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NAVIGATING INTERNALIZED STIGMA AND IDENTITY DEVELOPMENT IN
BIPOLAR DISORDER I: A GROUNDED THEORY INVESTIGATION

By
Kaylyn L. Watterson
B.A., Butler University, 2010
M.S., Bucknell University, 2014
M.Ed., University of Louisville, 2016

A Dissertation
Submitted to the Faculty of the
College of Education and Human Development
in Partial Fulfillment of the Requirements
for the Degree of

Doctor of Philosophy
in Counseling and Personnel Services

Department of Counseling and Human Development
University of Louisville
Louisville, Kentucky

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DEDICATION

This dissertation is dedicated to my grandmother, Evelyn Horvath.

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I would like to thank my advisor, Dr. Lali McCubbin, for her generous academic, clinical, and professional mentorship over the past five years. Thank you for all the advocacy and support you provide to graduate students.

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ABSTRACT

NAVIGATING INTERNALIZED STIGMA AND IDENTITY DEVELOPMENT IN BIPOLAR DISORDER I: A GROUNDED THEORY INVESTIGATION

Kaylyn L. Watterson

September 30, 2021

Mental illness stigma occurs at multiple levels in Western societies. Internalized stigma, the application of negative stereotypes and prejudice about mental illness to self-concept, has deleterious effects on mental health for adults living with a serious mental illness. Historically, research on stigma in serious mental illness has centered on schizophrenia. Recently, researchers and clinicians have drawn attention to bipolar disorder I, an affective disorder that creates disruptions in functioning and increased risk for substance abuse and suicide. Despite the growing literature establishing the relationship between recovery in serious mental illness and identity, little is known about how adults in long-term recovery from bipolar I manage experiences of internalized stigma. Additionally, few qualitative studies have examined how lived experiences of internalized stigma may affect recovery in bipolar I disorder. This study aimed to understand how lived experiences of internalized stigma influenced identity and recovery processes in bipolar disorder I. Charmaz's constructivist grounded theory methodology was used to create a novel theory about how individuals navigated a diagnosis of bipolar I, internalized stigma, and the recovery process. Semi-structured interviews were

conducted in-person and via video conferencing with a sample of 13 adults undergoing current treatment for bipolar I. The data yielded seven themes related to navigation of the bipolar diagnosis, symptoms, and internalized stigma. Findings revealed that identity development occurred while participants reconciled internalized stigma with understanding of self in relation to bipolar disorder. This reconciliation process and identity development involved negotiation with family members and romantic partners. Throughout the recovery process, participants drew from gifts of bipolar disorder and acquired strengths that fostered self-acceptance and embracing of a transformed, unified identity.

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CHAPTER I

LITERAURE REVIEW

This chapter will begin with a brief description of the prevalence of serious mental illness, specifically bipolar disorder I in the United States. The conceptual framework and terminology of multiple levels of stigma (structural, public, and self) will be discussed. Then, the negative impacts of internalized stigma on mental health outcomes will be reviewed. Next, the literature review will describe two conceptual models on identity processes in concealed stigmatized identities. A process-based model on how individuals with mental illness shift from internalized stigma to positive self-beliefs will be explored. Additionally, a model identifying differential individual responses to stigmatizing beliefs about mental illness will be detailed.

Next, the chapter will present the evolving conceptual definition of recovery in serious mental illness. Due to the interconnected relationship between stigma and identity, qualitative studies on the recovery process of identity transformation will be discussed. Two systematic reviews on bipolar disorder and stigma will be described, and the qualitative literature on lived experiences of bipolar disorder, recovery, and stigma will be reviewed.

Serious Mental Illness and Stigma

According to the Center for Behavioral Health Statistics and Quality (CBHS, 2015), approximately 18% of U.S. adults 18 years or older had a diagnosed mental

illness, defined as a mental, emotional, or behavior disorder. Of these 43.6 million adults, an estimated 4% (9.8 million) were diagnosed with a serious mental illness (SMI), whereby mental, emotional, and behavioral symptoms resulted in significant functional impairment or limitation in one or more major life activities (CBHS, 2015). An even smaller proportion of the general population of U.S. adults (2.1%) met diagnostic criteria for lifetime bipolar I disorder (Merikangas et al., 2007). In clinical presentations, bipolar disorder is characterized by severe changes in mood states, with episodes alternating between the poles of depression and mania. While bipolar disorder is considered a life-long condition, people experience intermittent periods of stability and well-being (Goodwin & Jamison, 2007).

In addition to debilitating mental health symptoms, stigma poses a challenge to people with serious mental illness. Occurring across multiple levels, stigma may negatively impact a person's life opportunities, self-worth, and relationships (Corrigan & Kleinlein, 2005; Hinshaw, 2008). While a large body of quantitative research documents the negative consequences of stigma on mental health outcomes (Livingston & Boyd, 2010), few existing studies systematically investigate the lived experience of stigma in people with serious mental illness. First-person accounts describe experiences of schizophrenia, historically considered the most stigmatizing mental health condition (LeCroy & Holschuh, 2012; Schulze & Angermeyer, 2003). Recently, a small body of literature has begun to explore the extent of public and internalized stigma in bipolar disorder (Ellison, Mason, & Scior, 2013). To add to this nascent research, the current qualitative study aimed to explore the lived experiences of internalized stigma in people with bipolar disorder I.

In Western cultures, people with mental illness experience varying levels of the social phenomenon of stigma. The meaning of stigma has its roots in Erving Goffman's (1963) original definition of stigma as "an attribute that is deeply discrediting" that reduces an individual "from a whole and usual person to a tainted, discounted one" (p. 3). Stigma conveys an "undesired differentness" that separates the person from the majority group (p. 5). In his original definition of stigma, Goffman classified mental disorders as "blemishes of character," attributed to "weak will," "domineering or unnatural passions," "treacherous and rigid beliefs," and "dishonesty" (p. 4). Contemporary stigmatizing beliefs about people with mental illness (e.g., weak character, incompetence) can be traced to Goffman's original definition.

Social psychologists Crocker, Major, and Steele (1998) expanded upon Goffman's (1963) definition and linked stigmatized attributes to "a social identity that is devalued in a particular context." (p. 505). *Social identity* refers to the recognized group, status, or category to which the individual belongs (Rosenberg, 1979). Furthermore, what constitutes a devalued social identity is socially constructed, meaning that external bodies, such as the government or society, create the rules for who holds membership in the social category (Archer, 1985; Crocker et al., 1998). *Devalued* implies that stigmatized attributes carry a negative connotation, often perpetuated by stereotypes about the identity (Crocker et al., 1998; Goffman, 1963). The stigmatized identity exists within a context, since the meaning of certain attributes varies across time and culture (Archer, 1985; Crocker et al., 1998).

Crocker, Major, and Steele (1998) identified two critical dimensions of stigmatized identities: Concealability and controllability. Concealability refers to the degree of visibility of the stigmatized identity. People with concealable stigmatized identities have concerns related to disclosure, as they do not know how they will be socially received upon revealing their condition (Crocker et al., 1998). Unlike individuals with physical markers of stigma, individuals with concealable stigmas (such as mental illness) may have difficulty identifying their in-group members. In the second dimension, controllability reflects the extent to which the person is perceived as responsible for their condition (Weiner, Perry, & Magnusson, 1988). Perceived controllable stigmas elicit more anger and less willingness to help compared to uncontrollable stigmas (Weiner, Perry, & Magnusson, 1988). For example, Corrigan et al. (2000) found that adults rated mental disabilities (cocaine addiction, psychosis, and depression) as more controllable than cancer.

Conceptual Framework of Stigma

Stigma is a complex, multidimensional phenomenon that affects diverse social groups.

Contemporary researchers utilize a conceptual framework to classify stigma into three intersecting levels. The following section will define each conceptual level of stigma and discuss how particular experiences at each level interfere in the lives of people with mental illness.

Structural Stigma. Occurring at a broad systemic level, *structural stigma* refers to the institutional policies in private and public sectors that restrict the rights of people with mental illness (Corrigan, Kerr, & Knudsen, 2005). In the private sector, news media stories of people with mental illness disproportionately focus on violence, asocial

behaviors, and unpredictability. Such negative media portrayals of people with mental illness may propagate stereotypes, prejudice, and discrimination (Corrigan, Markowitz, Watson, 2004). In the public sector, state legislatures have passed laws that limit one's ability to exercise civil liberties. A survey of 50 state statutes from 1989 to 1999 found that states increased restrictions of rights based on grounds of mental illness over this 10-year period (Hemmens, Miller, Burton, & Milner, 2002). By 1999 approximately one-third of states limited the rights of people with mental illness to hold elective office, serve on a jury, and vote (Corrigan, Markowitz, & Watson, 2004; Hemmens et al., 2002). Additionally, over half of states (54%) ruled mental illness as grounds for divorce and restrictions of child custody rights (Hemmons et al., 2002).

Other policies may unintentionally stigmatize individuals with mental illness (Corrigan, Markowitz, & Watson, 2004). For example, the Mental Health Parity Act (MHPA) and the more recent 2008 Mental Health Parity and Addictions Equity Act (MHPAEA) do not require insurance plans to offer mental health or substance abuse benefits. Additionally, small businesses (less than 50 employees) are exempt from providing mental health benefits. Whether intentional or unintentional, structural stigma restricts participation in societal opportunities, resulting in losses of power and social status for people with mental illness (Link & Phelan, 2001).

Public Stigma. At the intermediate level, *public stigma* occurs when members of the public endorse negative attitudes and beliefs about people with mental illness (Corrigan, et al., 2005). While public stigma against people with mental illness is a common phenomenon in the United States (Corrigan et al., 2000; Pescondido, Monahan, Link, Stueve, & Kikuzawa, 1999), two systematic literature reviews found minimal

research on public stigma and bipolar disorder (Ellison et al., 2013; Hawke, Parikh, & Michalak, 2013). Examination of bipolar disorder stigma is important because public attitudes and perceptions of mental illness may vary across diagnostic categories and levels of symptom severity (Angermeyer & Dietrich, 2006). Several studies conducted in Western cultures found evidence of public stigma of bipolar disorder. In two general U.S. population studies, participants viewed bipolar disorder as less treatable than depression (Day, Edgren, & Eshleman, 2007) and endorsed poor recovery outcomes for people with bipolar disorder (Furnham, 2009). In a study with a national Canadian sample, approximately 28% of participants rated people with bipolar disorder as “violent” or “dangerous” (Stip, Caron, & Mancini-Marie, 2006). In a German convenience sample, college students reported negative emotional reactions to symptoms of mania (Wolkenstein & Meyer, 2008). Individuals with bipolar disorder endorsed negative effects of stigma on their self-esteem, quality of life, and functioning (Hayward, Wong, Bright, & Lam, 2002; Mileva, Vázquez, & Milev, 2013; Smith, Sapers, Reus & Freimer, 1996). These findings point to widespread stigmatizing public attitudes about mental illness that compromises emotional well-being for individuals with bipolar disorder.

Self-Stigma. At the individual level, *self-stigma* is the internalization of public stigma (Link & Phelan, 2001). Self-stigmatization occurs when an individual incorporates negative stereotypes and prejudice about mental illness into self-concept (Vogel, Bitman, Hammer, & Wade, 2013). For example, a person with a mental illness may endorse negative cultural attitudes (“People with mental illness are dangerous”), self-label (“I’m mentally ill”), and adopt these stereotypes as self-beliefs (“I am crazy”; Corrigan & Watson, 2002). The application of stereotypes to self-perceptions may result

in identity transformation, whereby the stigmatized attributes become a part of the self (Livingston & Boyd, 2010).

Self-stigma may prove harmful to people's physical and mental health. In a meta-analysis of 45 studies (N = 9,509), higher levels of self-stigma were significantly associated with multiple psychosocial variables, including increased feelings of hopelessness; reduced self-esteem; decreased empowerment/mastery; lower self-efficacy; poorer quality of life; and less social support/integration, with effect sizes ranging from $r = -.28$ to $r = -.58$ (Livingston & Boyd, 2010). Sociodemographic variables (gender, age, education, employment, marital status, income, and ethnicity) did not significantly relate to self-stigma in people with mental illness. Furthermore, the review found that self-stigma directly related to greater severity of psychiatric symptoms, with a moderate effect size ($r = .41, p < .001$). Internalized stigma was negatively associated with treatment adherence of mental health, with a moderate effect size ($r = -.38, p < .001$; Livingston & Boyd, 2010). Taken together, the above findings suggested that self-stigma had an impactful and detrimental effect on attitudes and behaviors related to mental health outcomes. Several models provide insight into how individuals with concealed mental illness manage internalized stigma.

Self-Perceptions of Internalized Stigma and Mental Illness

Concealable Stigmatized Identities. Quinn and Chaudoir (2009) proposed three intraindividual processes that comprise concealable stigmatized identities, which include anticipated stigma, identity centrality, and identity salience. *Anticipated stigma* refers to the expectation that revealing the stigmatized identity will result in devaluation and discrimination by others. *Identity centrality* is the degree to which the stigmatized

identity is important to self-concept. *Identity salience* refers to the frequency in which people think of their concealable identity. Research found that higher levels of anticipated stigma, identity centrality, and identity salience independently predicted greater levels of psychological distress in individuals with various concealable stigmatized identities (Quinn & Chaudoir, 2009).

Quinn and Earnshaw (2013) proposed an updated model for how concealable stigmatized identities affect sense of self. They classified anticipated stigma and internalized stigma as types of *valenced content*—identity-related constructs (thoughts, feelings, and experiences) about the stigmatized identity that positively or negatively affect views about the self. A study with 105 adults with concealed mental illnesses found that respondents who anticipated more instances of discrimination and devaluation reported higher levels of internalized stigma due to mental illness (Quinn & Earnshaw, 2013). These findings suggested that the perceived anticipation of stigma directly influenced the internalization of stigma. While this research sheds light on the components of stigmatized identities and predictors of internalized stigma, less is known about how individuals with mental illness understand and approach internalized stigma.

Perceptual Components of Self-Stigma. In a recent conceptual review of the literature, Stringer et al. (2017) proposed a model that incorporated three perceptual, interacting components of self-stigmatization: (a) concordant vs. discordant views of self, (b) balance of power, and (c) social distance. The model hypothesized that these perceptual components mediate processes of change from self-stigma to resilience and recovery.

Self-concordance refers to self-stigmatized individuals holding negative self-views *in agreement* with public stigma (Corrigan, Watson, & Barr, 2006). The shift from negative self-concordant views to positive, *discordant* self-beliefs represents a change process. The model proposes that individuals with negative self-concordant beliefs (internalized stigma) experience social distance in relationships, due to anticipated rejection and shame. Social isolation reinforces real and perceived imbalances of power (Link & Phelan, 2014) through societal exclusion and negative self-appraisals (Stringer et al., 2017).

According to the model, the perceptual components of self-stigma are modified through positive social interactions across diverse contexts (Stringer et al., 2017). For example, a validating social interaction with a friend or-coworker may help disconfirm negative self-views; thus, self-stigmatizing beliefs become discordant. Positive social interactions can foster a sense of equality and connection in relationships, which decreases social isolation and increases engagement in society. The person's response to the perceptual components of self-stigma may mediate the change from self-stigma to resilience. Additionally, the development of three moderators (competence, compassion for others, and self-compassion) act on perceptual components of self-stigma to move the individual along the adaptation continuum (Stringer et al., 2017).

Situational Model. Longitudinal research suggests that knowledge of public stereotypes about mental illness increases the likelihood that persons will accept and apply negative beliefs to their self-concept (Vogel et al., 2013). However, having an awareness of stereotypes does not necessarily mean that people will endorse these negative beliefs (Hayward & Bright, 1997; Jussim, Nelson, Manis, & Soffin, 1995). In

their situational model, Corrigan and Watson (2002) identified two interacting variables (perceived legitimacy of the stereotype and strength of in-group identification) that predicted an individual's emotional response to stereotypes about mental illness. Individuals with low in-group identification who perceived mental illness stereotypes as illegitimate tended to respond with indifference (Corrigan & Watson, 2002). Conversely, individuals with strong in-group identification who perceived mental illness stereotypes as illegitimate tended to respond with righteous anger (Corrigan & Watson, 2002). Righteous anger may contribute to increases in positive self-perceptions and active engagement in one's recovery (Rappaport, 1987; Rogers, Chamberlin, Ellison, & Crean, 1997). According to the situational model, disagreement with or disregard of mental illness stereotypes protects against loss of self-esteem in individuals with mental illness. Conversely, individuals who perceive the stereotype as legitimate experience reductions in their self-esteem and higher levels of self-stigma (Corrigan & Watson, 2002).

Empirical evidence supported the situational model in a community sample of 71 adults with serious mental illness (bipolar disorder, major depressive, schizophrenia). As predicted, individuals with more awareness of negative stereotypes were more likely to rate an inferior status of people with mental illness as unfair. In-group identification served as a protective factor for reducing stereotype agreement and self-labeling. Endorsing stigma and discrimination of mental illness served as a risk factor for increasing stereotype awareness and self-labeling (Watson, Corrigan, Larson, & Sells, 2007). Overall, this study suggested that the self-stigma process varies across individuals' personal responses and their in-group membership.

Recovery in Serious Mental Illness

In the literature of serious mental illness, recovery is a complex phenomenon used to describe the lived experiences of consumers, mental health treatment and service models, and social policy (Markowitz, 2005). Historically, psychiatry has adopted a biomedical model of serious mental illness. Medical descriptions of mania and depression as manifestations of underlying biological dysfunction date back to fourth century medical scholars and philosophers (Goodwin & Jamison, 2007). In the biomedical model, recovery is an outcome measured by symptom remission or a return to pre-morbid functioning (Bellack, 2006; Ralph, & Corrigan, 2005; Slade, 2009). Longitudinal and naturalistic research on the lifetime course of bipolar disorder has characterized recovery outcomes in bipolar disorder as poor, citing high recurrence rates of mood episodes, presence of inter-episode subsyndromal symptoms, and high suicide risk (Angst & Sellaro, 2000; Katz & Klerman, 1979). However, researchers and clinicians have found that long-term pharmacological management and person-centered therapeutic approaches to treatment can increase periods of long-term mood stability for individuals with bipolar disorder (Malhi, McAulay, Das, & Fritz, 2015). Furthermore, enjoyment of life, occupational functioning, and social functioning also represent important wellness domains for people with bipolar disorder (Miklowitz & Gitlin, 2014).

More recently, the potential for recovery has gained momentum as a guiding vision for mental health treatment. The President's New Freedom Commission on Mental Health 2003 report defined recovery as "the process in which people are able to live, work, learn, and fully participate in their communities," as the expected benchmark for improvement (p. 5). However, there is little consensus on what constitutes recovery. The operational definition of recovery differs across researchers, social agencies, mental

health professionals, and individuals with serious mental illness (Onken, Craig, Ridgway, Ralph, & Cook, 2007; Slade, 2009). Some researchers argue for criterion, outcome-based operational definitions of remission and recovery (Lieberman & Kopelowicz, 2005; Torgalsbøen & Rund, 2002), so that outcome measures can be used to test the effectiveness of services and facilitate development of policy (Jacobson, 2001). However, individuals with lived experiences of mental illness emphasizes self-defined meanings of recovery unique to their personal experiences and journeys (Corrigan & Ralph, 2005; Hatfield & Lefley, 1993).

Illness, Identity, and Recovery. Early definitions of recovery emerged from first person accounts of mental illness. As one of the first people to describe her “lived experience” with schizophrenia, Deegan (1988) described recovery as a process whereby individuals re-discover “a new and valued sense of self and of purpose” (p. 1). According to Deegan, recovery depends upon active participation, willingness, and gradual restoral after a “catastrophic shattering of [one’s] world, hopes, and dreams” (p. 2). Additionally, Deegan emphasized a non-linear trajectory involving multiple setbacks as individuals rebuild their lives. This multifaceted, process-based conceptual definition of recovery, while more ambiguous than definitions based on outcome, has guided personal accounts and phenomenological methods of qualitative research (Loveland et al., 2005).

Davidson, Sells, Sangster, and O’Connell (2005) conducted a thematic analysis of published first-person accounts, in-depth narrative interviews, and ethnographic studies of recovery. Across all qualitative inquiries reviewed, they identified *redefinition of self* in relation to serious mental illness as a crucial component of recovery. The re-defining of self appears integral to recovery because people with serious mental illness often

experience a loss of self. Unlike a physical illness that a person “has” separately from sense of self, serious mental illness has been described as an “*I am* illness” (Estroff, 1989, p. 189). With its impact on emotional, cognitive, and physical functioning, serious mental illness has the potential to drastically disrupt and reshape one’s internal experience of self and social identity (Estroff, 1989).

While conceptual definitions inform *what* recovery is, conceptual models inform *how* the process of recovery unfolds and operates. To develop a preliminary conceptual framework of recovery, Leamy, Bird, Boutillier, Williams, and Slade (2011) conducted a systematic review and narrative synthesis of papers on personal recovery in serious mental illness. According to the authors, the review consisted of 87 distinct studies, comprised mainly of qualitative studies ($n = 37$). They identified five recovery processes most relevant to research and practice, including connectedness, hope and optimism about the future, identity, meaning in life, and empowerment. This conceptual review did not utilize *bipolar disorder* in its search terms, limiting participant representation in the review findings.

Yanos, Roe, and Lysaker (2010) proposed the first theoretical model for how an individual’s self-conceptualization of mental illness influences recovery. The model proposed that individuals first become aware of their mental illness through the direct experience of psychological symptoms, whether hearing voices, having unusual beliefs, or experiencing disturbances in mood. Subsequently, the individual attempts to make sense of these experiences, which may include visiting a mental health professional or searching for explanations of the illness. Once informed of a mental illness diagnosis, the individual can either endorse or reject mental illness as the cause of the symptoms.

Accepting mental illness as real and valid evokes a meaning-making process, by which the person must decide what the mental illness means about the self (Yanos, Roe, & Lysaker, 2010). Individuals develop an illness identity, defined as “a set of roles and attitudes about the self” that relates to his/her understanding of mental illness (Yanos et al., 2010, p. 74).

At this juncture of meaning-making, the person is vulnerable to internalizing negative, stigmatizing messages about mental illness (e.g., “I am dangerous,” or “I am not able to hold a job.”). The meaning ascribed to the mental illness directly impacts recovery outcomes: Stigmatizing self-constructions weaken hope and damage self-esteem (Yanos et al., 2010). Conversely, an individual may identify with having the mental illness but adopt positive self-constructions, which has a protective effect on self-esteem and hope. In turn, self-esteem and hope play important roles in decreasing the harmful effects of internalized stigma on quality of life (Mashiach-Eizenberg, Hasson-Ohayon, Yanos, Lysaker, & Roe, 2013).

More recently, a meta-synthesis of 17 peer-viewed qualitative studies on the lived experiences of mental illness identified “an ongoing struggle for reconciliation with the self and the illness” as a core experience in the phenomenon of severe mental illness (Kaite, Karanikola, Merkouris & Papathanassoglou, 2015, p. 461). Individuals perceived disruption of life and a loss of self-identity, and the recovery process involved a “continuous fluctuation between self-acceptance [and] non-acceptance throughout different phases of the disease” (Kaite et al., 2015, p. 461). This systematic review contained only a few studies that exclusively focused on bipolar disorder and recovery (Jönsson, Wijk, Skärsäter, & Danielson, 2008; Pollack & Aponte, 2001).

To date, qualitative research on the influence of serious mental illness and recovery-related outcomes has primarily focused on schizophrenia or multiple mental illnesses (Davidson, Sells, Sangster, & O'Connell, 2005; Davidson & Strauss, 1992). Due to extreme fluctuations in mood and disorganized thought processes, individuals with bipolar disorder also experience an unstable sense of self (Lim, Nathan, O'Brien-Malone, & Williams, 2004). However, little is known about how individuals understand self in transition and experiences in internalized stigma during the recovery process. The proposed study aims to understand how lived experiences of internalized stigma influence identity and recovery processes in bipolar disorder I.

Self-Stigma, Identity, and Recovery

Although it is widely assumed that stigma has a negative impact on people with serious mental illness, few studies have examined how lived experiences of stigma influence the recovery process. In a meta-synthesis of 17 peer-viewed qualitative studies on serious mental illness and recovery, Kaite, Karanikola, Merkouris and Papathanassoglou (2015) found evidence that stigma is part of the reconciliation of self and illness. Specifically, they identified stigma as a social consequence consisting of labeling, rejection/loneliness, and interrupted family relations. Although not explicitly stated by the researchers, the phenomenon of stigma cut across other main themes, such as being an outcast and the oppression and burden of psychopharmacology. While this meta-synthesis found that stigma played a role in the reconciliation of self, the authors did not identify a conceptual framework of stigma and identity reconstruction. Future research is needed to understand the process by which self-stigmatization influences recovery processes.

Bipolar Disorder and Internalized Stigma

To date, two systematic literature reviews examine what is known about bipolar disorder and stigma (Ellison, Mason, & Scior, 2013; Hawke, Parikh, & Michalak, 2013). Both reviews noted that most research on serious mental illness and stigma has focused primarily on schizophrenia. In the first review, Ellison et al. (2013) reviewed 25 empirical articles that focused on public stigma (attitudes and/or beliefs) about bipolar disorder or internalized stigma in bipolar disorder. Of the 25 studies, only seven investigated internalized stigma, one which used a qualitative methodology (Michalak et al., 2011). Based on five cross-sectional studies, Ellison et al. found that individuals with bipolar disorder reported a moderate (Cerit, Filizer, Tural, & Tufan, 2012; Meiser et al., 2007) to a high degree (Aydemir & Akkaya, 2011; Hayward, Wong, Bright, & Lam, 2002; Lazowski, Koller, Stuart, & Milev, 2012) of internalized stigma. However, the reviewers noted difficulties comparing levels of internalized stigma across studies, due to inconsistency in measurement and heterogeneity of samples (Ellison et al., 2015). Consistent with previous research, reviewers found that internalized stigma was associated with higher levels of symptom severity, lower levels of self-esteem, and impairment in social functioning (Ellison et al., 2015).

In the second systematic literature review, Hawke et al. (2013) reviewed 32 empirical articles that included keywords of “Stigma,” “Stigmatization,” “Bipolar disorder,” “Mania,” “Hypomania,” “Cyclothymia,” and “Stereotyping.” Of studies categorized as “subjective experiences of stigma,” five were qualitative (Michalak, Yatham, & Kolesar, & Lam, 2006; Proudfoot et al., 2009; Sajatovic et al., 2008; Suto et al., 2012; Ward, 2011). Hawke et al. concluded that various levels of stigma negatively

impacted functioning, quality of life, and social relationships. They found that stigma related to social withdrawal, social anxiety, and attempts to conceal bipolar disorder. The reviewers noted several limitations, including general failure of studies to utilize conceptual frameworks of stigma. Qualitative studies tended to use “stigma-related terms interchangeably,” making it difficult to draw conclusions about distinct types of stigmas in lived experiences of bipolar disorder (Hawke et al., 2013, p. 189).

Qualitative Studies on Bipolar Disorder and Recovery

Historically, most systematic qualitative studies on serious mental illness have focused on recovery from schizophrenia (Davidson, 2003), likely due to the chronic nature of the disorder and its functional impairment. However, other researchers have noted the disruptive nature of bipolar disorder and its increased risk for suicide and substance abuse (Cerullo & Strakowski, 2007; Harris & Barraclough, 1997; Sharma & Markar, 1994; Simon et al., 2007). Recently, a small body of literature has examined recovery in bipolar disorder. The findings in these qualitative studies include quality of life (Michalak et al., 2006), meaning of living (Jönsson, Wijk, Skärsäter & Danielson, 2008) and acceptance of a bipolar diagnosis (Inder et al., 2010; Pollack & Aponte 2001). Following a broader trend in the literature on mental illness, some new research has focused on the impact of bipolar disorders on understanding of self and identity.

Bipolar Disorder and Identity. Several qualitative studies found that bipolar disorder shapes how individuals construct and perceive sense of self (Inder et al., 2008; Lim, Nathan, O’Brien-Malone, & Williams, 2004; Veseth, Binder, Borg, & Davidson, 2013). Variable mood states can create feelings of confusion; some individuals described difficulty differentiating between normal emotions and mood symptoms (Inder et al.,

2008; Lim et al., 2004; Veseth et al., 2013). Inconsistent emotions contributed to an unstable identity, negative self-evaluations, self-doubt, and difficulty accepting contradictory experiences of self (Inder et al., 2008). Inder et al. (2008) found that prolonged periods of mood stability facilitated the self-acceptance process, which entailed integrating different experiences of the self. In other studies, participants associated onset of bipolar symptoms with a loss self (Michalak et al., 2006; Proudfoot et al., 2009), changes in employment and financial status, alienation from friends and family, and disintegration of romantic relationships (Lim et al., 2004; Sajatovic et al., 2008). Individuals described regaining their self-worth through gradual self-acceptance, regaining control through independence, and redefining bipolar disorder as one part of the self (Michalak et al., 2006; Proudfoot et al., 2009). While participants described an ongoing process of accepting the illness (Lim et al., 2004), research does not examine how experiences of stigma contribute to the perception of loss of self.

Experiences of Stigma in Bipolar Disorder

In several qualitative studies, stigma emerged as an experience of bipolar disorder (Lim et al., 2004; Michalak et al., 2006; Proudfoot et al., 2009). Many participants expressed concern about the negative effects of stigma on their social lives, including feelings of anger and frustration at the unsupportive reactions from friends following disclosure of the illness. (Proudfoot et al., 2009). Some individuals identified stigma as contributing to social isolation, as family and friends did not know how to respond to the illness (Proudfoot et al., 2009). Participants believed that they lost friendships and intimate relationships due to bipolar disorder (Michalak et al., 2006).

Participants reported concealing information about their illness, carefully considering others' reactions, and selectively disclosing their diagnosis to close family members, friends, and important colleagues (Lim et al., 2004; Michalak et al., 2006). Other individuals expressed fear of losing social support and chose not to disclose (Proudfoot et al., 2009). Some individuals described bipolar disorder's negative effects on relationships. Mania and hypomania damaged social relationships, and irritability and impulsivity created interpersonal dysfunction. Bipolar disorder also created complications in romantic relationships, including hypersexuality during elevated mood states or low libido during depressive episodes (Michalak et al., 2006).

In Michalak et al.'s study (2006), nearly all the participants described experiences related to prejudice and discrimination, particularly in workplace settings. Participants believed that stigma resulted in dismissal, demotion, and alienation from coworkers. One participant referenced the media's perpetuation of harmful stereotypes of people with bipolar disorder as dangerous and violent (Michalak et al., 2006). In Lim et al. (2004), participants described feeling different from others, isolated from the community and their families, and feeling rejected due to bipolar disorder. These participants doubted their ability to achieve occupational goals, secure long-term romantic relationships, or find a sense of happiness (Lim et al., 2004).

In these studies, internalized stigma may underlie negative self-definitions and pessimistic beliefs about the future. Some participants viewed themselves as flawed and attributed their difficulty controlling symptoms to personal defects (Lim et al., 2004). Other participants cited little hope for future success in work and fulfilling personal relationships (Lim et al., 2004). However, the researchers did not inquire about how

experiences of stigma affected participants' expectations for future relationships, opportunities, and goals.

Few qualitative studies on bipolar disorder directly examined the experience of stigma. To the author's knowledge, only two qualitative studies (Michalak et al., 2011; Suto et al., 2012) exclusively examined experiences of stigma and recovery with bipolar disorder. In a community-based participatory action study, Suto et al. (2012) used the conceptual framework of the three intersecting levels of stigma (structural, public, and self) to explore the experiences of 28 individuals living with bipolar disorder and their 16 family members. On the level of structural stigma, participants reported discrimination in healthcare, school, and work institutions. Individuals with bipolar disorder reported experiences of disrespect and devaluation by healthcare professionals in positions of authority, including refusal to treat bipolar disorder. Even individuals serving in peer support roles to people with mental illness reported experiences of stigma. One peer support worker reported that he was not allowed to occupy staff spaces (Suto et al., 2012). In other work and educational settings, individuals expressed reluctance to disclose their illness, for fear of losing their job or loss of career advancement opportunities. One participant reported that they concealed their illness on graduate school applications, while another participant recalled that a university professor disclosed his illness to a classroom of students following his return from a two-week hospitalization (Suto et al., 2012).

On the level of public stigma, participants identified misleading, negative media portrayals of bipolar disorder. Individuals saw media as perpetuating stigmatizing images of bipolar disorder and condoning jokes about mental illness. In the domain of personal

relationships, family members identified stigma as the lack of support or acceptance of the affected individuals. Members of the extended family network excluded the affected individual from family social events. Individuals with bipolar disorder discussed the unexpected withdrawal of close friends (Suto et al., 2012).

On the individual level, self-stigma had harmful effects on personal thoughts and feelings, relationships, and choices and actions. Shameful feelings and self-judgments fueled depression. One participant described feelings of personal discomfort and negative self-evaluation. Additionally, self-stigma restricted actions and choices. One participant refrained from using public transportation due to shame of showing his disability pass to the bus driver. Blaming oneself for the illness, one participant excluded himself from personal relationships and career opportunities, because he viewed his skills as inferior. Healthcare professionals' messages about bipolar disorder also influenced participant experiences of self-stigma. Participants described the information provided by professionals as "brutal and discouraging" (Suto et al., 2012, p. 90). Client-centered healthcare professionals who emphasized psychosocial rehabilitation were perceived as more helpful to recovery.

Participants identified several strategies for overcoming self-stigma. First, they sought information about bipolar disorder from other sources. Second, belief in the ability to control one's thoughts and feelings instilled a sense of hope for taking personal responsibility for one's recovery. Third, disclosing one's illness and connecting to supportive others facilitated helpful coping strategies. Overall, efforts to reduce self-stigma corresponded with a broader perspective on reality and a more positive sense of identity and self-esteem (Suto et al., 2012).

In a qualitative study on how individuals with bipolar disorder experienced and understood internalized stigma, Michalak et al. (2011) identified four themes: (a) expectations and experiences, (b) sense of self and identity, (c) judicious disclosure; and (c) moving beyond internalized stigma. In the first theme, participants expected that bipolar disorder would result in negative responses by other people. Experiences involved the occurrence of negative events, such as exposure to media that depicted bipolar individuals as “dangerous” or “deranged” (p. 215). Additionally, participants identified ethnic and familial culture as contributing to the experience of stigma. In context of family culture, mental illness evoked shame; some participants experienced long-term judgment from family members.

For the theme of *sense of self and identity*, participants acknowledged positive and negative effects of bipolar disorder. While participants did not describe effects of bipolar disorder on identity in great depth, they did view the diagnosis as impactful. Some participants interpreted the bipolar diagnosis as representing personal defectiveness. Others anticipated negative consequences of labeling, fearing rejection and exclusion from their social group. One participant reported that other people defined her emotional expressions by her bipolar disorder, attributing happiness to mania. Positive effects of bipolar disorder on identity included the regaining of functioning and serving as a role model.

In the third theme, participants employed judicious disclosure to manage internalized stigma. Participants made disclosure-related decisions based on evaluations of the setting. Most participants chose not to disclose their mental health issues in work or educational settings, unless disclosure was perceived as necessary or advantageous.

Some participants reported forced disclosure that resulted in shame and embarrassment for some and relief for others. Support from others and personal empowerment served as positive outcomes of disclosure.

The final theme, *moving beyond internalized stigma*, involved participant reflections on their current self-identity. One participant described detaching from the label: “I don’t think of myself as [a] bipolar person anymore. I just think of myself [as someone] who went through something” (p. 219). This participant’s description of the disorder changed from a self-label to a term that professionals used to guide treatment. Other participants described a gradual progression of overcoming self-stigma through reducing shame and developing more positive views of self-identity.

Overview of Qualitative Methodologies and Limitations

Most studies on bipolar disorder and recovery identify stigma as a theme without utilizing a conceptual framework (Michalak et al. 2006; Lim et al., 2004). The lack of conceptual clarity results in a failure to distinguish between different types of stigmas and their effects on recovery. The current study aims to understand if and how internalized mental illness stigma influences identity during the recovery process.

The two identified qualitative studies on the lived experiences of bipolar disorder and stigma utilized focus groups with individuals and family members (Suto et al., 2012) and in-depth interviews (Michalak et al., 2011). Suto et al. (2012) used community-based participatory research and thematic analysis to understand how afflicted individuals and their family members understand and experience stigma. Michalak et al. (2011) used descriptive qualitative methods with focus groups and individual interviews. More broadly, the qualitative studies on lived experiences of stigma and schizophrenia and

heterogenous diagnostic samples have used interpretative phenomenological analysis (Knight et al., 2003) and thematic analysis (Forrester-Jones & Barnes, 2008; Schulze & Angermeyer, 2003). Due to the absence of a conceptual framework of relationships between internalized stigma and identity, the proposed study will utilize a grounded theory methodology to generate a theory of how individuals with bipolar disorder manage internalized stigma and understanding of self during the recovery process.

Present Study

While qualitative research documents the impact of serious mental illness on identity, additional research is needed to elucidate how internalized stigma influences self-understanding during the recovery process in individuals with bipolar disorder. The purpose of this study is to understand the processes of internalized stigma and identity development in people with bipolar disorder. The research questions include:

1. What are the experiences of internalized stigma for people living with bipolar disorder I?
2. What identity developments occur during the recovery process in bipolar I?
3. How do individuals with bipolar disorder I manage internalized stigma and identity development during the recovery process?

CHAPTER II

METHODOLOGY

This chapter will describe the grounded theory methodology used to examine the experiences of people with bipolar disorder I, specifically the impact of illness on identity and the recovery process. This chapter describes the following: (a) the research design, (b) the recruitment process for this study, (c) the participants, (d) the study procedure, and (e) the analytic plan. Finally, criteria for evaluating the quality of the research will be described.

Research Design

Due to a lack of systematic research on internalized stigma and recovery processes in bipolar disorder I, this investigation utilized a qualitative research design. Several strengths of qualitative research pertinent to this study included the emphasis on lived experiences of individuals with a stigmatized identity; the holistic examination of multiple, constructed realities; and the focus on complex psychological processes, such as recovery. Given the dynamic and multifaceted nature of internalized stigma, identity, and recovery, the researcher chose a constructivist grounded theory methodology. Charmaz (2009) stated, “Grounded theory is a method to study process. It is, moreover, a method *in process*” (p. 136). In line with an interpretative approach, this grounded theory study aimed to develop a deeper understanding of how individuals with bipolar disorder

managed internalized stigma and identity during the recovery process.

Interpretative Framework

The grounded theory method combines diverse philosophical traditions, including positivism, pragmatism, and symbolic interactionism. Glaser (1992) emphasized a rigorous, systematic approach to coding, in line with his strong quantitative training. Strauss (1987) assumed a pragmatic approach to fieldwork that centralized human agency and problem-solving in social processes. Glaser argued that theorists should inductively approach data with no preconceptions about existing theory. Strauss and Corbin (1998) deviated from Glaser by explicating a systematic methodology of inductive and abductive reasoning. Contemporary researchers have advocated for a more open, flexible approach to grounded theory inquiry (Charmaz, 2014).

Charmaz (2014) utilized methodological strategies of Glaser and Strauss (1967) but drew from constructivism and social interactionism to inform data collection and analysis in grounded theory. Broadly, constructivism accounts for the subjective nature of individual experiences and embraces researcher reflexivity throughout the research process (Charmaz, 2014). In symbolic interactionism, the ontological assumption is that reality consists of shared symbolic meanings created by individual interactions (Blumer, 1969). For instance, individuals with mental illness may anticipate negative social interactions with others; learned experiences may shape their successive social behaviors. From the epistemological perspective, knowledge is socially constructed through a dynamic interaction between the researcher and participants. Participants attempt to explain their lived experiences, which are informed by the framing of the research questions. From the methodological perspective, symbolic meanings are deciphered

between the researchers and participants through naturalistic research methods, such as interviewing and observation (Guba & Lincoln, 1994).

Researcher Positionality

Qualitative research acknowledges investigator reflexivity in all phases of the research process. As an interpretative approach, reflexivity requires the researcher to question and examine assumptions, values, thought processes, and interactions with participants in social environments (Bolton, 2010). This self-interrogation of perceptions helps researchers position themselves within the field of study (Creswell, 2003). As an ethical practice, reflexivity guides researcher awareness of the interplay between multicultural identities and power imbalances (Guilleman & Gillam, 2004). Consideration of such dynamics is essential when the research topic involves marginalized groups of people in health institutions.

The primary researcher is a White, cisgender woman and doctoral candidate in counseling psychology. As part of her training, the researcher worked as a therapist for four years across multiple treatment settings, including a public psychiatric hospital. In this inpatient setting, the researcher encountered individuals with bipolar disorder, who were frequently hospitalized involuntarily due to acute manic episodes. The researcher has positive experiences of working with individuals with bipolar disorder, due to their candid communication and expressed enthusiasm for treatment.

The researcher witnessed events that elicited strong reactions, such as seeing patients in physical restraints, administered sedative injections, and handled roughly by security guards. These coercive hospital practices conflict with the researcher's values on client welfare, client autonomy, and social justice. The researcher believes that

dehumanizing treatment of mental health consumers/patients contributes to the phenomenon of mental illness stigma. Additionally, the researcher views involuntarily hospitalization as an historical establishment intended to exclude people with mental illness from the community.

The researcher is committed to the equitable treatment of people with serious mental illness. The researcher believes that people with serious mental illness can and do recover, and that individuals reap the most benefit from psychological treatment when they willingly consent to participate in the treatment. The researcher's conversations with clients about their experience of living with a mental illness and perceptions of stigma served as an inspiration for this study.

Grounded Theory Methodology

The primary purpose of the grounded theory methodology is the discovery of an innovative theory grounded in the participants' perspectives of a phenomenon (Strauss & Corbin, 1998). The inductive process of theory generation involves an iterative approach whereby concepts develop through increasing levels of abstraction, eventually resulting in theoretical statements. Grounded theory utilizes simultaneous data collection and analysis through two components: Constant comparative method and theoretical sampling. The *constant comparative method* utilizes an iterative approach that compares new data to existing data at each level of analysis (Glaser & Strauss, 1967). The present study used constant comparative method to develop tentative theoretical categories. As data collection progressed, tentative categories were compared with emerging data to identify theoretically significant concepts, which attained the status of categories (Strauss & Corbin, 1998). In the current study, *theoretical saturation* g, the collection of new data

based on emerging concepts with theoretical relevance, was not employed (Strauss & Corbin, 1998).

Sampling and Recruitment

Because the study attempted to understand the experiences of internalized stigma in adults living with a diagnosis of bipolar disorder I, individuals with a lived experience of mental illness were necessary. The inclusion criteria for the current study were:

- 1.) Participants must be 18 years of age.
- 2.) Participants must speak English.
- 3.) Participants must have a diagnosis of bipolar disorder I from a health professional.
- 4.) Participants must have lived with the diagnosis of bipolar disorder I for at least one year.
- 5.) Participants must have received mental health treatment for bipolar disorder I for at least one year.
- 6.) Participants must currently be receiving treatment for bipolar disorder I.

This study utilized purposive sampling to recruit participants who met the selection criteria. The primary investigator created a study flyer including the investigators' credentials and contact information, and information about the Human Subjects Protection Program at the University of Louisville, which reviewed and approved the study and all associated materials. The flyer was posted at local mental health treatment centers and online forums and listservs. The first 10 participants were recruited at an academic outpatient psychiatry clinic located within a university hospital.

A psychiatrist at the clinic introduced the researcher to prospective participants, and the researcher shared more information about the study. The researcher's in-person introduction and contact with participants facilitated the alignment of iterative sampling, recruitment, data collection, and analytic strategies. In February 2020, the study's in-person data collection was suspended by the university due to the COVID-19 global pandemic. In line with national public health responses and the university policies to the novel coronavirus, data recruitment shifted to online methods, including email communication and social media groups. The last three participants were recruited from an online community support group for depression and bipolar disorders.

Participants

Pseudonyms were used to refer to each participant, with demographic descriptors (age, gender identity, race, age at diagnosis, years in treatment, and number of psychiatric hospitalizations; see Table 1 for participant demographic information). The sample consisted of 13 participants with a diagnosis of bipolar disorder I. All resided in an urban city in the Southern part of the United States. Participants' ages ranged from 32 to 77 ($M = 50.0$; $SD = 16.69$) years. In general, participants predominately identified as White ($n = 12$) and cisgender male ($n = 9$). Age at diagnosis ranged from 15 to 40 years ($M = 30.46$; $SD = 12.16$). Years in mental health treatment (medication management or therapy) ranged from 3 to 47 years ($M = 17.5$; $SD = 12.64$). Number of lifetime psychiatric hospitalizations ranged from 0 to 6 ($M = 2.85$; $SD = 2.08$). (Appendix A).

Table 1
Participant demographic information

| Pseudonym | Age | Gender Identity | Race | Age at Diagnosis | Years in Tx | Psychiatric Hospitalizations |
|------------------|------------|------------------------|-------------|-------------------------|--------------------|-------------------------------------|
| Tony | 77 | Male | White | 54 | 20 | 3 |
| Todd | 32 | Male | White | 15 | 5 | 0 |
| Charlie | 73 | Male | White | 48 | 25 | 3 |
| Avery | 46 | Male | White | 40 | 6 | 1 |
| Maya | 44 | Female | White | 23 | 21 | 5 |
| Ralph | 68 | Male | White | 39 | 29 | 4 |
| Devin | 36 | Male | Black | 25 | 11 | 6 |
| Nora | 69 | Female | White | 22 | 47 | 4 |
| Sandra | 43 | Female | White | 21 | 20 | 0 |
| Marshall | 33 | Male | White | 27 | 6 | 2 |
| Everett | 34 | Male | White | 17 | 17 | 6 |
| Lucas | 37 | Male | White | 27 | 3 | 1 |
| Hailey | 58 | Female | White | 38 | 20 | 2 |

Research Protocol

Along with demographic questions (Appendix A), the semi-structured interviews used a protocol with open-ended questions that pertained to the research questions (Appendix B). In line with a constructivist approach to interviewing, the interview questions were written to invite participants to tell their stories without being influenced by researcher preconceptions (Charmaz, 2014). Thus, conceptual terms, such as stigma

and internalized stigma, were not included in the interview questions. Additionally, the first question inquired about initial reactions to learning about the bipolar diagnosis to elicit participants' sequence and process. The interview questions were also written to encourage participants to reflect deeply on their experiences of bipolar and self. In line with Charmaz (2014), the protocol used 'what' questions to understand lived experiences of bipolar disorder, stigma, and recovery. In addition, the protocol used 'how' questions to explicate the processes by which participants made meaning of their lived experiences (Appendix B). Consistent with symbolic interactionism, 'what' and 'how' questions inquired about self-perceptions and experiences within social and family contexts (Charmaz, 2014). The protocol specifically addressed participants' understanding of recovery and strengths and advantages to living with bipolar disorder. Lastly, the protocol asked participants what they would say to other people living with bipolar disorder. To reach data saturation, the researcher continued to probe and ask follow-up questions to gain a deeper understanding of the participants' meaning and perspectives (Legard, Keegan, & Ward, 2003).

Procedure

Before conducting interviews, the researcher explained the informed consent process and informed participants of their right to discontinue the study at any time without penalty. To ensure that participants met diagnostic criteria for bipolar disorder I, the researcher administered modules A., C., and K. of The MINI International Neuropsychiatric Interview (MINI, 7.0.2) (Sheehan et al., 1997). The MINI was also used to make behavioral observations regarding current depressive, manic, and psychotic symptoms. The investigator then administered the demographic form (Appendix A) and

the semi-structured, in-depth interview using the research protocol (Appendix B). All interviews were recorded via audio. All multimedia data were stored on an encrypted, external hard drive that was stored in a locked drawer.

Analytic Method

Recorded interviews were transcribed verbatim by the primary researcher. Transcription increases the researcher's familiarity and understanding of the data (Payne, 2016). The researcher also maintained field journal notes, which were stored in a locked cabinet. Throughout data analysis, these field notes were examined for potential emergent themes. In line with constant comparison, three types of data analysis were used: (a) open coding, (b) selective coding, and (c) theoretical coding and integration (Charmaz, 2014). The researcher used the NVivo (2020) software to organize codes, build conceptual categories, and aid analysis.

For initial or open coding, the researcher coded data line-by-line to break down data into simple concepts, or basic units of meaning. Charmaz (2014) suggested using participant words, along with codes that "stick closely to the data, show actions, and indicate progression of events" (p. 112). The codes were labeled with a word or short phrase that cogently summarized the analytic meaning.

In focused or selective coding, the most significant and frequent initial codes were compared and sorted to organize large data (Charmaz, 2014). Focused coding utilized comparative methods involving the following, recursive steps:

- a.) Data were compared with data (developed codes)
- b.) Data were compared with codes (refined codes)
- c.) Codes were compared to codes (developed categories)
- d.) Codes were compared to categories (refined categories)

e.) Categories were compared to categories (examined relationships)

To summarize focused coding, codes were compared to codes and gradually grouped into categories. Categories were created through tentative decisions, which involved choosing which codes best captured what was happening in the data and examining relationships among categories (Charmaz, 2014). The coding process was repeated as new data are collected—new codes were compared to emerging categories, which were refined or modified. Analytic findings revealed that new codes occurred in the data at the fourth and 10th interview. The new code in the 10th interview, bipolar and intimate dating relationships, was classified as preliminary. This preliminary code did not reach the sufficient level of depth for the theoretical level of category.

For theoretical coding, written memos were utilized to theorize about the findings. Memos were sorted and compared to categories. Charmaz (2014) suggested that researchers use memos to specify potential relationships between categories. Additionally, memos were used to integrate the theoretical framework and examine theoretical relationships (Charmaz & Henwood, 2017; Holton, 2007).

Criteria for Quality of Grounded Theory

Charmaz (2014) proposed four criteria for evaluating the quality of a grounded theory study: (a) criteria of credibility, (b) originality, (c) resonance, and (d) usefulness.

Credibility. The credibility of qualitative data refers to the “trustworthiness” of the findings (Lincoln & Guba, 1985). The methodological rigor and consistency of constant comparison, development of concept development, theoretical sampling, and theoretical saturation are well-established (Strauss & Corbin, 1998). To increase confidence in methodological credibility, the researcher used NVivo (2020) to document

coding in each transcript (Urquhart, 2013). The NVivo software also used to examine logical relationships between open codes, selective codes, and participant quotations (Urquhart, 2013).

Originality. The emerging categories should be “fresh” and offer new insights into the theory. (Charmaz, 2014, p. 337). Originality ensures that the researcher does not simply duplicate or recreate an existing theory. Toward the end of data analysis, the researcher compared the grounded theory to scholarly literature (Charmaz, 2014; Fassinger, 2005). Urquhart (2013) noted that the grounded theory should be “at a sufficient level of abstraction” before relating it to existing literature (p. 137). The use of theoretical integration confirmed extant concepts and illuminated novel concepts that extended the literature (Charmaz, 2014; Urquhart, 2013).

Resonance. Resonant categories cover “the fullness of the studied experience” (Charmaz, 2014, p. 337). Participants were provided with the option to receive a typed copy of their transcript. Participants had the opportunity to make any modifications and/or clarification to the transcript to ensure that their intended meaning was conveyed.

Usefulness. According to Charmaz (2014), theory should offer practical interpretations for use in everyday life. Additionally, quality grounded theory analysis conveys a pattern of relationships in context. To increase the usefulness of the findings, Charmaz recommended that researchers scrutinize the tacit implications of participant statements and generic processes. The researcher attempted to capture implicit meanings and deep processes through continuous memoing. The researcher’s assumptions, biases, and ideas were documented after interviews and during all phase of the coding process (Birks, Chapman, & Francis, 2008; Charmaz, 2014).

CHAPTER III

FINDINGS

Across 13 interviews, seven total themes emerged from the data: 1. Crisis of Self-Coherence, 2. Incorporation of Illness into Self-Concept, 3. The Hidden Harms and Encompassing Reach of Internalized Stigma, 4. Negotiating Identity With Family Reactions to Bipolar Disorder, 5. Recovery: A Journey for Self-Definition and Identity, 6. Gifts of Bipolar; and 7. Integration of Bipolar Disorder Into Unified Sense of Self. Each theme consisted of higher order categories, with some higher order categories comprising sub-categories. The themes, higher order categories, and sub-categories were described and illustrated with direct participant quotes.

Theme: Crisis of Self-Coherence

The theme, Crisis of Self-Coherence, illustrated how the sudden onset of bipolar disorder symptoms elicited an internal crisis that threatened the coherence of self. The turmoil of manic symptoms fractured the integrity of mind while participants grasped to anchor themselves to a receding semblance of normality. This theme consisted of two higher level categories (See Table 2): Mental Illness Interrupting Life and Diagnosis as Confirmation and Rejection of Self. These higher-level categories reflected threats posed to self-integrity following major depressive, manic, and psychotic symptoms, in addition

to learning about the diagnosis. One sub-category emerged from the Diagnosis as Confirmation and Rejection of Self category: *Loss of Self*.

Table 2

Crisis of Self-Coherence theme, higher order categories, and sub-category

| Theme | Higher Order Categories | Sub-Category |
|---------------------------------|---|---------------------|
| Crisis of Self-Coherence | Mental Illness Interrupting Life | |
| | Diagnosis as Confirmation & Rejection of Self | <i>Loss of Self</i> |

Mental Illness Interrupting Life. All participants described disrupted functioning at work, school, and home. These drastic changes in mood overwhelmed participants’ sense of stability and control. Several participants identified clear memories of their first episode. For instance, Nora shared, “I remember the first episode. I was at work. And all of a sudden, I just started balling. And somebody took me to my parents’ house” (Nora, 69, Female, White, 22). Similarly, Charlie recalled how unexplained emotional symptoms interfered with his daily tasks:

I’d be riding on the tractor, or doing something, or whatever, and for some reason I’d just start balling. I’d just start crying, and I beat myself up because I couldn’t really think about why is this happening? It wasn’t because I was depressed; it wasn’t because I was high; it was just happening. (Charlie, 73, Male, White, 48)

Diagnosis as Confirmation and Rejection of Self. Receipt of the bipolar diagnosis elicited various initial reactions from participants, including relief, skepticism, and denial. Additionally, the official diagnosis offered an opportunity for a meaning-making process whereby participants contextualized the diagnosis within previous life

experiences. For some participants, the diagnosis provided a confirmation of lived experiences with mental illness. Equating the diagnosis with “validation,” Lucas described feeling “recognized” and “official,” stating, “It felt like I could have been bipolar ever since I was a teenager” (Lucas, 37, Male, White, 27). Likewise, Sandra indicated that the diagnosis offered “comfort” after a period of feeling “lost and confused” (Sandra, 43, Female, White, 21). Another participant, Avery, classified his newfound awareness of his symptoms as an “epiphany” that explained his lived experience of auditory hallucinations:

I started taking Seroquel, and maybe two days later, I was in my bathroom, and it just got quiet in my head. And that’s when I realized that I had been having auditory hallucinations, and I mean, it was bad. But I went quiet for the first time that I could ever remember things being quiet in my head. And I realized I was having these hallucinations and at that moment is when I realized that I’ve been off for a long time. (Avery, 46, Male, White, 40)

Multiple participants viewed the diagnosis as an affront to their sense of self. Upon receiving the diagnosis, Marshall disputed his doctor’s assessment, recalling, “I wasn’t bipolar, they just wanted to put a label. They just wanted to say it was because work was very stressful and dramatic” (Marshall, 33, Male, White, 27). Reflecting on his skepticism of “Western science and its relationship to mental health,” Lucas recalled his alternative explanation of his illness, stating, “Back then, I thought of myself more like a mystic than someone who was truly mentally ill.” (Lucas, 37, Male, White, 27).

Loss of Self. Two participants described profound losses related to pre-illness sense of self. These losses manifested as setbacks to educational and career goals. For instance, Everett, who suffered his first manic episode at age 17, recognized a fundamental shift in his experience of self:

I honestly feel like I lost my original identity at that point. I don't know which came first, the chicken or the egg, the diagnosis, and what the disorder is, or the meds. And I used to remember. Like I could remember...I used to be able to remember, like how I felt before all of that started. But now it's so long ago, I don't remember what it was like to feel normal. (Everett, 34, Male, White, 17).

Another participant described loss of self in relation to spiritual injuries. Devin's newfound understanding about symptoms of mania (grandiose thoughts) challenged his "mind, mental capacity, and [his] spirit." As he attempted to differentiate manic symptoms from spiritual experiences, he entered a "a mental place of darkness":

The diagnosis was hard. It felt like all the things that I had always believed about myself maybe were no longer true. When you Google stuff about bipolar disorder, it's all like, "You think you're special. You think you have a mission in life, or you think God has called you to do something," which are things that like spiritually I believe...I had to wrestle with issues surrounding my faith and what I believed, and why, and if that was just me being sick. (Devin, 36, Male, Black, 25)

Theme: Incorporation of Illness Into Self-Concept

The theme, Incorporation of Illness Into Self-Concept, described the developmental process by which participants incorporated bipolar disorder into a sense of identity. This theme consisted of two higher order categories (see Table 3): Coming to Terms With the Illness and Tension Between Central and Uncertain Experiences of Self. These higher-order categories reflected processes by which individuals adopted bipolar disorder into their sense of self.

Table 3

Incorporation of Illness Into Self-Concept theme, higher order categories, and sub-categories

| Theme | Higher Order Categories | Sub-Categories |
|---|---|--|
| Incorporation of Illness Into Self-Concept | Coming to Terms With Illness | |
| | Tension Between Central & Uncertain Experiences of Self | <i>The Split Self</i> |
| | | <i>Weighing Personal Responsibility With Illness</i> |

Coming to Terms With the Illness. Despite the nuances of their initial reactions, all participants reckoned with the new reality of their diagnosis and its collision with their pre-illness identities. This coming to terms process involved an endeavor of meaning making in which participants grappled with the implications for their self-concept, close relationships, life goals, and trajectories of illness. Devin, a former doctoral student, described the fallibility of his mind and its vulnerability to inaccurate perceptions of reality:

Your mind is your mind, and it's the only mind that you have. So, you're basically counting on other people to tell you what reality is. Because the things that are happening in your mind are not necessarily happening for everyone else. And it's hard to balance that, this instrument that you have counted on your entire life is no longer accurate. (Devin, 36, Male, Black, 25)

Avery identified the need for lifelong treatment to prevent psychotic symptoms and maintain ongoing emotional well-being:

I realized I could never go untreated again. That I would never allow myself to get back to that place where I was having hallucinations...It was instantly traumatic to realize that I'd been covering for myself for all of these years, and it was responsible for all of these things that had progressively been getting worse because I was cycling faster every year; each cycle would lead to another cycle. I

could have gotten treatment for it back when I was 15. But when you're 15 you don't tell people you're having hallucinations. (Avery, 46, White, Male, 40)

Tension Between Central and Uncertain Experiences of Self. While

participants identified bipolar disorder as central to their self-understanding, they also described uncertain experiences of self. These central but contradictory self-experiences created tensions in participants' attempts to navigate their understanding of self and identity. Two sub-categories emerged from the Tension between Central and Uncertain Experiences of Self category: *Split Self and Weighing Personal Responsibility With Illness*.

Living with bipolar disorder introduced implications for participants' self-identifications, in addition to guiding their actions and decision-making. For instance, Lucas described how carrying the diagnosis informed his thoughts, actions, and word choice:

Because I've internalized being bipolar, that's the language I use to describe it to myself and other people...When I'm thinking about myself or making decisions, then it's not in the context of me as just a human being. It's like me as a bipolar person. (Lucas, 37, Male, White, 27)

Sandra spoke to self-doubts encompassing her personal experiences with bipolar disorder, stating, "I really wish I wasn't [bipolar], all the time. And sometimes I think I'm not [bipolar], and then I'm shown that I am" (Sandra, 43, Female, White, 21). In describing his self-understanding in relation to illness, Todd spoke to the central, but contradictory experiences of bipolar disorder to his identity:

Bipolar puts a big question mark on how well I know myself...When I think about myself in relation to friends and family, bipolar is always a major facet of my character. So, it's always in everything I deliberate, almost in everything I do, every plan I make, in every interaction I have, it's always there. To make distinctions and what not. It's a very intimate diagnosis. But at the same time, I

continually battle with it, or I continually fight with it and try to figure out where I begin and the disease ends, and what's causing what. (Todd, 32, Male, White, 15)

These difficulties in disentangling overlapping identities of self and illness fell on a spectrum of struggling to describe the self to adopting "bipolar" into one's self-concept and identity.

The Split Self. Two participants described split, incompatible parts of self. Lucas explained how detrimental choices made by his "manic self" undermined the moral values held by his more realistic, "depressed self":

I feel like two different people, two different versions of one person. Right now, I sort of hate my manic self because it put me in this awful position with my family. My marriage is in a really hard spot because the stuff that I did while I was manic. There's this pattern of being down and being very lucid, and I'm feeling like the next time I'll be able to handle it better. But then when I'm up, I'm just as impulsive acting out as much as I have been (Lucas, 37, Male, White, 27)

In reflecting on bipolar disorder's influence on his sense of self, Avery identified the "before and after" phases of living with bipolar pre- and post- diagnosis:

There was the living with bipolar when I was in denial...I had a split self. Because I'm a scientist, there was this part of me that was coldly analytical and focused, and everything else was chaos; but because I was successful in this one area, it gave me cover for being eccentric in this other side. (Avery, 46, Male, White, 40)

Weighing Personal Responsibility With Illness. Given their difficulties differentiating symptoms from self-experiences, participants wrestled with how much ownership to take for their actions while symptomatic. Todd attempted to determine the degree of personal control against the influence of symptoms on his actions:

How much agency do I have? I try to figure out what I'm responsible for. What is my agency. Am I sleeping 15 hours a day because number one, I'm lazy, I can get away with it? Am I buying all this stuff because, you know, I'm ADHD and I'm impulsive and I got a good excuse...So, knowing what is you and what is the disease for me is very murky, and that's where a lot of the conflict is for me. (Todd, 32, Male, White, 15)

Lucas assumed ownership for his behavior while manic or depressed, but he qualified that mood episodes altered his decision-making:

I understand I'm sort of responsible for everything I do or say when I'm up or down, but my decision making was not the same as somebody who's "normal." Because when I am normal, I would never make those decisions, at least not most of them. (Lucas, 37, Male, White, 27)

Devin acknowledged his vulnerability to "surrendering [his] thought process to other people." He rejected the notion of subverting individual autonomy in favor of other people's comfort:

At some point you have to take responsibility for your thoughts and actions. And I understand the theme behind the idea. If I'm manic, can my thoughts be trusted? I get it. But fuck all that. That's my basic view right now (Devin, 36, Male, Black, 25)

Theme: The Hidden Harms and Encompassing Reach of Internalized Stigma

Although most participants did not identify the word "stigma," nearly all alluded to insidious injuries to self-concept. Internalized stigma perpetuated insecurities that inhibited emotional disclosure and impeded expressions of authenticity. The theme, the Hidden Harms and Encompassing Reach of Internalized Stigma, consisted of three higher level categories that elucidated the impact of internalized stigma (See Table 4): Shame, Damage to Self-Worth, and Impediment to Life Goals: Altered Trajectories.

Table 4

The Hidden Harms and Encompassing Reach of Internalized Stigma theme, higher order categories, and sub-category

| Theme | Higher Order Categories | Sub-Category |
|---|---|--|
| The Hidden Harms & Encompassing Reach of Internalized Stigma | Shame | |
| | Damage to Self-Worth | <i>Self-Punishment Mirrors Internalized Stigma</i> |
| | Impediment to Life Goals: Altered Trajectories | |

Shame. The receipt of a bipolar diagnosis elicited painful, self-conscious emotional reactions. Participants described a sense of shame, embarrassment, loneliness, and anger. These painful internal states reflected the internal experience of a damaged, defective sense of self. When recalling initial reactions to the diagnosis, participants used derogatory self-descriptions to account for their difficulties: “Like I was a mess and like nobody else had it” (Hailey, 38, Female, White, 58) and “Now I have a very good excuse for why I’m a low life” (Todd, 32, Male, White, 15). Likewise, Everett blamed himself for dropping out of college, stating, “I felt dejected. I felt pretty worthless, because I let myself and my family down” (Everett, 34, Male, White, 17). Sandra identified discomfort with her negative reaction toward people with bipolar disorder:

I think I’m like one person, personally, who is like, a productive, job holding, family person. So, I am judgmental of it, and I’m scared, and there’s just shame and there’s guilt and I feel like, those of are my people. We should all love each other. I feel a lot of shame about it. (Sandra, 43, White, Female, 21)

Damage to Self-Worth. This category described the dehumanizing ramifications of internalized stigma. The sub-category, *Self-punishment Mirrors Internalized Stigma*,

emerged from the Damage to Self-Worth category. Several participants (Everett, 34, Male, White, 17; Avery, 46, Male, White, 40) described feeling “different” and “less than” compared to seemingly appearing “normal” individuals. Feeling “off” and “broken” from a young age, Avery responded to feelings of alienation by estranging himself from social groups:

I didn't fit, I didn't belong here, and then that escalated to a me vs. them kind of separation and just building and closing a wall between me and the rest of the world and then me having to interact through this wall. It was very much of “I'm so different, I don't even deserve to be with the rest of humanity.” So that was internalized for 40 years, basically. (Avery, 46, Male, White, 40)

Describing his pre-illness self as “precocious,” Everett recalled his struggles with medications and cognitive impairments:

I was always a really good student, and I felt like the medicine made me feel stupid. I don't know if it was just the manifestation of the disorder itself, or the introduction of the medicine, but I felt like I went like being straight A, occasional B student to like, struggling to make Cs, Ds, and Fs. My academic performance definitely suffered. Like I had to try a lot harder. Whereas before, I could cram the night before a test and you know, get a high A on it. And then you know, after all that started, I had to study really hard just to make a C or something. (Everett, 34, Male, White, 17)

Describing labeling as the “biggest harm,” Nora explained how internalized stigma hurts:

It's just like if a parent keeps telling a child they're ugly or this or stupid. Well, what are you going to believe? If that's all you've heard, or somebody drilled it into you; you're the dumb one or you don't know when to keep your mouth shut. (Nora, 69, White, Female, 22)

Self-Punishment Mirrors Internalized Stigma. Two participants described negative self-treatment to compensate for the perceived shortcomings of mental illness. Charlie punished himself for falling short of artistic and creative potential, stating, “I feel like I beat myself up about it. And it makes me feel like I haven't accomplished what I can accomplish... That's what bothers me that most (Charlie, 73, Male, White, 48). Avery

recalled “hyper-focusing” at work to “cover” for the “uncontrollable mental thing going on”:

People would literally say, “You’re not human, you’re a robot, you’re an alien, because I was able to hyper focus, but then I would have no emotional connectedness to anybody...I overcompensated with the cruelly, analytical, and hyper-focused other side. It was the counterbalance to the chaos that was undiagnosed bipolar. But it was a conscious decision, because I knew there was chaos here, and the only way I could see to control it was by going analytical, cold. (Avery, 46, Male, White, 40)

Impediment to Life Goals: Altered Trajectories. This category illustrated how internalized stigma instituted barriers to participants’ life goals and undermined their self-confidence. For instance, Devin stated, “It’s hard to believe in myself all the time. There’s this Jay Z line, ‘But if everybody’s crazy, you’re the one that’s insane.’” (Devin, 36, Male, Black 25). Hailey, a customer service representative with 20 years of experience, alluded to internalized stigma as barrier to her career progression:

I don't go for promotions...So many people in customer service would just move on or get a better job... I have like memory issues now. I'm slower to get things. When I was in college, I thought I was going to accomplish all these things (Hailey, 58, White, Female, 38)

Similarly, Nora recalled doubting her ability to work while symptomatic, recalling, “I went to the backdoor and I just started crying. And so, I thought, well, maybe I can’t do this job. Maybe my emotions just...can’t do...be an art teacher.” (Nora, 69, White, Female, 22). Likewise, Maya, expressed self-disappointment and regret about her inability to work:

I’m not happy about it because I’d rather be able to work, and so I’m disappointed in myself, because I’d really love to get me a good paying job, 40 hours a week, so that I could have more money to play with. And I’m kind of depressed about it because I liked working when I could. I mean I enjoyed working when I could. There’s just no way I could do it now. It’s frustrating; it’s aggravating. Because I’d really like to be well enough to get a job and get me a bigger apartment, you know. (Maya, 44, Female, White, 23)

Lucas speculated how his life might be different if he did not have to contend with bipolar disorder, stating, “I might be teaching, I might not be teaching, I might have a more stable like office kind of job or like a more socially valued position. My marriage would probably be in a much better place.” (Lucas, 37, Male, White, 27). Marshall reflected on childhood adversities of being raised by a mother with bipolar illness. He contemplated the implications of his illness for raising children:

It makes me not really want to have children because, certain times...like one time it was really bad. She drove us, me and my little brother, when she was going through an episode...I don't want to put a child through that (Marshall, 33, Male, White, 27)

Theme: Negotiating Identity With Family Reactions to Bipolar Disorder

The theme, Negotiating Identity With Family Reactions to Bipolar Disorder, described participants' ongoing processes of navigating identity development and recovery while managing family reactions to the diagnosis and opinions about their treatment. This theme comprised of three higher level categories (See Table 5): Family Stigma, Managing Family Conflict, and Competing Needs: Individual Agency vs. Family Preferences. These higher order categories reflected participants' attempts to negotiate identity and independence within their family's concerns about participants' stability and well-being.

Table 5

Negotiating Identity with Family Reactions to Bipolar Disorder theme and higher order categories

| Theme | Higher Order Categories |
|--|---|
| Negotiating Identity With Family Reactions to Bipolar Disorder | Family Stigma |
| | Family Conflict |
| | Competing Needs: Individual Agency vs. Family Preferences |

Family Stigma. Many participants reported experiences of stigma occurring within their family system. Two female participants described their family’s disbelief of their mental illness. Maya shared that her parents doubted her account, even after the Navy discharged her for suicidal ideation, stating, “My mother didn’t believe I was sick. She thought I was playing some kind of game...The doctor at Job Corps called and told her, ‘Your daughter is sick.’ And she finally started to believe it” (Maya, 44, Female, White, 23). Sandra shared that her parents and siblings openly disputed the validity of her bipolar diagnosis. She quoted her brother, stating, “You are not bipolar. I don’t know who told you this, but you are not, I promise you.” (Sandra, 43, Female, White, 21). Likewise, Devin’s experience of family stigma reflected his brother’s attitude toward mental illness: “So my brother, when I first got sick, he, ‘Mental health? That’s not a thing, you’re being weak!’ It’s not real to him.”

Family Conflict. Other participants identified their family's lack of understanding about mental illness as a source of disconnection and conflict. Everett recalled that his diagnosis created tension between his parents' opinions about his mental health care, stating, "My dad and my dad's side of the family, they were definitely not as open to me being medicated as my mom was" (Everett, 34, Male, White, 17). Two participants described disconnection from family members. Hailey (58, White, Female, 38) stated, "My one daughter...she doesn't want me to know where she is, but we still communicate on phone, e-mail. She gave me her work number. But she's real distant, and it really makes me sad." Tony described how financial difficulties resulting from a manic episode contributed to conflict with his adult son:

The business I had, we were very wealthy. We still have money, but we don't have the wealth. The wealth is still there, it belongs to my son, who is partner, instead of me. And that was wrong, but I couldn't protect myself, or I couldn't be involved. All that wouldn't have happened had I not been sick (Tony, 77, Male, White, 54).

Family involvement in participants' care complicated family relationships.

Participants noted tensions between their autonomous decision-making and the family's opinions about their judgment and functioning. Devin and Todd cited "different philosophies" and difficulties "getting on the same page" with their family members.

Todd spoke to differing viewpoints between his and his family's assessment of his mood:

The family could agree that my mood has been sour for the last month and that to them, it's because I started taking Adderall or something. And for me, I may have been depressed at the time over something else that I'm not divulging or want to divulge. They see the situation correctly, but they cannot get at the intention or anything, and that's where we are always going back and forth...It's hard to take someone else's advice about you, especially on something as personal as your behavior or your mood. (Todd, 32, Male, White, 15)

Competing Needs: Individual Agency vs. Family Preferences. As family members questioned participant's judgement, some participants lost confidence in their agency and abilities. Participants and family members argued over independence, treatment decisions, and when to consult the psychiatrist. Alluding to his mother's exaggerated concern about his illness, Devin described "making concessions" to his mother after he was discharged from the hospital for a manic episode:

What happened is she saw that I was getting back to work, and she like, not fainted but like, sort of fell over on the couch, in a concerned motherly "This is hurting my heart" type of way. And she didn't say, she didn't ask, she insinuated that I should stop school. And I didn't agree with her, because it was against my primary programming. But then I sort of walked around, thought about it, I've never seen my mom fall on the couch before. That was different. And who wants their mom falling on the couch? So, a few days later, we sat down at the kitchen table and talked, and I told her, I'm going to pull out of school. I didn't agree with the decision at all (Devin, 36, Male, Black, 25)

Lucas attributed conflicts in his marriage to manic symptoms. Specifically, he described his wife taking on a parental role of managing his mood:

I think for my wife, especially it's also like there's has been this weird dynamic of where she helps me manage my bipolar. But then also she has this sort of authority figure or a mother figure aspect, where it's like, "Well did you do this? Did you do that? Why don't you go to sleep now?" kind of thing where this sort of like co-dependency or enabling kind of relationship. She doesn't hate me for being bipolar, but I feel like she hates dealing with the shit that happens because I'm bipolar, if that makes sense. (Lucas, 37, Male, White, 27)

Theme: Recovery: A Journey for Self-Definition and Identity

The theme, Recovery: A Journey for Self-Definition and Identity, illustrated how participants constructed their post-diagnosis selves and claim bipolar disorder as an integral and celebrated part of their identity. Participants drew from gifts of lived experiences of mental illness to build strengths that reinforced recovery practices. This theme consisted of five higher order categories: An Earned Identity, Recovery as Hard

Work, Self-Monitoring of Mood, Resources Promoting Recovery, and Challenges to Recovery.

Table 6

Recovery: A Journey for Self-Definition and Identity theme, higher order categories, and sub-categories

| Theme | Higher Order Categories | Sub-Categories |
|---|------------------------------|---|
| Recovery: A Journey for Self-Definition and Identity | An Earned Identity | |
| | Recovery as Hard Work | |
| | Self-Monitoring of Mood | <i>Minding the Present Moment</i> |
| | Resources Promoting Recovery | |
| | Challenges to Recovery | <i>Relational Conflict</i> |
| | | <i>Limitations of Mental Health Systems</i> |

An Earned Identity. Participants referenced broad identity themes when generating personal definitions of recovery. They defined recovery within the context of their careers, relationships, values, and goals. Everett spoke about his progress five years removed from legal difficulties related to a manic episode:

I guess recovery is kind of where I'm at now... I'm back in my house, back on rent to own situation. In a way, I'm kind of better off than I was. Because I'm still a car guy, I have a truck; it's an older truck though. And an older Camaro, and then I have a daily driver... I still have my dog. He's stuck with me through all of this. He's like 13 years old, almost 14. He's a lot lazier than he used to be, but I think that's what recovery is. I have a stable relationship. (Everett, 34, Male, White, 17)

Lucas described recovery aspirations for his self, family, and career:

The ideal part would be like, okay, I'm married, I have two kids, I have a steady job. We can pay our bills. Life is good. And in terms of my mood, like I'm managing it. And so even if I feel up or down, I can get to a more balanced state. Part of that, I feel like would be just behavioral. Like good sleep hygiene. You know, not acting out if I'm feeling up, and then, like, not having up or down moods very often, and when I do, figuring out how to be stable. (Lucas, 37, Male, White, 27)

Defining recovery as a “search for peace,” Ralph noted that removing job pressures allowed him to prioritize his wellness:

[Recovery] can be just life journeys that put me at the end of my retirement. When I had completed probably some of the best years of productivity working in the schools, but yet it was at a point where it's almost like a car running out of gas. You know the last three episodes were within four years...So now I can work on me, you know. (Ralph, 68, Male, White, 39).

Recovery as Hard Work. Notably, participants recognized the ongoing, concerted efforts necessary for living in recovery. Participants acknowledged personal growth arising from their efforts in recovery work. Describing his recovery efforts to form new relationships and connections, Avery noted:

It's a long walk to get from that complete mental isolation and emotional isolation to interacting in a whole and positive way.... I've distrusted everyone for so long that letting myself even get small steps, small group interactions has been...it's been a lot of work. A lot of hard work. (Avery, 46, Male, White, 40)

Similarly, Hailey referenced the continued upward motion of recovery:

Like the escalator. If you're trying to walk up a down escalator, and you quit moving and you quit working, you end up down. You keep working, you can get up. Then you get to the next flight, and you realize there's another escalator to go up. (Hailey, 58, Female, White, 38)

Likewise, Maya identified her daily routine for occupying her time in meaningful ways:

I listen to music, or I watch a movie, or I read a book. I get into my hobbies, get out of the house, those are all ways I deal with it. I get out of the house, I go to the library, get on the Internet there, check out a book, read the book. I do a whole bunch of things. Because if I stay at home, medication makes me sleepy, and I'll

sleep three hours. Nine to noon, I'll sleep the day away. I try to get out of the house every day and do something. (Maya, 44, Female, White, 23)

Lucas noted that his recovery efforts extended to managing depressive symptoms:

Even though I talk about things that I've done to manage my mania, I do even more to manage my depression, like exercise, being productive, being creative, like getting up, going to work, not staying in bed all day, those are all things I do just to keep the depression from only being mild. (Lucas, 37, Male, White, 27)

Todd acknowledged his lack of readiness to fully prioritize his recovery. He hypothesized that that recovery would require persistent diligence and sacrifices of other desires:

Recovery to me would be being in control. And I think, to be in control, I would have to be more serious about the disorder in that I would have to concentrate. If I'm concentrating 95% of my mental power on the disorder, that's not enough. I'd have to concentrate 100%, and completely give myself to being better. Which is something, I'm not, at this point...I have other desires; I have other agendas. So, for me to be completely healthy, I think, would be to give up a lot. And kind of just do management and control for the rest of your life. (Todd, 32, Male, White, 15)

Self-Monitoring of Mood. Multiple participants defined recovery as a stable or balanced mood. Participants noted that stability involved careful “self-monitoring” of mood changes while adhering to treatment, medications, and groups. One sub-category, *Minding the Present Moment*, emerged as a practice for monitoring mood. Avery (46, White, Male, 40) noted, “I have to pay attention to myself more.” I have to monitor myself more. It's becoming more natural and easier to do the longer I am in recovery.” Likewise, Lucas (37, Male, White, 27) stated, “I'm keenly aware of what mood I'm in and how it's affecting that from a day-to-day perspective.” Marshall (37, Male, White, 27) described himself as “very careful” when consuming alcohol. Several participants noted the challenges of maintaining stability and identified requisites for recovery. For instance, Avery cited self-awareness as crucial for resisting his temptation to discontinue medications:

I've been really stable for a good 2 years now. Well, maybe I wasn't that bad before, maybe I don't need meds. So that's the recovery part. Not falling into the trap, knowing it's a trap, noting there's a pit there. (Avery, 46, White, Male, 40)

Likewise, Ralph (68, Male, White, 39) noted the need to minimize stressors to prevent episodes, stating, "I understand what stress does to me, so I have to put myself in situations where I don't become stressed." Lucas acknowledged difficulties adhering to self-monitoring practices, given his short periods of mood stability:

The hard part is that it feels like the stable times are like the least often, the least frequent. And the other thing that's hard is usually they're when I'm on my way up or when I'm on my way down. So, I don't feel them for a long time. And that's really hard too. (Lucas, 37, Male, White, 27)

Minding the Present Moment. Two participants described deliberate efforts to modify their awareness of the present moment. Devin (36, Male, Black, 25) described existing in the presence, stating, "You just kind of like choose moments where it's like, 'Alright man, I just need to be right now.' Because for me, that being is a big part of mental health." Similarly, Marshall (33, Male, White, 27) identified his "mental state" as important to his mental health, noting, "You want to program your mind in a way where it's just like you're fine, you're going to get through it. You just like create like a positive atmosphere, positive energy."

Challenges to Recovery. Participants elaborated on unhelpful factors for recovery related to life circumstances, relationships, and mental health systems. Two sub-categories emerged from Challenges to Recovery: *Relational Conflict and Limitations of Mental Health Systems*.

Relational Conflict. Participants identified relational conflict as a barrier to recovery. Relationships consisted of family, friends, and romantic partners. Participants perceived relationships as introducing stress into their lives. Participants noted that

relational stress impacted personal wellness, hindered their career trajectories, or interfered with their recovery efforts. Describing a previous romantic relationship as “a bad influence,” Marshall noted that the relationship undermined his autonomy, stating:

I like to do my thing, and I hate for people to try to tell me what to do and control me. She was always trying to be controlling and I won't have that... You know, I got to take care of myself first. (Marshall, 33, Male, White, 27)

Similarly, Nora linked three romantic relationships over a fifteen-year period with frequent moves and changes in location. She recalled “letting men get in the way” of her educational and career goals. She also associated unstable relationships with onset of manic and depressive episodes, stating:

My husband, he was out of town a few years. I guess I just needed more TLC than I was getting. And after X number of years, I couldn't take it anymore. Him being gone, I'd get real independent while he was gone, and then I felt like I had to flip flop to be someone else or act a certain way. It was a routine; it was just hard on me. (Nora, Female, White, 22)

Limitations of Mental Health Systems. Other participants described the mental health system as unhelpful to their recovery. Participants identified the setting and design of the mental health care system as limiting their access to medications and complicating their recovery. Lucas referenced the expenses of therapy and medication, stating:

When you think of a state that has a public health care system, medication is not expensive, treatments not expensive. Where in the United States, it's like unless you're well off, you're either choosing to not get treatment or to get treatment, and that becomes a financial burden. Or you're privileged like I am, where you have family members that can help you. So, all of that makes it really difficult. (Lucas, 37, Male, White, 27)

Similarly, Everett (34, Male, White, 17) described how his seven-month incarceration disrupted his medication adherence, stating, “There were multiple times that I went more than a day or two without any of my meds because of their negligence in getting things refilled or ordered.” Speaking to the health care system’s need to “adapt itself,” Devin

noted:

Recovery assumes individuals are sick. I am being taught to think that that's not the issue...I think that has more to do with systems than individuals. So, when I think of recovery, I think systems need a recovery process...The healthcare establishment gets paid because I'm sick. They don't get paid to prevent me from getting sick. (Devin, 36, Male, Black, 25)

Resources Promoting Recovery. Multiple participants identified resources supportive of their stability and recovery, such as medications, social support, and community-based groups (Charlie, Lucas, Everett, Hailey, Marshall, Sandra, Tony). For instance, Lucas (37, Male, White, 27) noted that medications reduced the intensity of his manic and depressive episodes. Sandra (43, Female, White, 21) observed that medications provided stability, even during periods of fluctuating moods. Everett, Nora, Maya, and Lucas identified support and community-based awareness groups as helpful for hearing other's perspectives and receiving education about managing the illness. Several participants identified their support group as essential to their well-being (Hailey, Lucas, Nora, Everett). Other participants expressed gratitude for treatment, financial resources, and housing provided by their family members.

Theme: Gifts of Bipolar Disorder

The theme, Gifts of Bipolar Disorder, illustrated the wisdom, strengths, and power acquired by individuals living with serious mental illness. Participants described how their strengths reinforced recovery efforts and contributed to stronger identity in relation to self and others. Two higher level categories emerged from this theme (See Table 7): Increased Compassion and Empathy and Reaching Out to Help Others. These categories described processes of growth and healing occurring as part of the recovery process.

Table 7

Gifts of Bipolar theme, higher order categories, and sub-categories

| Theme | Higher Order Categories | Sub-Categories |
|------------------|----------------------------------|--|
| Gifts of Bipolar | Increased Compassion and Empathy | |
| | Reaching Out to Help Others | <i>Advocacy</i> <i>Practice Self-Compassion</i> |

Increased Compassion and Empathy. Despite the challenges posed by internalized stigma and symptoms, participants readily identified advantages gleaned from navigating the complexities of bipolar I. Multiple participants cited increased empathy toward suffering. Avery (46, Male, White, 40) stated, “I think it’s given me a level of compassion that a lot of people don’t have. From my interactions with people, I definitely think that I’m in the higher tier of compassionate people than most.” Todd expressed gratitude for his emotional sensitivity, and he noted the importance of supporting his niece:

My niece will probably be bipolar. In fact, I think she already even at age six already has a diagnosis, for being that young. For me, it’s very important that I stick around, to listen. I don’t think I’m going to be able to tell her, “This is what’s going to happen,” I’m sure I’m going give her warnings about alcohol and drugs and what not, but just for her to have somebody who understands what is going on. (Todd, 32, Male, White, 15)

Sandra described increased empathy and connection through disclosure of her diagnosis:

There are so many bipolar people in meetings, in recovery. People will share, “I’m a little raw, I’m bipolar, and this is a mess.” I can go up afterwards and say, “Hey, I’m bipolar too, let’s talk.” And this has gone the other way for me too; I’ll share, this is happening. I’m not super open about it in meetings, but every time

I've shared about it, somebody has come up to me and been like, "Hey, I'm struggling with that too." And that helps me, and that helps them. (Sandra, 43, Female, White, 21)

Maya shared how living with bipolar helped her see the humanity in other people:

I'm able to sympathize with people because I'm sick. And I'm able to have a little bit more compassion for people because they have the same thing that I've got, even if it's different. It's just a good thing because it helps me to prioritize and see things I might not see otherwise. I might see a person in one way. Then my illness, my symptoms, make me be able to see them in another way. And I look at people with bipolar eyes and without bipolar eyes... When I see them with my illness, I see that we have a lot in common... Because we have something in common, I can use that as a bridge to other people. To talk to them. To see what their experience is like (Maya, 44, Female, White, 23)

Reaching Out to Help Others. Many participants emphasized the need for individuals with bipolar I to seek professional mental health treatment. Sandra stated, "I would tell people, have people help you. Have a good doctor. Have support, you cannot do it on your own, at all." (Sandra, Female, White, 23). Likewise, Hailey encouraged others to reach out and access a support network, stating, "People listen, and you don't have to do this alone. And it can get better. I like to share my story, that I haven't been hospitalized in 20 years." (Hailey, 58, Female, White 38). Similarly, Maya (44, Female, White, 23) stated, "There's hope. It's a difficult illness, but it can be managed." Avery advised:

Take your meds. Even when you don't think you need them. That would be the first thing. And then find somebody smart to talk it through it. Therapy of some sort... somebody who knows that the hell they're talking about and can help you see and disrupt those bad thought patterns before they get to be a problem. Like everything after that, comes naturally, I think. Not easily, but it comes naturally. If you do those two things, then it makes it possible for everything else. Without those two things, I don't think it's possible. I don't think you recover without that, and honestly, I don't think you survive. I think it kills you. (Avery, 46, Male, White, 40)

Everett also spoke to the seriousness of bipolar and strongly advised against suicide:

The main takeaway, as someone that's attempted suicide and has been suicidal,

you know, at different times, I would say, don't do it. It's going to get better. Seek help. Don't be afraid to ask for help; don't be afraid to ask for medication (Everett, 34, Male, White, 17)

Two sub-categories emerged from the Giving back to Help Others category: *Advocacy* and *Practice Self-Compassion*.

Advocacy. This sub-category reflected participants' involvement in the mental health community and dedicated efforts to support others with serious mental illness.

Two participants described leadership roles to promote awareness of mental illness resources and supports in their communities. Hailey (58, Female, White, 38) described how her involvement with a community support group supported her recovery efforts while helping others, stating:

It [bipolar disorder] gave me the opportunity to become a leader. So that takes up a tremendous time in my life. I think giving back makes your better. Because you're thinking about other people and not yourself. (Hailey, 58, Female, White, 38)

Nora, a former facilitator for National Alliance on Mental Illness, described her efforts to educate others about their illness:

I went to some of the bipolar meetings and heard other people and then worked with NAMI. It gives you a sense of pride that you're doing something about, or helping other people recognize some of the same things you went through or how they're acting...You might somehow help them, too. (Nora, 69, Female, White, 22)

Practice Self-Compassion. Participants encouraged others living with bipolar disorder to have empathy for their difficulties. Charlie advised against self-punishment and encouraged others to own their worth:

Don't beat yourself up. I think we damn ourselves, so to speak, I'm sorry to use that word. But in so many instances, whether it's on a high or whatever, we beat ourselves up. It's not right. Yeah, for someone else, I don't want them to feel like they're...you should have more worth. (Charlie, 73, Male, White, 48)

Lucas warned that self-hate can intensify painful emotions:

To not be so hard on yourself because usually bipolar people are either depressed and feel bad about themselves, or they feel guilty about things they've done when they've been manic. So, try not to hate yourself, like things you've done or the way you feel like in that moment. (Lucas, 37, Male, White, 27)

Theme: Integration of Bipolar Disorder Into Unified Sense of Self

The final theme, Integration of Bipolar Disorder Into Unified Sense of Self, described the shift from internalized stigma to self-acceptance through embracing bipolar disorder into one’s identity. Two higher level categories emerged from the data: Self-Acceptance and Claiming Bipolar as an Identity. These categories reflected the process of moving from internalized stigma to rebuilding a whole, integrated sense of self.

Table 8

Integration of Bipolar Disorder Into Unified Sense of Self theme and higher order categories

| Theme | Higher Order Categories |
|---|--|
| Integration Bipolar Disorder Into Unified Sense of Self | Self-Acceptance Claiming Bipolar as an Identity |

Self-Acceptance. As participants acknowledged bipolar disorder as a lifelong illness requiring ongoing treatment and self-care, they came to accept the entirety of their personhood. For instance, Maya (44, Female, White, 23) stated, “I try to just accept that I’m sick and that I have to receive treatment, medication, therapy, and all that kind of stuff. Though, I try to accept that and not let it stress me out.” Similarly, Nora (69, Female, White, 22) shared, “I don’t let it bother me. I just know that everybody’s got different kind of issues. And mine’s not any different from...everybody’s dealt something. You know, nobody’s perfect.”

Claiming Bipolar as an Identity. Several participants spoke to the incorporation of bipolar disorder into their self-concept. These participants claimed bipolar disorder as an integral part of their self-understanding and their identity. In reference to her internalized stigma, Sandra stated:

I'm bipolar, I'm an addict, I'm widow, and it's like, what the hell, I can really get down on these three labels I put on myself, or I can just feel like a badass for it. There's many days where I do. There's many days where I'm like, how am I still here? It's just like anything; everybody's moods go up and down; you feel good some days and you don't. Just trying to have more of those days when I feel like, it is almost a gift, I have strengths from that. It's not all bad. (Sandra, 43, Female, White, 23).

Todd also expressed pride in his claimed bipolar identity, stating:

I wouldn't trade being me for anything even with the...If you were to ask, I always say this too. I'm ADHD, and I always say, if I could get rid of one thing, it wouldn't be the bipolar disorder, it would be the ADHD, because that disrupts me in everything I try to do. Where the bipolar is very disruptive but it's something more a part of me, and the ADHD is a disorder. I don't exactly associate with [ADHD], if that makes sense... I am Bipolar. It's the same as I'm White. I'm Male. I'm 32. I'm Bipolar. (Todd, 32, White, Male, 15).

Summary of Findings

A grounded theory analysis of the data yielded seven themes: 1. Crisis of Self-Coherence, 2. Incorporation of Illness Into Self-Concept, 3. The Hidden Harms and Encompassing Reach of Internalized Stigma, 4. Negotiating Identity With Family Reactions to Bipolar Disorder, 5. Recovery: A Journey for Self-Definition and Identity, 6. Gifts of Bipolar Disorder, and 7. Integration of Bipolar Disorder Into Unified Sense of Self. Each theme consisted of higher order categories, with some higher order categories comprising sub-categories. These themes related to navigation of the diagnosis, symptoms, and internalized stigma within a progression of identity development in recovery. Findings revealed that identity development occurred while participants reconciled internalized stigma with understanding of self in relation to mental illness.

This reconciliation process and identity development involved negotiation with family members and romantic partners. Throughout the recovery process, participants drew from gifts of bipolar disorder and acquired strengths that fostered self-acceptance and embracing of a new identity.

Identity Development Model: Theoretical Propositions From Grounded Theory

The emerging grounded theory suggested a phase approach to identity development during recovery whereby participants moved from fragmented sense of self and internalized stigma to embracing bipolar disorder as part of a transformed, unified identity (See Figure 1). Below are the hypothetical propositions for the emerging grounded theory.

Proposition 1: The sudden onset of manic and psychotic symptoms threatened the integrity and soundness of the individual's mind and self-concept.

Proposition 2: Individuals wrestled with the meaning of the diagnosis and its implications for their self-concept, their functioning, and their relationships to others.

Proposition 3: Individuals vacillated between perceiving the bipolar I diagnosis as a confirmation and threat to their self-concept: For some individuals, the diagnosis validated chronic mood imbalances and perceptual disturbances, while others questioned the relevance of the diagnosis to their self-experiences.

Proposition 4: Individuals grappled with tensions between symptoms and experiences of self: They had difficulty differentiating between mood symptoms and central self-experiences.

Propositions 5: Internalized stigma contributed to shame, damaged self-worth, and altered goals and career trajectories.

Proposition 6: Internalized stigma likely influenced the degree to which participants accepted or rejected the diagnosis as a reflection of self.

Proposition 7: Participants attempted to negotiate their illness identities within their family relationships.

Proposition 8: Family disbelief and skepticism about the illness contributed to individuals' internalized stigma.

Proposition 9: Recovery involved a journey for re-constructing and defining the self.

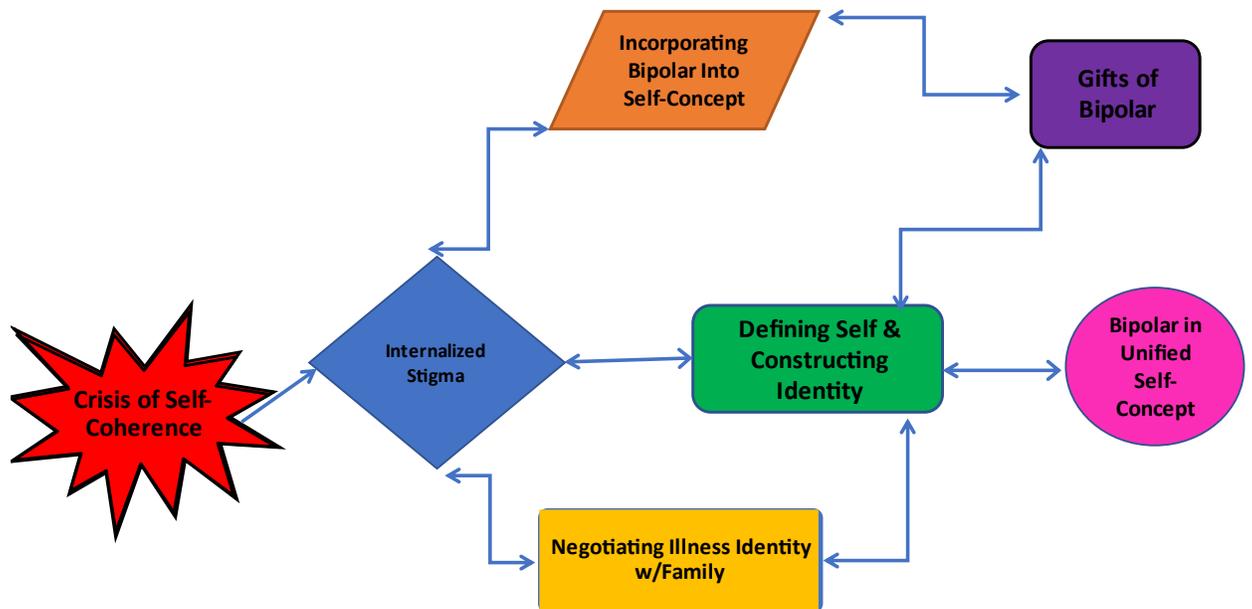
Proposition 10: During the recovery process, participants reconciled internalized stigma and acknowledged the gifts of bipolar disorder.

Proposition 11: During the recovery process, participants acquired strengths and skills during that increased mastery over mood management and contributed to a positive sense of self.

Proposition 12: Participants embraced and claimed bipolar disorder as a central and valued part of identity.

Figure 1

Identity Development: Reconciling Internalized Stigma and Identity in Recovery in Bipolar I



CHAPTER IV

DISCUSSION

Although research on mental illness stigma has proliferated within the past decade, few empirical studies have examined the lived experiences of internalized stigma in individuals with bipolar disorder I. This grounded theory study is one of the first to examine the interconnection between internalized stigma, identity, and recovery in adults living with a diagnosis of bipolar disorder I for at least one year. Seven themes related to the reconciliation of self and illness emerged from the data: 1. Crisis of Self-Coherence, 2. Incorporation of Illness Into Self-Concept, 3. The Hidden Harms and Encompassing Reach of Internalized Stigma, 4. Negotiating Identity With Family Reactions to Bipolar Disorder, 5. Recovery: A Journey for Self-Definition and Identity, 6. Gifts of Bipolar, and 7. Integration of Bipolar Disorder Into Unified Sense of Self. The emerging grounded theory sheds light on an identity development process unfolding as individuals navigate complex experiences of self and illness in relation to close others.

This chapter will integrate the emerging grounded theory within existing bodies of literature that informed the current study: Internalized mental illness stigma, identity, and recovery from serious mental illness. The implications of the current study will be explored. This chapter will conclude with limitations of the study, directions for future research, and clinical implications.

Reconciliation of Self and Internalized Stigma: Resisting Insidious Injuries to Self-Worth

Modified labeling theory (Link & Phelan, 2001) suggests that internalization of a deviant label occurs when individuals accept and absorb prejudicial messages about the label into their self-concept. Furthermore, research documents a relation between self-reported internalized stigma and detrimental consequences for mental illness, symptom severity, quality of life, and treatment adherence (Livingston & Boyd, 2010). While quantitative evidence indicates negative effects of stigma in individuals with bipolar disorder (Hayward et al., 2002; Lim et al., 2004; Mileva et al., 2013; Smith et al. 1996), few qualitative studies directly examined the lived experiences of stigma in individuals with bipolar disorder (Michalak et al., 2011; Suto et al., 2011). The current study offered important insights into how individuals with a stigmatized diagnosis of bipolar disorder I navigated internalized stigma and bipolar disorder and negotiated their bipolar identity with family members.

The terms navigation and negotiation were built on Ungar's (2005) work on resilience processes that follow adversity. In the current study, *navigation* referred to the process by which individuals grappled with the impact of bipolar disorder and internalized stigma on identity. Broadly, identity theory posits individuals understand themselves through social meanings attached to roles, group membership, and personal attributes (Burke, 1980; Burke & Stets, 2009; Stets & Serpe, 2013; Stryker & Burke, 2000). Identity theory draws from symbolic interactionism, which suggests that identity is shaped through social interactions, as individuals understand self in relation to others (Burke, 1980).

All participants expressed awareness of the larger societal stigma of mental illness. Most participants openly spoke about feelings of shame, defectiveness, and inferiority. Particularly, they referenced derogatory self-descriptions when recalling the crisis of self-coherence experienced after initial manic episodes and shortly after the diagnosis. The findings supported previous empirical studies suggesting that awareness and/or anticipation of public stigma increases one's likelihood for developing internalized stigma (Quinn, Williams, & Weisz, 2015; Vogel et al, 2013). Additionally, research has examined the conditions under which individuals reject or accept negative messages about mental illness into self-concept (Corrigan & Watson, 2002). At the time of interviews, participants disconfirmed negative stereotypes about mental illness. The current research revealed evidence of more nuanced processes in which participants consciously rejected the label but also referenced negative evaluations when speaking about self-concept. Certain word choices and phrases (e.g., "I used to be smart") alluded to the enduring loss of pre-illness self that may have reflected underlying internalized stigma. In this study, participants' co-existing refutation of public stigma and subtle reference of negative self-evaluations suggested that individuals can hold affirming and oppressive attitudes about self and illness at the same time.

Negotiating Self and Illness With Family: Responses to Family Support and Stigma

In the current study, *negotiation* reflected the process by which participants attempted to create space for their post-diagnosis identities within familial contexts. McCall and Simmons (1978) emphasized the importance of role identity in a social position. Individuals may enact "conventional" role identities in line with sociocultural expectations, or they may enact "idiosyncratic" role identities aligned with their personal

interpretations of the identity (McCall & Simmons, 1978, p. 65). Given that individuals enact role identities in relation to counter-identities (e.g., parent-child), parties may disagree on the meanings and behaviors of role identities. In response to this conflict, parties compromise through negotiating the different meanings and behaviors tied to their respective identities (McCall and Simmons, 1978). Stets and Burke (2000) suggested that role identities become shared through mutual compromise, as each party relinquishes some meanings and social expectations in favor of maintaining roles and identity perceptions (Stets & Burke, 2000).

The current study revealed participants' encounters with family stigma, including invalidation, disbelief, denial, and blaming. Furthermore, participants managed stigmatizing family reactions while receiving financial resources, emotional support, and assistance with treatment. Participants attempted to affirm post-illness identities through pursuing educational and work opportunities. Identity negotiation involved participants making concessions, which involved relinquishing independence needs in favor of appeasing their family's concerns. While participants expressed gratitude for family's support and involvement, they did not always agree with their family's vision for their life trajectories.

The current study's findings on family stigma and support corresponded with findings of previous qualitative studies (Michalak et al., 2011; Suto et al., 2012). Suto et al. (2012) found that individuals with bipolar disorder coped with internalized stigma by seeking family support. Michalak (2011) found that participants experienced family stigma in the form of silence around mental illness. While families often serve as an

important source of support, individuals may also experience negative reactions from their family. This stress and conflict may influence the course of recovery.

Historically, the large body of research on family and mental illness has examined the negative consequences of schizophrenia on family members, particularly family coping (Hatfield, 1979; 1981; Lefley, 1987; 1996; Zipple and Spaniol, 1987) and family/caregiver burden (Cook & Pickett, 1987; Noh & Avison, 1988; Ohaeri, 2003; Veltman, Cameron, & Stewart, 2002). Recent qualitative studies examined the impact of bipolar disorder from the vantage point of family members (Mousavi et al., 2021; Richard-Lepouriel, 2021). The current study expanded the literature on family interactions and serious mental illness by centering the experiences of adults with bipolar disorder I. Given the positive benefits of family support on recovery from serious mental illness (Cohen et al., 2013; Dunne, Perich, & Meade, 2019), the current study suggested that family support and individual agency may influence positive identity development during recovery in bipolar disorder I.

Progression From Internalized Stigma to Claiming Bipolar as Identity

Consistent with previous literature documenting the influences of bipolar disorder on understanding of self and identity (Inder et al., 2008; Jönsson, et al., 2008; Lim et al., 2004; Michalak et al., 2006; 2011; Proudfoot et al, 2009), the current study findings also revealed evidence that experiences related to bipolar disorder frequently introduced challenges to participants' self-understanding and relationships to close others. In the current study, unexpected symptoms of mania, psychosis, and discontinuous mood, in addition to educational and career disruptions, contributed to a loss of self. The phenomenon regarding the loss of self in serious mental illness is consistent with the

larger body of literature on recovery in serious mental illness, particularly schizophrenia (Davidson et al., 2005; Kaite et al., 2015) in addition to more recent qualitative and mixed methods studies on bipolar disorder (Inder et al., 2008; Michalak et al., 2006; Proudfoot et al., 2009).

Previous empirical studies and first-person accounts have documented an unfolding process by which individuals making meanings of self in relation to serious mental illness (Yanos et al., 2010). Similarly, participants in the current study described a process of reconstructing sense of self, usually in the aftermath of a manic episode. Previous qualitative and mixed method studies have found that individuals with serious mental illness harbor hidden feelings of shame about their illness but eventually come to embrace self-acceptance (Inder et al., 2008; Jönsson, et al., 2008; Michalak et al., 2006, 2011). Additionally, Springer et al. (2017) proposed a model suggesting that positive interactions, compassion for others, self-compassion, and competence facilitate movement on an adaptation spectrum from self-stigma to resilience.

In a mixed method study (Michalak et al., 2011), sense of self/identity emerged as a theme pertaining to individuals' experiences with bipolar disorder. Consistent with the current study, participants in the Michalak et al. (2011) study described positive and negative impacts of bipolar disorder on their self-views. They also spoke about "moving beyond internalized stigma" by viewing bipolar as one part of self that did not define their identity (pp. 218, Michalak, et al., 2011). Conversely, rather than distancing themselves from bipolar disorder, the current study participants coped with internalized stigma by incorporating bipolar disorder into self-concept. Eventually, they embraced bipolar disorder as a unique, and central part of their transformed identity. The current

study adds to the growing body of literature on the interconnection between mental illness stigma and identity. The study provided evidence of a developmental progression of reconciliation and reconstruction of self that takes place during recovery of bipolar I.

Limitations

The following section explores the limitations of findings according to Charmaz's (2014) criteria for grounded theory studies: (a) criteria of credibility, (b) originality, (c) resonance, and (d) usefulness. Future research directions for addressing shortcomings and expanding on current findings are explored.

Credibility

The current study findings are based on initial sampling with 13 adults at two different sites: Ten receiving treatment in an outpatient academic psychiatry clinic and three attending a mental illness support group. The researcher changed the setting of data recruitment and collection to comply with COVID-19 safety regulations. The credibility of the study could be strengthened through theoretical sampling, which should guide further data collection and sampling from different settings (Charmaz, 2014). In the current study, theoretical sampling would have expanded preliminary categories that required more elaboration, including bipolar disorder and addiction, spirituality in bipolar disorder, and disclosure of the diagnosis in dating relationships. While the current study used constant comparison to analyze data and data saturation to attain fullness of concepts, the credibility or "trustworthiness" of the findings (Lincoln & Guba, 1985) were limited by lack of theoretical sampling.

Originality

The emerging categories offered new insights about identity development in recovery from serious mental illness. Most noteworthy, rather than relinquishing an illness identity, participants adopted bipolar as an empowered identity. The comparison of the current findings to existing scholarly literature on mental illness stigma and recovery (see above) provided evidence for existing and novel theoretical findings. However, theoretical sampling of preliminary categories would likely increase the level of abstraction and reveal novel concepts not captured by the current study. Additionally, all interviews were coded by the researcher. A team approach to coding interviews would introduce contradictory interpretations requiring refinement of categories and discovery of new concepts.

Resonance

Due to sample demographics, the categories likely did not encompass “the fullness” of internalized stigma, identity, and recovery in bipolar I (Charmaz, 2014, p. 337). The sample consisted primarily of White cisgender men. Thus, the current study has limitations for understanding how cultural and racial/ethnic background may influence experiences of internalized stigma, identity development, and recovery trajectories. Different cultural groups may hold attitudes toward bipolar disorder and mental illness not represented in the dominant cultural narrative. Furthermore, some research finds evidence of “double stigma,” which occurs when individuals hold one or more marginalized identities (Gary, 2005; Roe et al., 2007; Sanders et al. 2004). Examining intersecting identities of bipolar disorder and cultural identities (e.g., race, gender, religion, sexual orientation, ability status, etc.) would strengthen the resonance in

the current study. Additionally, ten participants received mental health treatment from the same psychiatrist, who served a recruiting role in the current study. The current findings may not apply to individuals who lack access to quality mental health care.

Although participants expressed eagerness and excitement about the study, only two participants opted to participate in member checking. Thus, the extent to which the current findings adequately capture the experiences of participants is not known.

Additional member checks may have provided additional insights into internalized stigma and identity processes, especially if participants had more time to read their interviews and reflect on their responses.

Usefulness

The findings offer practical interpretations for use in everyday settings, particularly in clinical settings that provide mental health treatment (see Clinical Implications). Per recommendations of Charmaz (2014), the investigator attempted to capture implicit meanings of participant statements. The examination of subtle comments and phrases proved useful for capturing meaning units reflecting internalized stigma. The current findings suggested that the presence of internalized stigma may not be readily apparent to individuals with mental illness. Thus, the current study provided signposts alerting individuals to internalized stigma and offers suggestions for how they might resist negative stereotypes and prejudice.

Directions for Future Research

Although most participants did not identify the word “stigma,” nearly all referenced insidious injuries to self-worth. Due to its ingrained and normative nature,

internalized mental illness stigma may fall within the realm of implicit attitudes, which operate outside conscious awareness (Brener, Grenville, von Hippel, & Wilson, 2013). The Implicit Association Task (IAT) (Greenwald, McGhee & Schwartz, 1998) measures the strength of associations between sorting attributes (e.g., a person with mental illness) and stereotypes (e.g., “crazy,” “dangerous”) into categories. Faster reactions times for sorting attributes and negative stereotypes are thought to reflect higher levels of implicit prejudice (Greenwald, Banaji, & Nosek, 1998). In a study that used both implicit and explicit measures of self-stigma in 85 adults with mental illness, Rüsçh, Corrigan, Todd, and Bodenhausen (2010) found that higher levels of implicit stigma and explicit stigma independently predicted lower quality of life, even after controlling for diagnosis in multiple regression analyses.

Given evidence of internalized stigma as implicit, future research should employ diverse methodologies and data sources to capture internalized stigma. Charmaz (2014) suggested that integration of quantitative and qualitative approaches can deepen researchers’ understanding of complex phenomenon and processes. A follow up study should pursue different data sources of internalized stigma. Focus groups can give rise to organic and intimate discussions about the hazards of living with a serious mental illness. Focus groups consisting of individuals with the shared status of bipolar I may elicit thoughts and feelings that individuals would not typically share in most social interactions. Furthermore, the researcher could observe group dynamics to understand how stigma shapes social interactions.

The exclusion and disempowerment of people with serious mental illness within larger societal structures warrants future studies that adopt critical stances toward

constructs of mental illness and recovery. Participatory action research (PAR) approaches scientific inquiry as social justice work by collaborating with individuals in the community. Thus, a future investigation could enlist the input of individuals with bipolar and serious mental illness to develop comprehensive definitions of internalized stigma, identity processes, and recovery. Participatory action methods may be useful for centering the strengths of individuals with mental illness. Multiple social movements, such as the mental health consumer movement, anti-psychiatry movement, and more recent Mad Movement, have sought to dismantle oppressive policies and resist stigmatizing attitudes toward mental illness. Future research aiming to understand how individuals resist stigma could benefit from incorporating critical stances to the medicalization of mental illness.

Clinical Implications

The current study's findings on the lived experiences of internalized stigma and recovery offer valuable clinical insights for mental health practitioners and treatment provision. Given the injurious effects of internalized stigma on well-being, providers should practice caution in not reinforcing negative stereotypes about mental illness.

Unfortunately, research has documented that mental health professionals harbor stigmatizing attitudes and desire social distance from people with mental illness (Nordt et al., 2006; Schulze, 2007). The current research suggests that providers should reflect upon their personal attitudes, prejudices, and interactions with individuals with bipolar I. Furthermore, mental health service providers may facilitate individuals' processing of the diagnosis by exploring patients' reactions, beliefs, and concerns about living with bipolar disorder I. These rich findings suggested that individuals with bipolar disorder held

affirmative and stigmatizing self-views at the same time. Thus, providers can help participants access and sort through conflicting parts of self. They also can encourage participants to identify valued experiences of self and illness that participants can incorporate into their recovery process.

These findings shed light on how mental health systems may perpetuate experiences of public stigma. Several participants expressed concern about inadequate and inconsistent treatment received in restrictive mental health settings. Additionally, other participants spoke about broader societal forces, including lack of access to quality care and “sick” mental health systems that localized the source of pathology in the individuals. To combat stigma, providers who work in public mental health settings may consider steps for adopting organizational policies that empower clients as consumers. Clinicians also may incorporate consumer perspectives to improve treatment within their setting. Treatment models and systems that foster hope and encourage participants to develop their personal definition of recovery may increase patients’ motivation and adherence in treatment. Furthermore, the current findings suggested that providers can improve their treatment through carefully listening to personal accounts of their clients. The current findings revealed that prolonged awareness of mood and stress served as an important practice for maintaining mood stability. Although participants acknowledged the loss of control during major manic episodes, they also demonstrated increased confidence in their ability to respond to crises and weather these challenges. A caring, attentive, and non-judgmental provider can help participants to capitalize on their strengths and increase mastery for responding to challenges related to mental illness.

Finally, the findings have important implications for providers who treat individuals with bipolar disorder and their family members. While existing treatment models incorporate the involvement of family members in an individual's care (Miklowitz, 2011), the current study found that participants cited family stigma and conflict as unhelpful to their recovery efforts. Providers can assist their clients by educating family members on the harmful effects of stigma on recovery in mental illness. Clinicians might consider a shared decision-making model that accounts for both consumer needs and family preferences for treatment. Clinicians can help family members identify the extent of support they can realistically provide, in addition to understanding how this support may provide a springboard for their loved ones' self-determination and agency.

Conclusion

Despite the body of literature documenting the interconnected relation between mental illness stigma and identity, few qualitative studies have examined the lived experiences of internalized stigma in relation to perception of self and identity among individuals living with bipolar disorder I. The emerging grounded theory found that reconciling internalized stigma and illness constitutes a developmental identity process. Throughout the recovery process, participants drew from gifts of having bipolar disorder and acquired strengths that fostered self-acceptance and embraced a new identity. The act of reclaiming a stigmatized identity and embracing the gifts of illness represents a lifelong journey of resistance, resilience, and healing.

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APPENDIX A

Demographic Questionnaire

1. What is your age?
2. What is your gender identity?
 - a. Male
 - b. Female
 - c. Transgender Man
 - d. Transgender Woman
 - e. Gender Fluid/Non-binary
 - f. Prefer not to disclose
3. What is your race and/or ethnicity? Please circle all that apply.
 - a. African American or Black
 - b. American Indian/Alaskan Native
 - c. Arab American
 - d. Asian American
 - e. Native Hawaiian/Pacific Islander
 - f. European American/White
 - g. Latino/Latina/Latinx
 - h. Other_____
4. What is your marital and/or relationship status?
 - a. Married
 - b. Divorced/Separated/Widowed
 - c. Single/Never Married
 - d. In a relationship/Domestic partnership
5. What is your current work status?
6. At what age were you formally diagnosed with bipolar disorder

7. How are you living with bipolar disorder now? Please circle all that apply.
 - a. Medication Management
 - b. Mental health treatment/therapy/support group
 - c. Residential Living/Supported Housing
 - d. Live with a family member/friend
 - e. Other_____ (Please describe)

8. How long have you received mental health treatment for bipolar disorder? Please describe the treatment briefly.

9. Have you ever been involuntarily or voluntarily hospitalized for bipolar disorder? If, how many times? Approximately how long were you hospitalized each time?

10. Would you define where you live as urban, rural, or suburban?

10. Please indicate your highest level of completed education:
 - a. 8th grade or less
 - b. Some high school
 - c. High school diploma/GED
 - d. Some college or community college
 - e. Associates Degree
 - f. Bachelor's Degree
 - g. Master's Degree
 - h. Doctoral/Professional Degree (PhD, Medical, Law, etc.)

APPENDIX B

Interview Protocol

- 1.) I would like you to think back to the experience of learning that you had a diagnosis of a mental illness. What were some of your initial thoughts and feelings? What did this mean to you personally?
→Prompt: How did the illness affect you?

- 2.) How does living with bipolar disorder affect your understanding of self?
→Prompt: Follow up: How does having bipolar disorder affect your sense of self/thoughts and feelings about yourself?

- 3.) People have different perceptions of bipolar disorder. How have other people reacted to your diagnosis?
→Prompt: How do other people's reactions affect you?

- 4.) How have your interactions across social or family contexts affected how you view yourself?

- 5.) What does recovery look like for you? / What does recovery mean to you?
→Prompt: Based on your experiences What has helped your recovery? What has not helped your recovery?

- 6.) How have various forms of mental health treatment impacted how you view yourself and your recovery?

- 7.) Are there any strengths or advantages to your experience of living with bipolar I?

- 8.) Based on your personal journey with recovery, what would you say to other people living with bipolar disorder?

CURRICULUM VITA

Kaylyn Lee Watterson, M.Ed., M.S.

EDUCATION

- Dec. 2021 **Doctor of Philosophy in Counseling Psychology**
(Anticipated) *University of Louisville, Louisville, KY (APA Accredited)*
Dissertation: *Navigating Internalized Stigma and Identity Development in Bipolar Disorder I: A Grounded Theory Investigation*
- Dec. 2016 **Master of Education in Counseling and Personnel Services with a Specialization in Counseling Psychology**
University of Louisville, Louisville, KY
- May 2014 **Master of Science in General Experimental Psychology**
Bucknell University, Lewisburg, PA
- May 2010 **Bachelor of Arts in Psychology, English, & Spanish**
(Summa Cum Laude)
Butler University, Indianapolis, IN

CLINICAL TRAINING

- Sep. 2020- **Albany Consortium/Albany Medical College Psychology Internship**
Aug. 2021 Albany, NY
First Rotation: Capital District Psychiatric Center (CDPC), Forensic Unit
Responsibilities: Provided individual therapy, co-led groups, and conducted assessments to aid multidisciplinary team for treatment planning and discharge readiness on an adult inpatient psychiatric unit at a state hospital. Patients presented with a broad range of psychiatric disorders (mood disorders, psychotic disorders, personality disorders, cognitive disorders) and included forensic patients found not responsible for a crime by way of mental disease or defect.
Supervisor: Dr. Andrea Sopko, PhD, Unit Psychologist
Conducted year-long integrative psychotherapy with adult inpatient on acute psychiatric unit
Supervisor: Dr. Ron Gerrol, PhD, Chief Psychologist at CDPC

Second Rotation: Albany Stratton VAMC Behavioral Health Outpatient Clinic

Supervisor: Dr. Steve Nozik, PhD, VAMC Psychologist

Responsibilities: Provided individual therapy to 10 veterans weekly via videoconferencing and telephone platforms. Veterans ranged in age from 23 to 78 and presented with a range of psychiatric disorders and functional impairments.

Third Rotation: Albany Stratton VAMC PTSD Outpatient Clinic

Supervisor: Dr. Kevin Pertchik, PhD, VAMC PTSD Psychologist

Responsibilities: Provided short-term intensive outpatient treatment for veterans with combat-readjustment problems. Individual therapy focused on desensitization and emotional processing of traumatic memories via intensive exposure-based psychotherapy, including PE, CPT, and STAIR. Conducted year-long integrative psychotherapy with veteran in PTSD Clinic

Supervisor: Dr. Caitlin Holley, PhD, VAMC Psychologist

Other Experiences: Weekly didactics, professional seminars, grand rounds, and case conferences, clinical supervision of trainee in Masters program

Aug. 2018-
May 2020

University of Louisville Counseling Center (Graduate Assistant)

Louisville, KY

Responsibilities: Conducted initial triage evaluations. Made referrals to campus and services (Campus Health, Disability Resource Center, LGBT Center, etc.). Provided same day urgent consultation for walk-ins. Provided brief and long-term individual therapy for 6-8 clients weekly. Responded to university sanctioned outreach requests. Presented on mental health related topics to student organizations. Managed UCC social media accounts and posts. Provided on-site supportive counseling at university events. Created educational materials and implemented Wellness Workshops for campus community (LGBT and Going Home for the Holidays, Healthy Relationship, Self-Care for Graduate Students). Collaborate with Student Affairs Divisions and UCC staff to plan annual Self-Care Fair.

Population served: Traditional and non-traditional aged college students. First generation college students, and students of various backgrounds including race/ethnicity, socioeconomic status, sexual orientation, and religious orientation with a range of presenting problems, including mood and anxiety disorders, sexual assault, PTSD, Bipolar II, and personality disorders

Supervisors: Dr. Aesha Uqdah, HSPP, Director; Dr. Ruby Casiano, PhD, HSPP, Training Coordinator; Dr. Geeta Gulati, PsyD, Staff Psychologist

Aug. 2017-
July 2019

Providence House Self-Sufficiency Ministries

Georgetown, Indiana

Responsibilities: Conducted individual, family, couples, milieu, and group therapies for families involved with Department of Child Services (DCS) due to child abuse/neglect. Co-led an adult group aimed at increasing insight into the effects of early experiences with primary caregivers on current relational and parenting patterns. Designed and co-led a dual diagnosis group for adults to process the effects of substance use and build skills related to distress tolerance and emotion regulation. Participated in family-child team meetings with DCS to coordinate client care and treatment planning. Gained exposure to parent-child treatments like Thera-play, Parent Child Interaction Therapy, and Sand-tray. Administered, scored and wrote an integrated report including the WAIS-IV, PAI, & Rorschach. Provided feedback to client.

Population served: Adults with co-occurring substance disorders, severe personality disorders, and trauma-related disorders.

Supervisor: Liz England, PsyD, HSPP, Director

Aug. 2016-
June 2017

Central State Psychiatric Hospital, Dual Diagnosis Unit

Louisville, KY

Responsibilities: Conducted initial interviews, individual therapy, group therapy, milieu therapy, and relapse prevention planning for substance use and serious mental illness. Conducted suicide risk assessments, assessment of cognitive and adaptive functioning, personality assessments, and forensic assessments as needed (WASI, MCMI, TOMM, SIMS). Attended multidisciplinary treatment team meetings with medical doctors, psychiatrists, nurses, and social workers. Prepared documents for psychologists to use in court proceedings for resolution of patients' legal status; attended court to observe forensic psychology practices. Primarily utilized cognitive behavioral interventions, motivational interviewing, and a person-centered approach; utilized approaches from *Seeking Safety*, *Pathways to Recovery*, *DBT Skills Training for Integrated Dual Disorder Treatment Settings*.

Population Served: Adult inpatients diagnosed with serious mental illness.

Supervisor: Dr. Ann Brian, PhD, Dual Diagnosis Unit

- Aug. 2016-
May 2017 **Bellarmino University Counseling Center (Supplemental Practicum)**
Louisville, KY
Responsibilities: Provided individual psychotherapy services students. Co-
led a weekly interpersonal therapy group for two semesters. Conducted
triage assessments via phone for students seeking counseling services.
Utilized outcome measures (e.g. CCAPS, ORS, and SRS) for treatment
planning and case conceptualization. Utilized Therapist Assisted Online as
homework for individual therapy. Presented case conferences with video
recording of sessions. Attended on campus outreach and tabling events.
Population Served: Undergraduate and graduate students at a private,
Catholic university, ages (18-24). Clients comprised traditional and first-
generation students. Majority of caseload consisted of White women with
various socioeconomic status, gender identity expression, and sexual
orientation. Clients presented with adjustment disorders, major depression,
anxiety disorders, trauma, academic concerns, disordered eating,
perfectionism, and personality disorders.
Supervisor: Dr. Gary Petiprin, PhD, HSPP, Director.
- May. 2016-
July 2016 **Cedar Lake Lodge (Assessment Practicum)**
La Grange, KY
Responsibilities: Administered and scored testing for intellectual
(Stanford-Binet Intelligence Scales-5, WAIS-IV) and adaptive functioning
(Vineland-II). Interpreted test results and wrote 8 integrated psychological
reports for residents' annual treatment and progress review. Consulted
with psychologist, nurses, and care staff to make treatment
recommendations.
Population Served: Adults with severe intellectual and developmental
disabilities in a residential care setting.
Supervisor: Dr. Jeff Hicks, PhD, HSPP, Director of Psychology
- Aug. 2015-
May 2016 **University of Louisville Counseling Center**
Louisville, KY
Responsibilities: Conducted intakes and provided brief and long-term
individual therapy. Consulted with psychiatric providers in Campus
Health to monitor client's treatment and response to medications. Co-led a
women's support group with a staff psychologist. Participated in weekly
group supervision. Attended outreach events and spoke with students
about campus services
Population Served: Undergraduate and graduate students enrolled at a
large, urban public university. Clients presented with adjustment
disorders, depression and anxiety disorders, academic concerns, identity
exploration, interpersonal conflict, and grief. Clients comprised traditional
aged and first-generation college students of diverse racial/ethnic
identities, socioeconomic status, and sexual orientation.
Supervisors: Dr. Ruby Casiano, PhD., HSPP, Training Coordinator
Juan Pablo Kalawski, PhD., HSPP, Staff Psychologist

SUPERVISION EXPERIENCE

Jan. 2017- **ECPY 755- Supervision Course**
April 2017 *University of Louisville, Louisville, KY*
Responsibilities: Supervised a Masters-level art therapy graduate student as part of a supervision training course. Met with the supervisee for six sessions, which focused on case conceptualization, feedback, and trainee self-awareness. Reviewed videotapes of supervision sessions and received feedback from classmates and instructor.

CONSULTATION EXPERIENCE

May 2017- **Consultation with Non-Profit Organization**
June 2017 *Neighborhood House, Louisville, KY*
Responsibilities: Served as the point-person on a team of masters students engaged in an evaluation project with a local non-profit organization that provides services to families and children in a low-income neighborhood of Louisville. Analyzed survey data on protective factors of families and made recommendations for future data collection and outreach. Consulted with team administrators, collected and examined surveys, interacted with clients, and brainstormed ways to improve the mental health of attendees.

PROFESSIONAL AND RESEARCH EXPERIENCE

Jan. 2016- **Resilience Research Lab led by Dr. Laurie McCubbin, PhD, Associate**
May 2020 **Professor in the College of Education and Human Development**
Responsibilities: Conducted studies evaluating resilience across various age and cultural groups. Identified conceptual definition of resilience across various peer reviewed studies. Tested models of family resilience using Structural Equation Modeling. Reviewed lab member manuscripts and projects and provide written feedback.

July 2016- **Graduate Research Assistant, College of Education & Human**
May 2018 **Development, Dept. of Educational Leadership, Evaluation, & Organizational Development**
Responsibilities: Research and report writing to advance support for the Cadre and Faculty Development Course (CFDC), grant funded by the US Army and Training Doctrine Command. Coded and synthesized peer reviewed publications and wrote results for a systematic review about student soldiers in higher education.
Supervisors: Dr. Meghan Pifer, PhD. & Dr. Jeffrey Sun, PhD

- Aug. 2014-
May 2016 **Graduate Research Assistant, College of Education & Human Development**
Department of Counseling and Human Development (ECPY)
Responsibilities: Provided administrative and statistical analysis support for department faculty. Analyzed outcome evaluation data and co-wrote report for self-study of Cardinal Success Program Community Clinics. Created a recruitment presentation for applicants to the Master of Counseling program. Consolidated materials for licensure packet for graduating students. Research and report writing to advance support for the Cadre and Faculty Development Course (CFDC), grant funded by the US Army and Training Doctrine Command. Data analysis and report writing regarding mathematical development in gifted middle school students in KY.
Supervisors: Dr. Mark Leach, PhD, Dr. Jill Adelson, PhD, Dr. Katy Hopkins, PhD.
- Sept. 2011-
Jan 2012 **Research Consultant**
Illinois Positive Behavior and Supports Network
Responsibilities: Provided data management and analysis supporting school-based interventions in local and community agencies in Illinois. Screened data for internalizing/externalizing behavioral symptoms in school populations. Collected data and interviewed participants for doctoral dissertation by Rose (2012) titled *Cultural competence, does it matter? Lessons from a mixed methods study of Wraparound practice*. (Doctoral Dissertation) Loyola University, Chicago, IL.
Supervisor: Jennifer Rose, Ph.D.
- Sept. 2011-
Jan 2012 **Research Study Assistant**
University of Washington, Department of Psychiatry & Behavioral Sciences
Division of Public Behavioral Health and Justice Policy
Responsibilities: Supported various projects for the evaluation of evidence-based clinical practices. Conducted phone interviews with caregivers, youth, and Wraparound Service Providers regarding service utilization and evaluation of treatment providers. Interpreted fidelity data and provided consultation to off-site agencies to improve fidelity of treatment services. Wrote and submitted research proposals to the Washington State Institutional Review Board.
Supervisor: Eric J. Bruns, PhD.
- Jan. 2006- **Religiousness and Health Behaviors Lab**
Responsibilities: Attended and facilitated discussion in lab meetings, presented research projects at conferences, entered and analyzed data using SPSS, assisted in research experiments, collected data and completed an honor's thesis

PEER REVIEWED PUBLICATION

Watterson, K., & Giesler, R.B. (2012). Religiosity and self-control: When the going gets tough, the religious get self-regulating. *Psychology of Religion and Spirituality*, 4, 193-205.

CONFERENCE PRESENTATIONS

Watterson, K., Gonzaga, P., Zhong, J., Untalan, A., & McCubbin, L. (2019, April). *Qualitative Research in Resilience and Recovery: Exploring the Experiences of Diverse Populations After Adversity*. Symposia presented at the Great Lakes Regional Counseling Psychology Conference, Louisville, KY.

Watterson, K. & McCubbin, L. (2018, April). *Recovery from Self-stigma in Serious Mental Illness*. Poster presented at the Great Lakes Regional Counseling Conference, Kalamazoo, MI.

Zhong, J., McCubbin, L., Hardwick, J., & **Watterson, K.** (2018, April). *Barriers to Counseling for African Americans*. Poster presented at the Great Lakes Regional Counseling Conference, Kalamazoo, MI.

Watterson, K., Idigo, K.C., & Visalli, K.M. (2017, March). *Challenges for counseling psychologists in working with vulnerable populations in restrictive settings*. Roundtable discussion presented at the Great Lakes Regional Counseling Psychology Conference, Muncie, IN.

Watterson, K., McCubbin, L., & Toledano-Toledano, F. (2017, March). *Examination of family resilience model among Mexican caregivers of children with cancer*. Poster session presented at the Great Lakes Regional Counseling Psychology Conference, Muncie, IN

Watterson, K., & Leach, M.M. (2016, August). *Spirituality and religiosity as unique predictors of posttraumatic growth*. Poster presented in Trauma Psychology (Division 56) at the American Psychological Association Annual Convention, Denver, CO.

Williams, S.M., Frey, L.M., Stage, D.L., **Watterson, K., & Cerel, J.** (2017, April). *The unique experiences of a dual identity: Exploring lived experience in gender and sexual*

minority attempt survivors. Poster presented at 50th Annual Conference of the American Association of Suicidology, Phoenix, AZ.

Watterson, K., & Boyatzis, C.J. (2015, March). *God-concepts and the thin-ideal: Do religious art primes buffer against body dissatisfaction and unhealthy eating?* Poster presented at Great Lakes Regional Counseling Psychology Conference, Muncie, IN.

Watterson, K., & Boyatzis, C.J. (2014, August). *Religion, self-esteem, and meditation in women's body image and eating behavior*. Poster presented at the American Psychological Association Annual Convention, Washington: DC.

Watterson, K., Giesler, R.B., Wainright, K., Adams, K., & Joo, L. (2011, January). *Are the religious better at self-regulation?* Poster presented at the Annual Meeting of the Society of Personality and Social Psychology, San Antonio, TX.

Watterson, K., Brownson, C., Hunt, L., Ehlert, N., & Giesler, R.B. (2010, April). *Religiosity predicts physical health in young adults*. Poster presented at the Annual Meeting Annual Meeting & Scientific Sessions of the Society of Behavioral Medicine, Seattle, WA

TEACHING EXPERIENCE

April 2018 **Guest Lecturer: PSY 621 (Personality Assessment)**
Department of Counseling and Human Development, University of Louisville
Topic: Millon's Theory and Taxonomy of Personality

Aug. 2017- **Teaching Assistant: PSY 648 (Intellectual Assessment)**
Dec. 2017 *Department of Counseling and Human Development, University of Louisville*
Responsibilities: Scored mock assessments, viewed and graded videos of students administering the WISC-V & WAIS-IV. Provided feedback to students.

Feb. 2016 **Guest Lecturer: PSY 670 (Career Counseling)**
Department of Counseling and Human Development, University of Louisville
Topic: Psychology of Work

Sep. 2015- **Guest Lecturer: PSY 619 (Techniques of Counseling Psychotherapy)**
Department of Counseling and Human Development, University of Louisville
Topic: Interpersonal Process Theory and Intervention

- Aug. 2012-
May 2014 **Graduate Research and Teaching Assistant**
Department of Psychology, Bucknell University
Responsibilities: Served as the Subject Pool Coordinator for Psychology 100 (Fall 2013). Teaching Assistant for Introduction to Psychology (Fall 2012 & Spring 2013) and Psychological Statistics (Spring 2014). Graded assignments and exams, held weekly office hours, conducted exam review sessions.
- June. 2013 **Teaching Assistant for Bucknell in Denmark Study Abroad Program**
Department of Psychology, Bucknell University
Responsibilities: Acted as a liaison between students, faculty, and the Danish Institute for Study Abroad. Mentored undergraduate students, coordinated travel and events for study abroad program.
- Sept. 2009-
May 2010 **Peer Tutor**
Butler University Writer's Center
Responsibilities: Assisted undergraduate students with all parts of the writing process, including brainstorming ideas, thesis development, organization, clarity of expression, proper citations, and grammatical usage

ACADEMIC SERVICE

- April 2019 **Student Co-Chair Programming Committee**
Great Lakes Conference, University of Louisville, Louisville, KY
Responsibilities: Coordinate conference events for Great Lakes Regional Conference. Reviewed submitted conference proposals. Compiled official Conference Program. Responded to inquiries. Organized a student social event for conference attendees and promote APA Division 17.
- Jan. 2018 &
Jan. 2016 **Student Coordinator for Doctoral Interviews**
University of Louisville, Louisville, KY
Responsibilities: Communicated with doctoral applicants about the Counseling Psychology program. Coordinated travel and hospitality accommodations for doctoral applicants. Served as a student representative on two interview weekends
- Jan. 2015-
May 2016 **Student Representative for Dept. of Counseling & Human Development**
University of Louisville, Louisville, KY
Responsibilities: Attended monthly departmental faculty meetings. Took meeting minutes to distribute to doctoral students. Served as a liaison between department faculty and doctoral students. Communicated with faculty about doctoral training and student opportunities

- Jan. 2015 **Doctoral Student Interviewer**
University of Louisville, Louisville, KY
Responsibilities: Assisted in the doctoral interview process. Interviews occurred in group format with professor, Dr. Mark Leach.
- Aug. 2014-
 Aug. 2015 **Doctoral Student Organization**
University of Louisville, Louisville, KY
Responsibilities: Membership in a doctoral student-run organization. Collaborated with other students in the department to assist in advocacy among the department administrators and faculty.
- Dec. 2014 **Student Advisory Committee Leader**
Bucknell University, Lewisburg, PA
Responsibilities: Interacted with candidates of clinical health psychology faculty position. Complied undergraduate student committee member responses. Wrote letter of evaluation and recommendation for the Buckell psychology dept. faculty

PROFESSIONAL DEVELOPMENT

- 2/22/19 &
 2/23/19 Emotion-Focused Therapy Training: The Transforming Power of Affect. Dr. Rhonda Goldman, PhD.
- 11/1/18 Conscious Discipline: Building Resilient Schools & Homes. E-Course. Dr. Becky Bailey.
- 10/2018 Bridges out of Poverty: Strategies for Professionals and Communities. Providence House Self-Sufficiency Ministries.
- 9/15/17 Kentucky Psychological Association, Borderline & Narcissistic Personality Disorder Assessment, Treatment and Practical Skills. Dr. Eric Russ, PhD
- 9/18/17 Cognitive Processing Online Training Course. Medical University of South Carolina. 9 CE credits.
- 7/27/17 Parent Child Interaction Therapy (PCIT) for Traumatized Children Web Course. 10 CE credits.
- 2/28/16 Military Culture: Core Competencies for Health Care Professionals Self Assessments and Introduction to Military Ethos. VA Employee Education System, 2 CE credits
- 12/18/16 TF-CBT Web: An Online Training Course for Trauma-Focused Cognitive Behavioral Therapy. 10 CE units.

6/5/15 Brief Interventions for College Student Drinking: BASICS and Motivational Interviewing. Dr. Diane Logan, PhD

OTHER CLINICAL & VOLUNTEER EXPERIENCE

- Aug. 2019- **Assessment Therapist**
Dec. 2019 *Providence House Self-Sufficiency Ministries*
Responsibilities: Conduct psychological diagnostic evaluations in support of Indiana Department of Child Services (DCS) for family reunification. Administer and objective and projective assessments. Interpret results and write integrated report with treatment recommendations.
Population Served: Adults with DCS involvement
Supervisor: Liz England, PsyD.
- Aug. 2013- **North Central Secure Treatment Unit in Danville, PA**
Dec. 2013 *Bureau of Juvenile Justice Services*
Responsibilities: Shadowed counselors and participated in group and milieu therapies with at-risk youth and young women. Majority of clients comprised African American women from rural and urban counties in Pennsylvania.
Population Served: Adjudicated female youth and women (ages 15-20)
- Aug. 2012- **Pennsylvania Treatment and Healing (PATH)**
Dec. 2012 Milton, PA
Responsibilities: Participated in group therapy activities with children (ages 7-15) in an after-school evening day treatment program.
Population Served: At-risk youth returning to the community from institutional placements

PROFESSIONAL AFFILIATIONS

Graduate Student Affiliate, American Psychological Association (2014-Present)
Student Affiliate, Society of Counseling Psychology, Division 17 (2014-2016)
Student Affiliate, Society for Psychology of Religion and Spirituality, Division 36 (2012-2014)

AWARDS

- 2013 **APA Division 36 Research Award**
- 2010 **Phi Beta Kappa National College Honor Society**
Butler University, Indianapolis, IN
- 2009 **Top 100 Outstanding Student Recognition Award**
Butler University, Indianapolis, IN
- 2008 **Psi Chi Honors Society**
Butler University, Indianapolis, IN