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Krzysztof Dyga, Małgorzata Opoczyńska-Morasiewicz

IDENTITY OF PEOPLE DIAGNOSED WITH BIPOLAR DISORDER

Department of Health Psychology, Institute of Psychology, Jagiellonian University

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Summary

Objectives: The objective of this research was to explore the contents of experiences associated with the identity of people diagnosed with bipolar disorder (BD).

Methods: Six semi-structured interviews were conducted with people over 30. Their transcripts were subject to interpretative phenomenological analysis (IPA).

Results: The statements of the participants showed a complex picture of their struggles with identity in the course of BD. Attitudes towards diagnosis and treatment were a significant part of it. Half of the respondents expressed disagreement with the pathologization of bipolarity (which was part of their identity) and aggressive treatment resulting in, among others, the perceived reduction of intellectual capability which was one of the fundamental features of their identity. The remaining participants have accepted the current psychiatric narrative, being themselves mostly during remission and making efforts to stay in this state in accordance with the physician's orders.

Conclusions: Regardless of the ways of understanding BD and the attitude to treatment, none of the participants had any critical issues related to his/her identity. Participants demonstrated high tolerance of uncertainty, presumably being a function of variables such as age and duration of the disorder, well-developed postformal thinking, and motivation to learn about themselves. Positive reformulations and a clear narrative about life with BD made its acceptance possible. In some of them, this meant approval of the received diagnosis, in others, it was the affirmation of bipolarity. None of the participants defined themselves through the role of the patient. Identity-related senses of continuity and cohesion were favored by not separating the healthy and ill aspects of oneself.

Introduction

Bipolar affective disorder

Bipolar affective disorder is characterized by recurring phases of depression and mania. Depression, apart from a strong decline in mood, is accompanied by a decreased level of energy, aversion to life and to oneself, usually combined with a sense of worthlessness, often with an exaggerated sense of guilt and suicidal thoughts or even tendencies. Hope fades away, the positive aspects of life are completely put aside, all interests and passions are lost. This is accompanied by vegetative changes: usually extended or shortened sleep time and increased or decreased appetite. Reduced drive and ruminations translate into a deterioration of cognitive abilities, particularly with

attention deficits. In mania, the opposite is true: a person, unless he or she is mainly dysphoric, is filled with life, with a sense of happiness and living life to the full. The level of the organism's mobilization seems superhuman, particularly when accompanied by an exceptionally low demand for sleep and food; the creativity level increases rapidly (racing thoughts might appear), the activity level also increases (activities being more and more chaotic and destabilizing with time). Everything seems to make sense, to be mutually connected, thus justifying the particular point of view of the individual and his or her self-satisfaction (which evolves in psychotic mania to delusions of reference, grandeur, and mission).

Identity – a synthesis of psychological concepts

The awareness of this cyclical changeability raises the question of whether the divergence between the self-now and the self-then impacts the feeling of being oneself and the conviction that one has been the same self. This means the identity both in the subjective dimension, based on own "feelings" (of distinctiveness, continuity, or coherence), and in the objective dimension. The latter relates to such characteristics, values, beliefs, roles and social affiliations, memories, plans, etc., which, revealed in the process of self-reflection, constitute the foundations of an individual's identity [1]. The identity in the objective dimension implies focusing attention only on those personal features to which the greatest importance is attributed to the self-defining process [2]. The feelings of continuity and coherence are expressed in more or less conscious experiences, which, if verbalized, could sound as follows: "I am me, all my life" and "I am me, despite the diversity of my characteristics, states, behaviors in different moments and situations."

Since the reality behind the notion of identity, limited to a single theory or language of description, loses much of its diversity, we prefer to integrate both the various concepts of identity and the above-mentioned dimensions. This approach is in line with the atheoretical (although drawing on a rich theoretical output) conceptualizations already present in the Polish literature [1–3]. Identity in this article will, therefore, be related, on the one hand, to what an individual thinks about themselves and to what, at the same time, they apply the most importance (the latter distinguishes identity from self-concept), what they take as their own and without which it would be difficult for them to imagine themselves. On the other hand, identity will be related to how they find themselves in time and space (*i.e.* in different situations) and how much they feel to be themselves.

The research problem of this work includes this part of the world experienced (*Lebenswelt)* by people with a diagnosis of BD which relates to the identity as defined above. This problem corresponds with the aim of this study, which is to explore the meanings that accompany the experience of identity in the course of BD. No study on these issues has been published in Poland so

far, and there are only a few publications on the subject available worldwide [4–8]. Yet, these few existing reports, which will be mentioned in the discussion and which were discussed in detail in an earlier article [9], draw attention to the importance of the issue in question. This issue would consist of the following phenomena: a wide range and high intensity of moods manifested in swings and sudden changes of behavior, affect and thinking, resulting in confusion about who one is [see 5–7]; subjectively experienced "multiplicity of personalities" [7]; poorly controllable or predictable behaviors that are surprising even for oneself [5,7]; impossibility to recognize oneself, lack of substance, inability to identify the "true self" or to integrate different aspects of oneself; the sense of not being the same throughout time, difficulties in distinguishing oneself from others [6].

Method

Interpretative Phenomenological Analysis — IPA

The indicated aim of the study, related to the exploration of the topic for understanding and providing therapeutic assistance (not for explanation nor prediction), implies the use of qualitative methodology. The choice of this methodology also suggests focusing rather on the content of identity and not its structure, processes, nor formal properties. The choice was made for interpretative phenomenological analysis (IPA). This method equally enables the perspective of the participant (phenomenological aspect) and the researcher (hermeneutical aspect) to emerge. Research samples are usually small, making it possible to conduct a detailed analysis of all statements. In studies using IPA, it is recommended that a targeted selection and relative homogeneity of the sample be made. The sample for this study consisted of 6-8 participants [10, 11].

Participants

In accordance with the above-mentioned guidelines, the sample had the following setting: 6 people (3 women and 3 men) diagnosed with BD (currently in remission) aged 37-52[1], living in large urban agglomerations, and having university degrees (half of them also postgraduate). Information about the participants in the survey, outlining the context in which an attempt will be made to understand their experiences, is presented in Table 1 (the names have been changed to ensure the anonymity of the respondents).

[1] The choice of people over 30 years old was intentional and associated with the prolonged process of identity crystallization [12]. Nowadays, it is clear that the "crystallization" of identity is always relative. The age restriction served to guarantee that the participants had already been through the period of "the first, most intense shaping of identity" [13, p.15], so that the possible specifics of the group's identity would become more evident, undisturbed by developmental processes.

Table 1. **Information on subjects**

Nick	Characteristics
Magdalena	38 years old. Single “by conviction.” Graduated in economics, currently holds a management position in a corporation. Since the diagnosis 15 years ago, she has experienced three episodes of mania and two episodes of depression that ended with hospitalization. She only underwent pharmacotherapy when forced to do it; at the time of the study, she was taking a low dose of lamotrigine, which she was planning to give up in the near future. She had taken part in psychotherapy before the study.
Witold	48 years old. After graduating from law school he worked in his profession until the second episode of mania. Divorced, has a teenage son. He was diagnosed with bipolar affective disorder 2 years ago, during the first of two hospitalizations for mania. Although opposed to medicines, he has been taking lithium and lamotrigine since the last, unexpected and “meaningless” mania episode. He had participated in psychotherapy before the study.
Agata	52 years old. In the past, she was an editor and translator, now a private teacher. Divorced, has an adult daughter. It is difficult for her to tell how many episodes of the disorder she has had; the last one took place a few years ago, and she was first diagnosed 17 years ago. She has taken buproprion for a short time and underwent psychotherapy.
Marta	39 years old. In the past she worked in a bank, after being diagnosed (7 years ago) she changed her profession to teaching. Unmarried. She has experienced five hospitalized episodes of mania and one episode of depression. She is taking amotrigine, arypiprazol, and sertraline and is attending psychotherapy.
Marcin	38 years old. Previously a soldier, now a specialist and instructor. In a stable relationship. He was diagnosed with BD 11 years ago. Since then, he has experienced one episode of mania and two episodes of depression. Has been hospitalized twice. He is taking lamotrigine and venlafaxine and has taken part in psychotherapy of various modalities.
Robert	37 years old. Graduated in agroeconomics, for years on disability allowance. Currently training to perform the EX-IN[2] profession. Single. During the approximately 20 years since the first diagnosis, he has experienced 15 episodes of mania and 14 episodes of depression. Currently, he is taking valproic acid and olanzapine, has participated in psychotherapy.

Procedure

The examination was conducted by the first author, psychologist and psychotherapist currently in the process of certification. Purposive sampling was used in the study. Recruitment was carried out by means of an advertisement on relevant BD fora that included information about the search for participants that meet certain conditions, information about the research topic, the method of the study, its expected duration and potential benefits to the participant and the community. The first contact with volunteers took place via e-mails, followed by a phone call and then a meeting at a mutually agreed location. The second stage of recruitment took the form of a “snowball strategy”: the first participants recommended other people who could be potentially interested in the study and who met the assumed criteria.

Data collection

The initial instruction, which was suggested by the second author, had a projective-imaginary

[2] EX-IN (Experienced-Involvement), an "expert by experience", *i.e.* a person who, after having experienced a mental crisis and having undergone appropriate training, supports and accompanies others in their recovery and educating professionals by sharing "first-hand" experience.

character: “Imagine that you have the opportunity to create your very own identity card, one that would not necessarily resemble a familiar document. It would include everything that would allow you to identify yourself, to recognize who you are. What basic information about you would it contain? What kind of distinguishing marks?”

The use of projection technique in identity research has its precedents [14, 15] but, unlike previous quantitative research, our instruction was to serve as a starting point for in-depth statements. Its aim was to eliminate, as far as possible, content that might be of suggestive character, with as little prompting from the interviewer as possible [11, p. 61]. That is why the previously prepared detailed questions were abandoned, with the intention of using only a few questions referring to the ID metaphor in the course of the semi-structured interview: “How did it look like in the past?”, “How has it changed over time?”, “How will it look like in the future?”, “Would it be the same in mania and depression?”, “If not, what would be different in those states?” For the case of lack of a positive response to the projection stimulus, an alternative research scheme has been prepared, based on the most general and open questions about identity (who am I, what is important to me) and their development – ‘hints’ in the form of originally arranged detailed questions (as suggested by the creator of IPA [11]). The partially structured in-depth interview was intended to allow for far-reaching flexibility and to follow the participant, including the exploration of threads that might not always have been foreseen.

Data analysis and interpretation

The analysis and interpretation of the collected data were carried out by the first author according to the guidelines of the IPA Guide [10]. The analysis related to what had been said; this allowed the common threads in the participants’ statements to be grouped into thematic categories related to identity. The interpretation contained what had been heard by the researcher, according to the principle of a hermeneutic circle in a twofold sense: a repeated reference from individual parts to the whole and back, as well as from the pre-judgements to their revision [16, see 17]. In order to ensure credibility (the qualitative equivalent of internal accuracy), “testing by participants” was implemented: a strategy of agreeing the author's interpretation of the statements of the participants with the actual participants themselves [18, 19]. Since the results of the understanding process are the result of a creative meeting of the voices of participants and researchers, and the voices that had previously been heard speak through both of them, the presentation of these results could not take place without references to literature.

Results

In the course of the analysis, the following topics were identified: “common” (occurring in

the general population and represented in most of the psychological concepts) and "unique" (specific to people struggling with BD [see 20]). It is the latter that will be discussed in more detail in this article. However, understanding them would be incomplete without the awareness that "common" threads, which are so important for integrated identity, have become present in the narratives of the research participants. Here, however, the specificity of this group has been revealed – through a particular focus on various threads. For this reason, it seems necessary to briefly discuss these "common" aspects of the participants' identities.

The unique in the common

Exploration and engagement processes responsible for identity formation [21] are largely about values, and the question of "what is important to me" is as important a question as "who am I?" [22]. Investigating what is important in life, advocating certain values and receding away from others, allowed the majority of participants to maintain integrity despite the volatility of their self-sense. The greatest importance was attributed to the search for truth (particularly the truth about oneself), freedom, autonomy, responsibility, and independence, as well as for goodness. The values and goals that were most important for the participants were revealed during interviews as already implemented or as inspirations for their behaviors. Looking into the future, they were probably less anchored in the volatile here-and-now and thus were able to maintain a sense of integrity.

The most emphasized own personal qualities and skills were: flexibility and the ability to quickly find oneself in changing conditions as well as intelligence and reflectiveness. Surprisingly, social roles, generally considered to be the primary determinants of identity, were not often raised by the participants. At the same time, the statement "I don't know who I am" was most often made in the context of social roles, although it was mostly, for various reasons, devoid of negative overtones ("If I knew [who I am] entirely, I don't think it would be that interesting") [Agata]). Moreover, some of the participants, like Magdalena, even denied the importance of social roles as aspects of collective identity – by lack of identification with reference groups – and relational identity – emphasizing the "identity of a single" [see 23]. Others, particularly Marcin, focused on professional roles, but more on those performed in the past or planned for the future. Probably this peculiar atemporality enables integration and a sense of continuity in volatility.

The attitude of Agata is specific. For her, social roles (*e.g.* mother, teacher) are actually – using Jung's nomenclature – a number of personas with whom she more or less identifies herself, but who do not provide (comprehensive) answers to the question of identity. Agata expressed an aversion to unambiguous self-descriptions and "classification" and "intellectually undermined" her own identity contents. Their unchangeability and rigidity create a monotony, which is the source of

identity-enhancing compensation strategies based on the search for novelty and "adventure".

While the above-mentioned areas of identity were often not connected by the participants with the disorder experience, the thematic categories listed below refer directly to the basic question: whether and how do these experiences affect identity, or: do they modify the previous (premorbid) answers to the question "who am I?" and its derivatives, and to what extent do these answers (and the questions themselves) problematize.

Table 2: **Themes identified during the analysis**

Theme	Magdalena	Witold	Agata	Marta	Marcin	Robert
I am not my illness	x	x	x	x	x	x
I don't want to cure myself of what is mine, although it is not me	x	x	x	x		x
Past and future in the mirror of now	(x)	(x)	x	x	x	x
Being oneself – but which one?	x	x	x	x	x	x
More than being oneself	x	x			x	

"I am not my illness"

The participants of the study talked about what the diagnosis means for them and to what degree it relates to them. Some revealed development of their attitudes towards the diagnosis, others – a still present ambivalence.

Witold's attitude to bipolar affective disease (BD)[3] is closely related to the original understanding of it. Having an aversion to BD as a "iatrogenic disease" (*i.e.* post-pharmacological deterioration and stigmatizing label), he affirms what hides beneath it. Witold normalizes BD by looking for its origins in the evolutionary, though "somewhat atavistic and still incomprehensible mechanism of extraordinary and long-term mobilization and demobilization" of the organism, the high intensity of which is a particular trait of the "bipolar personality."[4] Bipolarity is an integral part

[3] The use of outdated nomenclature is justified when the participants themselves use the word "disease".

[4] Scientific literature contains only a few articles dealing with BD from an evolutionary perspective (which is in contrast to the mass of reports regarding unipolar depression); the majority, published in *Journal of Affective Disorders*, do not go beyond commonsense deductionism. In this context, Witold's hypotheses, quoted here only in fragments and in a simplified form, seem particularly interesting, partly converging with perhaps the first article on that subject [24].

of oneself ("If we put it outside, that which is a part of ourselves, and we wanted to eliminate it, in effect we would cease to be ourselves"), strongly linked to identity: "That's how I am and I do not want to be cured of it." Consequently, Witold does not agree with the separation of the "healthy" self from the "sick" one according to the principle: "This is not me, this is my BD, my mania is not me" (because in that case, who should be attributed with the achievements of hypomania?). Magdalena also presents an attitude of resistance against the psychiatric narrative. When asked whether the diagnosis affects her identity, she answered: "I try not to have it impact my identity. Because... all psychiatric diagnoses are limiting." And she added, "I wouldn't have done many of the things I've been doing if I'd accepted that there is such a thing as BD." Like Witold, Magdalena recognizes that BD is in fact a "nomenclature assigned to certain types of people" with similar experiences, but unlike him, she tries to see the source of these similarities in their histories of "more or less conscious traumas." This way of thinking is also indicated by Marcin, for whom BD is one of the "distinguishing features" by which he recognizes himself, and which give access to unusual content and the ability to understand deviations from what is typical.

The history of Marta's struggle with the diagnosis can be divided into stages: from denial ("I denied, (...) I didn't really want to be treated") through "absorption" [cf. 25] ("I had identified myself with the disease for a very long time and it was a very big problem for me") to acceptance:

"At this point, so to speak, I've begun to like my illness, *i.e.* maybe not so much to like it as to tolerate it. (...) After having accepted my illness and starting to stabilize myself, I feel that at this moment, there is such a way upwards, right? It's getting closer and closer to who I would like to be."

For Robert, the extent to which the diagnosis defines him is a fundamental issue, but it is full of contradictions and, therefore, still unresolved: "I've thought about it many times, am I for example a nut? Well, maybe I am. But I'm in good shape, so I'm sort of not. But the past says something else, so it's a bit like that is the truth." Finally, he comes to the conclusion: "My identity is already... it's like it's connected to this illness." However, this does not equal with identification with the illness: "I am not the illness. When the illness comes to me I can just look at it and say that I'm not the illness (...) I'm gonna get sick with it and I'm gonna be for a while, you can say in quotation marks, this illness, but then it goes away and again, it's the same Robert and I'm acting and functioning without the illness."

Agata, on the other hand, neither identifies with the disorder nor denies it completely. The diagnosis "does not determine my life for sure," and the accuracy of the diagnosis itself is questioned.

I don’t want to cure myself of what is mine, although it is not me

Treatment, particularly pharmacotherapy, may be associated with identity when it restores or takes away its basic determinants. Half of the participants manifested hostility to drugs with varying intensity. Particularly Witold and Magdalena mentioned this aspect. In Magdalena’s experience, drugs do not only disturb cognitive functioning (“Following the treatment, I am simply stupider”) and damage internal organs but they even “disturb my personality, identity, disturb everything.” Agata’s utterance is close to Witold’s concept of “iatrogenic disease”: “If I took these drugs – I didn’t buy anything, of course – but if I took this thing, I’d go crazy.” She was the only one of the participants who had never taken neuroleptics nor mood stabilizers, not approving of the artificial “balancing of neurotransmitter levels.” (“I don’t think you should change the chemistry of your brain.”) Not wanting to mute the suffering, she preferred facing it without anesthesia: “Because even after my fiancé died, I didn’t take anything. Because I think you have to deal with it by yourself, somehow.” The exception to this rule – the short-term acceptance of Wellbutrin – was connected with something else: the positively valorized hypomania, into which it put Agata: “In contrast, I’d be happy to take stimulants. Because sometimes I feel that my brain and my body cannot keep up with me [that is] with my imagination, with my strength, with my potential possibilities.” Eventually, Agata chooses a sense of security, which also seems to guide Marta, who belongs to those who do follow medical recommendations. In her case, this compliance is paid for – due to side effects – with certain disadvantages in the areas essential for identity: inferior intellectual (“Stupor: that was where I absolutely did not feel myself at all”) and emotional functioning (“a sort of indifference”, “flattening” of elementary emotions and the possibilities of expressing them: “Taking away from me sometimes such organs of self-expression that are important to me.”) Although Marta shares the complaints about side effects of drugs with her predecessors, it is more important for her to be able to control, to manage her life. Robert is driven by a similar motivation.

Past and future in the mirror of now

The past experiences of living with the disorder have brought to the majority of the participants knowledge of themselves, which has influenced not only how they perceive and experience themselves today, but also their current lifestyle and their perception of what the future might bring. At this point, it is worth referring to Dan McAdams' concept of narrative identity, the essence of which is a specifically understood life story [26]. It includes both the autobiographical memory-based past and the imagined future, aligned with the process of self-understanding [27, p. 41].

Marta would include in her identity card “experiences that have made me identify with who I am in some way,” including the illness that “has certainly largely affected the way I perceive myself”

– unless such a document is public or if the public perception of mental illness had changed. The disease would be one of the experiences "that has taught me a great deal about myself; it has probably taught me that I am a very sensitive person, that I react to certain social and stressful stimuli, probably more strongly than other people."

The experience of the illness is most strongly marked by ambivalence in the cases of Marcin and Robert. The former states: "Because those experiences of mine, they are both cool and uncool. It is cool that I have experienced them because I know what they are and I can sort of understand them. Uncool because that's what I have felt." On the one hand, Robert recognizes the elementary nature of these experiences for his own identity but on the other hand, he wants to get rid of them.

The participants also considered the story that life was about to write. And so, for Agata, who is unable to say who she (now) is, it is easier to speak of who she would like to be. As she is getting older, her subjective probability of realizing alternative visions of herself (*e.g.* becoming a writer) decreases, but the content of those visions does not change. For Robert, who he wants to be and what he wants to do in the future is also important, but remains deliberately blurred: "I set some goals for myself, some projects. I wouldn't say that I'm planning, because my plans usually fail, so I'm a bit spontaneous. And I prefer to use a slightly different word: maybe some sketch, maybe some outline? I avoid plans a bit." After a while, however, he gives up on that cautiousness and states: "so it's like you have to plan, and maybe it is worth it to be courageous and not being so afraid of that planning." What takes the shape of an ongoing modulated narrative in the conversation may in fact reflect two phases of Robert's agency: a long-standing sense of its absence and a slowly growing sense of efficiency based on accumulating achievements (*e.g.* graduation), which neutralizes the earlier fear of planning the future.

Being oneself - but which one?

The participants of the survey give unique answers to the "koan"[5] characteristic of Western culture: which face of Janus is true?

"It seems to me that the answer to who I am is that at any point in time we're sort of somebody else," admits Robert. This volatility is not, for him, the liquidity affirmed by the postmodernists [28], as it undermines the most traditionally understood identity, making it difficult to integrate the image of oneself and lowering the sense of cohesion and predictability of own reactions. For Robert, a way out of this impasse is what Piotr Oleś calls an answer to the question of identity *à rebours* [22]: do not pretend to be someone else, do not put on masks. Thus, it is easier for Robert to be aware of the falsification of self-presentation than to self-define. At the same time, he wants to

[5] In Zen Buddhism, Koan is one of the mind exercises in the form of a paradoxical question that is not subject to rational analysis.

”simply be in harmony with himself” (by which he mainly means the absence of internal conflicts and sticking to his own decisions). This shows that one may not know who one is and yet have a strong need to be oneself. This confirms the ontogenetic primacy of experiential manifestations of identity over cognitive ones [see 22]. Robert seems to be repeating after Gombrowicz: “I don’t know what I really am like but I suffer when I am being deformed. So at least I know who I am not. My self is just my will to be myself, nothing else” [29, p. 61].

When Marta talks about some of her traits, she expresses her doubts as to what degree they actually belong to her, and to what degree they are merely a function of the pathological changes in the brain: “When an ‘up’ appears, there is a lot of creativity, and that’s when you don’t know whether or not to put this creativity into the ID card or not because these traits appear all of the sudden and you don't know if they are in our subconscious, in fact (...) if it’s like we always have them, only at some point... they are more accessible to us than possible, or if we do not possess them at all, and only a certain level of dopamine causes something to happen.”

Marta is supportive of the first hypothesis, which probably allows her to preserve this kind of traits for her identity, all the more so because in the later part of the interview, she admits that creativity also appears in remission – due to an attitude that could be called staying more frequently in the “being mode” as opposed to the “action mode” [see 30]. The advantage of the latter in pre-illness functioning did not allow her for truly creative acts.

Witold most strongly emphasizes the value of mania, whose first episode was for him a “process of personality transformation.” He was then closest to his most important value – the truth: “I said various true things in mania, and it was by engaging in various conflicts that I learned different things about myself,” he experienced his intellectual potential be in full bloom, and mania’s milder forms (hypomania) enabled him to achieve what is still important to him. He does not really mention depression, he only considers it a “cost” of mania.

Magdalena makes it clear that the basic determinants of her normal identity were intensified in mania: “I think that when I was in mania, the traits of my personality such as empathy, spontaneity, vehemence, they were all just turned up.” A positive evaluation of the sharpened aesthetic sensitivity, and, judging by the tone of her voice, also of the above-mentioned traits, could suggest that she felt more like herself at the time. The extinction of vital qualities in depression could be considered as a “loss of identity,” defined by the decreased sense of inner content [31]: “I really was a vegetable. I barely spoke (...) there were no emotions, neither positive nor negative.”

Agata focused on the depressive pole, explaining this as follows: “Because I think depression is something surprising to me, while mania is something normal to me.” In the (hypo)maniacal state, which for her means constant admiration, “a substitute of falling in love,” happiness, “a sense of power,” she feels fully herself. The uniqueness of Agata’s experience is manifested in the declared

lack of changes in her perception of herself regardless of the phase of the disorder, which she connects with feeling distanced, being typical for herself.

A completely different view was presented by Marta, who, seeing the behavioral changes that accompany mania, admits that: "At that time, defining myself through certain different states becomes a problem. You don't know at what point you are yourself, you are a part of, so to speak, your subconsciousness, and when you really stop being yourself and it just starts to be a somatic excess of our brain."

For Marta, it is the state of remission which is "the time when I have an impact on who I want to be," while both mania (with a more dysphoric course) and depression disrupt this impact. Moreover, the euthymic state reminds Marta of what she was like before the onset of the disorder, which allows her for a sense of continuity of her identity. However, this very desire to "reconstruct" what once constituted her seems to be in a certain contradiction with the "traumatic development" which Marta emphasizes most strongly of all participants and which in her case takes the form of re-evaluation of pre-disorder values, shifting the emphasis from "having" to "being", bringing to the spotlight the tendencies hidden so far: "I began to pay attention to things which seemed to be the opposite of who I had been trying to be before and what I had considered being a success in life at the time(...) I am much happier, I am probably more in touch with myself than I was before my illness."

This change of attitude towards life, greater appreciation of its manifestations, the metamorphosis of identity (including the change of profession) based on being more in touch with herself is connected with the fact that she has to "observe herself from all sides." Robert, who initially succumbed to the deceptive charm of madness ("At first, it was a very attractive state"), now echoes Marta: "It is enough for me to be sane, to be in harmony with myself(...) then I can do certain things."

Marcin, recalling an episode of depression six months before, evokes the feeling of "not being himself." At that time, he had lost his natural extrovert qualities and social skills that were important to him, and in their place anxiety, unknown to himself, appeared: "I wasn't myself because I could not talk to people(...) I was totally afraid of people, I avoided them, unlike me." In depression, what normally made him special and was a source of pride, lost its meaning, and even served the purpose of self-depreciation. In this context, the mania experience is less clear: "I cannot say whether I was myself or not. But supposedly I was not." Marcin was not himself according to his relatives, but he did not have the feeling of "being separated from himself," typical for depression; on the contrary: "I identify myself with it," – he admitted after a while. What is unusual, not the experience of mania itself, but rather its residual form changed his perception: "After the episode, I

had the impression that my eyes opened and that I could see the world in color again" and gave him a sense of power: "I could do anything." Although this altered consciousness soon disappeared, the mania "influenced" his later life and "changed" him permanently. During mania, his ego was exaggerated, exposed, and expansive ("maximum intensity" of ego – to the level of "terrible egoism"), while in depression, it "vanished" ("there is no me at all"). The socially disapproved aspect of mania ("hell for others"), on the one hand, and the perceptible longing for euphoria on the other, begot an ambivalence expressed fully in a paradoxical statement: "I would wish everyone to experience mania. But on the other hand, I would not wish that to anyone." Nevertheless, when asked whether these discrepancies pose an identity problem for him, the participant answers: "No, I think this is more of a problem for the society. Because I, in quotes, am still the same, but I behave differently(...) I feel like myself all the time. When I'm in a state of depression, I'm in a state of depression, it's still me. When I am in mania, then I'm like myself in mania."[6]

Based on the above statements, it is reasonable to assume that the subjective and objective aspects of identity do not have to go hand in hand: episodically conditioned divergences of key components of the self-image did not break the sense of cohesion or continuity. The apparent exception in the form of depression is explained by the variable acceptance of self, depending on the state: "I felt myself(...) but I did not feel well with myself," "In a depressive state, I would rather be someone else." In Marcin's case, being oneself peaks not in mania but in remission: "In depression, I am like that, and in mania I am like that, and being, as I am now, in a state of stability, I am myself, right. Finally." It also turns out to have one exception: When the owner of the experience is questioned along with the loss of the memory trace of the event: "Only then could I say I do not know who I was." The fundamental issue of identity – memory, which has been overlooked so far, is revealed here, allowing for a sense of continuity of self in time [see 33].

The same participant provides a peculiar answer to the seemingly impossible question cited at the beginning of this paragraph. He believes that regardless of the phase of the disorder, a person does not lose his or her Self nor (self) awareness, and thus responsibility for what he or she is doing because even the most drastic behaviors are not only a manifestation of the current mental state, but a consequence of the previously hidden tendencies: "If a person was in mania... it could not be said that they had no idea what was happening to them. There's always some kind of self remaining. So, for example, if someone would explain(...) that he killed someone in mania(...) because he didn't

[6] Glen O. Gabbard sees "splitting" in similar phenomena, in which "the self-representation involved in the manic episode is viewed as entirely disconnected with the self in the eutymic phase" and notes, like Martin: "This lack of continuity of self does not appear to bother the patient, whereas it may exasperate family members and clinicians, " adding: "The clinician managing the patient needs to work psychotherapeutically, to piece together the self-fragments into a continuous narrative in the patient's life" [32, p. 252]. Probably, such observations and recommendations have their grounds for working with many people diagnosed with BD. Marcin's example, however, shows that the (un)interested party can be fully aware of the "fragmentation," at least *post factum*, and yet agree with it in his own way; however, the "society", including clinicians, is striving with his changeability and diversity. It seems therefore justified in such cases to cure (or at least support, educate, enhance understanding, mentalization and containing abilities) not only of the disordered one, but also that of society, consisting of loved ones, while extending the psychodynamic framework to systemic elements.

think about it at all(...) I think he had something inside himself to kill that person."

More than being oneself

According to Witold, raising the issue of identity is simply a specialty of the "bipolar": "Bipolars, for example, are philosophers in the sense that they produce some kind of answer to the question: who am I?" However, he means an answer that appears in the state of psychotic mania: "It may be weird... I, for example, was a twice-fallen devil, in the sense that once from heaven to hell, and then from hell to earth they kicked me out. I was also a fiery demon and – from my own texts messages I know – first I wrote that I am probably the embodiment of a servant of Shiva, then that I am the incarnation of the servant of Shiva, without 'probably,' and then that I am the incarnation of Shiva, and then that I am Shiva."

Witold's summary: "Generally speaking, I am more than I am" sounds identical to the transpersonal approach to identity [34] but nevertheless, and despite accepting the identity of spiritual entities, his understanding of these experiences is (now) of a logical-causal nature: As a result of self-observation, the sharpening of the senses, increased speed and effectiveness of one's actions, the subject becomes convinced of his own greatness, and the identity which he adopts based on it depends on the available cultural codes (in his case – the content of his own library)[7]. Witold's attitude to his psychotic identities as they had been appearing was not so unambiguous. He admits that he was partly aware of their meaning (*e.g.* the choice of Shiva as a deity symbolizing the demolition and rebuilding – of personality, in this case), partly not. Trying to sort out and understand in vivo what was happening with his identity, he adopted a reincarnation hypothesis at some point: "These contents appear because they have already been in me, in previous incarnations. Somehow, there is such a breakthrough to these previous incarnations, an expansion of consciousness." It is interesting that the transition from yogi to Shiva was accompanied by the replacement of the hypothesis with absolute certainty, which the participant himself rightly associates with the course of mania, during which a process of growing crystallization of beliefs and the removal of doubts about the nature of own experiences takes place. Witold's psychotic identities appeared and disappeared depending on the situation, performing different functions. Only the will differentiates this situation from dissociative identity disorder: "These identities were available and I kind of modified them depending on the person, on the situation." At the climax of mania, control was lost and one particular identity dominated the others. At least until that point, Witold's basic identity was preserved ("It's different, but it's me") on the principle of "double-entry bookkeeping": the paradoxical coexistence of psychotic and non-psychotic contents in the mind without following the

[7] Note the convergence of this reasoning with the phenomenological approach in psychiatry, which sees delusions as cognitive reactions to changes in the very structure of experience [35].

former despite being convinced of their authenticity [36].

Manic-psychotic changes of identity were also experienced by Magdalena, who in one breath lists three, linked by the religious sphere: “I was the Mother of God. I was also Mother Teresa. In 2015, I was to replace Francis. In Rome. They were to come for me from Rome.” In retrospect, she seems to associate these experiences with the very phenomenology of mania: “It is such a conviction that you are, that you do have these powers.” Probably even to a larger degree than Witold, she does not separate herself (*i.e.* her basic identity) from these psychotic identity figures: “As whom I saw myself in mania is still a part of me today.” The incorporation of “certain aspects” of delusional identification to her current self makes it possible to maintain a sense of identity continuity.

During the psychotic mania, Marcin experienced a kind of identity loss, similar to a “sequence of death and rebirth,” supposedly characteristic of the transpersonal phenomenon of spiritual emergency [37]. While in the isolation ward, he had “the feeling that I died and that I was born again.” The participant does not go into details of this experience, whose inexpressibility would confirm its quasi-mystic nature.

Discussion

The experiences of people diagnosed with BD highlight an observation that is counterintuitive and already forsaken on the semantic level of the word “identity” but, on the other hand, obvious: Identity is a process, not a once and for all achieved state. This process seems to be circular: The “who” I am affects the “I am” and the given “I am” modifies the “who.”

However, while research to date has shown multifaceted challenges to identity and suggested that they most often make a breakthrough in its current form [5–8], the results shown here, while remaining to some extent consistent with the earlier ones, show that other implications are possible. These include: cyclical variability of personality traits, a new understanding of the past, an undefined identity, and ways of experiencing social roles. These topics will be discussed below. Next, the results that have somehow confirmed the results of previous studies will be discussed. The fact that there were clearly less such convergences than discrepancies explains the decision to devote a large part of the discussion to the possible explanations of the latter.

For the majority of the participants, the variation of their own characteristics depending on the phase of the cycle was more quantitative than qualitative. Adopting a continuum perspective with the greatest intensity of these characteristics in mania, and the smallest in depression, provided them with a sense of continuity of their identity. Half of the participants seemed to value mania positively – as the time when they were “more” themselves – experiencing a kind of loss of their selves in depression, which, however [depression], was diminished as a “cost” of mania (Witold) or side effects of pharmacotherapy (Magdalena). The integration of identity was therefore easier for them

since they did not see themselves as manic and depressive but only periodically more manic and poorly treated. Those who decided to take responsibility for their entire behavior and did not want to separate their healthy selves from their sick selves (Witold and Marcin), maintained a high sense of cohesion. The other half of the respondents located "being oneself" in remission, which also ensured their internal cohesion, as long as they were stable enough, because of pharmacotherapy and adequate lifestyle modifications. Disapproval of both phases of the disorder (Marta and Robert) did not mean a lack of acceptance of their condition.

A distinction should be made between acceptance of the illness and acceptance of what is behind it (bipolarity as a trait), and what has a direct impact both on the content of identity (in the latter case generally more saturated) and on episode management strategies, including compliance or non-compliance with medical recommendations.

Although the phenomenon of redefinition of the past did not appear in this group [6, 7], some participants spoke about experiences of mania and/or depression as one of the most significant fragments of their life history, while indicating a strong ambivalence towards them. As for the future, one of the participants (Robert) expressed a "learned helplessness" in planning it, which corresponds to the trends noted previously [5, 7, *cf.* 8], while another participant (Agata) had a clear vision of her future combined with little faith in its fulfilment [*cf.* 8].

The ignorance of who one wants to be and what to do, most fully presented in the New Zealand study [6], was shared by half of the participants of this study, however, it was not accompanied by a clear discomfort, and was not a direct result of being ill (or at least was not presented in this way). These subjects, displaying a certain indeterminacy or variability of identity, at least in terms of roles, locate close to the moratorium, *i.e.* an identity status characterized by a high level of exploration, but not of commitment [21].

So far, it has been demonstrated that this status positively correlates with the sense of well-being among young people [38] and facilitates the adaptation to post-modern reality [39]. The fact that in another study [6], young adults declared decreased quality of life due to problems with self-determination and, on average, the same problems were accepted with philosophical distance by one generation older participants of the study in question, may be explained by the stage of life variable. Another explanation relates to the way of attribution. Seeing the source of these problems solely in the illness leads to pathologizing them, and this in turn leads to a self-stigmatization that remains not without its impact on the self-image and self-esteem, contributing to a reduction in quality of life. The undisturbed sense of continuity in the studied group can be understood in the context of identity narration based not on maintaining the status quo (and, thus, on the supremacy of the stability dimension of [12, p. 308]) but on change (the predominance of the openness dimension), which is

not uncommon in the population of young healthy people (*i.e.* from late adolescence to early adulthood [40]). It is possible that BD is a specific mediating variable, which extends the moratorium period or appears in a new, more age- (and epoch-)appropriate version. Or, to put it differently, questioning oneself protects those who suffer from the variability of their state and position due to BD in the same way as, being an expression of concern for oneself (gr. *epimeleia heautou*), it protected the Therapists (sic!) recounted by Philo of Alexandria in De vita contemplativa from changing fortunes [after: 41].

The participants complained less frequently than participants of other studies [5–8] about the loss of important social roles. This may be related to having other types of identity "anchors" [see 12]. The type of "anchors", one might think, favors or does not favor maintaining one's own identity in the face of a disorder; it seems that the participants in this study most often chose the ones that allowed for their identity to be maintained: Not the roles that could be lost, but rather values, and particularly those that could even be favored by bipolarity (truth and freedom, but not, for example, security or moderation). Thus, the loss of important life roles (for example, the professional role in Witold's case) [*cf.* 7] or their frequent change (the case of Magdalena, partly of Marcin) did not pose a threat to identity because it was based on other grounds. This favored the creation of the role-distance described by Kraus [4], which was expressed explicitly by Agata. The very reluctance to take on some social roles, a kind of withdrawal from relationships (at least intimate – not entering them or difficulties in keeping them) could result from a more or less conscious strategy of identity preservation and provide circumstances preventing its crisis. After all, the classical understanding of identity assumes not only finding the answers to the question "who am I" but also confirming these answers by others [42]. Thus, if others have the power to recognize someone as someone, then the non-recognition of someone who is still him/herself in mania or depression, may lead to a crisis of the self (identity), against which withdrawal from the world (Filon's anachoresis) is a defense – not necessarily in the sense of alienation but a return to oneself ("conversion to oneself", as Foucault would say [41]), descending into oneself as a way of achieving resistance to the changeability of the world and one of the ways to ensure the above-mentioned self-care.

Some of the phenomena known from previous reports concerning identity-relevant characteristics were reflected in the statements of individual participants of this study. These include: the disappearance of spontaneity, related to the recollection of manic episodes and their consequences (Magdalena, *cf.* [5]) and uncertainty as to whether a given trait (*e.g.* creativity in Marta's case) is an own trait, although rarely available, or only an epiphenomenon of a manic state [*cf.*6]; the importance of returning to premorbid activities with the view of "renegotiating identity" (Marta) [*cf.* 7], self-acceptance [6], and the more general and complex phenomenon of "redefinition of identity in relation to recovery" [7]. Although among the participants of this study, the essence of

this process, *i.e.* the development of identity based on both pre-diagnostic and post-diagnostic selves (as they rarely divided themselves into "before" and "after" diagnosis), this process could take place in an implicit way. Its effects were, however, similar to those reported by Pedersen and colleagues: increased self-acceptance based, among other things, on the "bipolar" version of the posttraumatic development (development of traits and attitudes resulting from the struggle with the disorder) [7], inclusion of bipolarity features in the self-image [6] and development of identity neither reduced to the disorder nor abstracted from it [*cf.*25].

However, how to explain the discrepancies between this study and previous reports? In addition to the ones mentioned above, it is necessary to indicate the highly developed, as we can presume (based on the complexity of statements and insights), post-formal thinking and high level of reflectiveness. The prerequisite to a developed identity is self-awareness, which in turn has its foundation in this pair of abilities, because "deficiencies in cognitive development may limit the formation of identity understood as a result of reflection" [12, p. 11]. Identity content is a relatively easy potential to extract (from the pre-consciousness, speaking the language of psychoanalysis) but the scope and level of insight and verbalization necessary for this purpose depend both on the intellectual efficiency and on the motivation to know and define oneself, to commit to self-reflection [12, p. 30]. Reflectiveness may contain what could be called a metaclinical perspective, according to the existential approach: the ability to see sense, that is, the direction (from Greek *sensus*) in symptoms, that is, to go beyond what is, in the direction of what has been or what could be (longed-for or fear-ful) [*cf.*43]. The participants of this study, perhaps because they go beyond the sensual level (of what is visible)[8] through reflection, perhaps due to its containing function [see 45], save their identity from a crisis. People who allow the medical discourse (about the disorder) to dominate them may be more exposed to a crisis. It is also possible that reflectiveness itself arises from the volatility of the position in which people experienced in the course of BD find themselves. The fact that not all of them display that level of reflectiveness [see 5–8] suggests that this is not a simple linear relation and must be mediated by other factors. One of these factors may be psychotherapy (which all the participants had taken part in), generally serving the development of self-awareness and reflectiveness. Another is time, as reflectiveness usually develops gradually over the years. The longer the experience of living with the disorder, the more time and opportunity to reconcile the

[8] This intuition is confirmed by Witold's words: "This bipolar psychoticism, understood as a departure from the senses, it is not even the beginning of civilization, but consciousness. Departure from the senses differentiates man from animals. The animal is sensual. It smells, sees, hears, has no delusions, etc. (...) we have the opportunity to just get away from the senses. Well, that's what thinking is about. To get away from the senses, to do something that does not exist in these senses." See remarks of Novalis: „It is the most capricious prejudice to believe that a human being is denied the capacity to be outside himself, to be consciously beyond the senses. (...) Without this, he would not be a citizen of the world — he would be an animal. (...) But the more conscious of these circumstances we can be, the more lively, powerful, and ample is the conviction which derives from them — the belief in true revelations of the spirit. It is not seeing, hearing, feeling — it is (…) more than all the three — a sensation of immediate certainty — a view of my truest, most actual life — thoughts change into laws — wishes are fulfilled. (...) Certain moods are especially favorable to such revelations." [44, p. 175-176].

premorbid identity with the consequences of BD. Age of onset is another factor in coping, including "negotiating" one's identity. The vast majority of the study participants experienced the first full episodes of the disorder (and were diagnosed with it) in the phase of life when supposedly their identity was already relatively consolidated.

Positive reformulations and idiosyncratic evaluations, both of the disorder itself (particularly for Witold) and of the lacking definition of one's own identity (particularly for Agata), and even of the strategy of episode control, also contributed to a relatively well-integrated identity: for example, constant monitoring of one's own condition, which usually weakens self-confidence and self-efficacy and values [7], was experienced by one of the participants (Marta) as a way of establishing contact with herself.

Another explanation of these discrepancies points towards the methodology of the study itself. Following the recommendation of the so-called epistemological reflexivity [10], it should be considered how the design of the study and the method of analysis could have affected its results.

The concern, mentioned at the beginning of this article, to take into account both "common" and "unique" elements of identity has probably contributed to much greater exposure of the former than in previous studies. This was to be achieved by means of a projective stimulus and open questions about identity, abstracted from the issue of the diagnosis until it was addressed. All this was intended to limit suggestions for any content, including potential identity problems. The awareness of the latter, however, may have created in the researcher a counter-identification attitude with an identified pre-consciousness, provoking not so much the phenomenological postulate of "bracketing" previous knowledge and assumptions (based, among others, on the results of previous studies) but rather closing the mouths of participants to the expected (sic!)words. Therefore, the implementation of the "follow the participant" ideal may have gone too far.

Although the vast majority of the themes appeared without any guiding stimuli, the very "stimulus" in the form of a projective task could have been interpreted as an encouragement to provide the more superficial or formal characteristics in the first place. Recognizing this mechanism, as in the case of Agata, made it possible to clarify the recommendation and further deepen the subject.

Also, the recruitment strategy may have had an impact on this discrepancy. Unlike previous studies, it did not take place through healthcare facilities. This allowed for a situation where half of the sample did not accept the current psychiatric narrative of the chronic and/or of ongoing pharmacotherapy requirement of the disorder. In addition, the information contained in the advertisement about potentially inspiring effects of the study could have attracted people particularly interested in self-discovery.

The directions of further research are determined both by the discoveries accompanying the

main subject of the study, such as the beneficial influence of psychotherapy as a process that improves the ability to reflect, as well as by the questions posed by the answers to the research question itself: about the importance of recruitment strategies, the age of the participants and the time of their disorder's onset, their sociodemographic profile, and the type of the disorder.

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E-mail address: krzysztof.jan.dyga@gmail.com