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The Lived Experience of Driving with Bipolar Disorder
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Abstract

Cognitive, psycho-motor, and emotional regulation abilities of people with psychiatric diagnoses, particularly bipolar disorder, are assumed to be less efficient compared to the general population, and, as a consequence, may not be conducive to safe driving. This research aimed to investigate the lived experience of driving with a diagnosis of a bipolar disorder, as a study on this subject has not been located in the literature.

Two focus groups were conducted during a bipolar day program in an independent psychiatric hospital in an Irish city (n = 18). Data was analysed using thematic analysis. Themes emerging from the data include; the meaning of driving as an essential instrumental activity of daily living, that bipolar disorder can impact driving behaviour, and that participants are able to make decisions to manage their driving effectively when unwell. An unexpected theme was the perceived discriminatory nature of the recommendations regarding the disorder in the Irish Road Safety Authority’s fitness to drive guidelines.

The findings complement other research conclusions in that driving is highly meaningful, enabling engagement in many areas of occupation. Participants’ desire to collaborate with their treatment team while implementing their own strategies for managing their driving when unwell, can be viewed as a process of taking control in their recovery and minimising the effects of occupational disruption. Their perception of the fitness to drive guidelines as inequitable could be a result of a feeling that illness has long lasting influences on their life narrative.

Keywords

meaningful occupation, driving, occupational participation
Introduction

A leading cause of disability (World Health Organisation 2001), with estimated prevalence rates between 1% (Tijssen et al 2010) and 4.4% (Merikangas et al 2007), the Diagnostic and Statistics Manual of Mental Disorders V (DSM V) (2013) describes four types of bipolar disorders; Bipolar I, Bipolar II, Bipolar Disorder Not Otherwise Specified and Cyclothymia. Along with significant shifts in mood and decreased emotional regulation, difficulties in attention, information processing speed, reaction times and executive functions have been reported by those with the illness (Hatcher et al 1990, Gildengers et al 2007, Moore et al 2010). Substance abuse disorders have also been identified as a common comorbidity (Prisciandaro et al 2012), with DUI offenders found to be more likely to have a bipolar diagnosis (Shaffer et al 2007). Given these cognitive, psychomotor and emotional regulation difficulties associated with the condition, it could be argued, intuitively, that they may not be conducive to competent driving. In 2013, the National Programme Office for Traffic Medicine in Ireland, working with representatives from professional bodies, including the Association of Occupational Therapists Ireland, issued the “Sláinte agus Tiomáint” medical guidelines of fitness to drive (Road Safety Authority 2013a), drawing from those by their British (Driver and Vehicle Licencing Agency 2013), and Australian (Austroads 2013) counterparts. They state that bipolar disorder is “particularly dangerous to driving when there are repeated changes of mood” (RSA 2013a, pg.45).

This study therefore aimed to investigate if those with bipolar disorder experience changes in their driving due to their illness. It is presently argued that decreased participation in driving may put an individual at risk of occupational deprivation, whereby “people are precluded from opportunities to engage in occupations of meaning due to factors outside their control” (Whiteford 2000, pg. 200). An important aspect of mental health recovery is social and community integration which includes the ability to safely drive (Gibson et al 2011). Yet, qualitative studies on the lived experience of bipolar 1 disorder revealed that the illness is often associated with functional and social challenges in individuals’ narratives, attributed to changes in participation in areas of occupation (Ward’s 2011; Freedberg 2012). The research therefore asks two questions. Firstly, what meaning does driving have for people with bipolar disorder? Secondly, what is the self-reported impact, if any, of bipolar disorder on driving behaviour?
Literature Review

Driving an automobile has been found to be an important instrumental activity of daily living (IADL) and an occupational enabler, that empowers the individual, the occupational being, to participate in other significant roles and routines essential for quality of life (Di Stefano et al 2012). The International Classification of Functioning, Disability and Health (ICF) stipulate that driving cessation due to illness is a limitation to full participation (WHO 2001).

Csikszentmihalyi and LeFevre (1989) found that the greatest amount of “flow”, or optimal experience, during free time, was experienced while driving. Research by Mezuk & Rebok (2008), Curl et al (2013) and also Sullivan & Buckley (2013), found that driving cessation among older adults, and those with epilepsy, led to compromised independence and decreased engagement in productive and social activities, all compounded by limited public transport and alternatives to the dearth of services. It is argued therefore, that culturally embedded Western historical notions of autonomy mediates the meaning perceived in driving, which allows an individual to harness a sense of purpose and value in his or her life (Reed et al 2013). Vrkljan & Polgar’s (2007) case study the with a person facing driving cessation, revealed how his narrative changed as he transitioned from occupational disruption, to occupational adaptation, and finally to a restored sense of self. With their call for further research on the relationship between occupational participation and meaning, this study complements that request.

In research examining Canadian psychiatrists’ attitudes of fitness to drive among people with mental illness, 30% agreed that bipolar disorders in particular were the mental illness most likely to affect safe driving (Ménard et al. 2006). However, research focusing specifically on the ways the disorder and other mental illnesses effects driving ability is sparse and what is available illustrates “controversial and inconsistent findings across these studies and patient groups” as a systematic review of fourteen studies by Ménard et al found (Ménard et al 2008, pg. 61). In Vaa’s (2003) meta-analysis, completed as part of the European Union funded IMMORTAL Project, the author found that despite a significant (1.72%) increased risk for road traffic accidents across all kinds of psychiatric conditions, age and gender are the variables that predict greater risk of incidents, rather than any particular diagnosis. Other studies have found links between various mental illnesses and driving cessation (Rouleau et al 2010), while Levine (2001) found this specifically with bipolar disorder. An elevated risk of collisions associated with lithium has also been found among a cohort of elderly individuals (Etminan et al. 2004). However, it has also been suggested that medical treatment, including medication, of individuals with a mental disorder has a positive effect on driving performance.
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(De las Cuevas et al 2010). Additionally, Di Stefano & McDonald (2012) argue that functional deficits arising from illness do not necessarily render a person incapable of driving. The aim of this study was therefore to build on limited research in the literature, and generate a perspective of whether or not bipolar disorder effects driving from those who, through experience, are experts in their illness.

Methodology

A qualitative research method, informed by phenomenology, and utilising a focus group design, was employed for the study. This technique facilitates understanding beyond the natural and taken for granted meanings of everyday phenomena, and therefore complements the study's aim to reveal participants' interpretations of their 'the lived experience' of driving (Merriam 2009). Focus groups were deemed advantageous for the study’s exploratory nature and inductive approach, as control of discussions is with the participants (Boyatzis, 1998; Barbour and Kitzinger 1999). They were also appropriate considering the limited access to the convenience sample selected and the time constraints on data collection.

Following transcription, data was analysed using thematic analysis. As a method for identifying, analysing and reporting coherent patterns and meaning, Braun & Clarke (2006) contend that it offers a complex, ‘thick description’ of the data set. The authors identify the six phases of which were undertaken during analysis of the focus groups' transcripts:

1. Familiarisation with the data
2. Generate initial codes
3. Search for themes
4. Review the themes
5. Define and name the themes
6. Complete the report

A list of words was therefore generated that appeared to illuminate answers to the questions asked by the researcher. Themes were actively sought from lists of codes considered to be similar. For example, “freedom” and “independence” were two codes that were related in terms of how they described the meaning of driving, itself induced as a theme.
Participants

Participants were recruited with the assistance of a gatekeeper from a bipolar day programme based in an independent psychiatric hospital in an Irish city. Two focus groups were conducted twelve weeks apart. Participants could not attend both groups. Eleven people took part in the first group while seven others participated in the second group. Groups were between sixty and seventy-five minutes in duration. A semi-structured interview was conducted using an interview schedule to help to promote discussion (see Appendix).

Participants had to meet the following inclusion criteria:

- Aged eighteen years or over
- Fluent in English
- Have a Diagnosis of Bipolar I Disorder, Bipolar II Disorder, Bipolar Disorder Not Otherwise Specified (NOS) or Cyclothymia.
- Hold a valid driving licence (provisional or full)
- Attending the weekly bi-polar programme in the hospital as a day patient

Exclusion criteria pertained to the following:

- A diagnosis of dementia or any other cognitive impairment.
- A DSM Axis III diagnosis of an ophthalmological condition, head injury, sleep apnoea, epilepsy or other neurological or physical condition which may impair driving ability.
- Not having a diagnosis of Bipolar I Disorder, Bipolar II Disorder, Bipolar Disorder Not Otherwise Specified (NOS) or Cyclothymia.
- Not attending the bipolar programme as a day patient at the hospital
- Not having a valid driver’s licence
- Aged under eighteen years
- Not fluent in English

Ethics and Trustworthiness

To ensure trustworthiness of the study, a trusted research method was utilised, and attempts were made to minimise the risk of researcher bias by keeping a research journal (Shenton 2004). The research supervisor analysed a portion of the transcript to ensure validation of the themes. In addition, full ethical approval to conduct this study was obtained from the research ethics committees of both the independent psychiatric hospital and University of Limerick. Consideration of ethical issues including; consent, confidentiality and potential harm which could come to participants, also served to ensure credibility of the study.
Participant information sheets were given prior to the focus groups explaining the study, and written consent was obtained from those who wished to take part. Participants were reminded that they were free to ask any questions, and also withdraw at any time throughout the focus group or research process without fear of repercussion. It was made explicit before the focus groups, both in writing and verbally, that the discussions would be recorded.

To protect anonymity, pseudonyms were used in analysis of the data. All participants received a copy of the themes that emerged during the focus group to facilitate member checking, and were advised to contact the supervisor by email or telephone if they had any queries. They were asked not to speak about group discussions with persons not involved in the research to ensure anonymity. Data collected was stored on a USB key and the secondary researcher stored this in a locked cabinet.

There are no known risks associated with participating in the study. While it was possible that some participants could have found it upsetting to discuss negative experiences of driving cessation or past road traffic accidents if these had happened, this issue did not emerge during the groups. To minimise such a risk, the researcher informed the participants that they were free to take a break at any time, and not to answer questions that made them uncomfortable (King 2004). Also, the clinical nurse specialist was available to meet with the participants should they have become upset.

Results

Thematic analysis of the data revealed the participants’ own stories about driving with bipolar disorder. Four themes were generated. They include: the meaning of driving as an IADL, the impact of bipolar disorders on driving behaviour, and self-management of driving behaviour when unwell. The last, and rather unexpected, theme was the perceived discriminatory nature of the Irish Road Safety Authority Sláinte agus Tiomáint fitness to drive guidelines. All four themes contain subthemes that describe the data in further detail.

1. **Meaning of driving as an IADL**

**Driving is a means to an end**

For the majority of the group, driving was perceived as a vital instrumental activity of daily living which aided them in achieving engagement in other areas of occupation including; work, leisure and social participation. Their primary perception was that driving was very meaningful in how it represented a functional activity that allowed for freedom and
independence, and not having to rely on others. This view was very well illustrated in Aaron’s point that driving is a “form of social connection to the rest of the world because you go on roads with others, so you are connected into the…when I put on AA Road-watch that’s actually quite a profound amount of information. I’m being told how to engage, how to navigate the planet”. Enjoyment in driving was not reported across both groups. Indeed, not one participant considered driving to be a leisure occupation and some disliked driving entirely but still recognised it as a necessity to participation. That sense of conflict was salient in Derek’s statement; “I identify it’s a means of freedom in one way but a bond in another because traffic is so bad”.

Driving remains essential throughout illness

Apparent throughout the discussions in both groups, was a sense of the importance of driving, and the inconvenience that is caused when a person has to cease driving due to manic and/or depressive mood cycles. When asked if cessation of driving due to acute symptoms affected engagement in day to day life, the consensus was that it did, but there is little that can be done to prevent it. As Patricia pointed out; “You are more isolated than you need to be”. There was also a sense of the loss of autonomy which brought its own emotional challenges. “You have to find someone else to drive you places, it’s quite awkward. You do it because you know you are not capable of driving. But you feel it yourself.” – Louis

2. Impact of bipolar disorder on driving behaviour

Bipolar can affect driving ability

Some participants spoke of their own experiences of driving when manic or hypo-manic, remembering occurrences of speeding, making poor decisions and not feeling in control of their vehicle. One such example was given by Leslie in the following statement; “I was driving a lot slower than usual and I remember feeling quite apprehensive… I was in a hypo-manic mixed state, that’s what I was told when I came in, but I do remember feeling “Oh my God, I don’t think I was 100% in control of that turn there”. While others did not have those driving experiences, they assumed that decreased concentration levels they have had in a depressive state, or impulsivity and decreased judgement experienced in a manic or hypomanic state, could seriously affect driving, and that a person should not drive when unwell. The participants who drove when unwell described themselves as being in the early stages of a cycle when this occurred, a matter of time before hospitalisation. Shauna described the cognitive and motor processes involved in driving and her own driving behaviour as a “barometer” for the stage her illness. Feelings of heightened anxiety about
being on the road and an increasingly cautious approach to driving were, for her, indicative of an impending cycle.

**Bipolar does not affect driving**
A minority felt that their bipolar disorder was not more likely to affect their driving behaviour and ability compared to those in the general population. Rather, unsafe driving could arise out of a “relationship breakup, daydreaming, talking on the phone” as Robert asserted, or as Alison explained; “I don’t think it affects it any more than people without bipolar disorder maybe who are terrible drivers. I don’t think it necessarily correlates to your driving ability”. Suggestions were also made that its effects on driving is very unique to every individual, with illness stage, and certain aspects of the illness, such as mania, being more likely to influence driving behaviour.

3. **Effective management of driving behaviour when unwell**

**Knowing the effects of illness and adjusting for it**
Participants spoke about the strategies used when unwell in terms of their engagement in driving. Their insights included being aware of the seriousness of illness. For example in a cycle of depression, they spoke of being aware of the consequent low concentration levels, and purposefully slowing down. Requesting that another person would drive was reported as a strategy, even though this was not always hugely appealing. As Damien said; “I know that when I have been depressed my concentration would be low, so I would get somebody else to drive or avoid driving. I would ask my wife how is my driving because I know you could be a wee bit off hand about it so I would be very careful about my driving when I am either side, when I’m quite horizontal and when I’m okay.” The general consensus that positive decisions can be made even when unwell was summed up by Louis in the following; “We are all adults. We understand the dangers of driving if we are tired so we understand the dangers of driving if we are high or if we are low. I think we have to be allowed make those decisions.”

**Adjusting for the effects of medication**
The majority of participants agreed that drowsiness is a common side effect of medications, and recognised that in some people this could affect driving. Many in both groups spoke of how they took their medication at night so it did not have an impact on their routine during the day. Leslie stated; “I would take mine early, for example, when I was on the higher dose, because I would feel groggy in the morning just if I had to drive…”, while others went further in saying that they would not take medication until certain that they would not be driving.
again that night.

4. **Discriminatory nature of the Irish Road Safety Authority guidelines on fitness to drive**

The last theme involving the response of the participants to the first edition of the Sláinte agus Tiomáint fitness to drive guidelines (RSA 2013a) was unexpected. They are “just bad guidelines” - Aaron

In both groups, some felt that the discrepancies in guidelines between various diagnoses were incomprehensible. The example of stroke was given to participants in terms of the requirements as set out in the guidelines. They responded with frustration to its apparent leniency in comparison to mental health diagnoses. Patricia’s sentiment; “we shouldn’t be discriminated, I don’t think” complements Derek’s argument that; “It could have a reverse effect in that if discrimination is increased against people who are diagnosed then people could be more reluctant to seek and accept a diagnosis”. The majority felt that it would make more sense to have a general practitioner or a consultant psychiatrist decide if a person should drive. A minority spoke of how their psychiatrist had told them of the risks of driving and that they should not do so, with which they were happy to comply.

**Being penalised for having a diagnosis**

The anger and frustration regarding the perceived injustices contained in the guidelines, and the worry that they could become law in the future, was illustrated in Geoffrey’s statement that; “All these things are targeted at people who are diagnosed as with mental illnesses as well. Like there’s so many people in Ireland who are going around un-diagnosed with bipolar. It is one of the least diagnosed psychiatric illnesses and they would have no insurance loadings. We all know we have an illness and therefore take steps against it, it is almost like you are being penalised for being responsible for your illness rather than just drinking it away or whatever people do”. The perceived unfairness of guidelines elicited exasperation among the participants and prompted them to consider theoretically how they would be personally affected by a prohibition lasting months. None of the participants spoke of experiencing a lengthy ban. Hilary stated that she would “end up back in here” (hospital), indicative of a fear that the guidelines would not only effect everyday living but could also serve to exacerbate symptoms.
Discussion

While the participants’ descriptions of the meaning of driving did not allude to a perception of it as a leisure pursuit, or an activity that necessarily gave rise to the “flow experience” as in Csikszentmihalyi & LeFevre’s (1989) study, it was still perceived as an occupational enabler, something which facilitated occupational participation in other meaningful occupations. As Gray argues; “the ultimate significance or meaning of the occupation is primarily determined by the person or persons participating in it” (Gray 1997, pg. 9). The results are therefore consistent with research on the meaning of driving by Mezuk & Rebok (2008), Curl et al (2013), Sullivan & Buckley (2013) and Vrkljan & Polgar (2007), in that the realisation of driving’s meaning and importance is truly appreciated with the onset of biographical disruption. It could be argued that participants in this study would have been at risk of occupational deprivation if driving cessation had lasted beyond remission of acute symptoms. Those in the group with children experienced how cessation for even a short duration interfered with parenting roles. Shauna informed the group that “when I was high I didn’t drive. I had to collect my son from somewhere and I would put the keys on the table and say…” ‘I can’t drive’. Their sense of isolation and dependency therefore still indicates, at the least, an experience of occupational disruption (Whiteford 2000). Health professionals need to be aware of this kind of reality that their patients may experience. As Hammell (2004) asserts, it could be that occupational therapists have an additional role in informing other mental health professionals about dimensions of meaning in activities of daily living, and the impact that a biographical disruption can have on the meaning of leading an autonomous life. Of course, clinicians would have to be mindful about the socio-cultural context they operate within and how it influences notions of independence and freedom, often important values to individuals in recovery (Reed et al 2013).

Incidents where participants found bipolar disorder severely impacted on their driving ability were reported to occur early in a cycle, usually just before hospitalisation. Speeding, making poor decisions and not feeling in control of their vehicle were the principal recollections for the group. As a strategy to ensure their safety and safety of others on the road, their decision to then cease driving temporarily is also loaded with meaning. It became an outward display of illness and occupational adaptation became a necessity, as the individual in Vrkljan & Polgar’s (2007) study discovered. There appeared to be a sense of conflict inherent in knowing that the decision would restrict their independence, yet at the same time it is a testament to their insight into making effective decisions when unwell. That bipolar changes the actual performance of driving activity for the groups’ members, is somewhat
reflective of the conclusions of the systematic review by Ménard et al (2008), in that mental illnesses are associated with an adverse change in driving. Just as Levine (2001) and Rouleau et al (2010) found too, a period of driving cessation is done if necessary. As no road traffic accidents or convictions for driving offences were reported in this study, unlike findings in some studies (Etminan et al. 2004; Shaffer et al. 2007; Rouleau et al 2010), it could be argued that the participants’ control over decisions to cease driving, or their timing of medication so as it does not interfere with driving performance, could offer an explanation for this.

Based on these findings, it is argued that as part of occupational therapists’ clinical reasoning when working with people with bipolar disorder, questions regarding performance components of driving should be asked throughout the occupational therapy process. For example, if participants speak to their occupational therapist about changes in their driving behaviour or performance including; driving at increased speeds, driving to places without reason, or not feeling in control of decisions, being easily distracted, not remembering where they have driven, it may be an effective means of highlighting the potential onset of a manic or depressive episode. As a result, treatment could then be modified earlier to prevent full relapse. Indeed as one participant pointed out, changes in anxiety levels she felt when driving was, for her, a “barometer” for the stage of her illness. According to Wilby (2007), when occupational therapists consider the performance components of an activity, they facilitate a greater client-therapist relationship built on in-depth knowledge of a person’s performance skills, which in turn leads to even more meaningful therapy experience.

Unexpected in this study was the participants’ perception of the first edition of the Sláinte agus Tiomáint guidelines (RSA 2013a) as being discriminatory towards mental illnesses. There is a stipulation that six months stability would be required following four or more episodes of mood swing in twelve months before being declared fit to drive. However, a search of the literature has not revealed a study that would lend some validation to this claim and support such criteria for the ban. It may be that the participants perceived subjectivity within the wording of the guidelines, compounded by a lack of definitions of phrases such as “well and stable” and “compliant with treatment”. In addition, discrepancies between guidelines for other psychiatric conditions may have been difficult to comprehend. ADHD, with prevalence among adults of 4.2% and co-morbidity with bipolar disorder itself (Spencer 2008), arguably affects similar cognitive capacities affected during experiences of mania, yet does not have a specific guideline insisting that those affected cease driving. Rather it states; “Factors such as impulsivity, lack of awareness of the impact of own behaviours on self or
others need to be considered” (RSA 2013a, p. 48). It could also be argued that the participants’ emotional responses to the guidelines are the result of a view that these regulations are yet another instance of where their illness has long lasting influence in defining them and their life narrative. Indeed, Potter (2013) argues that radical shifts in mood and activity for the individual with bipolar disorder undermine their trustworthiness to family and friends, and results in continual fragmentation of their narrative. To the individuals in this study, the guidelines could be another example where they are facing societal discernment that they are unpredictable.

The finding that participants thought it useful to have open communication with a health professional regarding their decisions around driving highlights their wish to balance the need for safety in the community with their own need for occupational engagement. This demonstrates a synthesis of their aspirations with what Canadian medical guidelines stipulate is the role of medical practitioners in assessing fitness to drive (Canadian Medical Association 2012). However, O’Grady and Buckley (2014) found that only 14% of psychiatric inpatients discussed driving with their psychiatrist. Assessing fitness to drive is in itself complex, reflected in the fact that only eight months after its publication, a draft of the second edition of the guidelines has been published (RSA 2013b). Just like guidelines in the international context, Slainte agus Tiomaint specify that in most circumstances a judgement on fitness to drive can usually be made by a general practitioner. However, the abilities of medically trained professionals to evaluate driving suitability have been called into question due to a dearth of training given to practitioners (Sims et al 2012; Omer et al 2013). Internationally, specially trained occupational therapists have made advances in working with many client groups in driver assessment and rehabilitation (Dickerson et al 2011; Di Stefano and McDonald 2012), but in Ireland this remains an emerging area. It could be argued therefore, that in the area of mental health, occupational therapists trained especially to work in this area could fill the gap as part of a multi-disciplinary team approach. Not only could they utilise their skills in activity analysis, but also apply an occupational science understanding of appreciating the dimensions of meaning within seemingly taken for granted instrumental activities of daily living.

**Limitations**

A limitation of this study is the bias inherent in the convenience sample. All were recruited from an independent mental health service provider which could have influenced the findings, in that these patients are more likely to come from a better socio-economic group, compared to patients in public psychiatric hospitals and psychiatric wards of general hospitals in Ireland.
Another potential influence on the findings is the possibility that participants omitted negative driving experiences. In addition, the researcher did not ask questions about alcohol use, a commonly cited comorbidity and influence on driving (Shaffer et al 2007).

**Directions for future research**

Future research could focus on individuals with bipolar disorder in public health system which would be more representative of the patients in the Irish health service context. Indeed, only twenty percent of people in Irish psychiatric hospitals use independently funded mental health services and they are more likely to possess a higher socio-economic status compared to those in the public system (Daly & Walsh, 2011). Further study could also firstly highlight the effects of longer term driving cessation among those with bipolar disorder, or other mental illnesses, and secondly ascertain if it leads to occupational deprivation and impacts recovery. By replicating this study using a quantitative method, with a larger sample size, findings about the experiences of those with bipolar disorder could be generalised to a wider population.

**Conclusion**

To the author’s knowledge, there has not been a qualitative study focusing on the lived experience of driving with bipolar disorder. The research answered two questions. Firstly, regarding the question about what meaning is derived from driving, the findings illuminated that it is an essential instrumental activity of daily living and imperative for facilitating occupational participation, reflective of conclusions in studies on driving cessation among older adults and epilepsy sufferers. Secondly, in investigating the self-reported impact, if any, of bipolar disorder on driving, the participants’ responses highlighted that they were acutely aware that symptoms of their illness could potentially affect their driving, regardless of actually having such experiences. Independently adopting strategies to manage their own driving when unwell was vital for them, attributable to their desire to have a sense of control in their recovery process. The group’s response to the Sláinte agus Tiomáint fitness to drive guidelines could be regarded as an insight into their feelings of disillusionment about how they perceive society defines them in terms of their illness. It is possible therefore that there is conflict for participants between the implications of social and functional changes resulting from the illness, and having to be the person to instigate these changes, even when it is not desirable. This research has initiated a bridging of the gap in the literature, by providing a perspective on driving from those who are experts, by experience, in their own illness.
Occupational therapists could have a lot to offer by working in collaboration with individuals whose driving has been impacted by having bipolar disorder or another mental disorder. As Hammell (2004) asserts, when clinicians work to help people identify occupational choices and ways to maximise engagement, health and wellbeing is greatly facilitated while on the road to recovery.
References


Road Safety Authority (2013a) *Sláinte agus Tiomáint* [online], available: [http://www.rsa.ie/Documents/Licensed%20Drivers/Medical_Issues/SI%C3%A1inte_agus_Tiom%C3%A1int_Medical_Fitness_to_Drive_Guidelines.pdf](http://www.rsa.ie/Documents/Licensed%20Drivers/Medical_Issues/SI%C3%A1inte_agus_Tiom%C3%A1int_Medical_Fitness_to_Drive_Guidelines.pdf) [accessed 4-3-13].


Appendix

Focus Group Interview Guide

- Describe what driving means to you.
- How do your mental illness and/or current medication/s affect your driving?
- Do you notice a change in your driving ability when you are starting to become unwell?
- Have you ever modified/ceased you’re driving behaviour based on how you felt? How did you modify your behaviour?
- When you have modified or ceased driving how did that affect your engagement in activities such as work, school, and leisure activities?
- Has your consultant psychiatrist or multi-disciplinary team ever discussed the implications of your mental illness and or medication/s on driving ability with you? If yes, how?

- Any other thoughts?