

The Making of “White Spaces”

The construction, disruption, and maintenance of stability in bipolar realities in Sweden

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Abstract

Bipolar disorder is a condition rarely approached in anthropological research, and even less so through the eyes of people living with the disorder. Therefore, to focus on understanding the experience of the state in-between episodes, here referred to as a “white space”, is rare and in need of further examination. The aim of this study was to explore the various experiences of a “white space”, how it is constructed, disrupted, and maintained. The thesis is also an attempt to look at what factors affect these experiences using the anthropology of becoming, and concepts of power and agency. With the interviews of eleven individuals that have experienced different lengths of “white spaces”, a representative of a non-profit organization, a clinical psychologist, and minor participant observation, the author explores the complex views, interpretations, and experiences of a life within a “white space”. Apart from the sub-field of medical anthropology, the thematic framework and concepts involve the anthropology of becoming, agency, and power to explain and discuss the “white space” experience. The analysis shows that a “white space” has many different forms and that agency and power have a great impact on the experience. What the author also discusses in the analysis is the dynamic between what they define as knowledge-production and knowledge-sharing, alongside agency and power in relation to these “white space” experiences. The author emphasizes the importance in using these concepts to further understand and affect the experiences of “white spaces” positively. The conclusion summarizes the findings and emphasizes the need to explore this form of research further.

Keywords

Medical anthropology, mental illness, bipolar disorder, treatment, mental health, anthropology of becoming, knowledge production, agency, power, knowledge-power

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Introduction: bipolarity and “stability”

Bipolar disorder is most defined by episodes of mania, hypomania, and depression, and according to Psykiatri Sydväst (n.d.) it affects about 5%¹ of the Swedish population. In mania and hypomania, one experiences exaggerated elevations and energetic moods, where the main difference is that mania can cause symptoms of psychosis and delusions. Depression is an opposite state where one instead experience loss of motivation, energy, and can be filled with suicidal thoughts and anxiety (1177, 2020) (Psykiatri Sydväst, n.d.). Bipolar disorder is a serious condition where life without treatment increases the risk of lowered cognitive abilities and suicide in depression, and severe consequences in one's economy, relationships, and social situations in states of mania and hypomania (1177, 2020) (Balans Riks, n.d.) (Psykiatri Sydväst, n.d.).

The main treatment for bipolar disorder in Sweden is medication, and it is individual, meaning it can take time to find the right combination and dosage. Side-effects are common and therefore important to understand for optimal treatment and life experience. The experienced stability varies, where some can live without any symptoms at all, while others still experience some symptoms. In the West, there is a high regard held in relation to medication, which means that it is a long-standing practice that is continuously expanding (Janes, 2002). As biomedicine is expanding, other influences are also reaching the West (ibid). This can be seen in the increased focus on supplemental treatments for bipolar disorder as well. These include therapy, mainly cognitive behavioral therapy (CBT) accompanied with mindfulness, encouragement of physical activity, dietary and sleep recommendations, and other lifestyle changes that can improve one's life and work (1177, 2020).

Purpose and research question

In January of 2016 I was diagnosed with bipolar disorder type II, which I had been living with for approximately twelve years. At the time I was in a prolonged state of depression, called

¹ This number tends to vary depending on what variations of bipolar disorder one includes. The most common forms being bipolar I & II. So, it is important to note that the 5% includes every variation of the disorder according to Psykiatri Sydväst.

dysthymia, and was prescribed anti-depressants, which catapulted me into an episode of hypomania, something that was explained to be not uncommon for people with this disorder. Coming back to the clinic, the nurse saw me in that state, quickly dragged me over to the psychiatrist's office and I was instead put on a mood stabilizer. It was not until I asked what it was for, that I found out that I had received the diagnosis bipolar disorder type II. What followed was a long journey to try and understand what that meant for me, with little help from the healthcare system, and more searching on internet forums, in Facebook groups, and Google. It was hard to find ways of understanding what it meant to live with the disorder.

There is much information and research in the medical fields of clinical psychiatry and psychology about bipolar disorder as a mental illness, less so in anthropology. Most research in all fields focus on the symptoms of episodes and emphasize the importance of treatment to "stay healthy". What I found to be missing is information and research regarding how "healthiness" is practiced, and what tools appear to be important to not only maintain stability, but to feel like it is worth living in. The purpose of this thesis is to provide a more nuanced depiction of bipolar disorder from the experiences of those who find themselves within the medicalized idea of "stability", and what appears to affect these experiences in positive or negative ways.

Therefore, the research question is: *How is "stability" interpreted by someone living with bipolar disorder in Sweden, and what appears to affect the manifestations and experiences of this "stability"?*

Stability as a "white space"

I have decided to use the concept of "white spaces" that is borrowed from a lecture held by Emily Martin (2012) at UNE Center for Global Humanities. Martin describes the CREP Mood Chart, created by Emil Kraepelin, which was an old chart used to mark every episode a person would have during their lifetime. Why I find this concept fitting, as Martin points out, is that there are several, long spaces of unmarked areas seemingly unimportant and left blank, left white. Martin explains how the white spaces signifies times where a patient was, and she quotes Kraepelin, "able to re-enter the family, employ themselves properly, and return to their profession," then she adds: "and those are the spaces that are neither red, nor blue" (ibid, 2012). This "white space" definition of "stability" seemed a fitting analogy as it highlights the underlying focus on illness throughout history that contributes to the stigma and reification of

people, reducing them to matters of symptoms and not symptoms, subject or object, rational and irrational, “sane” or “crazy”. For a person with bipolar disorder both sides of these dichotomies are true depending on relations, time, place, and knowledge, and this gives way for a life in constant balance between the two.

Thesis outline

This section gives a brief outline of the different sections of the thesis. The construction of the study has used the idea of “focused ethnography” as inspiration, which will be elaborated on in the method’s section (Vindrola-Padros, 2021:53ff). The *introduction* presents an overview of the study, why it is needed, and a main concept, the “white space”, to facilitate the direction of the study. The next section will focus on *method* with descriptions on how the work has mainly been conducted through semi-structured, formal interviews, with a small-scale participant observation. There will be short reflections on researcher positionality and the importance of anonymity. The section of *theoretical framework and concepts* describe previous works and theories within medical anthropology, anthropology of becoming and the concepts agency and power which has inspired the research. The *analysis* shows, with the help of empirical material, how “white spaces” can have different meanings and hold a variety of experiences. It also shows how specific internal and external factors can act as negative and positive influences on the “white space” experience. Throughout the analysis the experiences and what appears to affect them is put in relation to each other while discussed through the concepts of agency and power. The discussions also provide insight into how knowledge-production and knowledge-sharing could be used to affect the “white space” experience positively. Lastly, the *conclusion* will summarize the thesis and provide thoughts on how to conduct further research on the topic of “white space” experience, bipolar disorder, and mental illness.

Method

This section will define and discuss the methods for the study, and the methods used to analyze and process the data gathered. It is here that I also discuss my own reflexivity in relation to a topic upon where I have an emic, “insider”, experience, how this has affected my entry into the field, and the ability to act in an etic, “outsider” positioning in the gathering, treatment, and analysis of data (Göransson, 2021:39). I start by defining “focused ethnography” and how it has inspired the study.

Vindrola-Padros (2021) discusses the concept of “focused ethnography”, tying it to an ability to gather rich information in short amounts of time, within an area that is well-known and easy to access for the ethnographer (ibid, 2021:53ff). This study has been constructed in a similar matter as in not simply short-term, but encompassing a subject of bipolar experience that I am familiar with and had narrowed down to such a degree that it solely examines one part of the bipolar experience that may seem small but contains rich information: stability. This was a way to fully experience an open access to a field easily because of my doubled position (Martin, 2009:xviii).

Setting up and approaching the field

The fieldwork was conducted over two months, with my positioning as someone with bipolar disorder, I wanted to make sure that most of the interlocutors were individuals that I did not know beforehand. That was a way to try and create a distance to an already familiar area; as much of an “insider” as I was, the bipolarity would work as the sole common denominator (Göransson, 2021:93ff). I asked for permission from admins of Facebook groups for people with bipolar disorder, as described important when entering a closed virtual space (ibid:81f). I sent a short description where I declared what I was studying, that I was looking for participants with bipolar disorder who had been living stably at least one consecutive year. I explained my intention to bring forth voices that are rarely heard, in the experience of stability, and what tools seem most important to maintain this stability. In addition to the Facebook groups, I approached a non-profit organization that focuses on bipolar disorder, depression, and exhaustion which posted my inquiry on their website, and held an interview with a representative of the organization. I also proceeded to become a member of the organization and signed up for a support group there, and visited a café they arranged where I booked four interviews. Lastly, I

directly approached four individuals, where two of them were individuals to which I had prior relations. One with bipolar disorder who was the mother of a friend, and the other a psychologist who had treated me in the past. The other two I approached as a client, and through a mutual contact respectively.

The café I visited provided an opportunity to meet members, considering of the anonymity of these gatherings, I had trouble deciding whether to announce ahead of time that I was gathering data for my thesis. When the time came for introductions, I took the opportunity to speak about my thesis, which caused a great deal of interest. I made sure to inform them that I would not include anything from the café in the thesis, other than how I approached it.

Participants and anonymity

As some of the participants are not open with their disorder, and as this form of research requires a form of anonymity, apart from using pseudonyms, I ensured them to keep as much of their own individual markers as anonymous as possible (Göransson, 2021:49). There has been a balance between how much I can unveil of their personal lives to what is necessary to understand context. This provides a challenge in trying to write about individual experiences without including much of the individual, and my positionality in relation to them. This has instead been approached when processing the data, where I coded interviews and fieldnotes from them. My choice of mostly interviewing individuals I did not know previously has helped tremendously in my work as all the experiences were quite different, meaning that the divide between us came naturally (Göransson, 2021:93ff). To place all focus on the interlocutors, I have brought myself out of analysis, which does not mean removal of my positioning but putting focus on ethnographic depictions rather than autobiographical ones.

It has been hard to say whether my relationship to the mother has affected the outcome of the interview. When focusing on an interpretation of stability, how that relates to explicit or implicit values and views, I found no difference in transparency between them and her.

The psychologist that I interviewed treated me for anxiety for about a year and a half in 2018-2019. We do not have another relationship, but it is important to note the power dynamics between us, mostly in relation to how I might react coming into another role in our interaction. We both decided that the focus of the interview would not be on my own treatment and work

with him, but rather his subjective view of general treatment of bipolar disorder and other mental illnesses, and therefore it would not be a problem ethically for either of us.

Apart the psychologist, the interlocutors all had different types of bipolar disorder, mostly type I and II, but some undefined. Eleven were ethnic Swedes, one with Western European descent, and the psychologist from England. All of them live in Sweden. All of them from Western cultures that are similar in views of biomedicine, individualism, and social behavior. All the interlocutors with bipolar disorder were at different places in their lives, one was facing breast cancer, another going through a divorce, a third just coming out of a depression, a fourth was a mother of two small children, a fifth soon to give birth, a sixth just stepping into retirement, a seventh reeducating herself in her 60's, some had trauma, others did not. All of them ranged from being in their early 20's to late 60's with different lengths of "white spaces", different backgrounds, different tools, different medications, different journeys, and different interpretations of a "white space" experience. All of them graciously willing to participate in this study.

Interviews

The interviews were constructed in a semi-structured but formal design, in accordance with Göransson's (2021:121) definition, meaning that they were formal because they were booked on a specific time and location, but they were semi-formal as they were focused on themes rather than constructed from a questionnaire. I needed to make sure that I had a space and time that was devoted to what I wanted to talk to them about and be able to record the interviews. My focus was stability, which we placed an emphasis on, but I also wanted to have an open space to talk about whatever came to mind for them regarding their disorder, their journey, and themselves. That gave me insight into thought processes and a larger context with behaviors, perspectives, and self-identification that could provide background to certain experiences.

As I realized that I would likely not be able to conduct more than one interview per person with the limited time of fieldwork, the interviews would be given a natural end, meaning that they had no preset time limit. The idea was to enter the interview with an attempted openness to the experiences of my interlocutors, to let them speak, and ask follow-up questions on what they explained. At times, I found myself agreeing with interpretations but with the variety of experiences I was met with, the same ideas were questioned in the next interview. This led to

my insight expanding, rather than trying to control the narrative to extract what I wanted to uncover.

I started the interviews with introducing myself, my own journey within the bipolar experience, and provided background on why the thesis centered around the topic of “stability”. They were informed of their anonymity, their right to stop at any time and to ask to be pulled out of the study during the writing process if they wanted to.

Participant observation

As participant observation is a common method in anthropology and although it can look different, it implies a more physical presence and movement alongside the individuals of study (Göransson, 2021:13;106-109). I decided that interviews were a more appropriate approach to study this, but these interviews acted not only as interviews but as conversations upon which I experienced a form of participation observation. As described by Emerson, et al (2011:24ff), participation to be able to write can be valuable, it can also be a way to mirror the emotions and positioning of the interlocutors. This was something that I did experience in the actual interviews because I had prior knowledge, I could follow along with the thoughts and frustrations of the interlocutors. It was my assessment that had I not allowed part of myself to become part of the conversation, it would have created too much of a distance. This could have caused the interlocutors to speak more on what they thought I wanted to hear, rather than what they wanted to share as they were constantly checking in with me, describing events and ideas to see what I had to say, rather than the other way around.

Although the participation in the organizational activities fall more into the clear definition of participant observation, they were limited and did not bring much data to my research, especially as they were anonymous (Göransson, 2021:106-109). They did help me see what type of support is available outside of psychiatric care. It also created a source of insight into what was important in people’s lives, this made it possible to narrow down the most common themes I should focus on, agency and power and access to knowledge.

Theoretical framework, background, and concepts

This section includes the main research used as inspiration in looking deeper into medical anthropology as a discipline, the concepts of power and agency, and the overarching idea and framework of anthropology of becoming as method and theory. It also includes history on the themes and topic. The section has been divided into three parts: (1) The mind-body dichotomy, (2) Experiences of mental illness and “becoming”, (3) On power and agency.

The mind-body dichotomy

Medical anthropology, a sub-discipline to anthropology, has its roots embedded in the mediation between anthropology’s history of looking at healing from ritualistic, spiritual, and religious perspectives and biomedical profession and practice (Carroll & Parkhurst, 2019:1). While medical anthropology has become a binding element between exploring and aiming to understand different forms of healing practices in both Western medicine, and traditional medicine, it tends to look deeper into the meaning-making in healing and practice. It can help to understand why someone is compliant or non-compliant in proceeding with a treatment, or the value of a meaningful life in the face of illness. Anthropologists have studied mental illness in various degrees, and the idea of what mental illness is, but often the focus lies heavily on being ill, rather than being stable, “healthy”, or “sane”. From *A History of Madness* (Foucault, 2006), to *Bipolar Expeditions: Mania and Depression in American Culture* (Martin, 2009), the experiences of people with mental illness, and the production, performance, and interpretations of mental illness have been studied and declared. While these are interesting stories, they all focus on the symptoms, and the symptoms’ positioning in society, rather than all aspects of an individual. In this thesis I have looked at, and interpreted, the subjective view of a “white space” to understand the different dimensions of everyday life with this disorder in a stable, but sometimes incomplete experience.

Mental illness has had stigma held over its head since the dawn of time, something that Michel Foucault (2006) shows in *A History of Madness*. How the institutions that once worked as places to put people with leprosy to isolate them from other sick individuals, was sold hundreds of years later and made into asylums (ibid:47f). This separation of people depending on danger tells a story worth mentioning when looking at the separation of body and mind in clinical practice and research today. It is as if the mind and body are two separate entities, unable to

talk to or affect each other and while today's Sweden knows this is not true, the gaps in knowledge are still palpable and disruptive. Talia Weiner (2011) writes about a mixture of rational and irrational when it comes to a person's ability to act in favor of one's needs and well-being when sick. If it were mainly a physical condition, the rationality was not questioned, but once it came to matters of the mind itself then rationality was a thing of doubt, and the mistrust in one's ability to manage oneself, and one's recovery, grew. Emily Martin (2009) also reflects on rationality/irrationality when she writes that once a person becomes diagnosed, their rationality comes into question (ibid:37). This could affect if someone decides to seek help, as any eventual help risks several negative labels that one must disprove, or embrace, for the rest of their lives. As will be discussed in the analysis, there are actual societal ramifications of getting such a diagnosis. Mental illness is stigmatized still, it comes with various amounts of preconceived ideas and fears, for patients, loved ones, and even clinical practitioners. This is an important aspect to consider in relation to the complex notion of agency and power, upon which I will expand further in the sub-section "On power and agency".

When discussing the view of a body plagued with illness, Taussig (1980) writes about the problems of reification "- the thingification of the world, persons, and experience, as all these are organized and constructed by market exchange and commodity production." He raises an important aspect in a production driven society, such as in the Western culture, and that is the objectification, the "thingification" of the individual in a Western life. The body becomes a vessel of parts, the individual itself a diagnostic criterion of symptoms and biological aspects. Janes (2002) discusses the globalization of Tibetan medicine, and the mind-body separation. He shows us two sides of this globalization that shine a light on the deeply rooted views of a commodity driven society, as well as the inner workings of human desire. Firstly, what Janes explains is the way that Tibetan medicine is distributed and explained. From being seen as something "foreign" and "exotic" it is reframed and redistributed in packaging and mass production to fit the scientific narrative. On the other hand, he also shows us that individuals of Western societies have long before this found their way to alternative or traditional medicine. What this means exactly is complicated, but what he brings up is the holistic view of Tibetan medicine and healing that speaks to more than just the bodily symptoms. What we could possibly draw from this information is that in a world of hard science and biomedical efficacy, people seem to want something more than just biological explanations.

Experiences of mental illness and “becoming”

This section presents research that touch specifically upon different aspects of mental illness related to the subject of the thesis. It also explains the methodical theory of anthropology of becoming which I have used as a guide through my data analysis.

Stigmatization, objectification of a person with an illness, and cultural context can affect how a person acts, as well as how they view themselves and their abilities in the present and future. Luhrmann and Marrow’s (2016) book of case studies of schizophrenia in different cultures examines this further. They manage to show how cultural aspects form contexts that can make people feel valuable and complete as members of society and within themselves. They portray how this is affected by several factors within the cultural expression: the amount of social support, a view of what is important work, amount of value placed in individualism, and most importantly; the interpretation of the illness itself. What they show is that people in cultures with much importance placed upon individuality, and the ability to be economically productive also show signs of feeling separate from society within their schizophrenic population. When one views themselves as obsolete because they do not fit into the narrative, then the future and sense of self becomes bleak. Cultures that place less weight on financial productivity, more importance of the closeness of social networks, often consisting of relatives, show less signs of perceived isolation and dejection. This way of living appears to result in more productive, independent, self-assured, and satisfied individuals than those in individualistic cultures. The experiences of great negativity toward oneself as a patient of bipolarity, one’s abilities, and prospects in American culture is also evident in Emily Martin’s depiction of the bipolar experience. The authors show how deeply engrained structures of a cultural imprint can affect the view of self, and thus affect the actions, reactions and embodied experiences that they have in relation to their own value and opportunity (Luhrmann & Marrow, 2016) (Martin, 2009).

While cultural aspects and preconceived ideas can be seen as fixed entities unable to change, Biehl and Locke (2017) emphasizes that “people are not stable or fixed entities, unidirectionally determined by history, power, and language, nor are they only cultural and social” (ibid:42). They make important the knowledge of fluctuations and plasticity of the individual experience in a dynamic world and time. Through the book *Unfinished: The Anthropology of Becoming* they provide arguments against the generalizations sometimes made of life within a culture, they do so by declaring three factors that build the anthropology of becoming. The *first* concerns multiple systems, meaning how individuals exist and make up multiple systems at once. The

second attends to the idea that an individual acts within multiple timelines at once that affect each other but mostly the present; past holds history and prior knowledge that color the present, and views of the future. Events in the present affect interpretation of present, and past, and future outlooks. Future desires or fears can affect one's positionality and experience of the present. The *third*, attends to the importance of being open to how the unknown can open new pathways and knowledge. Through this, they bring up two valuable points. The first is that for a researcher to see the complexities of a subject in relation to multiple systems, in one space affected by multiple spaces in time, such as past and future, and to be open to the unknown aspect of what one might face, or what someone, or something might become (ibid:5f). This is no less true in relation to the "white spaces" and "non-white spaces" of a person's life, i.e., stability and non-stability respectively. By diving into one "white space" no matter how periodically long it may be, one is able to understand the creation and recreation of several factors within that specific person's life. If one is willing to look at how that "white space" is influenced by all different aspects around it. In relation to the colored spaces, to the individual themselves, to history and desires of the future, to the individual's own interpretations of this experience, and how they twist and turn with, or against it, that is when true knowledge of experience can begin to be crafted.

The second point made by Biehl and Locke (2017) is for a researcher to take the time to scale back the generalizations and overarching theories of unity of beings, actions, behaviors, and sentiments applied to the people studied. To place onto them the complexities and ambiguities we so gladly give ourselves (ibid:42). What Luhmann and Marrow (2016) has done with discussing a collection of works that show other ways of looking at life with, and because of, mental illness, and not just treatment, speaks to this. What Janes (2002) discusses with the growing desire for holistic treatment as a comment on Western ideals, while at the same time neither validating nor denying its importance speaks to this. Emily Martin's (2009) work raises discussions on how to understand the gray areas in which one tries to function within a society and system that simplifies their experiences. She shows how looking at something from the perspective of both insider and outsider provide knowledge that might be overlooked by other researchers. There is a significant value to understanding, and respecting which context one acts in, and comes from, when entering a field. This, in turn, can lead to new pathways that wills themselves forward to carve out new meaning and connection. As Biehl and Locke (2017) points out, unfinishedness is a part of life, and I would argue that a diagnosis that comes with

expectations does not “make” a person into something, but rather provides the knowledge and power to become and explore what is next. This will be further explored in the analysis.

On power and agency

Before trying to theorize about the concepts of power and agency, it is important to look at what these concepts mean in relation to the locality of where I have conducted my research. Mental illness is stigmatized in Sweden, a culture that value independence and measure success in productivity, efficacy, performance means that a mental illness is something that can stand in the way of this. Emily Martin (2009) approaches this specific infantilization of a mental illness in her work, while at the same time contrasting the problematic reality of the societal cravings and endorsement of manic behavior in the workplace. She provides examples of CEO's, celebrities, and sales. This leaves bipolar disorder in limbo where a person with the disorder is supposed to strive for “normalcy” but at a time when “normalcy” implies the ability to function on a level that is directly harmful and triggering to many with bipolar disorder. When one of the recommendations is to stay away from stressful situations and jobs, bipolar disorder gets stuck in the middle of rationality and irrationality (Martin, 2009) (1177, 2020). This is something that Luhrmann and Marrow (2016) addresses when they contrast different cultural experiences of schizophrenia, where they show that there are correlations between the individual-relational aspects in the different cultures, and how one can look differently at individual productivity in a way that makes the experience of life more or less “full”. They show how a network of individuals, a community, lessens the sense of isolation. An isolation posed on an individual at a very early age in individualistic cultures, they argue, which increases risks of mental health issues (Luhrmann & Marrow, 2016).

Emily Martin (2009) describes, through her interlocutors, the sense of a loss of self or acquiring a sense of self in the face of a treatment. The sense of having agency again, as one individual expresses (ibid:90f). The fundamental meaning of agency can vary, especially views on how agency should be practiced. Debates on where the responsibility should be placed for someone to be healthy show that agency can be a problematic word to apply in practice. Even within anthropology the term is uncertain and Björklund and Hannerz (2020) warns that if one wants to use the word in an analytical aspect, then the term should be made clear, they also state that it:

in contemporary anthropology is seen as ethically correct to acknowledge a person's agency, often ambiguously understood, possibly in relation to current political discourse [...], where powerful readiness to act but also the readiness to make conscious choices are celebrated. [my translation] (Björklund and Hannerz, 2020:3)

In the analysis I discuss just how problematic the view of agency can be understood in relations between people, to institutions and political structures through the concept of power and culture. The ability to perform agency, as described by Björklund and Hannerz (2020:3), is plagued by one's own expectations in contrast to "everyone else's". A sub-concept that is not as much discussed, as implied in the analysis is that of the patron/client relation that signifies the various power dynamics that exist and can affect the outcome of one's "white space" experience, and interpreted ability to perform agency, it is highly important to note where the power is placed when understanding the interlocutor experiences. Björklund and Hannerz (2020) explains in their guide for keywords in anthropology: "The "patron" can at once be a bully, exploiter, and protector, and the feelings between client and patron can therefore be ambivalent." [my translation] (ibid:35). Whether it is the power one holds over themselves, the power of an illness or medicine that can be life altering, the power placed onto medical professionals, or the power that political decisions enforce upon an individual's life, the hierarchical structures of patron and client, or perhaps more fittingly; protector or destroyer, are inevitable to touch upon in this topic of mental illness.

Power as a standalone concept is present throughout all the concepts and theories, it encompasses our views of ourselves, or others, others' views of us, and so it continues. It is a tool that can be used to enforce or lessen the possibility to perform agency. Power exists within a person's relation to themselves, human interactions, in structures, hierarchical political systems, and the definition of a diagnosis in a book. Whether it is the power one has over themselves, or have this power taken away, the concept of power holds many meanings, but what is worth noting is that without agency, the claim for power seems impossible. Agency without power, however, could sometimes prove to be the exact right recipe to provide the spark for someone to claim power through agency. This can be seen throughout history in every collective action for change.

Analysis: The construction and maintenance of “white spaces”

This section will, with the help of empirical material, account for and discuss how “white spaces” are constructed, maintained, and sometimes disrupted. This to further understand what influences affects and forms the experiences of these “white spaces”. All interlocutor experiences of bipolar disorder from the twelve interviews are woven into this analysis, and where some are not described, they are used in support of others. The analysis will also include information from an interview with a clinical psychologist. The analysis is divided into two sub-sections, *Agency and power* and *Access to knowledge*. As described in the theoretical section, the analysis will be based on the anthropology of becoming (Biehl & Locke, 2017), and the concepts of power and agency. It is important to note that it is not possible to draw concrete conclusions from such a short study, the aim is rather to show how some relations and circumstances could affect one’s own experiences within a “white space”, the knowledge one believes one has or could have, the placement of power, and what form of agency can, or cannot, be performed.

Agency and power

This sub-section will exemplify and discuss how agency and power can affect and be affected by the “white space” experience, and external and internal relations and situations. Biehl and Locke (2017) describes the first of three fundamental factors of anthropology of becoming as “the mutual constitution of entangled agencies”. This view will help to understand the intrinsic connections that build the human life-experience, they argue, because to understand this, one needs to understand and consider all the different systems that a person is a part of at the same time (ibid:5). This is no less true in the case of a person’s experience within a “white system” that is not simply created or destroyed by one agency, or one power dynamic, as a person is more than a splinter of their person or community.

In addition to the rational and irrational that shape the book of Emily Martin (2009), she continuously brings up how the interlocutors felt a sense of loss while living in the “white spaces” of bipolarity. They mentioned how they felt like less of a person with some of their interpreted bipolar traits missing with treatment. It shows throughout her book how this could be linked to where power and agency is placed, and who can practice it, this is something that I have found both opposing, and similar, accounts of in my study. All participants, including

the representative from the organization I have met, agree that there are a multitude of factors that play a part in how a “white space” is constructed and maintained, where medication is the overall common denominator. The effect of medication varies and seems to affect one’s attitude towards them.

The sense of a loss of self was present throughout my interview with Maja who is recently retired and has lived with the disorder since she was in her early 20’s. She was diagnosed in 2013 after having walked into a doctor’s office saying she had bipolar disorder. She explains that it was not necessarily because of the bipolarity itself, but because the depressions started to last longer than the hypomanic episodes, suddenly the drive that she had valued started to fade. She says she feels better today and that the sense something is wrong is suddenly gone. At the same time, she says there is a numbness now that wasn’t there before, this is something that has been bothering her, because while it feels good to be out of the “chaos”, she cannot help but feel that the medication took something from her:

I feel like the medication has taken the edge out of a lot of the things that I liked about myself. [...] it was a personality trait for me, not that it was an illness. The medication has taken the edge off my personality trait. But I do think that the illness made that personality trait go overboard. That part of my personality can probably be there, just incredibly weakened, and I can feel sadness about that. [my translation]

Maja seemingly identifies with her bipolar disorder as part of her person, this appears to make it hard for her to come to terms with this new reality. She accepts it, she says, because she avoids the depressions and the “chaos” as she describes it. What is interesting here is that she seems to attribute both disorder and medication agencies of their own. They act when the medication “takes” and the bipolarity “gives”, something she does not feel she has any control over. In this way she portrays an “either or” experience; either “chaos” or “calm”, something she defines below to be what she thinks that “society” wants. As Martin (2009) describes: either you are “rational”, or you are “irrational”, to Maria either she is rational, “normal”, and not a “full person”, or she is irrational, “sick”, and a “full person”. Maria puts her views in perspective when she describes what she calls the “arrival” of Prozac to society:

I know in 1996, it was my final year. I was starting my final year in school and this Prozac came into the picture and first thought was: “Prozac, well, okay, that is because people shouldn’t be able to be the way they are in the society we have today. Because if they are too happy; it’s wrong, and if they are too sad;

that's wrong". [...] I have always been odd in that way. I have never fit in anywhere; I don't want to fit in anywhere. [my translation]

When it comes to ascribing personality onto the disorder, Tomas appears to do this as well. He has recently turned 50 years old, been diagnosed for over 20 years and been on various forms of treatments, and his latest "white space" period lasted nine years. He is on his way out of a depression when we meet. During our interview, he made it clear that he did not care for the title "bipolar disorder". It is not important, he says, while at the same time he seems to attribute much of his personality to his definition of the disorder. Tomas describes himself as sensitive to others' issues and struggles, often helping others at the cost of himself. He speaks of heightened empathic tendencies and excitement for high paced situations. He often says "people like us" when referring to behaviors or reactions. I can see what he means, as many of the traits he refers to can be seen as "lighter" versions of bipolar symptoms. His and Maja's thought processes appear alike in many ways. The attribution of agency and power onto their illness, and then to medication shows a way of surrender, however unconscious it may be. This becomes the controlling factor to which they must adapt. Tomas explains that he has been on medication for so long, he no longer recognizes himself and he believes this has to do with the medication.

When Marika expressed the same sense of loss of self and ability to feel in our interview, she described a different course of action. Marika is in her 40's and has lived with bipolar disorder since she was around 16-18 years old. She was diagnosed at 36 years, even though she was in the system for many years, prescribed with various forms of medication, among them an anti-depressant that sent her into a hypomanic state. With no follow up, the diagnosis was not discovered at that time. What followed was a rollercoaster of depression and hypomania for several years and it was hell, she says, never a moment of "stability". Eventually she walked into a doctor's office and told them that she had bipolar disorder. She says that a friend and her were discussing politics upon where her friend proceeded to ask her why she was not angry, and her response initially was that she did not know, she did not feel much at all.

Then I started to realize that "shit, I am kind of indifferent. And numb". And a while later we were talking about the animals... Yeah, and I said; "shit, this is a little frightening." You know, I do know that I love my animals, but I can't feel it. That, right there, was when I decided for myself that I would lower my dosage on my own. [...] And I think that, even if you... I mean, you should be able to feel something. It's not okay to just be completely gray. [my translation] – Marika.

When she told her doctor, he agreed with her, although not satisfied with the approach. This form of knowledge could be vital for someone to see that there are different ways of affecting a “white space” to something one could perhaps want even more, a knowledge which will be further elaborated on in the next sub-section. In Maja’s and Tomas’s experiences of a sense of “loss of self”, where there are undertones of how society does not expect them to be whole, and this could result in an acceptance of such an experience. Luhrmann and Marrow (2016) show us that how expectations and interpretations of societal norms can play into one’s expectations of what is possible and not. It seems that these views do appear to affect the “white space” experience. Power lies not only in the agency of the medication itself, but also in the structures of societal ideals, and psychiatric; the various patron/client relations.

Sonya is in her 60’s and has only experienced manic episodes and not depressions. Her first episode was almost exactly 40 years ago, and her last around 20 years ago. This means that her “white space” has lasted for about 20 years, and I ask how she manages this. She says that she reminds herself that she only has herself to answer to. I ask her if she has any specific tools to handle her bipolarity. She says, besides medication she reminds herself of what she has, and what she feels is important in her life. The priorities reflect importance in autonomy and power, in being able to support oneself, and right at the top is “me”, she says, “because if I am not okay, then nothing else will be either” [my translation]. Where, to Maja and Tomas, the perceived ability to practice agency appears to be deeply inhibited, she sees it from another perspective.

Kim has asked to be anonymous in as great of a capacity as possible, therefore I will simply use their account as example. As we speak about the idea of agency and control, they mention how “people today” in a broader sense have too much faith in the welfare system. What they mean by this is not that people should not be able to have the access they have today but that if the goal is to help people become productive members of society, then the recipe is wrong: “They don’t say that it’s *your* responsibility. They try, they use those words, but everything... nothing is owned, you know.” [my translation] Kim compares it to the rap-music scene in Sweden before and after Spotify. Before, the large record companies would go out into neighborhoods and find talents that they could sign and promote. Then Spotify came and suddenly the record companies disappeared but that resulted in these individuals recording music themselves, put it out, and made more money. “And the record labels [can be

synonymous with] the government, the healthcare system and so on.” [my translation] What Kim proceeds to explain is that the problem is not that the welfare system is there for people who are sick [depressed, hypomanic, manic, and other forms of symptoms and illness]. The problem lies in that people appear to believe that the welfare system is supposed to “fix everything” and that is not possible. Kim points to a gap in knowledge and communication between the healthcare systems and individuals who are at the receiving end of them. Especially in reference to chronic conditions such as bipolar disorder, where the request for help continues long after the “white space” has been entered. Kim do emphasize that it is important that for a person to assume the full ability to reclaim power and agency, this requires for person to be in a place of stability and a solid foundation. The apparent problem is that the final definition of this foundation is not owned by anyone. It seems that the main issue here rephrased would be that no one truly knows when to let go or move on.

The act of power being transferred onto a patient by a healthcare professional was something that Klara shared twice, once with her psychiatrist, and once with a psychologist. Klara is in her 40’s and has lived with bipolar disorder, anxiety, eating disorders and suspects that she has ADD. She was diagnosed at 36 years old and has dealt with mental illness since she was around 15. She is works full-time, has two older children, and is going through a divorce. She considers herself to have been in a “white space” for about six years and at this point the bipolarity is under control. Unlike the experience of Maja, she feels like she has finally found herself for the first time in many years. Especially, she says, when her psychiatrist changed one of her medications; “It was like a fog had lifted”, she states. [my translation] She notes that her life is a process of decisions and awareness, of taking care of herself and making sure that she does not put herself in situations she cannot handle. It has to do with attitude, she explains, and brings up the point where she was guided to an insight that entirely changed her thoughts on her positionality, by her psychologist. She explains that when she was depressed her husband would say to her that he expected her to get out of bed and take the children to school because he had to work. This made her angry for many years because he was supposed to be there for her, she reasoned, and she felt betrayed that he did not support her. Then, she went to a psychologist:

and she was like “well, it feels like you are one of these tiny bundles that you... [she gestures holding something tiny in her hands] you’re waiting for someone to come and pick you up and save you.” And I was like, “yes, that is exactly how I feel, exactly.” And then she just said: “yes, but no one is coming. You must get up on your own.” And I was so angry and thought that “well, this is shit” and it took about a week

or two until I realized that yeah, that is exactly how it is. No one else is going to help me, I must get out of this myself. And right there, that was when a way of thinking changed for me that was very important. In hindsight, I am very grateful to the ex for forcing me to take care of myself. But then again, the relationship became severely damaged by it all, but I think that would have happened either way, no matter what he did.

What the psychologist did here could be described as a transference of power to Klara, to help her realize her own potential of being in full control. This, as well as the situation with her psychiatrist, shows that it is possible to not only nudge someone into a direction of self-realization but also providing a foundation for that to happen. It is possible to live within a “white space” but how that experience feels, as well as who or what is in control can differ widely, and more importantly, it can apparently shift with the right circumstances.

As Foucault (2006) shows, the power dynamics of such institutions is firmly etched within the walls and systematic work conducted. The power to decide on a diagnosis, to decide what form of treatment one should have, and whether one’s own voice is needed or not. Circumstance in relation to the institutional power can affect someone’s life, “white space”, and relation to self in different ways. Tomas explained that before his recent depression he had gone to the clinic where he was registered to ask for help with trying to sort through his life. He feared he would go into a depression. The response he got was, as he describes it, that “we treat bipolar disorder, not life-situations” [my translation]. Sometimes the power and agency that patients are expected to perform become impossible in the face of institutional power, and it begs to question how much power and agency it is possible to have.

Once again, circumstance and removal of power is practiced when conversational therapy started to work for to feel like it was working for Marika. However, what she then did shows hints of how the desired agency, quest for knowledge, and circumstance transferred power back to her. The psychologist quit in the middle of treatment, and it took years for another appointment. Six years ago, Marika had begun to try to understand what her mother’s narcissism meant; this led her to a path of understanding what her life had been, what had not been okay growing up, and that it was not her fault. This work continued and by the time she got a new appointment, she felt that she no longer needed it. What she claims is that the inconsistency of the healthcare system was problematic, but separating herself from it was not necessarily because of spite, rather that she felt she no longer needed it.

In this example, Marika was excluded from the system in the same way that Tomas was, but she was still able to find a way forward that worked for her, and much of it came out of various circumstances that added up at the time. When I ask Tomas if he thinks he is going to try to explore other treatment options or reevaluate his situations he is not opposed to it, and with his current therapist he is now starting to do simple things for himself. However, he says, as much as he understands that his current situation does not work, it is hard to see how it could change with no support. His circumstances and positioning are different from Marika's in many ways, and this makes it seem like Tomas, for the time being, is in a "survival mode" for the sake of others.

When one holds the power, they hold abilities, knowledge, and control over someone or themselves whether they want to or not. I have found that knowledge, knowledge-production, and sharing of knowledge are also important factors. This leads us into the next sub-section of this analysis.

Access to knowledge

Biehl and Locke (2017) emphasizes the importance of being open to the unknown, as the unknown poses many new insights if we are willing to take them in. Findings in this study tells a story of how knowledge can create and take away power, and how that power is distributed will also affect the knowledge one is prone to find. Most importantly, as noted by Biehl and Locke, it has the potential to open new pathways (ibid:6). This section approaches how knowledge-sharing and knowledge-production can affect the placement of power and agency, and the bottom-line experience of a "white space".

Knowledge-sharing, in my definition, refers to the ways people share what they know with others to help forge a larger picture. Klara tells me a story of how her doctor tells her that if you feel like something is missing, then you are probably on the wrong medication. Marika had this form of experience with medication earlier in her treatment where she decided to lower her dosage. These two situations exemplify knowledge that could make a significant difference to Maja's and Tomas's experience in the "white space". Where they express a loss of self because of societal expectations, or psychiatric practices, Klara and Marika express finding themselves through various tools and attitudes.

The best way to share large amounts of knowledge could be through an organization and community. A representative of the non-profit organization told me that one of the main points of the organization is to act as a supplement to where psychiatric care can no longer reach. When that is, depends on the clinic and municipality, but primarily it is to act as a resource of knowledge, to provide a base for exchange of information both to members, loved ones, and the healthcare systems. The organization can be seen to act as an agent all that through the cells of its members shares knowledge to anyone who will listen, and therefore it has the capacity to distribute power by knowledge. An organization such as this also holds greater power in that it acts as a legitimized entity with the medical community, is invited into the discussions of clinics, and other aspect of society that affect the bipolar experience.

In terms of being able to acquire the proper treatment, Michael, the psychologist I interviewed, told me that there is a need for patients themselves to want to get better and go through treatment, but how that treatment looks, must be in line with who that person is. The way he approaches treatment is through a collaboration with the patient, rather than above their head. This leads to the idea of knowledge-production as a form of claiming or transference of power. What I mean by this is that for a doctor to know what is wrong, they must be told, but in return it can also be hard for someone who does not know what their possibilities are to say what it is they want. Communication, and treatment in collaboration with can become essential here, as rather than deciding what is best, the two can find this way forward together. Michael uses an example by saying that there is a difference between the expression “ADHD-patient” and a person who has ADHD, and that this formulation may seem small, but one signifies a reification of the patient, the other a step toward a more holistic view.

How one names or describes something is an interesting aspect to look at. While it is not possible to dive deeper into linguistics, there is knowledge to find in Luhmann’s and Marrow’s (2016), because what they show is that in the cultures where the illness is less clear, patients tend to not put as much weight on it. It defines them less, and with this knowledge it could be worth exploring why that is, and especially why such negativity and stigma can manifest in patients when receiving a diagnosis at times. Although, this is not true for everyone but perhaps it could be worth discussing if the way this illness is presented affects the way that it is received. If one were to be told how well they could live, instead of all the risks involved with the illness upon diagnosis, perhaps people would act differently. Emily Martin (2009) has bipolar disorder and while she does approach the bipolar disorder, she does so from a perspective of hardship

and symptoms. Why I believe this can be problematic is that these lays emphasis on how in-between symptoms there is breathing room, rather than how in-between the “white spaces”, symptoms may occur. Language, and knowledge of language, as well as where focus lies could possibly make a difference in self-perception and one’s views of ability. This is not to take away the severity of the disorder, rather to find ways to face it.

Knowledge-production can be experienced through a variety of ways, whether it is planned or circumstantial, but circumstances appear to play a part in someone’s experience of a “white space”. Amelia is in her 30’s, has two young children, a partner, and she was diagnosed in her late teens after a manic episode. Consequently, Amelia has not experienced an episode since. Much of her experience with bipolar disorder comes from when she was studying in school, and it was hard to relate to them. Her image of an episode seems to have been built up into a terrifying unknown, that she has no way of tapping into. Much like an outsider she tries to understand the early symptoms, triggers, and risk situations without remembering the experience of an actual episode. This leads to doubt, but it also leads to fear and anxiety of not knowing, as well as what would happen if she were to become sick around her young children.

Producing self-knowledge seems to influence the experience of the “white space”. The more individuals tell me about transformations from not knowing, to learning something new, the more they seem positive toward their experience, and what is possible. Whether this knowledge is instigated from the inside or outside does not seem to matter, only that something puts them in that form of situation.

When I ask Marika how she manages the experience of cancer without falling into a depression, she says that she tries to always stay positive and envision the desired future. She would, of course, rather not have cancer or bipolar disorder, but that is not the way it is, and somehow one needs to find a way to make peace with that. She reckons that an odd number of months of treatment in exchange for so many years to live, is easy math at the bottom line. She seems to prioritize the things that matter most, and not spend much time on the things she cannot have. This serves no purpose, she explains, the past will not change. “I stay positive”, she says. Positivity shines through in many of the interlocutors’ visions, no matter their “white space” experiences, and this seems to make for a more hopeful future.

Conclusion

The purpose of this thesis was to interrogate the “white space” experience. This through the research question *How is “stability” interpreted by someone living with bipolar disorder in Sweden, and what appears to affect the manifestations and experiences of this “stability”?*

What I have found is that there are many experiences of “white spaces” in the world, and they do not exist in a vacuum. These spaces can be interpreted as a welcome experience, yet somewhat inhibiting of one’s person, other times interpreted as a way of coming into the self. To some, the spaces come with anxiety and fear, to others they are calming and fulfilling, sometimes there is a balance. It is impossible to say that a “white space” consists of a certain thing and that is what makes it important to view it from the individual perspective.

Through this study I have also shown that “white spaces” are affected by a multitude of factors such as forms of treatments, circumstances, placement of power and agency, individuality, and especially access to knowledge. There are many gaps in terms of knowledge in all aspects of society in relation to bipolar disorder, but the important thing to remember is that if one can find ways to identify these gaps, one can start to find ways to close them.

Lastly, I want to note that this thesis has explored a small portion of a large topic. It has never been the intention to say what is right or wrong or decide what way of life is better or worse, but rather to shed light on a space that often seems forgotten. For future studies, this is something that should be explored further both in small and larger scales.

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