present study focused on the notion of diagnosis in terms of bipolar disorder; thus, other aspects of the disorder, such as individuals' experiences with the disorder or its effects on their relationships, could only be included in the study to some extent. Further studies are needed to better understand these dimensions of the disorder.

Lastly, bipolar disorder is a controversial and ambiguous concept in psychoanalytic theory. Research on this subject is also quite limited. The mechanism and origin of it is still obscure. In addition, even though mania and depression are investigated separately, bipolar disorder as a combination and repetition of these two formations, is almost completely unexplored. As it fell outside the scope of this study, only a very limited discussion could be conducted on this subject based on the available data. However, it is believed that more comprehensive research and observations should be carried out in order to gain a better understanding of the nature of bipolar disorder. Given the uncertainty surrounding which structure bipolar disorder corresponds to, discourse analysis, which directly examines individuals' speech, can provide a better answer to this question. A better understanding of the nature of the disorder would also have clinical implications, as the course and structure of the therapeutic process and the approach of the analyst also change depending on the individual's structure in terms of a psychoanalytic approach.

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APPENDICES

A. APPROVAL OF THE METU HUMAN SUBJECTS ETHICS COMMITTEE

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ APPLIED ETHICS RESEARCH CENTER	 ORTA DOĞU TEKNİK ÜNİVERSİTESİ MIDDLE EAST TECHNICAL UNIVERSITY
DUMLUPINAR BULVARI 06800 ÇANKAYA ANKARA/TÜRKİYE T: +90 312 210 22 91 F: +90 312 210 79 99 ueam@metu.edu.tr www.ueam.metu.edu.tr	
Konu: Değerlendirme Sonucu	21 OCAK 2025
Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)	
İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu	
Sayın Prof. Dr. Faruk GENÇÖZ	
Danışmanlığımı yürüttüğünüz Meriç Manka'nın " <i>Bipolar Tanısı Almış Kişilerin Bu Tanıya Dair Yorumları: Psikanalitik Bir Çalışma</i> " başlıklı araştırmamız İnsan Araştırmaları Etik Kurulu tarafından uygun görülerek 0055-ODTÜİAEK-2025 protokol numarası ile onaylanmıştır	
Bilgilerinize saygılarımla sunarım	
	Prof. Dr. Ş. Halil TURAN Başkan
Prof. Dr. İ. Semih AKÇOMAK Üye	Doç. Dr. Ali Emre Turgut Üye
Doç. Dr. ASIL KILIÇ OZHAN Üye	Doç. Dr. Murat Perit ÇAKIR Üye
Dr. Öğretim Üyesi Süreyya ÖZCAN KABASAKAL Üye	Dr. Öğretim Üyesi Müge GÜNDÜZ Üye

B. ANNOUNCEMENT OF THE STUDY

Merhabalar, ben ODTÜ Klinik Psikoloji Programından Psikolog Meriç Manka. Prof. Dr. Faruk Gençöz danışmanlığı ve Dr. Öğr. Üyesi Fazilet Canbolat eş danışmanlığında yürüttüğüm tez çalışmam kapsamında bipolar tanısı almış kişiler ile görüşmeler yapmayı amaçlıyorum. Görüşmelerin online veya yüz yüze olacak şekilde bir saat kadar sürmesi planlanmaktadır. Çalışmama gönüllü olarak katılmak isterseniz bana meric.manka@odtu.edu.tr adresi üzerinden ulaşabilirsiniz. Desteğiniz için teşekkür ederim.

C. INFORMED CONSENT FORM

ARAŞTIRMAYA GÖNÜLLÜ KATILIM FORMU

Bu çalışma ODTÜ Psikoloji Bölümü Klinik Psikoloji Yüksek Lisans öğrencisi Psikolog Meriç Manka tarafından Prof. Dr. Faruk Gençöz danışmanlığında ve Dr. Öğr. Üyesi Fazilet Canbolat eş danışmanlığında yürütülmektedir. Bu form sizi araştırma koşulları hakkında bilgilendirmek için hazırlanmıştır.

Bu çalışmanın amacı bipolar tanısı almış kişilerin bu tanıya dair yorumlarını araştırmaktır. Araştırma online veya yüz yüze bir görüşme şeklinde yapılacaktır. Araştırmaya katılmayı kabul eden katılımcılar ile yaklaşık bir saat olmak üzere en az bir görüşme yapılacaktır. Bu görüşmeler sırasında ses kaydı alınacaktır.

Bu çalışmaya katılmak tamamen gönüllülük esasına dayalıdır. Herhangi bir yaptırıma veya cezaya maruz kalmadan çalışmaya katılmayı reddedebilir veya çalışmayı bırakabilirsiniz. Araştırma esnasında cevap vermek istemediğiniz sorulara cevap vermeyebilirsiniz. Araştırmaya katılanlardan toplanan veriler tamamen gizli tutulacak, veriler ve kimlik bilgileri herhangi bir şekilde eşleştirilmeyecektir. Katılımcıların isimleri veya demografik bilgileri kesinlikle paylaşılmayacak ve değiştirilecektir. Bu araştırmanın sonuçları bilimsel ve profesyonel yayınlarda veya eğitim amaçlı kullanılabilir, fakat katılımcıların kimliği gizli tutulacaktır.

Çalışmayla ilgili soru ve yorumlarınızı araştırmacıya adresinden iletebilirsiniz.

Yukarıdaki bilgileri okudum ve bu çalışmaya tamamen gönüllü olarak katılıyorum.

İsim Soyisim

Tarih

İmza

D. SEMI-STRUCTURED INTERVIEW QUESTIONS

- 1- Tanı alma sürecinizden bahsedebilir misiniz? Doktora gitmeye nasıl karar vermişsiniz? Tedavi süreciniz nasıl başlamıştı? Siz bu süreci nasıl deneyimlemişsiniz?
- 2- Bipolar tanısı aldığınızda neler düşünmüş/neler hissetmişsiniz?
- 3- Siz bu rahatsızlığı nasıl deneyimliyorsunuz? Sizce tanı almakla birlikte rahatsızlığınıza dair deneyimlerinizde bir değişiklik oldu mu?
- 4- Sizce bipolar tanısı almakla birlikte sizin için değişen şeyler oldu mu? Olduysa eğer sizce bipolar tanısı almak hayatınızda neleri değiştirdi?
- 5- Bipolar tanısı almış olmak sizin için ne ifade eder? Siz bu tanıyı nasıl yorumlarsınız?
- 6- Sizce bu tanının sizin hayatınızda nasıl bir yeri vardır?
- 7- Şu an nasıl bir tedavi alıyorsunuz? Sizce tanı almış olmak sizin bu sürece bakış açınızı etkiledi mi?

E. TURKISH SUMMARY/TÜRKÇE ÖZET

1. GİRİŞ

1.1. Mevcut Soruna ve Çalışmaya Genel Bir Bakış

Yapılan literatür taramasında bipolar bozukluk tanısı konusunda yapılan çalışmaların yetersiz ve sınırlı olduğu veya konunun yüzeysel olarak ele alındığı görülmüştür. Ayrıca, elde edilen bulguların yeterince çeşitlilik göstermediği ve çelişkili olduğu sonucuna varılmıştır. Bunlara ek genel olarak tanı ve bipolar bozukluk kavramları psikanalitik teori çerçevesinde kapsamlı bir şekilde incelenmemiş ve araştırılmamıştır. Bu çalışma, tematik analiz yönteminin yardımıyla psikanalitik açıdan kişilerin bipolar bozukluk tanısına dair yorumlarını ve bu tanı ile ilişkilenmelerini derinlemesine incelemek amacıyla kavramsallaştırılmıştır.

1.2. Bipolar Bozukluğa Genel Bir Giriş

Bipolar bozukluk, duygudurum bozuklukları arasında sınıflandırılan bir ruhsal bozukluktur ve kişinin duygudurumunun mani ve depresyon olarak tanımlanan iki uç arasında dalgalandığı bir durum olarak tanımlanmıştır (Nierenberg vd., 2023).

DSM-V'e (APA, 2013) göre, bipolar I bozukluk tanısı konulabilmesi için manik dönem kriterlerinin karşılanması gerekir. Bipolar II bozukluk tanısı için hipomani ve majör depresif epizodun olması gerekir. Ayrıca, mani veya hipomani epizodu sırasında en az üç depresif semptomun varlığı veya depresif epizod sırasında en az üç mani veya hipomani semptomunun varlığı durumunda karma özellikler gösteren bipolar bozukluk tanısı konulabilir.

Bipolar bozukluk, kötü klinik seyirle ilişkilendirilen kronik, tekrarlayan ve giderek ilerleyen bir bozukluktur (Angst ve Sellaro, 2000). Ek olarak, bipolar bozukluk erken

ölüm ve yüksek intihar oranları ile ilişkilendirilmiştir. Bipolar bozukluğun diğer ruhsal bozukluklar ve fizyolojik durumlarla yüksek komorbidite oranlarına sahip olduğu gösterilmiştir. Manik, karma veya depresif dönemleri düzenlemek ve ardından gelecekteki dönemlerin tekrarlanmasını önlemek, bipolar bozukluk tedavisinin ana hedefleri olmuştur (Nierenberg vd., 2023).

1.3. Bipolar Bozukluk Tanısı ile İlgili Eleştiriler

Tanı koymada yaygın olarak kullanılmasına rağmen DSM'nin güvenilirliği ve geçerliliği büyük ölçüde sorgulanmıştır (Ghaemi, 2013). Buna ek olarak, boyutsal değil kategorik yaklaşımı da yoğun bir şekilde eleştirilmiştir. Kategorik yaklaşımın daha güvenilir sonuçlar sağladığı iddia edilse de bunun sonucunda son derece geçersiz sonuçlar da ortaya çıkmaktadır (Vieta ve Phillips, 2007). Buna ek olarak, kategoriler arasındaki sınırlar belirsiz olduğundan, farklı kategorilerin semptomları birbiriyle örtüşmekte ve yüksek komorbiditeye yol açmaktadır. Bu durum ya yeni kategorilerin ortaya çıkmasına ya da insanların mevcut kategorilerin dışında kalmasına neden olmakta ve böylece sonsuz sayıda kategoriye yol açmaktadır (Allsopp vd., 2019).

1.4. Literatürde Bipolar Bozukluk Tanısı Üzerine Çalışmalar

Bipolar bozukluk tanısı, literatürde “etiket” ve “damga” gibi kavramlarla ilişkilendirilmiştir (Russell ve Moss, 2013). Bununla birlikte “tanınma” ve “meşrulaştırma” (Baltacı vd., 2023) kavramları ile de tartışılmış ve genellikle “kimlik” kavramı ile birlikte ele alınmıştır (Dyga, 2019).

1.5. Psikanalitik Literatürde Bipolar Bozukluk

Psikanalitik literatürde bipolar bozukluk çoğunlukla mani yerine melankoli açısından ele alınmıştır, çünkü mani melankoliye karşı bir savunma mekanizması olarak görülmüştür (Rabaey, 2023). Yas ve Melankoli adlı eserinde Freud, melankoliyi nesne libidosunun kaybedilen nesneden çekildiği bir durum olarak tanımlamıştır ve ona göre mani, melankoliye karşı kazanılan bir zafer olarak ortaya çıkan bir durumdur (1917).

Lacan, depresyon, melankoli ve mani konularını ayrı ayrı ele almış ve depresyonu “ahlaki bir başarısızlık” olarak nitelendirerek depresyonu öznenin kendi arzusundan vazgeçmesi ile ilişkilendirmiştir (1974/1990).

Melankoli, Grigg (2015) tarafından nesnenin yokluğunun aksine varlığı olarak ele alınmıştır. Hook (2023) ise melankoliyi öznenin aşırı olarak deneyimlediği Başka ile arasındaki mesafeyi ayarlayamaması olarak kavramsallaştırmıştır.

Lacan maniyi nesne *a*'nın işlevsizliği olarak tanımlamış ve maniyi dil düzeyinde var olan bir durum olarak konumlandırmıştır (2004/2014).

Leader ise paranoya, melankoli ve şizofreni olmak üzere üç tür psikozdan bahsederek bunların anlam yaratma ve Başka ile ilişkilene biçimlerindeki farklılıklar ile birbirinden ayrıldığını öne sürmüştür (2023). Leader'a göre melankolide esas olan suçluluğun öznenin kendisine atfedilmesi iken manide Başka'nın tehlikede olduğu ve kurtarılması gerektiğine inanılmaktadır. Bu durum ise manik depresyonda suçluluğun özne ile Başka arasında gidip gelmesine neden olmakta ve dolayısıyla kimin sorumlu olduğuna dair bir soruyu da gündeme getirmektedir.

1.6. Psikanalitik Bir Perspektiften Tanı

DSM temelli bir tanıda semptomlar herkes için sabit bir anlamı olan, sabit bir tanıya işaret eden ve genelleştirilebilen belirtiler olarak kabul edilirken psikanalitik bir bakış açısıyla semptomlar gösterenler olarak kabul edilmektedir. Bu nedenle de psikanalitik bir bakış açısıyla semptomların sabit bir anlamı yoktur ve kaynağı da her özne için farklı olacaktır (Verhaeghe, 2008).

Psikanalitik bağlamda yöneltilen bir başka eleştiri ise psikolojinin benimsemeye başladığı pozitivist tutuma yöneliktir. Lacan bunu, analistlerin kendilerini “bildiği varsayılan özne” (1964/1998) konumuna yerleştirmeye başlamaları olarak kavramsallaştırmıştır. Bu konum, analist değil, efendinin konumu olarak değerlendirilebilir (Baltacı, 2019).

Verhaeghe (2008) tarafından belirtilen bir diğer nokta ise, daha iyi bir tanının daha iyi bir tedavi anlamına gelmediğidir. Aslında tanının kendisi tedavidir. Tanı almak, zihinselleştirmenin gücüyle geçici bir rahatlama sağlayabilmektedir, bu anlamda Verhaeghe de tanı almayı “yara bandı tedavisi” olarak adlandırmıştır (2008).

DSM, özneyi bir nesne, bir semptom konumuna indirgeyerek, öznenin kendi yorumunu ve semptomuyla olan refleksif ilişkisini göz ardı etmektedir. Psikanalitik yaklaşıma göre ise semptomlar öznel deneyimler etrafında şekillenmektedir. Bu nedenle semptomlar kişisel yapılar olmakla birlikte öznenin kendisi dışında kimse tarafından yorumlanamaz. Bu yorumlama ise ancak dil aracılığıyla mümkün olabilmektedir. Anlam ancak dil yoluyla inşa edilebilmekte ve klinisyen de hastanın konuşmasındaki gösterenler zincirini takip ederek bilgi toplayabilmektedir (Vanheule, 2014).

1.7. Psikanalitik Bir Bakış Açısından Bipolar Bozukluk Tanısı

Rabaey (2023), Lacan'ın bakış açısına göre kişilerin öznelliklerinin ve kimliklerin temelini oluşturan şeyin dürtüler, ego, dil ve Öteki arasındaki etkileşim olduğunu belirtmiş ve bu bakış açısıyla bipolar bozukluk tanısını tartışırken Lacan'ın çift ayna modelinden yardım almıştır. Araştırmasında tanı almanın mani döneminde kontrolden çıkan dürtüleri ve ego distonik deneyimleri dil yoluyla temsil etmenin bir yolu olarak işlev gördüğünü ortaya koymuş ve kişilerin tanı ile özdeşleşme yolu ile bipolarite hakkında bir anlatı ve yeni bir “bipolar ego” oluşturarak maniyi kontrol etme ve yakalama hissi kazandıklarını ve hastalık üzerinde bir kontrol ve etki yanılmasına kapıldıklarını ileri sürmüştür.

1.8. Çalışmanın Amacı ve Kapsamı

Bu çalışmanın amacı, bipolar bozukluk tanısı almanın kişiler için ne anlama geldiğini, kişilerin bu tanıyla nasıl ilişkilendikleri ve bu tanının kişilerin deneyimlerinde nasıl yer bulduğunu araştırmaktır. Bu sorular ışığında, çalışmanın araştırma sorusu “Bipolar bozukluk tanısı alan kişiler bu tanıyı nasıl yorumlamaktadır?” şeklinde oluşturulmuştur. Bu çalışma, psikanalitik teori, özellikle

Lacanyen psikanaliz çerçevesinde yürütülmüş ve çalışmada kişilerin ifadelerindeki bilinçdışının tezahürleri büyük önem taşımıştır.

2. YÖNTEM

2.1. Nitel Araştırma ve Psikanaliz

Nitel araştırmalar, karmaşık ve derinlemesine verilere ulaşmayı amaçlamaktadır. Amaçlarına uygun olarak, bu verilere nasıl ulaşılacağı konusunda yöntemleri değişiklik gösterebilmekte ve nitel araştırmalar da araştırmacıya bu konuda gerekli özgürlük ve esnekliği sağlayabilmektedir (Denzin ve Lincoln, 2011). Araştırmanın yöntem ve prosedürünün belirlenmesinde önem kazanan faktörler ise ontoloji ve epistemoloji, çalışmanın amacı, araştırma sorusu, örneklem ve araştırmacıların kendileridir (Ormston vd., 2014).

Vanheule nitel araştırmaların psikanalitik yönelimli araştırmacılara sağlayacağı faydaları vurgulamıştır (2002). Uygulamalı psikanaliz, nitel araştırma yöntemlerinden faydalanabilmektedir, çünkü bu yöntemler, bilinçdışı ve dili araştırırken öznelliği ve yorumu merkeze almak için gerekli fırsat ve özgürlüğü sağlamalarının yanı sıra psikanalitik odaklı araştırmacılara araştırma ve sistematik çalışmalar yürütürken psikanalizi kullanma imkanı sunmaktadır.

2.2. Çalışmanın Yöntemi: Tematik Analiz

Tematik analiz, Braun ve Clarke (2006) tarafından “verilerdeki kalıpları (temaları) belirleme, analiz etme ve raporlama yöntemi” olarak tanımlanmaktadır. Tematik analiz, araştırmacılara kendi seçtikleri teoriyi çalışmalarına entegre etme özgürlüğü sağlarken, aynı zamanda refleksivite yoluyla çalışmanın güvenilirliğini de garanti etmektedir (Finlay, 2021).

Mevcut çalışma psikanalitik yönelimli bir araştırmacı tarafından yürütüldüğünden dolayı çalışmada eleştirel ve yorumlayıcı bir bakış açısı benimsenmiştir. Çalışmada hem tümdengelsel hem de tümevarımsal analiz yöntemleri kullanılmıştır. Son olarak çalışmada örtük bir analiz düzeyi kullanılmıştır.

2.3. Örnekleme Yöntemi ve Katılımcılar

Çalışmada katılımcıların kişisel özelliklerine göre seçildiği bir yöntem olan amaçlı örnekleme kullanılmıştır. Amaçlı örneklemenin temel amacı, araştırma konularının ele alınmasına en iyi şekilde yardımcı olabilecek belirli demografik özelliklere odaklanmaktır (Rai ve Thapa, 2015).

Çalışmanın dahil edilme kriteri çalışmanın araştırma sorusu “Bipolar bozukluk tanısı alan kişiler bu tanıyı nasıl yorumlamaktadır?” ile paralel olarak “bipolar bozukluk tanısı almış olmak” olarak oluşturulmuştur. Toplamda 6 katılımcı veri analizine dahil edilmiştir. Bu 6 katılımcının 4’ü kadın, 2’si erkektir ve katılımcıların 3’ü bipolar II, 1’i bipolar I, 1’i psikotik özellikler gösteren bipolar I, 1’i psikotik ve karma özellikler gösteren bipolar I tanısına sahiptir. Katılımcıların tanı aldıkları yaş 16 ile 27 arasında değişirken tanı aldıkları zamandan bu yana geçen süre ise 4 ile 21 arasında değişiklik göstermiştir.

2.4. Prosedür

Araştırma için etik onay alındıktan sonra çalışma çeşitli sosyal medya platformları aracılığıyla duyurulmuştur. Araştırmanın kriterlerine uyan kişiler ile görüşmeler planlanmıştır. Görüşmelerden önce katılımcılardan çalışmanın koşulları açıklanarak hem sözlü hem yazılı onay alınmıştır. Tüm katılımcılar ile bir kez süresi 68 ile 112 dakika arasında değişen yarı yapılandırılmış online görüşmeler gerçekleştirilmiştir.

2.5. Veri Toplama ve Veri Analizi

Braun ve Clarke (2006) tematik analizde veri analizini altı aşamaya bölerek bu aşamaları verilere aşına olma, ilk kodları oluşturma, temaları arama, temaları gözden geçirme, temaları tanımlama ve adlandırma ve rapor yazma olarak belirlemiştir. Bu çalışmada da bu adımlar takip edilmiş, gerektiğinde ise bu adımlar arasında geçişler yapılmıştır. Temalar kesinleştirilirken araştırma sorusu merkezde tutularak temaların doğrudan bu soruyla ilgili olmasına önem verilmiştir. Bununla birlikte temaların mümkün olduğunca basit ve net olması sağlanılmaya çalışılmıştır.

2.6. Çalışmanın Güvenilirliği

Nitel araştırmada güvenilirlik tartışılırken ortaya çıkan temel kavramlar öznellik ve refleksivite olarak değerlendirilebilir. Patton, çalışmalarında araştırmacıların öznelliklerini kabul etmelerinin, bununla barışık olmalarının ve hatta bundan yararlanmalarının öneminden bahsetmiştir (2002).

Benim bir araştırmacı olarak bu neden konuyu seçmiş olabileceğime geldiğinde ise, hem ergenlik döneminde psikiyatrik tanı almış biri hem de bir klinisyen olarak gözlemlerime dayanarak tanı almanın insanlar için ne anlama geldiğini hep merak etmişimdir. Bipolar bozukluğa dair merakım ise çocukluğumdan geliyor. Çocukluğumda bu hastalığı yakından gözleme ve duyma fırsatım oldu. Hatta duyduğum ilk psikiyatrik hastalık olabilir. Daha sonrasında ise merakımın kişilerin bu tanıyı hayatlarında nasıl kullanıyor olabileceklerine doğru kaymasıyla bu tez ortaya çıkmış oldu.

3. BULGULAR

Uygulanan tematik analiz sonucunda çalışmada beş ana tema ve toplam on iki alt tema belirlenmiştir. Bu bölümde çalışmanın temaları kısaca açıklanacak ve görüşmelerden alıntılar sunulacaktır.

3.1. Artık Net Görebiliyorum: Bir Kimlik Olarak Tanı

Bu ana tema, bipolar bozukluk tanısı konulan bireylerin bu tanıyı kimliklerinin bir parçası ve kendilerini kendileri yapan bir şey olarak gördüklerini göstermektedir.

3.1.1. Biliyorum Öyleyse Varım: Bir Anlamlandırma ve İşaretleme Olarak Tanı

Bu alt tema, tanının bireyler için bir “anlamlandırma” ve “işaretleme” yöntemi olarak oynadığı rolü göstermektedir. Tanı almak, kişilerin kendilerine bir bipolar imajı, anlatısı ve kimliği oluşturmalarının önünü açmıştır. Ekin bu durumdan şu şekilde bahsetmiştir:

Ekin: *Benim için tanıyla başladı o yüzden çoğu şey. Ya tanıdan öncesi şey gibi karanlık çağ. Ha yaşamışsınız ama ne olduğunu bilmiyorsunuz. Ha güzel miydi güzeldi kesinlikle çok güzeldi ama çok zordu ve zor olmasının nedeni de buydu. Yani bir şey var ama bilmiyorsunuz.*

3.1.2. Ben Gerçekte Kimim?: Tanının Yabancılaştırıcı Etkisi

Bu alt tema, tanının yabancılaştırıcı etkisini ve tanı konulan bireylerde ortaya çıkan yabancılaşmayı göstermektedir. Ekin bu durumu şu şekilde örneklendirmiştir:

Ekin: *Ben şeyi çok net hatırlıyorum. Sonrasında ben böyle şey gibi hissetmişim, bir süre acaba **karaktersiz hissetmişim** kendimi. Hani şu an **sahip olduğum bütün her şey aslında bipolar olduğum için mi, yani bu hastalığı benden alsalar ben kim olacağım? Ben neyim hani?***

3.1.3. Ben Eşittir Bipolar: Tanıyla Özdeşleşme

Katılımcıların yorumlarına dayanarak kişilerin bu tanıyı kendilerinin bir parçası olarak gördükleri ve hatta bu hastalığı doğrudan kendileriyle özdeşleştirdikleri sonucuna varılmıştır. Neslihan bu konuda şunları söylemiştir:

Neslihan: *Yani, bu benim için şu an **benim bir parçam**. Hani nasıl ki **saçlarım** dalgalıysa zihnen de böyle bir durumum var diye düşünüyorum...yani **direkt benim aslında**. Benim bir özelliğim de denebilir yani, çünkü **kolum** gibi bir şey değil. **Belki sakat kalabilirim, onuz devam ederim, ama bipolarlık artık öyle bir şey değil benim için.***

3.1.4. Normal Değil, Bipolar: Ayrıcı Bir Özellik Olarak Bipolar Olmak

Bu alt tema, bipolar bozukluk tanısı konulan bireylerin bu tanıyı kendilerini diğer insanlardan ayıran bir unsur olarak nasıl konumlandıklarını ele almaktadır. Buna örnek olarak Feray şunları ifade etmiştir:

Feray: *Bazı insanların yapamayacağı şeyleri de yapabilmiş oluyorum kısa bir süreçte, çünkü uykuya zaman ayırmıyorum. Ya da şöyle bir etkisi var, **sağlıklı bireylerin yaşayamayacağı belki de ömrü boyunca yaşayamayacağı mutluluk seviyesini yaşadım yaşıyorum**. Yani o mutluluk seviyesini yani yaşamadan ölmek ister miydim bilmiyorum. Çünkü dünyanın en güzel şeylerinden biri.*

3.2. Suçluluğunu Bırak Özgür Ol: Tanı Almak, Sorumluluktan Kurtulmak

Katılımcıların söylemleri, bipolar bozukluk tanısı almanın suçluluk duygularını ve sorumluluklarını hafifletmede rol oynadığını göstermektedir.

3.2.1. Ben Değildim Bipolardı: Hastalığı Kendinden Ayırarak Suçluluk Duygusundan Kurtulmak

Bu alt temada bireylerin suçluluk duyguları ve bu suçluluktan kurtulmada tanının oynadığı rol anlatılmaktadır. Tanı almak, kişiler için davranışlarına meşru bir mazeret ve gerekçe oluşturmuş, böylece kişiler kendilerini suçlamayı bırakmışlardır. Feray'ın şu ifadeleri bu duruma örnek oluşturmaktadır:

*Feray: Evet, en azından hani bu yaşadığım durumun ya da düşündüğüm şeylerin, yaptığım hareketlerin vesaire, **geçerli bir sebebi olduğuna** inandığım için daha da rahatlamış hissetmişim. Hani bunu hiçbir zaman **böyle bilerek bir şey yapıp da “Ben bipolar olduğum için böyle yapıyorum”** deyip bahane etmedim. Ama mesela aykırı diyeyim, toplum tarafından, hani toplum tarafından aykırı bir davranış yapıyorsam, aslında bunu o an fark etmesem de o dönem geçtikten sonra fark etsem de **“Bipolar olduğum için yapmışım kendimi suçlamama gerek yok”** diyebiliyorum.*

3.2.2. Aynı Şeker Gibi: Hastalığı Biyolojikleştirmek

Katılımcılar, hastalıklarını tartışırken çok belirgin bir tıbbi söylem kullanmışlardır. Katılımcıların hastalığı biyolojikleştirerek ve öznel yönlerini göz ardı ederek hastalığı nesnel bir yapıya dönüştürme eğilimleri, sorumluluktan kurtulma çabası olarak değerlendirilmiştir. Bilge bu durumdan şu şekilde söz etmiştir:

*Bilge: Benim için, yani dediğim gibi, o yani **fiziksel süreğen hastalıklar gibi bir hastalık** yani açıkçası artık. Yani **şeker kalp gibi bir hastalık**. Yani sadece hani **beynimde** olan bir hastalık, Yani aslında böyle düşününce hani, biraz insanı **rahatlatıyor** yani.*

3.3. Senden Önce Senden Sonra: Tanı Almakla Birlikte Değişen Deneyimler

Bu ana tema, tanı almanın kişilerin hastalıkla ilgili deneyimleri üzerindeki etkisini ve tanının bu deneyimlerin dönüşümünde oynadığı rolü göstermektedir.

3.3.1. Uçlarda Yaşamak: İki Kutup

Katılımcılar, ruh hallerindeki aşırı değişimlerden, her iki ucun yoğunluğundan ve yaşadıkları döngülerden bahsetmişlerdir. Bu durumun onlara çok yorgun ve dengesiz hissettirdiğini ve verimliliklerini ve üretkenliklerini kaybetmelerine neden olduğunu belirtmişlerdir. Neslihan bu durumu şu şekilde açıklamıştır:

*Neslihan: Yani, iki yönden de tehlike var. Biri, manik olduğum zaman iyi olduğumu düşünsem bile aslında gerçekçi olmayan bir noktaya da gelebileceğim için, bir yandan da **maninin sonrasında hep bir depresyonun devam ettiğini** benim için gördüğümünden, ve depresyon dönemlerim o manide elde ettiğim her şeyi çöpe atacağım kadar benim için derin gerçekleşiyordu. Yani bu anlamda bir tehlike. O nedenle **stabil kalmaya** çalışmak daha mantıklı gelmişti.*

3.3.2. Kendini Tanı: Tanı Almakla Birlikte Dönüşen Deneyimler

Neredeyse tüm katılımcılar artık ruh hallerinde büyük değişiklikler yaşamadıklarını ve bir süredir çok daha istikrarlı olduklarını belirtmiş ve bunu tanı almış olmalarına bağlamışlardır. Cenk bundan şu şekilde bahsetmiştir:

*Cenk: Şöyle artık, benim belli başlı **rayına girdi** diyebilirim. Yani küçük dalgalanmalar bir defa çabuk sönümleniyor, yani öyle söyleyeyim. Yani kıvılcımı çaktığınız zaman artağan bir şekilde değil de, biraz parlayıp tekrar böyle düşüşe geçen bir hale bürünmesi, o önemli oldu en başta.*

3.4. Tanınmak ya da Tanınmamak, İşte Bütün Mesele Bu

Tüm katılımcılar, tanınmanın önemi ve gerekliliği hakkında konuşmuş ve aileleri, arkadaşları veya romantik partnerleri, meslektaşları veya öğretmenleri ve doktorları tarafından tanınmaktan bahsetmişlerdir.

3.4.1. Doktor! Doktor! Doktor Tarafından Tanınmak

İstisnasız tüm katılımcılar doktorların rolüne ve önemine değinmiştir. Doktorlar, tanı koyma yetkisine sahip olan kişiler olarak bu hastalıkta önemli bir rol oynamış ve

kişiler tarafından “bildiği varsayılan kişi” konumuna yerleştirilmişlerdir. Bilge bu konuya şu şekilde değinmiştir:

***Bilge:** Yani bugüne kadar gerçekten bana yardımcı olmak isteyen bir doktor olduğumu hissettim. İlk defa ya beni önemseyen, ciddiye alan bir doktor olduğumu hissettim ilk defa karşımda.*

3.4.2. Şimdi Beni Görüyorsun Şimdi Görmüyorsun: Tanınmak İçin Çabalamak

Bu tema, katılımcıların görülmek ve B/başkaları tarafından tanınmak için gösterdikleri çabaları ve bu amaçla gerçekleştirdikleri bazı eylemleri ortaya koymaktadır. Bununla ilgili Ekin şunları anlatmıştır:

***Ekin:** Paylaş, ya şöyle paylaşıyorum, zaten çok yakın arkadaşlarım biliyor yani, direkt söylemişim onlara ben böyleymişim diye, tanı alır almaz söylemişim. Almanya'ya gitmişim, o zaman mesela ilaçlarımı kullanmayı unutuyordum, ve o yüzden direkt çıkartıp lityum şişesini masanın üzerine koymuştum. Ya tabii ilk gün koymamıştım.*

3.5. Ayna Ayna Söyle Bana

Bu ana tema, katılımcıların başkaları tarafından nasıl görüldüklerine ilişkin referanslarını ve “imajları” hakkındaki endişelerini ortaya koymaktadır. Başkalarının bu imajı onaylaması da kişiler için büyük önem taşımaktadır.

3.5.1. Havalı, Deli ve Çürük: Bipolar Bozukluk Başkaları Tarafından Nasıl Algılanıyor?

Katılımcılar, bipolar bozukluğun toplum tarafından nasıl algılandığına ve bipolar bozukluğu olan kişilerin başkaları tarafından nasıl algılandığına değinmişlerdir. Cenk bu konuyla ilgili olarak şunları ifade etmiştir:

***Cenk:** Çevremden şimdi şöyle birkaç çeşit tepki var. Bir tanesi, işte “Vay sanatçı hastalığı, işte bilmem hani, çok cool adamsın bu hastalıkla”. Bir diğer tepki de “Zaten işte sen bu hastalığa sahipsin, o nedenle ne yapsan yeridir, ben seninle olamam”. Bir de olayı işte hastalık olarak değerlendirip, yani “Bu mücadele edilmesi gerekir, ciddidir, şey olması gerekir, üstüne*

durulması gerekir ve alaya alınacak bir durum değildir, çünkü alaya aldığında sonuçları çok ağır olabilir” diye bana söyleyen arkadaşlarım oldu.

3.5.2. Asla Anlayamazsınız: Ben Başkaları Tarafından Nasıl Algılanıyorum?

Bireyler, “bipolar bozukluk” imajından bahsetmenin yanı sıra, “bipolar kişi” olarak kendi imajlarından da bahsetmiş ve bu iki imajı birbiriyle karşılaştırmışlardır. Neslihan bundan şu şekilde söz etmiştir:

*Neslihan: Son zamanlarda insanlar bipolar olduğuma şaşırıyor çünkü beklentileri daha farklı oluyor. Mesela şu an çalıştığım ofiste herkes biliyor bipolar olduğumu, ama çoğu zaman unutup bipolarlıkla alakalı bir şaka yapabiliyorlar. Sonra diyorlar ki, “Kusura bakma hani **senin öyle bir bipolar olduğunu unuttuk çünkü hiç öyle davranmıyorsun**”...Gördüğüm kadarıyla artık insanların hayatlarında tanıdıkları birden fazla bipolar insan var, ve benden önce bir bipolarla tanışmış kişiler hep o kişilerin çok dengesiz, işte hayatlarını bir türlü düzgün şeye oturtamamış insanlar olduğunu söylüyorlar, her an ne yapsa yeridir şeklinde anlatıyorlar. Ya o nedenle bana şaşırıldıklarını söylüyorlar.*

4. TARTIŞMA

Katılımcılar tarafından anlatılan tanı alma sürecinin Lacan'ın ayna evresi ile doğrudan örtüşüyor olduğu düşünülmüştür. Lacan'ın ayna evresi, öznenin önce bir “başka”nın görüntüsü olarak deneyimlediği ve sonra kendi görüntüsü olarak kabul ettiği ayna görüntüsü ile özdeşleşmesi sonucunda kendi kimliğini inşa etmesine denk düşen süreci tanımlamaktadır (Lacan, 1949/2007). Tanı, bir “anlamlandırma” ve “işaretleme” işlevi görerek yeni bir kimlik ve anlatı oluşumunun inşasını başlatmaktadır. Sonuç olarak tanı, önceden kaotik ve parçalanmış olan deneyimlenen imgeyi birleştiren ve bütünleştiren bir şey olarak aynada görülen bütün imgeye karşılık gelmektedir.

Ancak, bu tanımlama süreci Büyük Başka'nın varlığından bağımsız olarak gerçekleşmemektedir (Vanheule ve Verhaeghe, 2009). Bu aşamada aynı Büyük Başka'nın kişiye aynadaki yansıma görüntüsünü gösterip “Bu sensin!” dediği gibi, bu durumda da doktor “Sen bipolarsın!” demektedir. Benzer şekilde, Rabaey (2023) de tanıyı dilin yardımıyla Başka'nın aynasında tanınmanın bir yolu olarak görmüştür.

Bu doğrultuda tanı almak, tanınmanın ve kabul edilmenin doğrudan bir yolu olarak işlev görmektedir.

Büyük Başka pozisyonuna oturtulan ve “bildiği varsayılan özne” olarak kabul edilen doktorlar tarafından tanınmanın yanı sıra, kişiler için aileleri, arkadaşları veya romantik partnerleri tarafından da bipolar olarak tanınmanın büyük önem taşıdığı düşünülmüştür. Aynı zamanda kişilerin bu tanınma ve görülme gerçekleşmediği durumlarda kendilerini duyurmak ve göstermek için çeşitli eylemlerde buldukları da görülmüştür.

Tanıyla özdeşleşme sonucunda oluşan bipolar egoya paralel olarak ideal ego ve ego ideali de oluşmaktadır. Birincil özdeşleşmeye karşılık gelen ideal ego ve ikincil özdeşleşmeyi temsil eden ego ideali, ancak Başka'nın bakışı aracılığıyla oluşabilmektedir. Birincil özdeşleşmeler doğası gereği narsisistik ve imajiner iken ikincil özdeşleşmeler normalleşme ve sembolik bir gelişme olarak kavramsallaştırılmaktadır, çünkü bunlar, sosyal standartlar tarafından tanımlanan ve genelleştirilen gösterenler ve konumlarla özdeşleşmeyi içermektedirler (Vanheule ve Verhaeghe, 2009). Katılımcıların ifadelerine göre, kendini kontrol edebilen, başarılı, istikrarlı ve sorumlu bipolar bireyler olmak ego idealine karşılık gelirken, kendilerini istikrara kavuşturmak ve hastalığı kontrol altına almak ve kendilerini tanımak konusundaki imgeleri ve inançları ise ideal egoya denk düşmektedir.

Tanı almanın aynı zamanda kişilere meşru ve geçerli bir neden sunarak sorumluluk, suçluluk ve utanç duygularını kendilerinden ayırmanın bir yolu olarak işlev kazandığı düşünülmüştür. Lacan, suçluluğun yasaktan kaynaklanmadığını, yasaktan bağımsız olarak var olduğunu ve suçluluğun ortaya çıkması için herhangi bir ihlal gerekmediğini öne sürmüştür (Soler, 2015). Soler, suçluluğun, insanların Başka'ya, Başka'nın ideallerine ve Başka'nın kurallarına ilişkin kendi yanlış davranışlarına dair algıları tarafından tetiklendiğini öne sürmüştür (2015). Bunu “yabancılaşma” üzerine kurulu bir suçluluk türü olarak tanımlamış ve bunun, öznelere Başka'nın söylemine, daha doğrusu Başka'nın taleplerine tabi olmalarıyla ilişkili olduğunu belirtmiştir. Utanç duygusunun ortaya çıkması için ise bir Başka'nın varlığı gereklidir. Bölünmüş

öznenin temel eksiğinin gözlemleyen bir Başka'nın bakışına maruz kalması durumunda utanç duygusu ortaya çıkmaktadır (Green ve Vanheule, 2024).

Hem suçluluk hem de utanç duygularının katılımcıların söylemlerinde mevcut olduğu düşünülmüştür. Kişiler anlamlandıramadıkları veya izini süremedikleri bir suçluluk duygusundan bahsederken, aynı zamanda topluma ve normlara aykırı olan bazı davranışları nedeniyle de utanç ve suçluluk duyduklarını dile getirmişlerdir. Yine de bir kişinin suçluluk ve utanç hissetmesi için bir Başka'nın varlığı gerekmediği ve bu duyguları içselleştirdikleri Başka aracılığıyla da hissedebilecekleri ileri sürülmüştür. Sonuç olarak, bu duygular kişilerin bu duyguları düzenlemenin yollarını bulmalarına yol açmıştır. Bu noktada ise bipolar bozukluk tanısının devreye girerek bir “meşrulaştırma” aracı olarak işlev gördüğü ileri sürülmüştür.

Bipolar bozuklukla ilgili çalışmasında Lane (2018) de bipolar bozukluk tanısı konulan kişilerin genellikle bu tanıya güçlü bir şekilde özdeşleştiğini ve başkalarıyla etkileşim kurmak, yardım almak ve davranışlarını açıklamak için de bu tanıya başvurdukları sonucuna varmıştır. Bipolar bozukluk tanısı, kişilerin rahatsız edici ve sorunlu davranışlarını da meşrulaştırma kapasitesine sahip gibi görünerek kişilerin bu tanıyı aramasına da neden olmaktadır. Yani tanı almak ikincil bir fayda olarak kişiler için rahatlama ve onaylanma anlamına da gelmektedir. Başka bir deyişle tanı almakla birlikte kişilerin deneyimleri nominalizasyon yoluyla haklı gösterilmiş ve tanınmıştır (Baltacı, 2019).

Leader'a (2023) göre tanı aynı zamanda sorumluluk meselesini de netleştirmektedir. Leader manik depresyonda söz konusu olanın özne ile Başka arasında gidip gelen suçluluk duygusu olduğunu öne sürmüştür. Bu da kimin sorumlu olduğu sorusunu gündeme getirmiştir. Bu durumda, tanı kimin sorumlu olduğu sorusuna bir cevap vermektedir: Sorumlu olan kişi değil, hastalıktır.

Bipolar bozukluğun kişiler tarafından nörobiyolojik bir durum olarak ele alınması literatürde de tartışılmıştır (Lane, 2018). Hastalığın kişiler tarafından nörolojik bir kökeni olan bir durum olarak kavramsallaştırılması da hem hastaların hem de klinisyenlerin psikiyatrik semptomları haklı çıkarmalarını da mümkün kılmıştır.

Hastaların da daha az suçlayıcı oldukları için biyogenetik ve nörobilimsel açıklamaları tercih ettikleri ve somatik açıklamaları daha rahatlatıcı buldukları bildirilmiştir. Buna ek olarak, bipolar bozukluk tanısı kişilerin kendilerini hastalıktan ayırmalarını da mümkün kılmıştır (Lane, 2018). Bu duruma paralel olarak tıbbileştirme söyleminin ve hastalığı biyolojikleştirmelerinin de bu kez suçu beyne, kimyasallara veya hormonlara atfederek kişiler için sorumluluktan kurtulmanın bir yolu olarak da işlev kazandığı düşünülmüş ve bu durumun da kişilerin öznelliklerini hastalıktan ayırmaya başlamaları ile sonuçlandığı görülmüştür. Hastalığı bilime dayandırmanın ise neredeyse gerekçeyi gerekçelendirmek olarak işlev görüyor olabileceği öne sürülmüştür. Ancak, tıbbileştirme söylemini benimsemenin kişileri kendi öznelliklerinden ve öznel deneyimlerinden daha da uzaklaştırdığı düşünülmüştür.

Bipolar bozukluğun hangi yapıya karşılık geldiği sorusu psikanalitik literatürde tartışmalı bir konudur. Psikanalitik açıdan psikoz semptomlar ile değil, hesaptan düşme mekanizmasıyla kavramsallaştırılmaktadır. Lacan'ın (2004/2014) bakış açısına göre, mani, nesne *a*'nın işlevsizliği olarak kabul edilmekte ve hesaptan düşme mekanizmasıyla kavramsallaştırılmaktadır, ancak remisyon dönemlerinde nesne *a*'ya ne olduğu sorusu cevaplanamamaktadır (Leader, 2023). Ayrıca, Lacan'a göre, bir kişi dil bozukluklarının mevcudiyetinde psikotik olarak nitelendirilebilmektedir (Fink, 1997). Ancak bu durum dil bozuklukları yoksa bipolar bozukluğun nasıl psikoz olarak kavramsallaştırılabileceği sorusunu gündeme getirmektedir. Bu koşullar bir araya geldiğinde, bipolar bozukluğun hangi yapıya karşılık geldiğine karar vermek daha da zorlaşmaktadır. Bu çalışmada yalnızca psikotik özellikli bipolar I bozukluk tanısı olan Ceyhun'un dil bozuklukları sergilediği düşünülmüştür. Ayrıca Ceyhun'un söyleminin de diğer katılımcılardan farklılaştığı düşünülmüştür, çünkü diğer katılımcılar için tanı, deneyimlerini ve benlik algılarını bütünleştiren ve birleştiren bir şey olarak görülürken, Ceyhun için tanı, kontrolünü kaybetmesine neden olan bir şey olarak görülmüştür. Buna ek olarak Ceyhun diğer katılımcılardan farklı olarak bu tanıyla özdeşleşmemiş ve tanı almak ona daha da parçalanmış hissettirmiştir. Bununla birlikte bipolar bozukluk tanısı bazı katılımcılar tarafından kol, bacak veya saç gibi vücut parçalarına benzetilirken Ceyhun tarafından tanı “kafasında mermiyle yaşamak” veya “dizlerinde platinle yaşamak” ile karşılaştırılmıştır. Diğer bir deyişle,

tanı diđer katılımcılar için vücudun ve benliğin ayrılmaz bir parçası olarak görülürken Ceyhun için dışsal ve yabancı bir unsur olarak değerlendirilmiştir. Sonuç olarak bipolar bozukluk üzerine yapılan arařtırmaların psikanalitik teori açısından oldukça sınırlı olduđu ve bipolar bozukluğun doğasını daha iyi anlamak için daha kapsamlı arařtırmalar ve gözlemler yapılması gerektiđi düşünölmüştür.

5. SONUÇ

Çalıřmanın bulguları, kiřilerin tanıyı kimliklerinin bir parçası ve deneyimlerine ve eylemlerine anlam kazandırmanın bir yolu olarak yorumladıklarını ortaya koymuřtur. Ayrıca tanının kiřiler için B/başkaları tarafından tanınmanın, meşrulařtırılmanın ve böylelikle sorumluluktan kurtulmanın, bunun yanı sıra suçluluk ve utanç duygularından da arınmanın bir yolu olarak işlev gördüđü düşünölmüştür.

Çalıřmanın sonuçları, tanının bireyler için bir kimlik olduđunu göstermiştir. Ancak, özdeşleşme yoluyla oluşturulan ego, bir yanlış tanımanın ürünüdür, bu nedenle beraberinde yabancılaşma ve disosiyasyon da getirmektedir. Kendilerini bu tanı ile tanımlayan kiřiler, kendi öznelliklerinden uzaklaşmaktadırlar. Psikanalizde ise amaç, kiřilerin öznelliklerini ve arzuları ve eksiklikleri ile ilişkilerini keşfetmektir. Ancak tanı, kiřilerin eksikliklerini örten bir konumda gibi görünmektedir. Klinik uygulamada ise amaç, tanı ile kurulan bu imgesel özdeşleşimleri sorgulamak ve bunların ötesine giderek bireylere kendi öznellikleri ve arzuları üzerinde çalışabilecekleri bir alan sağlamak olmalıdır.

Son olarak, çalıřmanın heterojen örnekleme hem bir güç hem de bir sınırlama olarak değerlendirilebilir. Tanının işlevini daha iyi anlayabilmek adına bu çalıřma daha çeşitli veya daha spesifik tanı kategorileriyle tekrarlanabilir. Ayrıca, kiřilerin bipolar bozuklukla ilgili deneyimlerine veya bu durumun ilişkilerine etkisine odaklanan çalıřmalar veya vaka çalıřmaları sonraki arařtırmalar için fikirler olabilir.

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YAZARIN / AUTHOR

Soyadı / Surname : Manka
Adı / Name : Meriç
Bölümü / Department : Klinik Psikoloji/Clinical Psychology

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