

**Bipolar Disorder is a Two-Edged Sword: A qualitative study to understand the positive edge.**

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## **Abstract**

Background - Bipolar Disorder (BD) can have highly detrimental effects on the lives of people with the diagnosis and those who care about them. However, growing evidence suggests that aspects of bipolar experiences are also highly valued by some people.

Method – We aimed to understand how participants with a diagnosis of BD made sense of what they took to be positive about their bipolar experiences. Interpretative Phenomenological Analysis was used in the collection and analysis of data from 10 individuals in the UK.

Results - Positive aspects were numerous, highly valued and participants welcomed the opportunity to discuss them. Three important themes emerged: 1) Direct positive impact of bipolar experiences on everyday life including amplification of internal states, enhanced abilities and more intense human connectedness; 2) Lucky to be bipolar - the sense of having been given a special gift; 3) Relationship between the self and bipolar experiences.

Limitations – Given the small size, further research is needed to explore how widely positive aspects of BD are experienced.

Conclusions - These themes highlight the need to invite people to talk about the positive aspects of their bipolar experiences as well as the difficulties they face. This may help us to understand ambivalence to current treatment and to develop interventions that minimise the negative impacts, whilst recognising and potentially retaining some of the positives.

(225 words)

**Key words - positives; bipolar; qualitative**

## Introduction

*“I have often asked myself whether given the choice, I would choose to have manic depressive illness.....strangely enough I think I would” (Jamison, 1996, pp 217-218)*

Bipolar Disorder (BD) is generally seen as a severe and enduring mental illness with serious negative consequences for the individual and their friends and family (Calabrese, 2003; Hirschfeld et al., 2003). Long-term unemployment rates are high (Dickerson et al., 2004), relationships are marred by high levels of family burden (Perlick et al., 2007) and quality of life is often poor (Michalak et al., 2005). High rates of substance misuse are reported (Weiss et al., 2007) and suicide rates are twenty times that of the general population (Tondo et al., 2003). The impact of BD is estimated to cost the UK £5.2 billion per year (McCrone et al., 2008).

However, since the first description of manic depressive illness by Kraepelin (1921), the positive aspects of these experiences have been noted. Kraepelin proposed that “the disease may under certain circumstances set free powers which otherwise are constrained by all kinds of inhibition”(Kraepelin, 1921 p17). Despite this, clinical assessment tools and academic research have focused almost exclusively on the negative aspects of bipolar. This is a problem for 2 key reasons.

Firstly, focusing only on negative aspects paints a biased picture that perpetuates the view of bipolar as a wholly negative experience. Long-term follow-up studies are often conducted with people recruited via mental health services and therefore findings are biased towards describing outcome only for those people who remain engaged with services. This is only a subsample of people who meet criteria for BD and is likely to consist of those with the poorest outcomes and requiring the most support (Frye et al., 2005). Consequently, clinicians working in this area develop an experiential understanding of BD through contact only with people who are significantly impaired by their experiences. Subsequently, when giving a diagnosis, the picture presented by these clinicians is informed

by biased research evidence and by their own biased clinical experiences. This picture is generally one of long-term disability, the need to avoid stress and the prospect of daily medication with severe side-effects. Given the strength of the self-fulfilling prophecy (Merton, 1948), it is reasonable to expect that painting this picture will itself trigger emotional and behavioural responses in the individual receiving the diagnosis, which may lead to reduced levels of functioning and poorer quality of life (Lovejoy, 1982).

The second problem is failure to understand ambivalence towards treatment. Although there is a range of biological and psychological interventions available with proven efficacy in reducing relapse and improving outcome (NICE, 2006; Scott et al., 2007), there are high levels of non-adherence and poor engagement with services (Lingam and Scott, 2002). This phenomenon is generally understood in clinical settings in terms of “lack of insight” (e.g. (Copeland et al., 2008; Trauer and Sacks, 2000), comorbid drug or alcohol abuse (e.g. (Keck et al., 1997) and “personality disorder” (e.g. (Colom et al., 2000). However, it may be that in understanding the positive aspects of bipolar we can better understand ambivalence towards engaging with services, as an entirely predictable and rational response. In order to test this, we first need to comprehend the full range of bipolar experiences – positive as well as negative.

There is a growing ‘popular literature’ which tells us in great detail about the positive aspects of bipolar experience. Book titles such as ‘The Bipolar Advantage’ (Wootton, 2005), ‘The Hypomanic Edge’ (Gartner, 2005), ‘Touched with Fire’ (Jamison, 1996) and ‘Bipolar Breakthrough’ (Fieve, 2006) reflect the way in which this literature, written by people with personal experience of the disorder and highly experienced clinicians, presents aspects of bipolar experiences often ignored in more academic literature. US psychiatrist Gartner (2005) discusses ‘grandiose types’ whose unusual energy, creativity and enthusiasm result in ‘spectacular entrepreneurial zeal’ and ‘drive for innovation.’ In ‘Bipolar Expeditions’, Martin (2007) argues that people with BD are ‘the kind of person who is highly desirable in corporate America: adaptive, scanning the environment, continuously changing in innovative ways’ (pg 216). The personal value of bipolar experiences was demonstrated in a British Broadcasting Corporation (BBC) documentary (UK) in which a highly biased sample of high-achievers and celebrities with bipolar diagnoses were asked, ‘If there were a button

you could press which would take away your bipolar disorder, would you press it?’ No-one said yes (Wilson, 2006). Slightly more representative (though still self-selecting) was a survey of 3,330 adults with BD, from which only 54% said that they definitely would push a hypothetical button which would eradicate their illness (Equilibrium: The Bipolar Foundation, 2008).

Positive aspects of BD have been the focus of academic research. Jamison (1980) showed that people were able to identify short- and long-term positive effects of their mood experiences in areas of sensitivity & alertness, productivity, social outgoingness, sexual enjoyment, and creativity. She also reported that levels of manic or hypomanic symptoms are overrepresented in people defined by high levels of creative achievement, such as writers and artists (Jamison, 1989). More recently Murray & Johnson (2010) have addressed this question from the alternative perspective, looking for evidence of elevated levels of creativity and accomplishment in people with mania. They suggest that hypomanic experiences are associated with more creative, occupational and educational attainments, but that episodes of full-blown mania interfere with this process. A recent review of the literature in this area (Galvez et al., 2011) suggests support for enhanced levels of spirituality, empathy, creativity, realism and resilience in BD.

A key limitation of current research is that experiences have been evaluated along dimensions prescribed by researchers. Consequently, they may miss positive aspects of bipolar experiences that are valued by service users. A qualitative approach that explores people’s experiences more openly would overcome this problem and explore the full range of positive experiences. Michalak et al. (2006) used such an approach in their study of the impact of BD on quality of life. Although mainly identifying negative impacts, some participants described how bipolar experiences had opened up new opportunities for them by positively changing their career paths or social networks.

In this study we invited people with a diagnosis of BD to tell us about the positive aspects of their bipolar experiences. We used their responses to help us understand the varied and often ambivalent relationship people have with this condition, and to consider the implications of this for clinical interventions.

## **Method**

### ***Design***

Interpretive Phenomenological Analysis (IPA) (Smith et al., 1999) was used to understand the data. This approach is grounded in interpretive epistemology and emphasises the perceptions and experiences of individual participants from their point of view. It attempts to understand how participants make sense of their world and, in this instance, the positive aspects of their bipolar experiences. IPA recognises the active role of the interviewer and analysts and, therefore, prior to the interviews the authors documented their expectations about what the study would find and made explicit their underlying assumptions where possible. The interviewer also informed all participants of her own diagnosis of BD at the outset of the interview.

### ***Recruitment***

The study was given ethical approval by Lancaster University's Ethics Committee (UK). The recruitment strategy focused on user-led voluntary organisations such as MDF: The Bipolar Organisation, and Mood Swings Network. Recruiting outside of statutory mental health services allowed us to include people with a range of perspectives. Participants were included if they met DSM-IV criteria for Bipolar Disorder (First et al., 1997), were able to give informed consent and communicate in English to a standard which allowed the interview to be completed without an interpreter. Exclusion criteria included meeting DSM criteria for a bipolar mood episode within the previous 4 weeks, or being under the influence of alcohol or drugs assessed by clinical presentation.

In order to maintain the open qualitative nature of the interview, diagnostic criteria were assessed initially using the Mood Disorders Questionnaire (MDQ) (Hirschfeld et al., 2000) as a screen and then in full using the SCID interview (First et al., 1997) at the end of the process.

### ***Procedure***

Interviews took place in the University or voluntary group premises. A loose topic guide served as a prompt but the exploratory interview was largely guided by the

participants. At the outset, the interviewer was clear that although the interview would focus on what participants perceived to be the positive aspects of BD, she acknowledged there could also be negative aspects and by not asking about these, she did not mean to imply that these were not also important.

The following areas were covered in the topic guide:

- 1) The participants' understanding of what BD is. The language and model of understanding used by the interviewee was adopted by the interviewer to guide the rest of the interview.
- 2) Open question to introduce the topic of positives in BD.
- 3) Probing to elicit further detail on issues raised by participant.
- 4) Differences the participant feels BD has made to their life.
- 5) Aspects of BD the participant would identify as something they would look forward to or miss if absent.

Twelve interviews were conducted, but data from two was excluded from analysis as the participants met criteria for a current hypomanic episode. Each interview lasted between 45 and 70 minutes. All interviews were digitally recorded and transcribed verbatim by the interviewer. Names of participants have been changed to ensure anonymity.

### ***Analysis***

All transcripts were read and coded by the first two authors (FL, KT). These codes were taken to the wider team for discussion, during which theme content and provisional titles were agreed upon. The transcripts were reread with these themes in mind and recoded, taking particular note of data that was not captured by the themes. Further discussion led to refining and relabeling of the key themes. The themes are fully grounded in the data and highlight that which is shared by the interviewees, along with any significant variation or exceptions to the pattern of group responses reported.

The analysis team consisted of 2 clinical academic psychologists (FL, SJ), a research associate with personal experiences of BD (KT) and an academic psychologist with expertise in qualitative methods (CM). At the outset, the team anticipated that people would be able to identify positive aspects to bipolar experiences, that these would be valued and that people would embrace the opportunity to discuss them. However, we were concerned not to be perceived as minimising the very real suffering that bipolar experiences can cause. We wondered whether all the positives would be associated with the (hypo)manic state and whether people would also find positives in depression. Finally, we were unsure as to the extent to which the positives would compensate for the negative aspects of BD.

## **Results**

### ***Participants***

Demographic and clinical data is presented for participants in Table 1.

*Insert table 1 here*

The median age of participants was 39.5 years (range 24-57). Half were in full- or part-time work, and two worked voluntarily. All met BD criteria (six bipolar I and four bipolar II) and eight reported that they had received a clinical diagnosis of BD in mental health services. The two without a clinical diagnosis had been diagnosed with depression and treated for this. Scores on the MDQ ranged from 10-13 and all but 1 person rated their difficulties as either moderate or severe. Patterns of mood episodes varied considerably with estimated number of previous (hypo)manic episodes ranging between four and forty, and number of previous depressive episodes ranging between three and forty.

### ***Findings***

It was very easy to recruit to this study as many people were keen to talk about this issue. The interviews did not seem to be distressing to participants and in general people found it easy to maintain focus on the positive aspects of BD, had a lot to say on this issue and did not feel offended to focus specifically on the positive aspects of BD. This keen response may in part be because of the lack of opportunity to discuss positive aspects of bipolar experiences in other settings:



**Raphael: “Because you tend to find when you’re dealing with clinicians and everything, it’s all, it all focuses on the negative side.... So I thought it’d be nice to talk about something- cos you do, you know, it is nice, but you’re not really allowed to say that, cos that’s bad insight, you have to say it’s all terrible, and it isn’t.”**

We were struck by the passion and enthusiasm with which people talked about the positive aspects of their bipolar experiences. The interviewer experienced nostalgia for her own previous mood episodes and the analysis team were left feeling they were missing something in not having had such experiences. Our interpretation of the data resulted in 3 key themes.

### **Theme 1 = Direct positive effects of bipolar on everyday experiences.**

In this theme, we try to capture the direct positive experiences that participants attributed to their bipolar status. These reflect the ways in which their everyday experiences were accentuated and fall into 3 main subthemes:

- a) Amplification. Participants described a wide range of perceptual experiences and internal states that, whilst familiar to us all, were felt to be experienced to a far greater intensity by those with bipolar experiences. These included increased perceptual sensitivity, creativity, focus and clarity of thought.

**Alan: “It’s almost as if it opens up something in the brain that isn’t otherwise there, and er I see colour much more vividly than I used to. ....So I think that my access to music and art are something for which I’m grateful to bipolar for enhancing. It’s almost as it’s a magnifying glass that sits between that and myself.”**

Sometimes the amplification is clearly psychotic and recognised as such, but still highly valued.

**David: “. ....I wouldn’t even be thinking about demons and witches controlling my thoughts without the psychosis and this, this is the foundation for most of my writing. “**

- b) Ease and ability

Some of the participants held (or had previously held) high functioning professional jobs or had been studying for higher level qualifications. They described in detail how they experienced times when tasks that are usually quite difficult or time consuming, would feel incredibly easy and the ability to achieve at a high level during these was clearly immensely rewarding.

**Sam: "I can just come up with a solution like just like that, like a moral dilemma or an academic task or whatever and most of the time if I just stick with it, it tends to be just right, it's just sort of like gut instinct.....It's just like having a 100 watt bulb in your head instead of like a 40 watt one"**

In some instances, participants believed that they had achieved goals that would have been impossible without the advantages they gained from their BD.

**Alan: "...it enabled me to be so sharp, it was comedy theatre, and um, it was an astonishing two years.....Had it not been for being bipolar there's no chance I could have done it [comedy theatre]"**

It was not that people believed that they suddenly developed powers or abilities that they previously did not possess, but more that pre-existing talents or aptitudes were enhanced so that this combination of inherent ability and BD could lead to greater levels of accomplishment.

**Rebecca: "Okay, I'm fairly bright which I know from doing MENSA test and things like that, so if you combine that with a high it puts you in a whole different ball game. I'm fairly capable at any sport I try so if you combine that with a high it makes you, you know, fully able to attend to it. I'm absolutely useless at anything artistic and no high in the world will ever allow me to sing a note in tune."**

On the whole, these periods of enhanced functioning were linked to an elevated mood such as in the hypomanic state, but this was not exclusively so. Positive aspects were identified in relation to both high and low mood states and inter-episode experiences:

**Alan , “We live in a world where all the time everything positive has to be emphasised and we’re not allowed to face up to the negative, and I think that I’ve been closer to people because of the negative..... I’ve had to take the funeral of many children, many young adults, erm, and um, to be able to enter in to the terrible suffering of their parents you have to have been able to explore something inside yourself of darkness, and I think that that’s a real positive...”**

c) Human connectedness

As well as the intra-individual experiences of amplified perceptual states and enhanced ease and ability, participants talked at length about the positive influence of BD on interpersonal relationships.

They described how in elevated mood states there was a drive to share their positive emotions with others and an increase in self-confidence which led to a perception of more open and approaching interactions which otherwise would not have occurred.

**Sam “...because everything around seems so much more like energised and vibrant and like beautiful it sort of like makes you er, want to replicate that in your head and just sort of keep the good feelings flowing from you to like everyone, like a sort of mass consciousness really.”**

The positive impact of mood swings on relationships was not confined to the immediate effects of being elated. People described feeling that, as a result of having themselves experienced such extremes of mood (both high and low) they had a greater understanding and empathy for others and that this made them generally very sensitive to other people’s needs.

**Sam “It can give you that sort of like every man trait, because you’ve felt like a lot of things, you’ve got more stuff that you’ve experienced so you’ve got more common ground for conversation with people and I think it can just help you to be more open, like to see your limits and to see other people’s limits but in a positive light, not in a discriminatory way.”**

**Theme 2 = Lucky to be bipolar.**

Whereas theme 1 gives us a flavour of the specific positive experiences that people attributed to BD, theme 2 explores how participants explained why it was that they had these positive experiences whilst those around them did not. What was most striking was the fact that most participants clearly viewed their “bipolarness” as a gift for which they felt extremely grateful to have been given.

**Dominic “I don’t know, I’ve just gone, blessed, I’ve been blessed haven’t I?..... because I’m able to experience life in sort of what some people describe as kind of extremes, it just gives me an opportunity to feel things and experience things that I wouldn’t otherwise do, simple as that”**

The reasons for such gratitude were explicitly linked to the belief that being bipolar gave them an increased range and depth of emotion and experience. There was a clear underlying assumption that more is inherently better, i.e. more experiences and more emotions is better than a more restricted range of life events or emotions, even when these were sometimes difficult experiences or negative emotions:

**Raphael: “That’s what life is isn’t it really? It’s all about experiencing....”**

For some participants, it felt that an increased range of experience was inherently a good thing. However, others did explore this assumption further and talked about how experience offers the opportunity to learn and that this learning offers an enhanced appreciation of life.

**Raphael: “If you have the chance to be laid really really low by something, or raised really high by something, then that feeling, it’s about them saying well why, why am I experiencing this, and what can I learn from it. And I think that you know that, that’s the gift of it.”**

Viewing bipolar experiences as a gift made people feel special. This was expressed in many different ways, but always with an emphasis on special in the sense of being different in a good way, but not special in a morally superior sense.

**Dominic: I'm talking about special, not better, not worse, just special, special in the sense that er, different, erm, people who um are experiencing life, you know smelling it, feeling it, touching it, er rather than people who are just here."**

It would be wrong to give the impression that the participants saw bipolar experiences in a wholly positive light. Although asked specifically about the positive aspects of BD, the participants talked about how these were inextricably linked to difficulties. A widely shared view was that it is not possible to have the positive aspects of bipolar without having experienced periods of intense pain and difficulty, either because these negative experiences were necessary to appreciate the positive aspects, or because the insights gained during these periods formed the basis of the positive aspects. Some human experience is both positive and painful:

**Alan: "it's a two-edged sword, because the very gift is also a curse but the gift in itself was simply wonderful at times"**

**Raphael: "There are things we're not supposed to know, things we're not supposed to see, but I think occasionally we can have a little glimpse of it. But it hurts (laughs). It hurts".**

### **Theme 3 = Relationship between self and bipolar experiences.**

A strong theme in the data was a debate about the relationship between self and bipolar experiences. Although the interviewer endeavoured to take a neutral and open stance about the nature of bipolar experiences, the title of the study as presented to participants on the information sheet was 'Positive Aspects of Bipolar Disorder'. Participants were invited to take part on the grounds that they met DSM IV criteria for Bipolar I or II Disorder. Therefore, in coming forward to take part in the study, participants were, at least on some level, identifying themselves as having a disorder.

However, there was interesting variation in how participants reconciled the direct positive aspects of their experiences (as described in theme 1) and the concept of bipolar as a disorder.

Some participants felt it did not make sense to talk about bipolar as a separate entity from the self as they viewed these as one and the same thing. The episodic nature of different mood states was easily reconciled into this view:

**Dominic: “A person might have a sense of humour they’ve got it all the time, you can’t say sometimes I’m funny and sometimes I’m not so therefore I’ve got this kind of episodic sense of hu- no you haven’t, you might as well say that about bloody dandruff. No, no it’s nonsense. “**

Others described a different model in which, although they understood mood experiences as part of the self, their experience of different extreme mood states was accounted for by purporting the existence of different ‘selves’. Parallels were drawn with Jekyll and Hyde:

**Christina: “I’ve read all the books I’ve been on all the courses, and I know that when I’m in that place of nothingness, it won’t matter, I’m not that person, I’m not that other person, you know it’s like calling me you know, my name’s K L, one of them’s K and the other’s L, and K and L are completely different people.”**

Only one person described the mood swings as an illness that was separate from the self and “it” was something that “they” needed to manage:

**Luke “It’s finding who you are again after the illness or between the illnesses, that’s hard. Cos I don’t know if, for me, when I become ill, you lose yourself.....I know I’ve got it for life, I’m not going to get cured, unless they come up with some gene therapy, but I’m er, but I can be asymptomatic. So I can be completely well but still have the condition.”**

It was difficult to identify from this data what influenced the development of such different models. However, the fact that some of the experiences that they attributed to the label of bipolar were felt to be so positive was explicitly identified as a source of confusion in reconciling this with an illness model.

**Christina “well I don’t know whether to believe it or not, I’ve been diagnosed this but I don’t actually believe it, how you can now diagnose that somebody who is incredibly effective is actually ill.”**

Interestingly, BD as a diagnosis was also explicitly acknowledged as a useful means of protecting a positive sense of self by distancing some behaviour that was judged as undesirable.

**Raphael". It's just a way of dealing with the world isn't it. But it's kind of good isn't it, because instead of being a bolshie arsey bastard now, I'm bipolar, so great! And it has kept me out of jail on a couple of occasions, so that's good, you know they're good things, and it did get me a load of benefits, and that's a good thing."**

## **Discussion**

It was very easy to find people with BD who wanted to talk about the positive aspects of their experiences. Contrary to our initial concerns there was no evidence that participants felt we were somehow minimising the negatives, or failing to understand the distress this disorder can cause. Participants highly valued the positive changes in their lives attributed to their bipolar experiences and talked at length about this topic. These positive changes are described in the first theme as an amplification of perceptions, emotions and cognitive ability; an increase in ease and ability to carry out complex tasks related to work and personal life; and an enhanced ability to connect with other people. This picture is difficult to reconcile with the image of BD generally reported which is one of poor occupational and social functioning (Calabrese, 2003; Dickerson et al., 2004; Hirschfeld et al., 2003; Michalak et al., 2005). However, it is consistent with more recent reports which attempt to present a more balanced perspective of peoples' experiences (BPS, 2010).

Also, in contrast to what might be reasonably expected from most of the current literature, there was a consensus that even depression can be a valued experience. In contrast to elevated mood, there was less discussion of direct positive impacts of depression on everyday experiences, and more emphasis on how experiencing such a range of human emotion led to important personal insights and an enhanced ability to relate to others. The experience of such positive changes resulting from struggle with major life crises, including physical and mental health problems, is a well-recognised phenomenon and has been termed "post-traumatic growth" (Calhoun and Tedeschi, 1999). Some felt

that depression was such an inherent part of the valued gift of experiencing this wider spectrum of emotion that it made no sense to talk about these as distinct episodes. The evidence that positive aspects were identified in relation to depression as well as elevated mood states is particularly interesting given the severity and high number of depressive episodes experienced by this sample. Although not a focus of the interview, four of the participants discussed periods in their lives during which these emotions had been so unbearable that they had made serious attempts to take their own lives. Therefore they are not biased by the fact that they have experienced fewer episodes of severe depression than would be typical for people with BD in mental health services (Scott et al., 2006).

Our second theme goes beyond the direct impact on everyday experiences, and explores how participants explained why it was that they had these positive experiences, whilst those around them did not. Metaphors such as “it’s a gift”, “it’s an ability”, “I’ve been blessed” convey the extent to which bipolar experiences were valued. Generally, having a diagnosed mental health problem makes people feel stigmatised, which has been associated with low self-esteem (Wahl and Harman, 1989), low self-efficacy (Link et al., 2001), failure to develop social networks (Perlick et al., 2001) and reduced levels of employment and independent living (Link, 1982). Here, the opposite seemed to be the case. People expressed the belief that they were at a distinct advantage and felt they had been “blessed” in some way. There is some preliminary evidence to suggest that people may experience some positive consequences of having severe and chronic health problems, but these are only present in those who have recovered. For example, people who have recovered from a physical health problem show evidence of elevated bravery, kindness and humour when compared to those who have never been ill, and those in recovery from a psychological disorder show increased appreciation of beauty and love of learning (Peterson et al., 2006). However, descriptions of direct positive impact of the defining symptoms of the disorder on everyday life, is far less prevalent.

The third theme explores the way in which bipolar experiences were experienced in relation to the self. Some participants questioned whether bipolar was a disorder – and were responding to the advert for the study in acknowledgement that they were defined by others as having a disorder, though they did not necessarily agree with this themselves.



They felt that the experiences that were labelled by others as part of bipolar disorder were so inherently part of who they are, that it made no sense to talk about these as a part of a separate disorder. Others felt that their bipolar experiences resulted in them being very different at different times, but rather than being “ill” sometimes and “well” at others, they maintained the attribution of experiences to the self, but purported being different selves in different mood states. Only one person talked about his bipolar experiences as an illness that happened to him and from which he recovered. Even for him, there was a strong association between self and mood experiences, as he talked about having to find himself again after the episodes of illness. This variation in conceptualisation of self and bipolar experiences is consistent with previous research highlighting the disruption that bipolar experiences can cause to the development of sense of self (Inder et al., 2008). This may be due partly to disruption in emotional regulation during a crucial developmental phase leading to a lack of coherence and consistency to emotional experiences (Carlson and Meyer, 2006), or may also be due to difficulties reconciling positive experiences with the dominating medical model of BD as a predominantly biological illness.

We acknowledge that in inviting people to tell us about the positive aspects of BD, we imply firstly that positive aspects are distinct from negative ones, and secondly that these experiences can be seen as part of BD. Both of these implications are problematic. Firstly, we agree with Wood & Tarrrier (2010) that most characteristics are neither inherently positive or negative, but dependent on the context, goals and motivations and the extent to which they are experienced. For example, one participant (David) talks about how the psychotic experiences of believing his thoughts were controlled by demons and witches has been very positive for him as he felt it gave him an edge to his writing that he would not otherwise have had. For someone else in a different context, this could be a very negative and frightening experience.

Secondly, we acknowledge that many of the experiences described in this study as positive aspects of BD, could more usefully be conceptualised as manifestations of underlying personality traits (neither inherently positive or negative) on which people who score highly have also been shown to be more vulnerable to the symptoms that define BD. It is well established that there is a normally distributed trait of hypomanic personality in the general population. High scorers have elevated rates of positive and negative features

associated with BD including increased positive mood, sociability and energy (Akiskal, 1996; Eckblad and Chapman, 1986); more ambitious achievement related life goals (Johnson and Carver, 2006); disrupted sleep/wake cycles and reduced stability of social rhythms (Ankers and Jones, 2009; Shen et al., 2008); higher rates of substance and alcohol use (Eckblad and Chapman, 1986); more depressive episodes (Krumm-Merabet and Meyer, 2005); and lower work-related task engagement (Meyer et al., 2007). Indeed interventions which focus on helping people to reframe these experiences as valued personal traits, rather than part of a disorder, have the advantage of promoting a more dimensional view of mental health and well being, and show promising results (Mansell, 2007).

However, our motivation was not to promote a particular model of bipolar experiences, or to engage participants in this debate. Our aim was to understand in more depth positive experiences associated with BD as understood by people who identify themselves as having this diagnosis. Such experiences have been written about, drawn, sung, and alluded to in clinical sessions by service users since the term was originally developed by Kraepelin (1921) but remain too poorly understood.

This study is the first to directly explore the positive experiences of BD as defined by people with this diagnosis. The findings help us to understand the experience of BD more fully, and to appreciate why some people may be ambivalent about treatments which are designed to eradicate these experiences, whilst causing unpleasant side-effects. However, there are a number of methodological limitations which need to be taken into account in interpreting the findings. The qualitative approach explores in-depth experiences of a small and self-selected sample of people. There is no attempt to generalise the findings to all people with BD. Our own clinical experience indicates that for many people it is very difficult to find any positives to this diagnosis which can have such a detrimental impact on their lives. Further research is needed to identify factors which predict the degree to which bipolar related experiences are positively construed.. Although the majority (8 / 10) had a clinical diagnosis of BD and were currently being treated within mental health services, the participants were recruited largely outside of mental health services, through user groups and voluntary organisations. It is possible that people attending such groups and electing to take part in the study may be those who have experienced the most positives, but their very existence suggests that this is an area that requires further investigation. Two participants

had been given a clinical diagnosis of depression. Interestingly, they accurately believed that their symptoms were more consistent with the criteria for BD and one described in detail an episode of mania for which he had avoided seeking help.

Finally, this study focuses only on the individual's lived experience. We have no evidence, other than self-report, for the existence of any of the positive aspects of bipolar experiences described in these interviews. It may be that perceptions of a gift that bestows intense perceptual and cognitive experiences, increased abilities, and an 'everyman' trait to engage empathically with others, is actually experienced very differently by close friends and peers.

Despite these limitations, the findings of this study highlight the need to broaden our focus of attention, both academically and clinically, to include the positive aspects of bipolar experiences. As argued by Wood & Tarrrier (2010) in their vision for a positive clinical psychology, an equally weighted focus on positive as well as negative characteristics offers the potential for a more thorough understanding of the lived experience of people with this diagnosis, potential for enhanced ability to predict outcome, treatment engagement, and resilience to relapse, and an opportunity to draw on additional techniques that seek to promote the positive aspects of life.

In the short-term, we would encourage clinicians to explore the positive aspects of people's bipolar experiences in more depth, acknowledge the value of this where appropriate, and ensure that interventions accentuate rather than eliminate positive aspects of bipolar experiences wherever possible.

## **References**

- Akiskal, H.S., 1996. The temperamental foundations of affective disorders. In: Mundt, C., Goldstein, K., Hahlweg, K. and Fiedler, P. (Eds.), *Interpersonal factors in the origins and course of affective disorders*. Gaskell, London, pp. 3-30.
- Ankers, D., Jones, S.H., 2009. Objective assessment of circadian activity and sleep patterns in individuals at behavioral risk of hypomania. *Journal of Clinical Psychology* 65, 1071-1086.
- BPS, 2010. *Understanding Bipolar Disorder: Why some people experience extreme mood states and what can help*. The British Psychological Society, Division of Clinical Psychology, Leicester.
- Calabrese, J.R., 2003. Impact of bipolar on a U.S. community sample. *Journal of Clinical Psychiatry* 64, 425-432.
- Calhoun, L.G., Tedeschi, R.G., 1999. *Facilitating Posttraumatic Growth: A Clinician's Guide*. Taylor & Francis, Inc., Mahwah, NJ, US.
- Carlson, G.A., Meyer, S.E., 2006. Phenomenology and diagnosis of bipolar disorder in children, adolescents, and adults: Complexities and developmental issues. *Development and Psychopathology* 18, 939-969.
- Colom, F., Vieta, E., Martínez-Arán, A., Reinares, M., Benabarre, A., Gastó, C., 2000. Clinical factors associated with treatment noncompliance in euthymic bipolar patients. *Journal of Clinical Psychiatry* 61, 549-555.
- Copeland, L.A., Zeber, J.E., Salloum, I.M., Pincus, H.A., Fine, M.J., Kilbourne, A.M., 2008. Treatment Adherence and Illness Insight in Veterans With Bipolar Disorder. *The Journal of Nervous and Mental Disease* 196, 16-21 10.1097/NMD.1090b1013e318160ea318100.
- Dickerson, F.B., Boronow, J.J., Stallings, C.R., Origoni, A.E., Cole, S., Yolken, R.H., 2004. Association Between Cognitive Functioning and Employment Status of Persons With Bipolar Disorder. *Psychiatr Serv* 55, 54-58.

Eckblad, M., Chapman, L.J., 1986. Development and validation of a scale for hypomanic personality. *Journal of Abnormal Psychology* 95, 214-222.

Equilibrium: The Bipolar Foundation, 2008. International Bipolar Disorder Survey. Retrieved from <http://www.bipolar-foundation.org/2008/the-international-bipolar-survey-results-summary/>.

Fieve, R.R., 2006. *Bipolar Breakthrough: The Essential Guide to Going Beyond Moodswings to Harness Your Highs, Escape the Cycles of Recurrent Depression and Thrive with Bipolar II*. Rodale, New York.

First, M.B., Gibbon, M., Spitzer, R.L., Williams, J.B.W., Benjamin, L.S., 1997. *Structured Clinical Interview for DSM-IV Axis I Disorders, Research Version, Patient Edition*. American Psychiatric Press, Inc., Washington DC.

Frye, M.A., Calabrese, J.R., Reed, M.L., Wagner, K.D., Lewis, L., McNulty, J., Hirschfeld, R.M.A., 2005. Use of health care services among persons who screen positive for bipolar disorder. *Psychiatric Services* 56, 1529-1533.

Galvez, J.F., Thommi, S., Ghaemi, S.N., 2011. Positive aspects of mental illness: A review in bipolar disorder. *Journal of Affective Disorders* 128, 185-190.

Gartner, J.D., 2005. *The Hypomanic Edge: The Link Between a Little Craziess and a Lot of Success in America*. Simon & Schuster Ltd., New York.

Hirschfeld, R.M., Lewis, L., Vornik, L.A., 2003. Perceptions and impact of bipolar disorder: how far have we really come? Results of the national depressive and manic-depressive association 2000 survey of individuals with bipolar disorder. *J Clin Psychiatry* 64, 161-174.

Hirschfeld, R.M., Williams, J.B., Spitzer, R.L., Calabrese, J.R., Flynn, L., Keck, P.E., Jr., Lewis, L., McElroy, S.L., Post, R.M., Rapport, D.J., Russell, J.M., Sachs, G.S., Zajecka, J., 2000. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry* 157, 1873-1875.

Inder, M.L., Crowe, M.T., Moor, S., Luty, S.E., Carter, J.D., Joyce, P.R., 2008. 'I actually don't know who I am': The impact of bipolar disorder on the development of self. *Psychiatry: Interpersonal and Biological Processes* 71, 123-133.

Jamison, K.R., 1989. Mood disorders and patterns of creativity in British writers and artists. *Psychiatry: Journal for the Study of Interpersonal Processes* 52, 125-134.

Jamison, K.R., 1996. *An Unquiet Mind*. Crown Publishing Group/Random House, New York, NY US.

Jamison, K.R., Gerner, R.H., Hammen, C., Padesky, C., 1980. Clouds and silver linings: Positive experiences associated with primary affective disorders. *The American Journal of Psychiatry* 137, 198-202.

Johnson, S.L., Carver, C.S., 2006. Extreme goal setting and vulnerability to mania among undiagnosed young adults. *Cognitive Therapy and Research* 30, 377-395.

Keck, P.E., Jr., McElroy, S.L., Strakowski, S.M., al., e., 1997. Compliance with maintenance treatment in bipolar disorders. *Psychopharmacology Bulletin* 33, 87-91.

Kraepelin, E., 1921. *Manic-Depressive Insanity and Paranoia*. E & S Livingstone, Edinburgh.

Krumm-Merabet, C., Meyer, T.D., 2005. Leisure activities, alcohol, and nicotine consumption in people with a hypomanic/hyperthymic temperament. *Personality and Individual Differences* Vol 38(3) Feb 2005, 701-712.

Lingam, R., Scott, J., 2002. Treatment non-adherence in affective disorders. *Acta Psychiatrica Scandinavica* 105, 164-172.

Link, B., 1982. Mental Patient Status, Work, and Income: An Examination of the Effects of a Psychiatric Label. *American Sociological Review* 47, 202-215.

Link, B., Struening, E.L., Neese-Todd, S., Asmussen, S., Phelan, J.C., 2001. Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric Services* 52, 1621-1626.

Lovejoy, M., 1982. Expectations and the Recovery Process. *Schizophrenia Bulletin* 8, 605-609.

Mansell, W., 2007. An integrative formulation-based cognitive treatment of bipolar disorders: Application and illustration. *Journal of Clinical Psychology* 63, 447-461.

Martin, E., 2007. *Bipolar Expeditions: Mania and depression in American culture*. Princeton University Press, Princeton, NJ US.

McCrone, P., Dhanasiri, S., Patel, A., Knapp, M., Lawton-Smith, S., 2008. Paying the Price: the cost of mental health care in England to 2026. In: *The King's Fund* (Ed.), London.

Merton, R.K., 1948. The Self-Fulfilling Prophecy. *Antioch Review* 8, 193-210.

Meyer, B., Rahman, R., Shepherd, R., 2007. Hypomanic personality features and addictive tendencies. *Personality and Individual Differences* 42, 801-810.

Michalak, E.E., Yatham, L.N., Kolesar, S., Lam, R.W., 2006. Bipolar Disorder and Quality of Life: A Patient-Centered Perspective. *Quality of Life Research* 15, 25-37.

Michalak, E.E., Yatham, L.N., Lam, R.W., 2005. Quality of life in bipolar disorder: a review of the literature. *Health and Quality of Life* 15, 72.

Murray, G., Johnson, S.L., 2010. The clinical significance of creativity in bipolar disorder. *Clinical Psychology Review* 30, 721-732.

NICE, 2006. *Bipolar disorder: The management of bipolar disorder in adults, children and adolescents in primary and secondary care*. National Institute for Clinical Excellence, London.

Perlick, D.A., Rosenheck, R.A., Clarkin, J.F., Sirey, J.A., Salah, J., Struening, E.L., Link, B.G., 2001. Stigma as a Barrier to Recovery: Adverse Effects of Perceived Stigma on Social Adaptation of Persons Diagnosed With Bipolar Affective Disorder. *Psychiatric Services* 52, 1627-1632.

Perlick, D.A., Rosenheck, R.A., Miklowitz, D.J., Chessick, C., Wolff, N., Kaczynski, R., Ostacher, M.J., Patel, J., Desai, R., 2007. Prevalence and correlates of burden among caregivers of patients with bipolar disorder enrolled in the Systematic Treatment Enhancement Program for Bipolar Disorder. *Bipolar Disorders* 9, 262-273.

- Peterson, C., Park, N., Seligman, M.E.P., 2006. Greater strengths of character and recovery from illness. *The Journal of Positive Psychology* 1, 17-26.
- Scott, J., Colom, F., Vieta, E., 2007. A meta-analysis of relapse rates with adjunctive psychological therapies compared to usual psychiatric treatment for bipolar disorders. *International Journal of Neuropsychopharmacology* 10, 123-129.
- Scott, J., Paykel, E., Morriss, R., Bentall, R., Kinderman, P., Johnson, T., Abbott, R., Hayhurst, H., 2006. Cognitive-behavioural therapy for severe and recurrent bipolar disorders: Randomised controlled trial. *Br J Psychiatry* 188, 313-320.
- Shen, G.H., Alloy, L.B., Abramson, L.Y., Sylvia, L.G., 2008. Social rhythm regularity and the onset of affective episodes in bipolar spectrum individuals. *Bipolar Disord* 10, 520-529.
- Smith, J.A., Jarman, M., Osborne, M., 1999. Doing Interpretative Phenomenological Analysis. In: Murray, M. and Chamberlain, K. (Eds.), *Qualitative Health Psychology*. Sage, London.
- Tondo, L., Isacson, G., Baldessarini, R., 2003. Suicidal behaviour in bipolar disorder: risk and prevention. *CNS Drugs* 17, 491-511.
- Trauer, T., Sacks, T., 2000. The relationship between insight and medication adherence in severely mentally ill clients treated in the community. *Acta Psychiatrica Scandinavica* 102, 211-216.
- Wahl, O.F., Harman, C.R., 1989. Family Views of Stigma. *Schizophrenia Bulletin* 15, 131-139.
- Weiss, R.D., Griffin, M.L., Kolodziej, M.E., Greenfield, S.F., Najavits, L.M., Daley, D.C., Doreau, H.R., Hennen, J.A., 2007. A randomized trial of integrated group therapy versus group drug counseling for patients with bipolar disorder and substance dependence. *Am J Psychiatry* 164, 100-107.
- Wilson, R., 2006. *Stephen Fry: The Secret Life of the Manic Depressive*. United Kingdom, p. 115 mins approx.
- Wood, A.M., Tarrier, N., 2010. Positive clinical psychology: A new vision and strategy for integrated research and practice. *Clinical Psychology Review*.
- Wootton, T., 2005. *The Bipolar Advantage*. Bipolar Advantage Publishing, Tiburon, CA, USA.



Table 1. Demographic and clinical data to describe participants

	Gender	Age	MDQ	Severity (self rating on MDQ)	Employed	Clinical Diagnosis	SCID	Meds	Last episode (yrs ago)	Prev. (hypo) mania	Prev. depression.
Sam	M	24	12	Moderate	Full time	Depression	BD1	No	0	25+	30+
Alan	M	56	11	Serious	No	BD	BD1	Yes	3	4	6
Rebecca	F	30	10	Moderate	Full time	Depression	BDII	No	1	10	10
Dominic	M	57	10	Moderate	Full time	BD	BDII	Yes	9	7	12
David	M	34	13	Serious	No	BD	BD1	Yes	1	6	11
Isabelle	F	41	10	Moderate	Voluntary	BD	BDII	Yes	3	40	40
Christina	F	46	10	Minor	Full time	BD	BDII	Yes	3	3 to 6	3 to 6
Raphael	M	38	13	Serious	Part time	BD	BD1	Yes	4	5	3
Katherine	F	38	13	Serious	No	BD	BD1	Yes	3	7 to 8	7 to 8
Luke	M	52	13	Serious	Voluntary	BD	BD1	Yes	3	dozens	8

*BD = Bipolar Disorder; Prev. (Hypo)mania = number of previous episodes of (hypo)mania; Prev. Depression = number of previous episodes of depression*