Psychiatr. Pol. 2019; 53(3): 691–707
PL ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
www.psychiatriapolska.pl
DOI: https://doi.org/10.12740/PP/92014

Bipolar disorder and identity. Systematic review

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Summary

The article was written with the intention of filling the gap in the Polish psychiatric literature, which has not yet found room for the analysis of the phenomenon of bipolar disorder (BD) in terms of consequences that it may have for identity of people diagnosed with it. In order to do that, taking into account absence of the research in Poland, an attempt was made to find all previous reports on this subject in English-language professional journals and monographs. As a result, a detailed description with commentaries was made on five thorough studies of essentially qualitative nature. Although the 'identity' was operationalized a little differently in each of them, it addressed each time the question: "Who am I?", both in phenomenological terms, most often manifested in the loss of a sense of continuity, and cognitive terms, associated with the key elements of self-image. The presented studies revealed a number of threats to identity, more or less specific for BD. The nature of these studies does not allow the generalization of their results, nor answer the question of a scale of the phenomenon. On the other hand, the relative similarity of these results reveals previously overlooked difficulties, potentially frequent and important to more holistic understanding and therapy of people with BD, for which the implications have been summarized in the final part of the text.

Key words: bipolar disorder, identity, psychotherapy

Introduction

The issue of identity in the context of bipolar disorder (BD) appears rarely in specialist literature. This state of affairs may come as a surprise when one tries to imagine what the threats for identity could be to people experiencing regular, extreme changes in not only mood itself – as suggested by the name of the illness. Various 'kinds' of BD[1]: mania and hypomania, depression and subdepression, euthymic and mixed state,

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[1] The disorder itself is divided in DSM-V into type I, type II, cyclothymia, and non-specified forms. Type I, in contrast to type II, is characterize by full-blown manic episodes (also with psychotic flavor) and mixed states, however, in type II higher frequency of the episodes occurs. In cyclothymia, mild depressive and hypomanic states do not meet the criteria of any episodes [1].

and finally ‘drug-induced’ state are, phenomenologically, different kinds of personality – ‘intensified’ in mania, ‘belittled’ in depression, ‘muted’ and less volatile (i.e., less disorganized and cyclothymic; cf. [2]), but also ‘neutralized’ as a result of treatment. Kay Redfield Jamison, a clinical psychologist, researcher as well as patient with bipolar disorder diagnosis, asked in her autobiography – sui generis (auto)idiographic study:

“Which of my feelings are real? Which of the me’s is me? The wild, impulsive, chaotic, energetic, and crazy one? Or the shy, withdrawn, desperate, suicidal, doomed, and tired one? Probably a bit of both, hopefully much that is neither”[2] [3, p. 62].

It seems reasonable to suppose that such a state of affairs affects elementary sense of continuity and cohesion [4], and the most important components of self-image. If that were the case, it would expand our understanding of the BD phenomenon, so that therapeutic interventions could be also more need-adapted.

This article was written with the intention of filling the gap related to the total absence[3] of this important topic in Poland. In the following part, detailed discussions of the few foreign studies linking bipolar disorder with the issue of identity are included. This detail of description is due to several reasons: qualitative nature of most research, which makes them difficult to succinct description, emphasis on methodological issues, important for the proper reading of their results, and above all, the desire to show the Polish reader a full picture of the discussed phenomenon.

Although the subject of the article seems to require a clear definition of the ‘identity’, this task is difficult due to the large diversity of the construct in nowadays psychology. This fact is reflected in the research presented here: the first one [6] assumes actually popular definition of identity (see below), New Zealand studies [7, 8] refer to the classic theory of Erik Erikson, in the publication on loss one cannot find any definition of identity (apart from key word phrase ‘social identity’, which incorrectly suggest narrowing of the subject to this aspect) [9], and actually only the last report use consistently understanding or rather special kind of identity grounded in psychology [10]. Therefore, without specifying numerous conceptualizations of the discussed construct, one can propose their brief synthesis in the shape of divisions often found in the literature: on subjective one, i.e., based on the experience of being oneself, manifesting itself in different ‘senses’ (most often of separateness, continuity, coherence) and the objective one, constituting an ‘extract from the self-concept’ [11], as well as personal and social one (i.e., comprises important roles played by the individual among others). Such atheoretical syntheses (detailed discussion in: [12]) have their own tradition in Poland [13, 14], are postulated as a way to integrate different approaches [15], and appear implicitly in most of the studies described in this article.

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[2] The author’s history shows that effective treatment (with relatively low doses of lithium carbonate) cancels to some extent this kind of dramatic doubts. However, as it results from the part of the research discussed below, this is not a typical course of struggle with the illness and pharmacotherapy.

[3] Except for the chapter from the monograph on qualitative methodology containing mainly the ‘internet’ study [5].

1. Challenges to identity in BD

The first work directly related to the discussed topic was found in a doctoral thesis by Jennifer Ruth Chapman from the University of Texas, available on the Internet, but not published yet [6]. The starting point of the dissertation was the desire to characterize the most important processes faced by BD patients, factors affecting their reactions and the meaning they attribute to their experiences. The main intention was to create a theoretical model representing the core aspects of these experiences, the one which would be also rooted in their perspective. For this purpose, the author used the grounded theory methodology in the constructivist version, using a semi-structured interview for data collection.

Twelve people (including nine women) aged 22 to 62 participated in the study. Half of the patients were diagnosed with bipolar I, and half – with bipolar II disorder. At the time of the study, everyone was in remission. Interpretation of the data led to the conclusion that challenging one's identity – which was understood simply as "a person's view of self, a collection of answers, large and small, to the question, ‹‹Who am I?››" [6, p. 47] – covers wide range of situations and occurs so often and with such an intensity that it should be considered as a central aspect of the BD experience. Chapman lists several key sources of information that challenge identity in the course of this disorder: symptoms, diagnosis, medicines, and psychotherapy. This information may have an intrapersonal character and result from the observation of one's own feelings and deeds, as well as interpersonal, taking into account the perceptions and reactions of others to the behavior of an ill person.

As for symptoms – the first of the identified challenges for identity – Chapman approaches them phenomenologically, which has little in common with the list of symptoms included in the diagnostic criteria of popular classifications. She divides them into four types. The first is named ʽvery wide range and high intensity of emotional experience'. On the one hand, it is about the extreme intensity of both positive and negative mood and the resulting differences in the sense of agency and drive quality, characteristic of BD. As reported by one of the respondents: "It seemed like, for a long time, it was like either things were overwhelming, I couldn't do anything, I was powerless, or I was like the opposite. You know, I could handle anything, it was wonderful, I could do anything. And I can't remember any times for several years when it wasn't one way or the other" [6, p. 55]. On the other hand, these symptoms include the aforementioned impossibility to predict what one will want and what could happen in the near future. Other symptoms challenging BD patients' identity are: being out of control, ʽactions or behaviors that are ‹‹not like me››[4]' and not being able to do things one used to do.

Diagnosis is the challenge to identity because it imposes new glasses on the vision of oneself at the present time and also on past and future. It adds bipolarity to the self-

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[4] This expression implies that you are usually yourself and you know who you are – which actually is not so obvious.

image. Past behaviors that were so far considered as ‛my own’ can be reinterpreted as ‛sick’ at the time of BD diagnosis. The individual is considered to be mentally ill, which often involves self-stigmatization and, actual or anticipated, social stigmatization. One feels different, misunderstood, no longer equal to his/her healthy friends. However, not all the respondents agreed with this type of diagnosis, believing that BD is not suitable for them.

Psychotropic medications are the threats to identity in double manner. First of all: by the very obligation to eat them. Many of the subjects suffered from the awareness of permanent dependence on drugs. Secondly, for some, drugs ‛change’ or even ‛take away’ personality. Such people, seeing emotional and behavioral changes, ask: “Is this the real me? Or is this just me on drugs?” However, there were also participants who might say that they are finally themselves thanks to medications.

Psychotherapy is quite a paradoxical challenge to identity. Some respondents, confirming its positive effects, had problems with adopting a new vision of themselves, because it involved rejection of long-established, deep-rooted views about themselves[5].

All listed challenges take a different form depending on the patient’s phase of life. Responding to challenges to identity is not a structured, linear sequence of stages that have a tangible end. It is rather a repeated pattern of processes that can take place in many different ways. Challenging one’s (objective) identity may be a source of severe discomfort and stress, and impaired subjective sense of coherence and, by extension, sense of predictability has a negative impact on both personal and social identity of a person.

An additional result of the Chapman’s study is the recognition of two basic ways of responding to information that is contrary to the way people perceive themselves so far. The first one implies pushing all data contrary to former identity beyond the consciousness. In this case, potentially threatening feedback will not cause any changes. As a result, the individual must constantly face the same information, constantly repeating their efforts to ward them off. The second way is to allow these information to enter the self and make changes in its structure. It involves the reorganization of the identity. The author considers the first way as non-developmental. Constant struggle with threatening information takes away the energy needed to cope with life, it also creates a false, somehow outdated, self-image. According to Chapman, in people with BD the second strategy is more and more frequent over time. In the restructuring process, an important role is played by getting to know the ‛middle self’, which sometimes involves unprecedented state out of mania and depression extremes, coping with the consequences of the illness, such as hurting others and all kinds of loss, answering the question “when am I actually myself?”, and the recognition of things that can or cannot be controlled (one of the respondents’ meaningful statement: “I think you can influence it. I don’t think you can control it” [6, p. 105]). A successful restructuring

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[5] It would be an exemplification and, at the same time, confirmation of the supremacy of a self-verification motive over a self-enhancement motive, which was postulated by Swann [16].

process makes possible to get on with life. It seems that Chapman at this point adopts an arbitrary interpretation of the described strategies, according to which the first is unequivocally the ‘worse’ one. It would be reasonable, however, to delve into the reasons behind such a solution. After all, there is a big difference between using primitive defense mechanism of denial (“nothing is wrong with me, I do not need treatment”) and disagreement with binding identity to the diagnostic label, which could result in the aforementioned self-stigmatization and social identity of the patient (“The fact that I happen to be ill does not mean that bipolarity is an essential aspect of my self-view or something that constitutes me”).

Inductance of grounded theory, which is particularly emphasized, suggests lack of preconceptualization that traditionally developed theories contain. It seems, however, that such a demand is more ideal than real, which can be illustrated by this study. The very choice of the method had to be the expression of the author’s conviction that the subjects’ experiences would be repeated and the results would be coherent enough to create a theory explaining the whole of the internal functioning of people diagnosed with BD. Moreover, one can treat with some reserve the very choice of these and not other problematic spheres on the basis of which future questions were constructed: interviewer’s ‘map’ contained paragraphs that were more or less related to the broadly defined identity, which could violate the respondents’ freedom of expression. In addition, unfortunately, there were no place to specify the process of ‘directing’ the respondents to the author, but one may have doubts whether they take part in the study voluntarily or maybe it was suggested to them by authority figures: therapists and doctors who mediated in the recruitment.

2. Identity development in the face of the illness

A New Zealand team of scientists under Maree L. Inder’s direction conducted qualitative research focused on the impact of bipolar disorder on psychosocial development, and especially on the development of the sense of self and identity [7]. Self is understood here as a cognitive and social structure whose development and integration leads to the development of identity, a structure that allows interaction with the world (social aspect), giving a sense of continuity and agency with the ability to perform specific roles and providing self-defining representations (subjective and objective dimensions of personal identity respectively). The authors note that the onset of the illness often falls within the period of late adolescence, when – according to the classic theory of Erikson – the basic developmental task is to create a consolidated self-identity.

The study was part of a larger, randomized and controlled trial comparing specialist supportive care with interpersonal social rhythm therapy. The study included patients diagnosed with BD aged 15–35. There were two phases of recruitment to the study. At the beginning, 6 out of 36 patients who completed the first three psychotherapy sessions were randomly selected. The therapist was looking for information on the consequences of BD, asking series of questions about the following areas: sense of self, BD picture, experiences of BD, and the impact of BD on the development of the sense of self. At the end of each session, therapists completed the coding sheets noting down issues related to self and identity. Using thematic analysis, the authors isolated four themes abounding in threads related to the above-mentioned topics from transcriptions of nearly 50 sessions of 15 patients with Bipolar I diagnosis: effects on relationships, others' definitions of self, disruptions (in patients' life caused by the illness), and – last but not least – problems in the development of a sense of self. The last theme contains four sub-themes illustrating the basic areas of difficulty: confusion, contradiction, self doubt, and self-acceptance.

The first component refers to *sui generis* meta-reflection on one's own cognitive and behavioral functioning, i.e., to reflection abstracting from the current state and taking into account all kinds of situations in which the illness 'places' individuals suffering from it. The key element defining the self turned out to be, what should not be surprising, the mood. The patients admitted that the mood rules their lives, causes abrupt changes in behavior and thinking; they distinguish between 'normal', 'up' and 'down' selves. Such a diversity of experiencing oneself caused in fact a sense of 'confusion' about who an individual is. One of the participants of the study described the struggle between his personality and mood: "Like I actually don't know who I am. There's a few kinds of core things, but it's almost like my personality was grappling with my mood" [7, p. 128]. Other respondents' statements revealed problems with self-separation from illness, associated with doubts about whether or not some of their past behavior was actually manic. Others, however, included various aspects of the illness in the self-image and considered them to be part of their personality, so they did not talk about themselves as depressives but only as having a depressive trait.

'Contradictions' are the result of going through different moods and opposing experiences. The authors note that the development of the sense of identity often occurs in the context of a specific affective aura. And so, one of the patients said that his identity was formed when he was depressed. Another admitted that the strong impression of who he really is appears during mania only. However, there are also those who spoke out directly about many personalities in themselves and about the sense of absurdity that goes with it[6]. As you can see, mood and behavioral changes form an experience of the self that takes on an affect-dependent shape, making it temporary by nature. It result in that contradiction in sense of the self which is difficult to overcome and which is tantamount to unstable identity.

The lack of a stable sense of self leads to 'self doubt', which is understood here as a kind of loss of self, manifested in a sense of non-substantiality, difficulties in self-differentiation, lack of knowledge about who one want to be and what to do, and in the struggle against negative self-beliefs. Some patients talked about not recognizing themselves, others about excessive susceptibility to external circumstances (merging with a given environment), others described themselves as reed in the wind. Many

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[6] These 'personalities' seem to indicate extreme positions on the dimensions of traits such as extraversion.

talked about the inability to come to terms with some aspects of themselves, and even about self-hatred and a sense of failure.

After all, ‛Self-acceptance’, involving the development of a more consolidated sense of self, is possible, thanks to the acceptance of the illness or, in other words, thanks to the integration of various aspects of experience and various aspects of the self. This is reflected in the words of one participant: “All the experiences I had were deeply felt by me and very difficult during their lifetime; I do not pretend it was different or they did not take place, because if it was, I would not be where I am – it’s just something I stemmed from. Every experience is a piece of me, good or bad; I remember them and I know that they happened, but I cannot do anything about it. I moved on, but I took them with me – and that makes me stronger” [7, p. 130].

Acceptance of bipolarity therefore facilitates a more integrated sense of self. However, for this to happen, longer periods of stable mood are necessary, as the authors claim.

The study’s conclusions are consistent with the predictions. BD affects the construction of a sense of self and identity in a number of ways. Many of the participants could not identify their ‛real self’, they had a sense of not being the same throughout time, they could not integrate different aspects of themselves, and as a result their self was underdeveloped. The participants also complained about the lack of a sense of cohesion, continuity and constancy. They also described lack of control and autonomy as well as feelings of shame. According to the authors, all of it adds up to identity diffusion described by Erikson.

Another study by Inder et al. [8] focused on the role that BD plays in the identities of the participants. The authors assumed that although any chronic disease leaves its mark on identity, BD is special in this respect. Not only the diagnosis itself, but also the experience of different moods causing confusion and contradictory expectations leads to self-doubt and questioning one’s identity. Two case studies illustrated the process which through the impact of BD on self and identity leads to a change in the latter. The study used procedures similar to those of the previous study, based on data from recorded sessions of psychotherapy. Due to similar methodology and overlapping research results, a more thorough discussion of it seems to be unnecessary.

The reflection on the results should take into account the fact that New Zealand researchers seemed to be sure what results they will obtain at the outset – it resulted from a simple juxtaposition of Erikson’s theory implications with the symptoms of the illness and time of their occurrence. Doubts are also raised by the fact that clinicians staying in the therapeutic relationship with the participants were those who asked the questions – instead of relatively neutral researchers; these questions in turn were related to identity-related areas identified by those clinicians, which could be additionally suggestive, and consequently the answers would be partly artifacts.

3. Loss as a consequence of the illness and renegotiation of identity

The starting point for the research of Maria E. Fernandez et al. [9] was the observation that people with a diagnosis of BD experience not only significant changes in mood but also many losses. They are associated with such factors as repeated hospitalizations, feelings of failure and hopelessness, social stigmatization, underemployment or loss of independence. Aside from identification of various types of loss, the authors were also interested in the experience of coping with them and the relationship of loss with identity and recovery.

Participants in the study were women diagnosed with BD, remaining in treatment and being able to provide informed consent (which in practice comes down to being in remission), recruited through ads in local mental health organizations, private psychologists offices, local newspapers and radio, as well as BD support groups (snowball method was also used). The collection of data was simultaneous with its analysis, therefore the recruitment was completed upon obtaining the so-called theoretical saturation. The gender of the subjects was not predetermined, but due to the fact that only one man came forward to the project, a decision was made to include 10 women aged 29–68 years, seven of whom had a diagnosis of BD I, two of BD II, and one of cyclothymia. 6 women had a university degree. Only one had full-time job, the other 9 divided equally into unemployed, part-time workers and retired. A semi-structured interview was used to collect data, based on questions from the questionnaire used to measure various types of loss (roles, daily activities, relationships, self, future), but extended to issues of coping, recovery, emotions and positive experiences. The constant comparative method was used in order to analyze the material, which allows to discover connections and differences between individual cases, and at the same time enables categories to be formed.

It turned out that the dominant thread emerging from the data are changes in identity of participants: identity bound by the diagnostic label, multidimensional effects of the bipolar identity and strategies for renegotiation of identity.

The first category was divided into two subcategories: ‘adopting the patient identity’ and ‘independent patient’. The former implies that being ill is a central point of identity. At first, the authors seem to accentuate the positive functions of such an ‘engulfment’ (in the literature this term is rather negative, see e.g., [17]) for the patients: aiding their understanding of who they were following diagnosis and determining direction for their treatment and their role in the treatment process (which undoubtedly facilitates medication adherence), as well as establishing credibility as a person with BD. A little further, however, they introduce the other side of the coin: loss of power, autonomy and independence. Adoption the identity of a patient thus gives some hope related to the treatment process, but also causes a sense of helplessness and distress. A different solution is an ‘independent patient’, which is a kind of paradox arising from the tension between the role of the passive patient and the need for self-determination. Unfortunately, the authors limited the exemplification of this solution to the meaningful but not comprehensive issue of medication adherence. Nevertheless, this very issue illustrates the patients' struggle to maintain their identity: when they do not want to take drugs because drugs took away their capacity to think properly and made them feel 'muffled'. Such an attitude may take place even in difficult circumstances, as in the case of a patient who consistently refused to 'swallow tabs' during hospitalization, knowing very well that he would be injected as a result. Although the effect was the same, this behavior allows him to maintain autonomy.

The multidimensional effects of the bipolar disorder identity are: diminished roles and relationships, 'operating on little fuel', loss of control, and the 'exciting and frightening me'. The first topic concerns the fact that BD impairs intimate relationships, which for almost half of the participants ultimately led to divorce. The loss of the partner's role was accompanied by an equally painful loss of a parental role related to the inability to perform a maternal function[7]. Some of the participants described the impact of BD on friendships. One woman declared willingness to meet her friends only when she was 'well', another described a typically bipolar experience: getting to know people during the 'creative' (i.e., manic) period and withdrawing during depression. For most, it was their own decision, resulting from a feeling of being 'a burden' for people around them, but two women spoke about the loved ones' lack of tolerance for their 'dark side'. Sometimes this took the form of loss of social status and credibility, which in turn resulted in being hurt and a feeling of being alienated. Some people hid the fact of being ill in order to prevent this situation.

'Operating on little fuel' means deterioration of everyday functioning, manifested, for example, by drug-induced cognitive impairment in the workplace. A recurrence of symptoms often resulted in a decision of transition from full-time to part-time employment or changing job to a less strained one. In the past, this took the shape of leaving a university (also during PhD studies) due to insufficient concentration or loss of self-confidence.

Loss of control was usually related to manic states, during which the participants behaved 'contrary to their own character', in contrast to their own morality and undertook life-threatening activities. As a consequence, they became later more 'serious' and less spontaneous. Constant self-monitoring also resulted in self-doubt, to the detriment of self-efficacy and self-esteem (which are also regarded as parts of subjective identity, cf. [14]). Some women also experienced an increased vigilance from their relatives or superiors.

Patients during depression, when they noticed changes in their personalities, that they became 'weak', 'quieter and more serious' or even felt 'insignificant', were 'frightening' for themselves. In turn, they were 'exciting' due to creativity, audacity, ecstaticity, and infinite energy accompanying mania. As a result, some subjects were reluctant to relinquish their manic experiences. However, women (maybe the same

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[7] It is worth noting that it is usually a temporary dysfunction due to hospitalization, which patients often generalize.

ones) also noticed destructive nature of manic episodes, their psychotic and paranoid contents and the loss of reputation and morality.

'Strategies for renegotiating identity' took a four-fold form: acceptance of BD as a new reality, reclaiming control through self-help strategies, connecting and identifying with others, and redefining identity in relation to recovery. Acceptance of the illness meant approval to the fact of its existence and its chronic nature and to the fact that one cannot have full control over its course. This attitude brought 'a sense of freedom' and self-discovery. The authors, however, do not seem to notice the paradox of it, and thus do not attempt to explain it[8]. Hence, another strategy, consisting in taking responsibility for one's own mental state and 'managing' the disorder, is more understandable. Some of the participants gained knowledge about BD through reading, cognitive behavioral therapy, mindfulness-based therapy and self-help books. For some, it resulted in the recognition of stressors being triggers of the episodes, others used specific techniques, such as exercises or relaxation, or set limitations, cared for the sleep hygiene and adopted a 'positive attitude'. Even though it was not easy, returning to activities and interests that defined various aspects of the subjects' identities was of particular importance. The use of various self-help strategies gave them a sense of self-control and autonomy, and also restored hope and a sense of purpose in life. Bonds with others in turn provided a sense of security and reinforcement, emotional support (which is well illustrated by a friend willing to listen to the patient, and also able to understand his/her need for isolation) as well as instrumental one, such as helping in everyday activities during a crisis. The participation in support groups, which was almost common among the subjects, particularly neutralized feelings of loneliness and otherness. The exception to this rule were statements critical towards these groups expressed by two women, coming down to the impression that participation in them reinforces the sense of being ill and gives rise to discouragement. 'Redefining identity in relation to recovery' implies the development of a new identity composed of both pre-diagnostic and post-diagnostic selves, and as such it has proved to be a key aspect of the recovery. This ongoing process of negotiation resulted in increased self-acceptance. The awareness that "Bipolar is what I have, it is not who I am" (it is worth noting that this is the opposite of the above-mentioned 'engulfment') was of particular importance. Nurturing the post-diagnosis positive traits – like compassion, empathy, persistence, strength, optimism, courage, and tolerance – fostered the development of self-acceptance. Six women expressed their satisfaction with the acquired self-knowledge, and one felt good with her uniqueness.

Perhaps the most important conclusion of the research of Fernandez et al. is that the identity of people with BD is not established once and for all – it is subject to constant fluctuations of mania and depression; neither achieving it nor losing it is ultimate. Going along with the 'sick' aspects of identity, successful or not, takes place simultaneously with the maintaining of 'healthy' ones; attempts to balance these two

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[8] Similar phenomenon, but profundly described and explained, is shown in the aforementioned Jamison's book.

poles of identity are never-ending, which suggest that recovery is also an ongoing process. Adaptation to life with BD is not linear – which is in contrast to popular theories describing stages of mourning – and also development of the patients' identity differs from a 'natural' one, taking on a cyclical nature like the illness itself. However, this result seems to be not scrutinized, what can be understood in the following way: if regress follows progress, then all growth is zeroed and it is actually hard to talk about the development of identity. However, an alternative explanation could imply that each repetition of the cycle brings new quality, the 'loss' of identity becomes less and less total, and important – and at the same time contradictory – aspects of self become more and more integrated with time. It would be concurrent with the observed dynamics of recovery. As a matter of fact, relationship between the development of healthy identity and recovery is extremely important for these considerations, which the authors seem to suggest in the following sentence: "Although recovery is often a long-term, even lifelong process, those who manage to achieve a balanced self-view appear to adapt to and accommodate the day-to-day struggles" [9, p. 26].

Among the clinical implications of the research, the authors indicate the need to arrive at the grief resulting from losses accompanying BD – to prevent the development of complex mourning – and to work out ways of helping patients in their struggles with post-diagnostic identity. They also emphasize the importance of accepting the illness for the renegotiation of identity, while stressing that developing the identity that would not be reduced to a 'patient' or 'sick person' is important to the processes of rehabilitation and recovery.

This study seems to be devoid of significant imperfections. The few include the fact that widespread participation in support groups was most likely an artifact resulting from the way of recruitment (thus investigating people with BD who do not participate in such groups and are more socially isolated could bring different results) and the potential social acceptance desirability bias resulting from participants' beliefs that their doctor or psychotherapist will read their answers (information on the confidentiality of data did not have to exclude this possibility).

4. Narrative identity of people diagnosed with BD

Before Anne Mai Pedersen et al. [10] carried out the research described below, they were convinced of the central role that both manic and depressive changes in self-perception (including self-esteem) play in BD phenomenology. They were also aware that the onset of the illness during peak period of identity formation might have impair its development. Additionally, the authors believed that not only reduction of symptoms but also quality of life is an important parameter of recovery, which in turn is closely related to the narrative identity – as research on healthy groups shown.

'Narrative identity', according to Dan McAdams – the author of the concept, constitutes an internalized life story, integrating different elements of biography and thus giving life a certain degree of unity and probability [18]. People select most formative events of their lives, which are thus particularly important for who they are, and which in the McAdams' method take form of chapters comprising knowledge about people, places or activities dominating specific periods of life[9].

Based on similar paradigm-based research on the other clinical groups and the awareness that BD is usually accompanied by a negative self-concept, the authors assume that having a mental illness may be associated with a more negative narrative identity, i.e., with the acknowledgement of negative events as significant for understanding of who one is and the conviction that they reflect the negative aspects of his/her personality. In the adopted methodology, this would take form of more negative and less positive chapters and self-event connections compared to the control group – referring to both the past and the projected future. In addition, researchers predicted that even if the participants describe the future chapters as positive, they will be less prone to believe that these events will happen and they produce less future chapters with shorter temporal projection. These characteristics could be in turn related to lower subjective well-being

The participants were 15 women, mostly in their thirties, who experienced between ten and twenty episodes of the illness. Two-thirds were not in any relationship, and with respect to work, women were evenly distributed on part-time work, unemployment and college. Eight women had secondary education and seven had higher education. All women were recruited from the outpatient clinic for people diagnosed with BD at Aarhus University; what is important, the diagnosis was confirmed each time by a second author, employed there as a clinical psychologist. The control group consisted of 15 'healthy' women[10]. Despite similar age, these women differed fundamentally from patients in all respects: (not) being in a relationship, employment and education level turned out to be in almost inverse proportion compared to the first group. Besides, the description of the recruitment method for this group is unclear ("they were recruited by word of mouth"). So, the question is: was the control group in fact control?

The participants were asked to describe up to 10 past and 10 future chapters, situating them in time, and estimating them (on the five-point Likert scale) in terms of emotional tone, self-event connections and subjective probability (in future chapters). The respondents also completed four questionnaires: *Satisfaction with Life Scale* and separate scales measuring level of mania and depression, and frequency of experiencing

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[9] In order to understand the discussed study, it is necessary to define terms resulting from the evolution of the concept: self-event connection, redemption sequences and contamination sequences. The first results from individual's reflection over the meaning of a given chapter and may carry a positive or negative emotional tone, both sequences come down to interpretation of significant events and their paradoxical effects, which in the first case takes the form of perceived transformation of a negative event into a positive result (like in the proverb: "when one door shuts, another opens"), and in the second – the other way round. Both of them are related to well-being.

[10] Such an assumption is very problematic, since the exclusion criteria were only several substance abuse, schizophrenia, personality disorders and concurrent affective episode, what is more, based on self-report. It means that a 'healthy' person of the control group could have, for example, various types of anxiety disorders. The same applies to the issue of the comorbidity among patients.

positive and negative emotions. All questionnaires were given to the respondents with the instruction to fill them in their free time and give them back in return for modest financial compensation.

As it turned out, patients with BD did not differ from the control group participants in terms of the number of past chapters, but they rated them as less positive and more negative, and produced less positive self-event connections (interestingly, the difference did not occur in the cases of negative ones). They also generated fewer future chapters (three women did not produce any of them), with a shorter temporal projection. Groups did not differ in terms of emotional tone and self-event connections, but the subjective probability of future events was smaller in the first group. With respect to additional scales, there were no difference in terms of positive and negative emotions, but subjective well-being was assessed as much lower by the patients. Correlations between the emotional tone of past (but not future) chapters and well-being were positive and significant, and the number of chapters was not significant. In addition, positive self-event connections, higher subjective probability of their occurrence and longer temporal projection correlated significantly with positive affect, whereas remaining measures turned out to be statistically insignificant.

As it appears, most of researchers' hypotheses have been confirmed. Patients with BD have described less positive and more negative past chapters and generated less positive self-event connections compared to the control group, which does not differ from the results of similar studies on other clinical groups, such as depression and schizophrenia. Relation between negative narrative identity and life satisfaction was also confirmed. Following the authors, however, it should be noted that the former may reflect both greater number of negative events experienced by people with BD, and their more negatively biased interpretations of events (e.g., resulting in the absence of ‘redemption sequences'). Probably both explanations are justified. A surprising result was a positive tone of patients' projected future, which is a paradox known from a study of patients with unipolar affective disorder, cited by Pedersen et al. The authors consider a universal scheme of constructing future based on individual goals and culturally shared knowledge of typical lives as a possible explanation. Catathymic thinking should also be taken into account. Nevertheless, the lower subjective probability of desired future events found in this group seems to strongly modify this unexpected effect. At the same time, the smaller number of future chapters and their shorter temporal projection have no clear explanation. This could be related to either the alleged poorer executive functioning of patients with BD (which seems completely unjustified) or difficulties in establishing self-continuity (which can be found more likely considering the typical clinical picture of BD).

The correlational nature of the study does not allow to determine direction of the observed relation between narrative identity and well-being. Moreover, any generalization of the results, even if gender is taken into account, is not legitimated due to insufficient number of the participants. In addition, in the light of convergent results from other clinical groups, it is impossible to say whether the obtained results are specific for patients with BD or whether they are associated with the mental illness in general. The quantitative nature of data analysis, although revealing potentially meaningful tendencies, also does not allow to explore and understand the generated content, and thus to discover the meanings behind the observed negativity.

All the aforementioned imperfections of the discussed study do not deprive it of cognitive importance, as well as practical implications suggested by the researchers. As Pedersen et al. point out: “Narrative interventions may emphasize more positive interpretations of what chapters tell about the patient’s characteristics or support the integration of chapters lending themselves to more positive self-event connections. In addition, narrative interventions could focus on how patients construct their personal future and help them construct positive, but realistic, future chapters as well as support belief in and develop skills important for turning the chapter into reality” [10, p. 8].

Conclusion

The five reports (including the mentioned one) described in this article constitute the majority of the published texts on identity in the experience of people diagnosed with BD. The rest include: interesting but mostly theoretical discussion of Kraus [19], quantitative study of Kesebir et al.[11] [20], ethnographic study of Pope[12] [21], and the only Polish accent – case study combined with thematic analysis of statements found in English-language forums on BD [5], as well as similar thematic analysis of blogs of people diagnosed with BD [22]; incidentally, the last two studies present spontaneously and freely generated material, and probably that is why ‘bipolar identity’ takes on a much broader expression in them.

One general conclusion arise from all these reports, namely: BD significantly impedes forming [7] and maintaining [6, 9, 10] a relatively stable identity. This, in turn, has impact on further course of the illness and breeds additional suffering. Moreover, these difficulties have a multifaceted nature.

An open question is whether described problems with identity disorders are specific to BD or are they results of nonspecific factors such as having a psychiatric diagnosis or assuming the role of a patient, which are common to various severe diagnoses. Further research is required, meanwhile one may risk the assumption that indeed some of the threat factors for identity are non-specific (three of the ‘challenges’ listed by Chapman, most of the losses identified by Fernandez et al., negative narratives from the study of Pedersen et al.), others (like Chapman’s ‘symptoms’, ‘confusion’ and ‘contradictions’ described by Inder et al. – which seems to be identical to the ‘frightening’ and ‘exciting’ selves from the research of Fernandez et al; redefinition of the

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[11] Unfortunately, this article was published in Turkish only.

[12] The author focused on the process of ‘transforming’ teenager from a correctional facility into a patient/ bipolar patient, showing mainly secondary benefits accompanying this transformation. In fact, none of the girls described in the article were diagnosed with BD.

past) are typical exclusively to struggles with BD [cf. 8]. Such distinctions, however, do not matter in practice, i.e., in understanding and treatment of people with BD who may, after all, experience both specific and non-specific difficulties with their identity. The most general recommendations for therapeutic work would be as follows: recognizing individual identity threat factors, mourning associated with particularly important losses, finding a 'core' of personality/'middle-self' and integrating both pre-diagnostic and post-diagnostic aspects of oneself in such a way that potential acceptance of the illness was not tantamount to assumption of the role of a patient or identification with the diagnosis.

The question that remains unanswered is the scale of the phenomenon. The qualitative nature of the quoted studies[13] does not allow any inference about the population. In turn, the attempt to closely integrate results encounters obstacles such as heterogeneity of participants. However, even when – as in the case of the two reports cited at the end – only women are investigated, and other potentially significant variables (such as age, education, relationship status, employment) could be omitted, the problem of semantic nature remains – namely a slightly different understanding of what lies behind the word 'identity'. This applies to all these studies, and is additionally reinforced by the synonymous leveling of 'identity' and 'self'. Similarly, the types of the disorder, although distinguished in most studies, have in no way been included in the discussion as potentially differentiating the subjects and their identity. To state that all people (or even most of them) with a BD diagnosis experience identity problems is therefore not validated on the basis of reports cited above. However, different methodologies that bring similar results may indicate that this is a frequent problem requiring serious attention from clinicians. It is also worth noting that some authors expected such results, which could affect their content [7, 8, 10], while others explored the wider areas of life with the illness in question, and struggles with identity proved to be an unexpected result, moreover, the one recognized as the basic characteristics of BD [6, 9].

The limitations of aforementioned studies constitute challenges for further research. Among them: a clear over-representation of women, most of respondents' participation in psychotherapy and/or psychoeducation[14] – and thus above-average self-awareness – and the conceptualization of the illness experiences, i.e., an adoption of Euro-Atlantic medical narrative. Recruitment process considering a higher proportion of men and not mediated in mental health facilities may be one of the ways to break the emerging pattern.

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[13] Essencially quantitative study of narrative identity is no exception due to insufficient number of participants.

[14] None of the authors specified kind of psychotherapy used in the case of particular subjects, which is important because each therapeutic approach structures patient's experience differently.

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