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A Chaotic Companion: Writers and Writing with Bipolar Disorder

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A CHAOTIC COMPANION:

WRITERS AND WRITING WITH BIPOLAR DISORDER

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Through in-depth interviews with 21 writers who have bipolar disorder and through an extensive review of scientific literature on bipolar disorder, this study examined the illness and its effects on writers and their writing. "Writer" was defined as a person who writes on his or her own time, by his or her own choice. In order to participate, writers had to have been diagnosed with bipolar I or bipolar II. Specifically, this study asks, how writers who suffer from bipolar disorder experience writing in their lives; how they write today; how they wrote in the past; how bipolar disorder affected how they wrote in the past and how they write today; why they write; how bipolar disorder affected their reasons for writing or not writing in the past and today; whether they see similarities between themselves and other writers with bipolar disorder, particularly famous writers; what they do when they write; why they do what they do when they write; whether their disorder affects what they write; whether they write about their disorder and for whom do they choose to write about it; how they handle writing about emotional issues; how they learn to write; what their experience with writing in school was; what their experience with writing out of school was; whether and how teachers helped or hindered them; and what they would recommend for teaching writers like them.

The study was conducted over a period of three years and involved approximately 34 hours of interviews and 585 pages of transcripts, which were carefully analyzed according to naturalistic, qualitative research methods. Findings included that processes changed in mania and depression, causing excessive writing and a block due to depression, respectively. Writers

explained how they write despite the disorder and how they deliberately use writing as a tool. Overall, the study points to the necessity of composition studies to re-evaluate assumptions about, among other things, writing, healing, and mental illness in general.

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PREFACE

Popular culture is alive with stories of bipolar disorder. Notable personalities such as Patty Duke, Jane Pauley, Jimmie Piersall, and the prominent researcher and psychologist Kay Redfield Jamison have published books detailing their turbulent lives with this mental disorder. Stories of famous people having bipolar disorder have become so as prevalent to warrant a book to be entitled, *You Don't Have to Be Famous to Have Manic Depression* (2007). Lately the stories have been told by more and more people not in the public eye. In the fall of 2007, two Oprah Winfrey shows were aired just one week apart, in which the viewing audience heard rock stars and actors as well as ordinary fathers, mothers and friends tell about how bipolar disorder had nearly or essentially destroyed their lives. Those two days, the public learned how bipolar disorder ripped apart families, and caused psychosis, suicide, and in extremely rare cases, homicide. In the meantime, images of bipolar disorder continue to flicker across the screen in commercials and public service announcements paid by large pharmaceutical companies.

In an age where bipolar disorder is, as one woman commenting on this study told me, "all the rage," it still—like other major mental illnesses—holds a place of stigma. Martin (2007) argued that people with bipolar disorder are "denied the status of being fully human." Hinshaw's (2007) thorough work on stigma, shame, and mental illness backs up this claim by noting the trends in society at large as still devastating for those who have to suffer from the illness. The academy is no exception: in her "pathography" or illness narrative, Hilary Clark (2007) wrote that no other illness, except probably AIDS, is so stigmatized.

According to Jamison (1993), at least eight percent of the population will experience bipolar disorder in one of its forms, it affects men and women equally, and its age of onset is around 18. Valentino raised a red flag in composition studies specifically when, in her celebrated

1996 article in Teaching English in the Two-Year college (TETYC), she discussed the prevalence of mood disorders—the large umbrella under which bipolar falls—on college campuses and the subsequent danger English teachers must confront in responding to papers which disclose depression and suicidal plans. But students alone do not suffer from the disorder. In Myers's (2007) recent book about illness writing in the academy, three out of 47 were stories across the disciplines about suffering from bipolar disorder as an academic.

In what follows, I discuss a study of 21 writers who come from various backgrounds and represent several different genres. What they have in common is that they have bipolar disorder and a strong relationship with writing. It is hoped that their voices will teach us as teachers and as writers to look at the practice of writing in new ways. But most of all, it is hoped that this study helps us reassess the way we see such writers when we meet them or try to understand their work, be they novelists, poets, colleagues, students, or—in some cases—ourselves.

CHAPTER ONE: SIGNIFICANCE OF THE PROBLEM

Introduction

In 1995, Marilyn J. Valentino presented a paper at CCCC in which she dealt with one fear that many teachers have: "Unfortunately," she said, "students with emotional disorders are not uncommon anymore. In fact . . . professors face new challenges, especially from those high-risk students suffering from hidden psychological disorders like schizophrenia, bipolar disorder, manic depression, and suicidal tendencies—or more common mental disorders…" (p. 2). Valentino (1995) ended her paper with options for feedback for disturbed writing, but what was more significant was that the paper—and the award winning article that followed it—unveiled the then newly acknowledged facts that the classroom is more heterogeneous than previously thought and that that difference made teachers perceive their roles as all the more dangerous.

Valentino's work was based at most on consultation with a few mental health professionals. And, even though she brought bipolar disorder to the forefront, a biochemical mental illness that is both manic depression and an illness with suicidal tendencies, what Valentino's conference presentation and subsequent article lacked was an in-depth interrogation of both what it means to have such a biochemical mental illness and write and what the presence of such students means for the classroom. Although the door was opened, very few articles or conference presentations in composition studies have taken a serious look at bipolar disorder. Two reflective essays on depression appeared in English Journal in 2003 and 2005. Six years after Valentino's (1996) article, Richmond (2002) called for a specific study on bipolar disorder, and yet, in 2009, we are is still left without empirically grounded answers. Rather than answers, we have assumptions: writing can heal a mental illness; writing is dangerous for people with bipolar disorder; writers are both writers and *better* writers for having bipolar disorder; and the

processes of writing with bipolar disorder have already been sufficiently explored by other fields such as psychology. Those assumptions come laced with ignorance about the disorder and downright fear. Fear is especially apparent in statements such as this:

> The scary news is that under ADA regulations, if these high-risk students do not require classroom accommodation, they do not have to disclose their illnesses to their professors. An even more dangerous situation is that many more who are unaware they even have a problem or have not yet been diagnosed are receiving neither medication nor counseling but are potential students. (Valentino, 1996, p. 276)

Therefore, this present study is the first of its kind. Through in-depth interviews with 21 writers who have bipolar disorder and an extensive review of scientific literature on bipolar disorder, I examine what happens when writers with bipolar disorder write, how writing might hurt or heal them, and what signs such writers bring to the classroom that teachers of which should be aware. The study was conducted over a period of three years and involved not only an exploration of scientific literature but also 34 hours of interviews and 585 pages of transcripts, which were carefully analyzed and are presented here.

Definitions

Bipolar Disorder

Bipolar disorder is a brain disorder that can wreak havoc on their energy, thoughts, emotions, eating and sleeping cycles, and perceptions. This havoc can be so severe as to cause the complete destruction of careers, families, relationships, and lives.

Bipolar disorder is popularly and traditionally known for its states of high-energy mania and low-energy depression. In mania, the body moves on its own. Mania speeds things up and makes sufferers more apt to engage in risky and impulsive behavior as well as to become highly

irritable and grandiose. Mania can cause a person to be euphoric for weeks, concoct plans, fall in love way too easily, believe in unrealistic dreams, and feel so energized that it is literally impossible to sit still. Then, in a depression, the body stops moving on its own. The person may find himself or herself in agony, hopeless and helpless. The world which had in mania been vibrant and full of meaning turns to dull, meaningless gray. But this traditional understanding stops short of the worst part. Mania may mix with depression and cause a treacherous, agitated, and explosive combination of negative yet high energy. Mood states may alternate quickly from one to the other. And with each alteration, each change in emotion, perception, and thinking, the world itself appears to change. Indeed, in their severity, high, low, and mixed states can bleed into psychosis.

Writers

In the midst of physiological changes brought on by the disorder and the treatments which control it, there are people who write. They may have books on bookstore shelves or poems published online, or keep journals and secret manuscripted novels, poetry, short stories, or screenplays no one else will ever, ever see.

Many are the amateur writers that Gere called for studying in 1994. Gere (1994) argued the benefits of looking at the other side of the "walls" of academia. She believed that compositionists should work to understand how writers learn to write in areas that are "largely invisible and inaudible to us" (p. 78). Such areas, Gere (1994) wrote, make evident "the increased need for access in writing instruction" and, therefore, can, among other things, help us "strengthen our vigilance . . . against institutional practices and curricular plans that make writing a barrier to overcome rather than an activity to be engaged in" (p. 88). Gere (1994) explained that "Such an inclusive perspective can lead us to tap and listen to messages through

the walls, to consider how we can learn from and contribute to composition's extracurriculum in our classes" (p. 86). After all, she wrote,

> Positive feelings about oneself and one's writing, motivation to revise and improve composition skills, opportunities for publication of various sorts, the belief that writing can make a difference in individual and community life—these accomplishments of workshops outside classroom walls mirror the goals most of us composition teachers espouse for our students. (p. 78)

Although this present study does not involve writer workshops, it does approach writers who are similarly motivated. Gere (1994) described the amateur writer, the writer who chooses to write outside of the classroom, the writer who, "as the Latin root *amatus* reminds us. . .write[s] for love" (p. 88). Likewise, Brand (1989) studied professional writers because they are people who are "unlike other individuals who write, . . . [in that they] *want* to" (p. 125).

Because they want to write, such writers must necessarily overcome the forces of bipolar disorder that hold the writer back. This includes depression, which as neurobiologist Alice Flaherty (2004), for instance, halts writing. Reflecting on her self-observations as a writer with bipolar, she wrote, "I was not really a blocked writer. I was no longer a writer at all" (p. 12). Moreover, perceptual changes in the writer may make assessment of his or her work swing in widely different directions. For instance, the writer will at manic stages assess the work as well done while in depressive phases think quite the opposite.

Studying writers with bipolar can shed light on the following: If a person is a writer, loves to write, takes time to write, what happens when the symptoms hit out of nowhere? What does it mean to write if one cannot trust one's perception of the world or of the writing that one produces? Such writers teach us about how and why and in what unique ways they write, despite

or because of shifting perceptions, impaired concentration, engulfing emotions, and memory loss. They might also challenge our assumptions, teaching use whether and how writing heals or is dangerous and whether their illness gives them a writing edge. Moreover, following Gere (1994), this study explores the real, practical consequences for which these writers write, how they use writing as a tool for specific ends and what those ends are.

What Happens When Bipolar Writers Write

Because bipolar disorder affects thinking, perception, and emotion, it necessarily adds to composition studies' disciplinary knowledge of writing processes. Much scholarship in composition studies has attempted to connect body, emotion, and mind, beginning with Alice G. Brand in the 1980s, continuing through Sondra Perl's (2004) *Felt Sense* and continuing further with other studies of emotion such as Laura Micciche's (2007) book, *Doing Emotion*. The current study does two things in particular: it places cognitive and emotional/somatic/affective components together to create a bigger picture of mind, body, emotion, and writing, and it challenges what composition studies does know about emotion and writing and healing.

With Emig's (1971) *The Composing Processes of Twelfth Graders*, composition began looking at cognitive processes. Shaughnessy's (1977) *Errors and Expectations* and Rose's (1984) *Writer's Block: The Cognitive Dimension* both shed light on the choices that thinking processes and patterns which lead to the choices writers make, and Flower and Hayes (1983/2003) developed a model of how the brain composes. But such models and understandings may in fact change when speaking in terms of bipolar disorder because the brain does not act in the same way it would usually act. For one, memory—the working memory needed to write according the Flower and Hayes's (1983/2003) model—is significantly diminished. And, in her 1999 work, Jamison demonstrated that there are sufficient changes in cognition which affect

writing and the creation of art. Mania, for instance, increases "fluency, rapidity, flexibility of thought on one hand, and the ability to combine ideas or categories of thought to form new and original connections on the other" (Jamison, 1993, p. 105).

As far as personal emotions are concerned, Alice Brand's (1989) *The Psychology of Writing: The Affective Experience* is the primary work. Brand (1989) argued for "putting Humpty Dumpty back together again," that is, reintegrating cognition and emotion (p. xix). She later continued, "As one would expect, I'm inclined to believe that real writing, like real thinking, is *rarely* just plain data. I have tried to show that cognitions are highly vulnerable to affective processing. Feeling is inherent in knowing. Knowing is inherent in feeling" (p. 36). As Elbow (1989) pointed out, "there is a continuous stream of feelings going on at every moment of the writing process" (p. xiii). However, Brand (1989) fell short of informative in terms of bipolar disorder in that she (perhaps inadvertently) blurred the lines between clinical mood episodes and emotional states. These blurred lines are evident in her review of quotations from both ill writers and those who may not have had experienced anything more than the normal ups and downs of life. Absent, then, from Brand's work is the understanding of deeper, biochemical, emotional currents which may fuel or stunt writing processes. The closest she does get it to the student poet whose experience she links with emotional disorders.

In "Repositioning Emotion in Composition Studies," Richmond (2002) believed looking into psychological theories is well worth it in order to better understand students and the role of emotion in composing. She believed that psychological theories should be brought into the composition classroom, despite the resistance of her colleagues: "On more than one occasion [I] had to clarify to other composition specialists that using strategies from psychology. . . does not mean that I am practicing psychoanalysis in my writing classroom" (p. 73). She proposed that

emotions be viewed from perspectives including the biochemical, extending that proposal *specifically* to the study of bipolar disorder, to understand "connections. . . between chemical imbalances in the brain and students' attitudes toward (or success with) writing assignments" (p. 78). She wrote, "I could conceive of a study of students with. . . Bipolar Affective Disorder"[1] (p. 78). Since writers with mental illnesses in general may also find their writing practices impacted by medications, Richmond (2002) also suggested that researchers try to understand the "connections between psychopharmacology and writing" (p. 78). Along those lines, other treatments might also be explored, such as electroconvulsive therapy (ECT), where electric currents are run through the brain in order to relieve a person of depression, but which can disrupt memory.

Others in composition studies theorize emotion in such terms as teacher-student interaction, as social constructions, and as connections to words (Micciche. 2007; Jacobs and Micciche, 2003). None of these make sense with regard to the current study, which looks at emotions as they affect the body and, therefore, writing processes. Although bipolar disorder is characterized by strong emotion, it is an illness which causes the emotions that characterize it—that is, it is more than emotion, than affect. What composition studies has explored and theorized about emotion falls short in the face of an actual affective *disorder*.

To speak only of cognition and affect is to neglect more profound ways that the body impacts writing. The physical impact of bipolar disorder includes disruptions in sleep patterns, excessive or not enough physical energy, increased or decreased libido, and psychosomatic pain. The body is out of whack. Furthermore, the switch from state to state, either dramatic or languid,

[1] Bipolar disorder is no longer known as "Bipolar Affective Disorder." The term "affective" refers to the outer manifestations of the mood rather than the inner experience (Mondimore, 2006, p. 9), which may be a reason the term was changed.

might put the writer in the position of seeing and feeling his or her work from, in many respects, essentially another mind, another body.

The body may have an even more profound effect if we consider Sondra Perl's *felt sense*. In her book by that title, Perl (2004) described "felt sense" as "bodily knowing" (p. 1). Perl (2004) walked writers through exercises through which they can get in touch with what might be called their felt sense or intuition. Paraphrasing Eugene Gendlin, the philosopher and psychologist from whom she borrows the phrase, Perl (2004) wrote, "It is from within this interconnectedness of bodies, language, and situations that a theory of embodied knowing is derived" (p. 52). In his philosophy, Gendlin uses the symbol <u>. . .</u> to, she wrote, stand "for a space that is open but not blank" (p. 51). She wrote with italicized emphasis that "*That new ideas, or fresh ways of speaking, thinking, and writing will come to us if we pause and wait patiently. . . if we contact a* <u>. . .</u> *and allow it to open"* (p. 51). The waiting is over when the words that simply feel right come.

The profundity of the statement that the body affects writing lies in the fact that the writer cannot be certain, as the writer in Perl's model is, that the body is telling the truth. Bipolar disorder distorts perception, and bodily perception and feeling become much less useful. To address Perl's model directly, in a manic state it may be difficult if not impossible to locate that one thought which is carrying the most weight, since all of them may carry equal and vitally important weight. It might be impossible to locate any thought at all in a depressive episode, since the mind can go blank.

A more direct example of how the body affects writing is in Alice Flaherty's (2004) description of hypergraphia, or the compulsion to write. She described the drive to write as a "compulsion" and "an unbelievable complex psychological trait," which nevertheless can be

studied (p. 2). Both writer's block and the drive to write, she wrote, "arise from complicated abnormalities of the basic biological drive to communicate" (p. 2). She isolates the cause of hypergraphia to the temporal lobes and the limbic system in the brain, saying that it is in these regions where word meaning is understood and emotion and drive begin (p. 4, 5). Flaherty (2004) later continued that, "even in normal writers, the neurobiology of mood and the limbic drive to write may be equally or more important than the purely cognitive skills taught in most writing courses" (p. 33).

Are Writers With Bipolar Better Writers Because of the Illness?

Bipolar disorder, like most mental illnesses, is both romanticized and stigmatized. Hinshaw (2007) explained that "mental illness tends to receive extremes of social perceptions, fluctuating between utter repulsion on one hand and fascination, awe, or reverence on the other" in terms of "creative genius" (p. 26). The stigma and utter repulsion associated with bipolar disorder makes this study important because it suggests how a difficult, skeptical audience affects writing. Moreover, bipolar disorder itself is also linked closely with *literary* genius. Brand (1989) wrote that "in and out of public attention, one group constitutes the poet suicide. . . Poets seem overrepresented on the rolls of the manic-depressives" (p. 173).

It has been established that many famous poets and writers have had the illness. Jamison (1993) identified the following writers as having a mood disorder of some type, including depression only: Hans Christian Andersen, Honore de Balzac, James Barrie, Arthur Benson, E. F. Benson, James Boswell, John Bunyan, Lord Byron, John Clare, Samuel Clemens, Samuel Taylor Coleridge, Joseph Conrad, Charles Dickens, Isak Dinesen, Ralph Waldo Emerson, William Faulkner, F. Scott Fitzgerald, Lewis Grassic Gibbon, Nikolai Gogol, Maxim Gorky, Kenneth Graham, Graham Greene, Ernest Hemmingway, Hermann Hesse, Henrik Ibsen,

William Inge, Henry James, William James, Charles Lamb, Malcom Lowry, Herman Melville, Eugene O'Neill, Franci Parkman, John Rushkin, Mary Shelley, Percy Bysshe Shelley, Jean Stafford, Robert Luis Stevenson, August Strindberg, Leo Tolstoy, Ivan Turgenev, Tennessee Williams, Mary Wollstonecraft, Virginia Woolf, and Emile Zola (p 268-269). Brand (1989) also included "Lord Byron, Hart Crane, Gerard Manly Hopkins, Edgar Allen Poe, Dante Gabriel Rossetti, John Ruskin, Percy Bysshe Shelley . . . John Berryman, Robert Lowell, Theodore Roethke, Sylvia Plath, Delmore Schwartz, and Anne Sexton" (p. 173). Both Jamison (1993) and Brand (1989) cited the diaries and work of several authors in order to back up their claims that emotional states and good writing might have possible connections.

Scientists have been moved by the high occurrence of mood disorders among writers to look at the connection between creative traits, or as Jamison (1993) calls the artistic temperament, and bipolar illness. In her book, *Touched With Fire: Manic-Depressive Illness and the Artistic Temperament*, Jamison (1993) admitted "that [the assertion that] impassioned moods, shattered reason, and the artistic temperament can be welded into a 'fine madness' remains a controversial belief." Part of the controversy is of which comes first, the writing or the illness. Still, Jamison (1993) continued to explore the connection between the temperaments of artists and the temperaments of individuals suffering from bipolar disorder. Jamison (1993) saw bipolar disorder in terms of multiple disorders along a continuum, "forming . . . a natural bridge between a virulently psychotic illness on the one hand and the moody, artistic temperaments on the other" (p. 97).

Kantor (1995), in speaking of affective disorders in writers, wrote that artists tend to have "excessively melodramatic streak[s]. This is one reason they fail to make the nice, healthy distinctions we all must make to avoid concocting and becoming the victim of depressing

cognitive distinctions" (p. 33). Balancing this view is Caramagno's (1992) work in which he was adamant that such writers neither succumb to neuroses or are weak; rather, he assured his readers that with proper medication, writers with bipolar disorder are no less disturbed than anyone else (p. 32).

Jamison's work comes in close proximity to composition studies in that she often brings up the Phaedrus, linking madness, passion, and inspiration. Whether her analysis is a misinterpretation is up for debate and is partially answered by the experiences of the participants in this study.

Interrogating Writing and Healing

A differentiation between a bipolar state and a usual up or down is important to make in considering whether writing can heal bipolar. It is important to point out that there is a serious difference between ups and downs and their clinical counterparts. The lay term "depression" and clinical depression are far apart. Depression is more than feeling "blue." Participants described it as feeling as if screaming on the inside; feeling trapped; feeling separated from the world; feeling that nothing gives you joy; feeling weepy; having difficulty thinking and remembering (especially positive things); having paranoia; having bodily aches; experiencing dulled senses; feeling hopeless; ruminating; feeling helpless; feeling apathetic; blaming oneself; feeling overwhelmed; having an inability to think straight; feeling that everything's an effort; not being able to get out of bed; feeling tired easily; having to put things off; becoming vicious, sarcastic; wanting to vanish; and, in extreme cases, having delusions and hallucinations. As for mania, it is more than the euphoria it is thought to cause. A manic state, participants said, involved being very social; feeling artistic; feeling impulsive; feeling unable to keep up with their own thoughts; thinking faster; experiencing scattered and fragmented thinking; having the sensation that

everything is moving faster; having high energy; having heightened senses; feeling as if falling in love; becoming vicious and sarcastic; and not being able to get enough done during the day.

As of now, composition theorists conflate mental illness and normal emotional states. This is apparent in both Brand's (1989) *The Psychology of Writing* and Anderson and MacCurdy's (2000) *Writing and Healing*. In Brand's (1989) work, the difference between emotions writers experience because they write and emotions writers with a mental illness might experience due mainly to the mental illness is confused. In Anderson and MacCurdy's (2000) book, trauma survivors are conflated with those suffering from PTSD: "because we are all witnesses to, perhaps participants in, this apparently endless succession of virtual and actual encounters with great traumatic potential, PTSD has become a central, material fact of our time. We are all survivors" (p. 5). The fallacy here is a bit dangerous: PTSD has severe, specific symptoms that not every trauma survivor develops. Such thinking parallels a persistent attitude about depression between the blues and clinical depression.

This might be the reason that the existing scientific literature on bipolar disorder stands in sharp contrast to what is being said in composition studies in the discussion on writing and healing. Most researchers and clinicians in psychology are adamant that talk therapy cannot cure bipolar disorder. Mondimore (2006) explained that "no one today would even think to recommend counseling or therapy as the only treatment for bipolar disorder; to do so would constitute malpractice" (p. 142). Psychotherapy fits in to "help patients come to terms with the repercussions of past episodes and comprehend the practical and existential implications of having bipolar illness" (Goodwin and Jamison, 2007, p. 904).

When equated to therapy to take care of moods, writing might heal only as much as therapy can, and therapy has been shown to not be able to heal bipolar disorder—with evidence

that it might heal being "virtually nonexistent" (Goodwin and Jamison, 2007, p. 905). Still, having bipolar disorder, being diagnosed, and possibly even hospitalized is traumatic. This study, then, helps create an understanding of how people use writing to aid in or maintain their recovery. Writing might help people work toward recovery as described by Davidson (2003):

> What recovery seems to entail is that people overcome the effects of being a mental patient—including rejection from society, poverty, substandard housing, social isolation, unemployment, loss of valued social roles and identity, and loss of sense of self and purpose in life—in order to retain, or resume, some degree of control over their own lives (Anthony, 1993; Deegan, 1996a, 1996b). (Davidson, 2003, p.38)

Scholarship rooted in understanding the lives and literacy practices of people struggling with trauma, intense emotions, or chronic illnesses extends our understanding of the profound effect of literacy in people's lives.

The seminal works on writing and healing have come from James W. Pennebaker, a research psychologist, who has dealt extensively the physiological impact of writing as a part of his study of expression and health. Also well cited by compositionists is psychiatrist Judith Herman's book, *Trauma and Recovery* (1997), which deals with the purpose of language in resolving issues associated with the impact of traumatic events, especially PTSD. Pennebaker and colleagues have demonstrated time and again how expressive writing can heal both mind and body (see Pennebaker; Lepore and Smyth, 2002). They offer some insight into what happens physically and mentally when one writes expressively, sometimes calling writing, "life changing" (Pennebaker, 2000, p. 3). One study conducted by Lepore (1997) examined students with depressive symptoms that were due to the stress of taking exams with high stakes. Lepore (1997) found that those who were instructed to write about their feelings were significantly less

depressed at the end of the study. Oddly, it did not matter what aspect of the stressor (or trigger to an episode) individuals wrote about; writing about positive things was just as beneficial as writing about negative things (Lepore et al., 2002).

Despite these findings, Pennebaker and colleagues have not studied the effect of writing on bipolar disorder.

The current study is especially pertinent because, in April, 2008, LoFaro (2008) gave a presentation at the Conference on College Composition and Communication in which she bemoaned the amount of psychiatric medication people in general take and suggested that writing more—examining one's life in writing—would stave off the use of such medication. Although she did not deny the existence of biochemical mental illness, she swept briefly past it. This pervasive idea—that writing heals regardless—echoes the insistence of DeSalvo (1999), in her book, *Writing As A Way of Healing*, that writing can save a person from a suicidal depression.

Not surprisingly, critics outside of the field have suggested that people with bipolar disorder and other mental illnesses would write more for the love of writing and take more advantage of writing as a tool for healing if they had not had bad experiences in school—"when writing is associated with strong negative experiences, such as being criticized at school, [they] are unlikely to want to try writing therapy" (Wright and Chung, 2001, p. 287). The question becomes, can English teachers with their best intentions destroy writing as a tool for healing by, as Gorelick (2005) wrote, "contact with English teachers who squeezed the life out of both poetry and students" (p. 118). Speaking specifically about hypomania, Flaherty (2004) believed that changes in the limbic system encouraged writing, and she postulated that writing is natural, especially for people with bipolar disorder, and is stunted by schooling. She wondered if her

children's "scribbles were the earliest signs" of hypomania or even a normal drive to write, which she said is specifically unleashed in mild manic states: she wondered "if more of us would write wildly if school didn't teach us to dislike writing" (p. 35).

Kaufman and Sexton (2006) believed that, "there is often an importance [sic] distinction to be made between eminent and everyday creativity" (p. 269). According to them, part of this distinction between career writers and everyday writers may be that career writers, who are thought to more likely to have a mental illness, naturally turn to writing as a form of therapy because they need it and they feel the need to search for meaning (p. 269).

Literary criticism tends to focus on neurosis as the cause of bipolar disorder. As a case in point, Virginia Woolf is widely said to have suffered from a classic case of manic depressive illness (Caramagno, 1992, p.1). DeSalvo and others have argued that Woolf's "'madness' was not really insanity but . . . a logical reaction to victimization" (as cited in Caramagno, 1988, p. 7). On the other hand, Caramagno's (1988) interpretation is that Woolf suffered from a biochemical illness and was a writer despite that fact, although she did use writing as a tool to better understand and cope with her suffering. Caramagno (1989) wrote that, with medication, individuals with bipolar are just as neurotic as the rest of the population (p. 32).

Are English teachers taking a healing art away from students? This study aims to question what the field already knows about writing and healing by looking at people who choose to write in particular for healing, despite previous negative experiences in school; in fact, some participants write despite negative experiences with teachers.

Dangerous Writing

Perhaps equally as prevalent as the notion that writing can heal is the notion that it might be dangerous. If, then, writing is dangerous, what does that mean for the classroom? It is helpful to explore why people think writing is dangerous.

Some have speculated on how writing might be downright destructive. Some of this speculation is grounded in trying to understand why famous writers have committed suicide. DeSalvo (1999) went as far as saying that the reason Virginia Woolf and Sylvia Plath ultimately did commit suicide had to do with how they approached writing. With Plath,

> though she kept a journal for years, she didn't reflect upon how writing her courageous work made her feel. Nor did she connect the effect of her writing upon her feelings and her life. On March 28, 1958, for example, she describes how she wrote eight poems in eight days:. . . "I feel these are the best poems I have ever done."
>
> By the end of the week, though, she was. . . completely exhausted and suicidal. . . Indeed, Plath seemed to feel worse, perhaps because she didn't reflect upon the link between her feelings and the events in her life. Nor did she write about how doing her work made her feel. Nor did she understand how to care for herself as she wrote. Because Plath didn't witness herself working—didn't record her feelings about her creative process—she didn't connect what she was experiencing with her work. (p. 89-90).

DeSalvo (1999) asserted that, with Virginia Woolf, pacing was important. When Woolf wrote *To the Lighthouse*, DeSalvo explained, she paced herself and was fine, but when Woolf wrote *The Years*, she did not pace herself—she was "overworked, producing about ten pages a day"—and this caused an emotional breakdown (p. 98).

Speculations get even more bizarre. Kaufman and Sexton (2006) argued that, based primarily on the high rate of poets with mental illness, the only writing that is beneficial writing is that which constructs narratives; they thought that narratives help organize and make sense of an event in a space long enough to allow a person's perspective shift from beginning to middle to end.

There is also the fear of not having support in case of emergency, a fear that echoes in various fields. Such warnings are apparent in the modern use of poetry as therapy as early as 1925. According to Mazza, Robert Haven Schauffler's *The Poetry Cure: A Pocket Medicine Chest of Verse* (1925) was one of the first to include a precaution "pointing to the potential dangers of indiscriminate use of poetry" (Mazza, 1999, p. 6). DeSalvo (1999) cautioned without explanation that her readers seek professional help in addition to writing if necessary: "I personally believe it is essential for people wanting to write about extreme situations to have skilled professional support while writing or to attend a reputable support group" (p. 40). (This contrasts sharply with her advertising that writing to work through severe emotions "is cheap," requiring nothing but pen and paper on page 13.)

Pennebaker (2004) expressed the fear that the writer might "Flip-Out," that is, "start screaming and ranting uncontrollably" (p. 13). Pennebaker (2004) has never seen this happen; although he has seen people become emotionally distraught, they quickly recover (p. 13). He also wrote that, over-analyzing a problem may make a person feel worse (Pennebaker, 2004, p. 14).

In a little-known essay in the seminal collection, *Poetry Therapy*, Burke (1969) wrote that there are other reasons that writing can be dangerous: "Whereas we begin with the (quite probably) sound assumption that the expression of the repressed is intrinsically therapeutic, there

can be complicating factors that threaten this result" (p. 105). Writing thoughts down for an outside audience makes a writer vulnerable to that audience (Burke, 1969, p. 105; Pennebaker, 2004, p. 14), who might find and read those thoughts and not act in the best interest of the writer. Pennebaker (2004) also asserted that using writing will change a person's coping strategies and, therefore, change relationships with other people, people that person may have previously needed to depend on but will no longer (p. 14).

Actual empirical, negative reports of expressive writing include the finding that people feel unhappy immediately after writing about unhappy events, even though the unhappiness resolves in the long term (Pennebaker and Seagal, 1999, p. 1244). Could further writing before a positive mood sets in increase the intensity of the negative mood? Lepore (1997) pointed out that there is a connection between negative mood and rumination (p. 1030). Some have said that the solitary, ruminating act of writing might contribute to if not trigger a full depressive episode (Andreasen, 1982), specifically because rumination itself has often been linked to depression (Kaufman and Sexton, 2006, p. 272).

Better understanding the literacy experiences of writers with bipolar disorder may help composition studies better understand whether and how dangerous writing might be.

Disturbing Writing

Valentino's (1996) CCCC award-winning article mentioned at the start of this chapter tackled the difficult question of what to "write in the margins" when students disclose in their work. She ended it with suggestions, such as responding to suicidal language with "is this the only solution you see?" (p. 280). But are these suggestions realistic when it comes down to the student's perspective? Although such suggestions are based in help from mental health workers, do they still seem realistic after consulting the clinical literature? The answer is best explored

through interviews and a study of the literature. For example, in her extensive work on suicide, Jamison (1999) explained that suicidal individuals cannot, by definition, see any other options. The picture for them is much bleaker. She cited poet Anne Sexton as writing, "But suicides have a special language/Like carpenters they want to know which tools./They never ask why build" (as cited in Jamison, 1999, p. 233). Back in composition studies, Valentino (1996) suggested to respond to disturbing writing by asking "simply, 'What would you like me to do?'" (p. 279), an answer that is not easily come by for someone dealing with the illness for the first time, as many with bipolar disorder are when they enter college.

What We Know

Across several fields, little is known about how students with bipolar write, what the negative and positive aspects are, and what the disability means for the classroom. Part of the reason for this is that it is easy to be caught up in assumptions: what bipolar is is sufficiently known; writing can heal a mental illness; writing is dangerous for people with mental illnesses; writers are both writers and *better* writers for having bipolar disorder; and the processes of writing with bipolar disorder have already been sufficiently explored by other fields such as psychology.

But this topic has not been explored in useful ways for composition studies. In composition studies, Brand (1989), in trying to understand the role of emotion in writing processes, conflated "normal" moods with clinical ones, thereby studying only the effects of state emotions on writing and the effects of writing on state emotions (as opposed to trait emotions, which, in bipolar, pass independently of writing). In literary criticism, work has been done on writers—mainly famous writers—who had bipolar, such as Woolf and Plath, and this work which sometimes contradicts itself is based mainly on posthumously found items. In the

field of psychology, Jamison has conducted surveys of writers as well as conducted in-depth analyses of diaries and products from famous writers. Though helpful, this approach does not capture the complexity of the experience of such writers, something that is better done in open-ended interviews, which provide richer contexts. Jamison's (1993) study of living, then-prominent British writers was based on structured interviews, those unlike what we find here in that they did not elicit stories and, therefore, did not tap into the rich experience of living with bipolar. Nor did her study involve writers with a lowercase "w," the benefit of which to include them is that they stand closer to what teachers find in their classrooms.

Furthermore in psychology, research psychologist James W. Pennebaker has conducted studies of students and writing in controlled settings, but these students do not necessarily consider themselves writers nor do they necessarily have mood disorders. The question in terms of those who already consider themselves writers is whether that consideration causes different processes to take place, for instance, whether writers can approach a situation from a healthier distance.

First person accounts of writers writing with bipolar also lacking. Written first person accounts of the lives of people with bipolar disorder are plentiful. Lizzie Simon's (2002) *My Bipolar Road Trip in 4D* is an autoethnographic account of living with bipolar disorder while traveling around the country to meet other successful young people with bipolar disorder to hear their stories. Kate Millet's (2000) *The Looney Bin Trip* is a chronicle of one woman's fight against the dehumanizing mental health system. Jane Pauley's (2004) *Skywriting* described her life with bipolar as does Jim Piersall's (1955) book, *Fear Strikes Out*. Kay Redfield Jamison (1993), the most popular author and authority on bipolar disorder, has her own famous book, *An Unquiet Mind*. Still, there are nearly no written first person accounts of bipolar disorder and

writing. The studies in which people might have been asked directly tend to be laboratory studies or structured surveys rather than narrative accounts.

Research Questions

In order to explore the lives of writers with bipolar disorder in an extensive and comprehensive way, 21 writers with bipolar disorder spoke about their lives with the illness. They were asked questions that emerged through conversational interviews, questions that began with the following:

1. How do writers who suffer from bipolar disorder experience writing in their lives?
2. How do they write today? How did they write in the past? How did bipolar disorder affect how they wrote in the past and how they write today?
3. Why do they write? How did and does bipolar disorder affect their reasons for writing or not writing in the past and today? Do they see similarities between themselves and other writers with bipolar disorder, particularly famous writers?
4. What do they write? Why? Does their disorder affect what they write? Do they write about their disorder and for whom do they choose to write about it? How do these writers handle writing about emotional issues?
5. How did they learn to write? What was their experience with writing in school? Out of school? How did teachers help or hinder? What would they recommend for teaching writers like them?

The answers to these interview questions and the ones which emerged as the study progressed challenge commonly held assumptions about writers with bipolar disorder, those held within composition studies as well as in other fields and the public imagination. Shaking up these assumptions is an important part of making the teaching of writing more effective for a larger

number of students as well as dispelling harmful myths about writing and healing and danger which make the classroom a less safe space and complicate our notions of the power and pitfalls of writing.

CHAPTER TWO: RESEARCH PORTRAIT OF A WRITER WITH BIPOLAR DISORDER

Part I: The Effects of the Disorder on Writers With Bipolar Disorder

Bipolar disorder is a mood disorder, a disorder in which a person does not have control over emotional, physical, or perceptual changes. Formerly known as manic depression, it is now considered one of the manic-depressive illnesses, sharing the title with its cousin, recurrent major depression; however, manic-depressive illness and bipolar disorder are often used interchangeably. Kay Redfield Jamison, a prominent researcher in psychology and of manic-depressive illness in particular, wrote that manic-depressive illness is "an inherited vulnerability to a disease that can manifest itself in a wide range of fluctuating emotion states, behaviors, thinking patterns and styles, and energy levels" (Jamison, 1993, p. 97). Taylor (2006) explained that "bipolar disorder . . . is a series of related neurobiological illnesses" (p. 17). Moreover, the disorder "can cause reductions in, among other things, physical motor coordination, information processing, abstract thinking, and technical and social skills" (Taylor, 2006, p. 19).

At the center of bipolar are the episodes, clusters of symptoms that have distinct starting and stopping points, distinguishable because they represent a departure from the individual's normal functioning. Although bipolar disorder is often characterized as having two kinds of episodes, or "poles," of high energy and low energy, such a description is grossly inaccurate. Though mania and depression are real episodes, they seldom come pure and so neat. Jamison (1993) explained that

> The clinical reality of manic-depressive illness is far more lethal and infinitely more complex than the current psychiatric nomenclature, *bipolar disorder*, would suggest . . . Moods may swing erratically between euphoria and despair or irritability and

desperation. The rapid oscillations and combinations of such extremes results in an intricately textured clinical picture. (p. 47)

Diagnosis depends on departure from the normal state that causes "either clinically significant distress or some interference" in functioning in facets of life that might include social, occupational, and/or interpersonal (*DSM-IV-TR*, 2000, p. 349, 357, 362). The kinds and intensity of variations from normal dictate the level of bipolar disorder diagnosis. According to the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders Text Revision* (2000), or *DSM-IV-TR*, the book which mental health professionals rely on to define their common language, an individual case of bipolar disorder is diagnosed in one of four discrete forms: bipolar I, bipolar II, cyclothymia, and bipolar not otherwise specified, a category which catches those forms of bipolar disorder yet to be defined. The most profound difference between bipolar I and the others (often-called softer bipolar disorders) is the presence of either severe mania or severe mixed states in bipolar I, which is described below.

Goodwin and Jamison (2007) asserted that among patients and throughout time—"from ancient times to the present, an extraordinary consistency characterizes descriptions of these conditions. Few maladies have been represented with such unvarying language" (p. 3). And Miklowitz (2008) asserted that "Bipolar disorder is one of the oldest and most *reliably recognizable* psychiatric disorders" (italics mine, p. 421). Although bipolar disorder has been recorded in all of written history, the current conception of it is most closely based on the clinical observations, classifications, and an understanding of prognosis developed by Emil Kraeplin[2] in the nineteenth century (Goodwin and Jamison, 2007, p. 25). Below continues the *DSM-IV-TR*

[2] Goodwin and Jamison (2007) explained that to Kraeplin "we owe…[among other things] the observations that cycle length shortens with succeeding episodes; that poor clinical outcome is associated with rapid cycles, mixed states, and coexisting substance abuse; that genetics is central to the pathophysiology of the disease; and that manic-depressive illness is a spectrum of conditions and related temperaments" (p.xix).

explanations and Goodwin and Jamison's (2007) *Manic-depressive Illness: Bipolar Disorder and Recurrent Depression*, the second edition of what is the seminal text on bipolar disorder in the mental health field. It also includes elaborations by noted professionals and researchers in the field of psychology, most specifically in explaining the differences some researchers make between major depressive episodes and bipolar depressive episodes.

The following review attempts to highlight marked changes in perception, concentration, and memory as well as the drive to communicate, the linguistic and social changes that mediate that drive and the person's ability, and the overall physical, bodily experience of having the disorder.

Depression

For an episode of major depression to be diagnosed, there must be "a period of at least two weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities" (*DSM-IV-TR*, p. 349). In addition, the individual must exhibit at least four of the following symptoms: "changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts" (*DSM-IV-TR*, p. 349). The episode must impair functioning; however, in milder states, "functioning may appear to be normal but requires markedly increased effort" (p. 349).

Depressed Mood Or Loss Of Interest

The *DSM-IV-TR* calls the depressed mood, "the essential feature" of depression. Goodwin and Jamison (2007) wrote that individuals tend to describe the illness "with [the following] common language fragments":

> The patient is “slowed down,” “in a fog,” or “exhausted” and describes life as having “lost its color,” “dull, flat, and dreary.” Everything is “hopeless, heavy,” “too much effort,” “drab, colorless, pointless.” Life is a “burden”; there is no point to living; all is meaningless. (p. 30)

The *DSM-IV-TR* grants that the person might not conceive of being or admit to being “sad” or “depressed,” but rather tired, “feeling ‘blah,’ having no feelings, or feeling anxious” (p. 349). The individual might be teary or on the verge of crying for no reason or might be unable to cry (*DSM-IV-TR*, p. 349; Taylor, 2006, p. 25). Also “nearly always present, at least to some degree,” is anhedonia, or loss of interest in things the person previously enjoyed doing (*DSM-IV-TR*, 2000, p 349).

The individual’s mood, rather than depressed, might be “tense, irritable, miserable” (Mondimore, 2006, p. 21; Goodwin and Jamison, 2007, p. 17). There may be also be anger, “reports of emotional pain,” and the sensation of feeling empty (Taylor, 2006, p. 25).

The Physical Symptoms

The most obvious physical symptom from an outside perspective is that the person may be dramatically slowed down and exhausted: “A person may report sustained fatigue without physical exertion. Even the smallest tasks seem to require substantial effort” (*DSM-IV-TR*, p. 340). For diagnosis, an individual must appear to others as having low energy, fatigue, and slowed body movements (*DSM-IV-TR*, p. 350).

Sleep patterns are also disrupted; according to Taylor (2006), the person might sleep too much, not at all, or wake after sleeping only little without being able to go back to sleep (p. 25). Even though individuals who are depressed might also experience early waking insomnia,

Burgess (2006) explained that many people with bipolar rather tend toward sleeping during the day (p. 22).

Some people may experience physical discomfort, pain, and difficulties (*DSM-IV-TR*, p. 349). Food may either be no longer appealing or more appealing than ever. Sometimes appetite is reduced so much that individuals feel they have to force themselves to eat. Conversely, appetite might be increased and diet might therefore become unhealthy (Taylor, 2006, p. 25), which, in addition to "low activity [and] low metabolism," leads to weight gain (Burgess, 2006, p. 22).

The person might be slowed down in thinking and speech, with longer pauses before answering questions and decrease "in volume, inflection, amount, or variety of content, or muteness" (*DSM-IV*-TR, p. 350). Conversely, the person might be unable to sit still, pacing, wringing hands or pulling skin (p. 350). But even though the person might move often, the stress of such movement makes it difficult to rejuvenate (Taylor, 2006, p. 26, 25).

Cognitive Difficulties

According to the *DSM-IV-TR* criteria, people with depression often find it difficult to accomplish cognitive tasks that they usually complete with ease. Concentration, making decisions, and remembering things are all difficult (*DSM-IV-TR*, p. 350). Taylor (2006) noted that working memory is decreased as well (p. 25).

Perception: Worthlessness, Guilt, and Paranoia

The *DSM-IV-TR* explains that

> the sense of worthlessness or guilt associated with a Major Depressive Episode may include unrealistic negative evaluations of one's worth or guilty preoccupations or

> ruminations over minor past failings. Such individuals often misinterpret neutral or trivial day-to-day events as evidence of personal defects. (p. 350)

An individual might feel defective as if something is missing in his or her character. Sometimes that which is missing is the strength to prevent or overcome the depression; an individual might think that he or she brought the depression on him or herself (*DSM-IV-TR*, p. 350), which is particularly easy to believe because there need not be an external stimulus for a depression to occur (see *Notes on Depression* below).

Thomas and Hughes (2006) wrote that the paranoia and anxiety that accompanies depression make it difficult to be around people: "This is a state where you are constantly asking people what they said and then processing their reply in your mind for any signs of treachery, mockery, or conspiracy" (p. 24). Though rarer than in mania, hallucinations are possible in severe depression, and they might be "frightening, even horrifying" (Mondimore, 2006, p. 24).

Suicidal Thoughts and Suicide

The range of thoughts included in the *DSM-IV-TR* that equate to suicidal ideation spans from "a belief that others would be better off if the person were dead, to transient but recurrent thoughts of committing suicide, to actual specific plans of how to commit suicide" (p. 351). In her 1999 work, *Night falls fast: Understanding suicide*, Jamison wrote, "nowhere is the danger of suicide more real than in the mood disorders: depression and manic-depression" (p. 103). In fact, in her 2007 work with Goodwin, Jamison explained, "manic depressive-illness is the most common cause of suicide," (Goodwin and Jamison, 2007, p. xix) with a fifty percent rate of attempt (Jamison, 1999, p. 110) and, of those, an eight percent rate of success (Goodwin and Jamison, 2007, p. 249).

Frighteningly enough, suicide is more frequent in the early stages of the illness and "when patients are actually recovering from depression" because energy returns and people experience volatile states of mixed depression and mania (Jamison, 1999, p. 114). Often mistakenly seen as a sign of weakness, suicidal thoughts affect those with mental illness differently than others. Jamison (1999) speculated, "The normal mind, although strongly affected by a loss or damaging event, is well cloaked against the possibility of suicide" (p. 199). The depressed mind is rather rendered helpless. Indeed, Fieve (2006) wrote that the clinically depressed mind responds out of proportion (p. 52). Suicidal thoughts and attempts stem from a depression-rendered inability to get distance and envision alternatives, as poet Anne Sexton wrote, "But suicides have a special language/Like carpenters they want to know which tools./They never ask why build" (as cited in Jamison, 1999, p. 233). People with depression "see the future with futility and despair" (Jamison, 1999, p. 92). In describing her own attempt, Jamison (1999) wrote,

> It was simply the end of what I could bear, the last afternoon of having to imagine waking up the next morning only to start all over again with a thick mind and black imaginings. It was the final outcome of a bad disease, a disease it seemed to me I would never get the better of. (p. 291)

Potential suicides may also think they are acting in the best interests of others. Jamison (1999) explained, "Decisions about suicide are not fleeting thoughts that can be willed away in deference to the best interests of others" (p. 292). She continued that in fact a suicidal person might see his or her death as something that gives others "a brighter future due to the fact that their lives are rid of an ill, depressed, violent, or psychotic presence" (p. 292). Again describing her own experience, Jamison (1999) reflected,

> I did not consider it either a selfish or a not-selfish thing to have done . . . I knew my life to be a shambles, and I believed—incontestably—that my family, friends, and patients would be better off without me. There wasn't much of me left anymore, anyway, and I thought my death would free up the wasted energies and well-meant efforts that were being wasted in my behalf. . . .
>
> No amount of love from or for other people—and there was a lot—could help. No advantage of a caring family and a fabulous job was enough to overcome the pain and hopelessness I felt; no passionate or romantic love, however strong, could make a difference. Nothing alive and warm could make its way in through my carapace. (p. 292-292)

Notes On Depression

Depression, for the majority of people with bipolar disorder, is the predominant mood state. A 2003 study by Post et al. found that "the average bipolar patient will spend three times as much depressed as manic" (Swann, 2006, p. 37).

The popular understanding of the term "depressed" equates the clinical episode with the blues or feeling down. But in bipolar disorder, depression is different and much worse. Though each depression is idiosyncratic, it might include any number if not all of the hallmark qualities: loss of interest, anxiety, cognitive difficulties, physical symptoms, psychomotor retardation or agitation, worthlessness, guilt, and perceptual changes. Furthermore, depression and clinical depression are different in the severity of response to unfortunate events, such as loss, and clinical depression causes an exaggeration of reality (Fieve, 2006, p. 52). Jamison (1993) explained that "When energy is profoundly dissipated, the ability to think clearly eroded, and the

capacity to actively engage in the efforts and pleasures of life is fundamentally altered, then depression becomes an illness rather than a temporary or existential state" (p. 18).

Another difference between depression and clinical depression as described in the *DSM-IV-TR* is that clinical depression can come upon a person out of the blue, lacking a reason, a phenomenon documented as far back as the second century A.D. (Goodwin and Jamison, 2007, p. 5). The fact that episodes come on by themselves only cements the notion in the depressed mind that the individual is to blame. Such a belief may lead to increased shame and stigma. People might not seek help because it may initially and appealingly seem manageable. Taylor (2006) wrote that "in the early stages of such an episode, when symptoms are mild, people might 'tough it out,' hope it will go away, or not seek help so as not to be labeled a 'complainer'" (p. 20). Escalation, however, follows.

Another difference between a blue or depressed mood and clinical depression are the presence of "guilty ruminations" in the latter. Mondimore (2006) wrote,

> Guilty ruminations are especially characteristic of the syndrome of depression, and psychiatrists often make a special point to ask about guilty feelings when examining a person being evaluated for depression. Ruminations on themes of guilt, shame, and regret are common in the depressed states of the mood disorders, and they are uncommon in "normal" depression. Persons experiencing the normal depressed mood that comes after a personal loss usually attribute their bad feelings to the fact that the loss has occurred; only in unusual circumstances will they feel that they are to blame for their problem and be preoccupied by guilty feelings or feelings of shame. The individual with a depressive syndrome, on the other hand, frequently feels to blame for his or her troubles, and sometimes for other people's troubles as well. (p. 19)

Depression as it is described in the *DSM-IV-TR* varies slightly from that found in bipolar disorder; that is, bipolar depression is not always the same as depression in those who do not experience mania, hypomania, or mixed states. Although the *DSM-IV-TR* does not distinguish between these two kinds of depressive episodes, some researchers have identified differences between the two. After a review of widely replicated studies, Goodwin and Jamison (2007) reported that people who suffer from the most severe form of bipolar depression have more mood swings, psychotic features, physical feelings of being slowed down, and are more likely to abuse a substance. On the other hand, people who suffer from depression only have more "anxiety, agitation, insomnia, physical complaints, anorexia, and weight loss" (p. 17). For bipolar II, the person might sleep too much, experience "increased weight and appetite, leaden paralysis, interpersonal rejection sensitivity, and preferential response" to certain antidepressants (Goodwin and Jamison, 2007, p. 17). Put another way, Burgess (2006) wrote that unlike major depression, with symptoms like "early waking . . . weight loss, and constant thoughts of death," those with bipolar depression tend to experience "daytime sleepiness, weight gain, fatigue, low motivation, and easily hurt feelings" (p. 22).

Mania

The *DSM-IV-TR* defines a manic episode as "at least one week (or less if hospitalization is required)" where mood is "abnormally and persistently elevated, expansive, or irritable" (p. 357). With elevated or expansive moods, three from the following symptoms must also be present for diagnosis. With irritable mood, four should be present. These symptoms include

> inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor

> agitation, and excessive involvement in pleasurable activities with a high potential for painful consequences. (p. 357)
>
> For those with mania, Goodwin and Jamison (2007) reported that many say
>
> Life is "effortless," "charged with intensity," and filled with special meaning. The patient is "upbeat" and "full of energy," his or her thoughts are "racing" and "speeded up," he or she is "wired," "hyper," "high as a kite," "moving in the fast lane," "ecstatic," "flying." Other people are described as "too slow" and "unable to keep up" (p. 30).

Individuals in a manic episode can be overly enthusiastic, euphoric, charming, uncritically self-confident. Still, even though the common understanding of mania is a feel-good high, "the manic state is not pleasant—even if it may sometimes start out that way. . . . The full-blown manic state is not only intensely unpleasant but also very dangerous," dangerous because of both the potential for violence and the stress it exerts on the body (Mondimore, 2006, p. 14).

Euphoria And/Or Irritability

Individuals are said to be enthusiastic—have "indiscriminate enthusiasm for interpersonal, sexual, or occupational interactions" (*DSM-IV-TR*, 2000, p. 357). They are likely to initiate "extensive conversations with strangers in public places" (*DSM-IV-TR*, 2000, p. 357). The manic mood is said to be infectious. Milder versions of mania can be entertaining to witness; individuals joke, pun, and discuss "amusing irrelevancies" (*DSM-IV-TR*, p. 358). The person with mania purposely draws attention to himself or herself, becoming "theatrical, with dramatic mannerisms and singing" (p. 358). But the entertainment might also end quickly. Kraeplin wrote that the person might become difficult to be around: "The patient is dissatisfied, intolerant, fault-finding. . . he becomes pretentious, positive, regardless, impertinent and even rough, when he

comes up against opposition to his wishes and inclinations" (as cited in Goodwin and Jamison, 2007, p. 32). In fact, in their review of literature, Goodwin and Jamison (2007) showed that manic moods in adults with the disorder are more manifested in mixed or irritable behavior than in euphoria (p. 40) and that "motor activation, flight of ideas, pressured speech, and decreased sleep"—all described below—are much more common signs than euphoria (p. 93).

Risk Taking and Grandiosity

The *DSM-IV-TR* explains that "expansiveness, unwarranted optimism, grandiosity, and poor judgment often lead to imprudent involvement in pleasurable activities such as buying sprees, reckless driving, foolish business investments, and sexual behavior unusual for the person, even though these activities are likely to have painful consequences" (p. 358). Taken from another angle, Kraeplin used the word, "courageous" (as cited in Goodwin and Jamison, 2007, p. 32). Mondimore (2006) wrote that "fears of unpleasant consequences disappear altogether, and a reckless enthusiasm takes over" (p. 12).

According to the *DSM-IV-TR*, a manic mood may include inflated self-esteem, "ranging from uncritical self-confidence to marked grandiosity, and may reach delusional proportions," such as giving "advice on matters about which they have no special knowledge (e.g., how to run the United Nations)[3]. . . Grandiose delusions are common (e.g., having a special relationship to God or to some public figure from the political, religious, or entertainment world)" (*DSM-IV-TR*, p. 357).

Decreased Need For Sleep

A decreased need for sleep is the most important indicator of a manic episode. The *DSM-IV-TR* asserts that this decrease is "almost invariably" true (p. 357), and Goodwin and Jamison

[3] At least one of my participants did in fact write letters to the United Nations between the interview and the end of the study.

(2007) call it “perhaps the most objective symptom” (p. 93). A decreased need for sleep may manifest itself as follows: “The person usually awakens several hours earlier than usual, feeling full of energy. When the sleep disturbance is severe, the person may go for days without sleep and yet not feel tired” (*DSM-IV-TR*, p. 357). The person might have excessive physical energy, be unable to keep still, and, as with depression, might pace (*DSM-IV-TR*, p. 358). Due to the impact of sleep deprivation on the body, research studies and histories of the illness show that it was once common in the days before modern medications to die of exhaustion from mania (Goodwin and Jamison, 2007, p. 240).

Verbal and Communication Manifestations

According to the *DSM-IV-TR*, manic thoughts call for urgency. Thoughts move quickly, sometimes too quickly for articulation, and the individual might be distractible, unable to concentrate long on any one concept while every concept and every thing calls out to be immediately, intensely noticed (p. 358). Thoughts may seem to jump around with disregard for linear logic or transitions. Sometimes words are connected only by sound (p. 358). In severe cases, thought falls into total disorganization and confusion.

Individuals in manic episodes experience changes in their speech. It can become “pressured, loud, rapid, and difficult to interrupt,” and individuals may “talk nonstop…without regard for others’ wishes to communicate” (*DSM-IV-TR*, 2000, p. 358). Interestingly, individuals in manic episodes seem to chose words based on sound rather than meaning (*DSM-IV-TR*, p. 358).

Increase in Goal-directed Activity

The *DSM-IV-TR* explanation for goal-directed activity “involves excessive planning of, and excessive participation in, multiple activities (e.g., sexual, occupational, political,

religious).” With great facility, the individual can multi-task, hold different conversations at the same time, or “write a torrent of letters on many different topics to friends, public figures, or the media” (*DSM-IV-TR, p.* 358). The individual might begin to take part in more activities, volunteering or taking on extra work and challenges, whether or not they are feasible.

Sometimes the goal is to be social. The *DSM-IV-TR* described it best: “Almost invariably, there is increased sociability (e.g., renewing old acquaintances or calling friends or even strangers at all hours of the day or night), without regard to the intrusive, domineering, and demanding nature of these interactions” (*DSM-IV-TR, p.* 358). The *DSM-IV-TR* also has it that “Increased sexual drive, fantasies, and behavior are often present” (p. 358).

Perception

Although perceptual changes are not mentioned in the *DSM-IV-TR*, they are widely discussed elsewhere. Goodwin and Jamison (2007) wrote that the illness has “gross cognitive and perceptual distortions and both subtle and profound changes in sensory experience” (p. 30). They wrote that individuals in manic episodes have heightened senses (p. 38). Lights are brighter, smells and tastes stronger, easier to identify, and sound is louder. Akiskal (2002) wrote that an individual in a manic episode can experience “senses [that] are so vivid that colours and textures are richer, and reality more exotic, both of which can be easily transformed into a vision” (p. 16). However, Goodwin and Jamison (2007) explained that there is variance in degree and kind, “from mild increases in awareness of objects and events actually present in the individual’s environment to total chaotic disarray of the sense, resulting in visual, auditory, and olfactory experiences unrelated to existing phenomena” (p 38).

Hypomania

A hypomanic episode is a milder version of the manic episode. The two are so closely alike, however, that the symptoms laid out in the *DSM-IV-TR* are in fact, according to Akiskal (2002), "insufficiently discriminatory" (p. 18). Akiskal (2002) defined hypomania simply as "a non-psychotic, milder or subthreshold manic state of short duration and without marked impairment" (p. 18). However, in the *DSM-IV-TR*, hypomania is considered its own discrete state.

The specific *DSM-IV-TR* definition of hypomania is, at least four days of an "abnormally and persistently elevated, expansive, or irritable mood" with symptoms including at least three from the following (four, if irritable):

> inflated self-esteem or grandiosity (nondelusional), decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable activities that have a high potential for painful consequences. (p. 365)

Unlike mania, which seems more likely to be irritable than euphoric, hypomania's prototypical form is cheerfulness, productivity, and things like infectious good humor and wit. Unlike mania, hypomania can be diagnosed after only four days of symptoms, which is three less than mania, as long as delusions, psychosis, and the necessity for hospitalization are not apparent. Another specific departure from mania criteria, according to the *DSM-IV-TR*, is that it is also uncommon to have flight of ideas—where ideas move quickly from one to another (p. 366), which is observable by outsiders in speech by abrupt changes from concept to concept and it isn't difficult to interrupt speech (p. 358). Individuals might be impulsive also, but their actions are not bizarre: "The increase in goal-directed activity may involve planning of and participation

in, multiple activities. These achievements are often creative and productive (e.g., writing a letter to the editor, clearing up paperwork" (p. 366). It might be that the drop in severity makes otherwise potentially destructive symptoms useful, leading sometimes to "marked increase in efficiency, accomplishments, or creativity" (p. 366).

Rather than being diagnosed based on functioning impairment, hypomania is diagnosed based on whether or not the episode is "clearly different from the individual's usual nondepressed mood, and there must be a clear change in functioning that is not characteristic of the individual's usual functioning" as observable by others who know the person well (*DSM-IV-TR*, 2000, p. 365). The mood may also alternate between euphoria and irritability. Indeed, Fieve (2006) pointed out, "it isn't always a pleasurable high, particularly when behaviors include being hot-tempered and argumentative" (p. 58). Indeed, Goodwin and Jamison (2007) described hypomania as a mood "ebullient, self-confident, and exalted, but with an irritable underpinning" (p. 32). Fieve (2006) wrote that even though "hypomania can generally make a person vivacious and exhilarating . . . it can also make that same person increasingly haughty, ill-tempered, and difficult to be around" (p. 24). Mondimore (2006) pointed out that some of the negative consequences of hypomania are risky investments, promiscuity, and irritability (p. 16). He wrote that "persons with even mild hypomania can quit a good job in a burst of overconfidence or irritability, withdraw a life's savings for a get-rich-quick scheme, or simply begin to drive their car too fast—all behaviors with potentially devastating consequences" (p. 17).

Note on Mania and Hypomania

In terms of mania actually being pleasant, people who do experience good hypomania tend to be very productive. Often they are so confident, charismatic, and persuasive that others rally behind them. In fact, in *The Hypomanic Edge* (2005), Gartner drew parallels between

people who can get their wacky ideas off the ground with inspired and inspiring energy and hypomania (mild mania). As examples, he included Christopher Columbus, Alexander Hamilton, and Andrew Carnegie. Even some of the negative parts of mania might be beneficial in hypomania: touting the importance of hypomania to the advancement of business and technology, Gartner (2005) explained that "Anyone who slows them down with questions 'just doesn't get it'" (p. 2).

It is important to stress the potential drawbacks to hypomania because they are often forgotten in the popular layman's view of the illness. In cases of individuals who experience full-blown mania, hypomania is sometimes only a stepping stone. According to the studies used to define the episode in the *DSM-IV-TR*, "5% to 15% of individuals with hypomania will ultimately develop a manic episode" (p. 367). Hypomania may be a warning sign that bad things are to come and may often be ignored in favor of keeping the high. This is not, however, to say it is always a matter of ignoring it; like mania, the person might not even notice the change unless alerted to it by someone else.

In cases of individuals who do not experience full-blown mania, there still exists the experience of full-blown depression. And, in addition to the regular symptoms of depression, there is the impotent feeling of what had been lost: One does not go from normal to nothing, but rather from superhero or genius to powerless or deficient.

Mixed States

The *DSM-IV-TR* lays out the criteria for a mixed episode as follows: it is "a period of time (lasting at least 1 week) in which the criteria are met both for a Manic Episode and for a Major Depressive Episode nearly every day" (p. 362). While this combination of symptoms present themselves, the mood might switch rapidly among "sadness, irritability, [and] euphoria."

A mixed episode may include the symptoms of "agitation, insomnia, appetite dysregulation, psychotic features, and suicidal thinking" (p. 362). Mixed states may be diagnosed also if they require hospitalization or cause psychosis. Ultimately, diagnosis is more dependent on the severity of impairment than whether the criteria—with the exception of psychotic features—are met (p. 362).

Goodwin and Jamison (2007) wrote that mixed states "can be conceived of as transitional states from one phase of illness to another or as independent clinical states combining various mixes of mood, thought, and activity components" (p. 72). They listed these symptoms of a severe mixed state: "dysphoric mood alternating with elevated mood racing thoughts, grandiosity, suicidal ideation, persecutory delusions, auditory hallucinations, severe insomnia, psychomotor agitation, and hypersexuality" (Goodwin and Jamison, 2007, p. 79).

A lighter form of a mixed state occurs with the combination of hypomania and depression. Quinn (2007) identified this as a "dark" form of bipolar II, a bipolar type which does not hit full-blown mania: "Such patients are typically moody, critical, irritable, demanding, controlling, and may have explosive tempers" in addition to "racing or crowded thoughts, loud and pressured speech," distractibility, and hypersexuality, all in spite of numerous symptoms of moderate to severe depression (p. 4).

Notes on Mixed States

Although mixed states involve a mixture of mania and depression, to the layperson's eye mixed states seem to look more like mania than depression; unlike depression, there is no loss of energy or slowed movement. And unlike depression and mania which seem to follow each other, a mixed state can remit entirely by itself (*DSM-IV-TR*, 2000, p. 363).

As with mania, not everyone with bipolar disorder experiences or has experienced a full blown mixed state. The *DSM-IV-TR* does not spend a lot of time on mixed states, despite the fact that they are common in bipolar I. According to Goodwin and Jamison (2007), in fact, the mental health community is having a hard time defining them an attributing causes (p. 72).

Kinds of Bipolar Disorder

The psychiatric community distinguishes between four types of bipolar disorder: bipolar I, bipolar II, bipolar disorder not otherwise specified, and cyclothymic disorder. These types depend on the kinds, intensities, and durations of episodes.

Bipolar I

The official diagnostic features of bipolar I disorder are as follows: "a clinical course that is characterized by the occurrence of one or more Manic Episodes or Mixed Episodes. Often individuals have also had one or more Major Depressive Episodes" (*DSM-IV-TR, p.* 382). Taylor (2006) explained that a person who has exhibited only mania will be diagnosed as bipolar I because "statistically the individual has a high probability of experiencing a major depressive episode at some point in their life" (p. 20). Although persons who experience mixed states only might be diagnosed with bipolar I, mixed states are underrepresented in the *DSM-IV-TR*.

Bipolar I affects roughly one percent of the population (Goodwin and Jamison, 2007, 185) and is the most severe form of bipolar disorder as well as the most recognized. As a severe form, it often results in hospitalization and sometimes in delusions and hallucinations. Well known people who have had bipolar I include Patty Duke, Virginia Woolf, and Sylvia Plath.

Bipolar II

Bipolar II, although cyclical and involving a state that is "up," does not involve mania or mixed states (p. 393). Unlike bipolar I, the central feature of bipolar II is depression; it is even

often misdiagnosed as Major Depressive Disorder (Fieve, 2006, p. 57). The official criteria for the illness puts major depressive episodes first (whereas bipolar I disorder may or may not include major depressive episodes). Fieve (2006) reported that, according to some findings, people with bipolar II spend fifty percent of their time in depression, whereas those with bipolar I only spend thirty percent (p. 57). Bipolar II looks like depression and people with it might not even remember having a hypomanic episode. Bipolar II is often referred to as "soft bipolar," but its depression can be just as severe as depression in bipolar I, causing a greater number of suicides (Fieve, 2006, p. 71).

Three to eight percent of the population is said to suffer from bipolar II. Some people with bipolar II—including one participant in this study—are careful to point out that they do not have bipolar I, which is so often seen as "crazy," since the madness of bipolar I can be destructive and public. Flaherty (2004) wrote, "not all mania is the textbook mania of flamboyant dressing, risk taking, and barroom fights. Its principal effect on me was to make me hole up in my office and write" (p. 12).

Bipolar Disorder Not Otherwise Specified

Bipolar Disorder Not Otherwise Specified is the catch-all diagnosis for illnesses appearing to be bipolar but which do not meet the official criteria. Mondimore (2006) wrote that "bipolar disorder is probably not divided simply into type I and type II. . . and patients often don't fit into *DSM* pigeonholes" (p. 57). Although the *DSM-IV-TR* defines only these types of bipolar disorder, researchers and clinicians are increasingly arguing for a broader spectrum that would seem to better delineate what is now bipolar nos (see Goodwin and Jamison, 2007 for the most detailed account). The concept of a spectrum allows for multiple combinations and intensity of episodes. The spectrum, rather than ranging from mania to depression as popularly

believed, ranges from bipolar I (bipolar with mania) to recurrent depression (bipolar without mania) (Fieve, 2006, p. 39). Quinn (2007) defined the spectrum as running from "bipolar I to temperamentally normal individuals with varying degrees of extroversion, high energy, and creativity" (p. 3)

Many individuals do not meet all of the criteria in the *DSM-IV-TR*, but it is still believed that they have bipolar disorder rather than unipolar depression (Quinn, 2007, p. 4). In the meantime, such individuals might also be diagnosed as having a personality disorder or schizophrenia and treated accordingly (Quinn, 2006, p. 4).

Cyclothymia

Cyclothymic disorder, according to the official diagnostic criteria in the *DSM-IV-TR*, "is a chronic, fluctuating mood disturbance involving numerous periods of hypomanic symptoms and numerous periods of depressive symptoms" (p. 398). More specifically, there must be two years of hypomanic symptoms and some mild (not full blown) depression (p. 346). These symptoms, however, are not severe, pervasive, or persistent enough to be considered episodes; however, over a two year period, periods of normalcy would not last more than two months (p. 398). Jamison (1993) explained that it "can be manifested in several ways—as predominately depressive, manic, hypomanic, irritable, or cyclothymic" (Jamison, 1993, p. 14).

Cyclothymia can be diagnosed in tandem with bipolar I or bipolar II. In instances where it appears alone, cyclothymia might be a harbinger for the more severe illnesses: "there is a 15%—50% risk that the person will subsequently develop Bipolar I or II Disorder" (p. 399).

Other Kinds of Bipolar Disorder

An additional kind of bipolar disorder, schizoaffective disorder, has not been included in this study. In order to be diagnosed as having bipolar disorder as opposed to having

schizoaffective disorder, the individual must have a predominance of mood rather than psychotic symptoms (Goodwin and Jamison, 2007, p. 103).

Cycles

The natural course of the disorder is movement in and out of remission, sometimes full remission, except in cases of chronicity, of which seem rarely if at all mentioned in the literature (see Goodwin and Jamison, 2007 for discussions of such cases). In fact, Goodwin and Jamison (2007) wrote that "The recurrent pattern of the illness—that of recovery to normal or change to an opposite state—makes it an unsurpassed paradigm for separating state and trait variables in mental illness" (p. xxi). Many individuals with bipolar disorder spend years completely well and functional. Some live better than that. Fieve (2006) asserted that, "When properly diagnosed and treated with medications and psychotherapy, it is possible for 70 or 80 percent of those with bipolar disorder to lead a normal and extremely productive life" (p. 32). Still, although the course of the illness usually includes cycles through moments of normalcy, "residual symptoms" can "cause problems in daily functioning and adjustment difficulties for over 50% of people with bipolar" (Taylor, 2006, p. 20). People dealing with these problems may be able to function, but they struggle to do so.

For some, the rate of change from episode to episode is faster than for others and the duration is shorter, in which case the disorder is considered to be rapid cycling. Rapid cycling describes the state of experiencing four or more episodes over the course of a year (*DSM-IV-TR*, 2000, p. 427). Akiskal (2002) wrote that rapid cycling "is usually dominated by depression" and that "sometimes individuals can move so quickly through the cycle that they "rarely have freedom from affective episodes during the rapid-cycling phase of their illness" (p. 31).

It is possible that a person might only experience either mania or depression and still be under the manic-depressive heading (Goodwin and Jamison, 2007, p. 36).

Also in terms of cycling is the seasonality of bipolar disorder. Goodwin and Jamison (2007) identified two "peaks" of major depression: one in spring and a smaller one in the fall (p. 680). Mania, on the other hand, peaks in the summer months (p. 681). Summer mania corresponds with suicide attempts (Jamison, 1999, p. 207).

Prevalence, Population, Statistics

As previously noted, Goodwin and Jamison (2007) reported that "findings of recent studies generally indicate an overall lifetime prevalence of bipolar-I disorder of about 1 percent"; moreover, this percentage is nearly the same across the world (p. 185). For the broader bipolar spectrum, Goodwin and Jamison (2007) reported lifetime prevalence rates between 3.0 and 8.3 percent (p. 185). According to studies, bipolar disorder occurs equally regardless of race and ethnicity (Goodwin and Jamison, 2007, p. 183), presenting itself across cultures. For example, according to one study, "Manic behaviors to the Amish include racing one's horse and carriage too fast, buying or using machinery or worldly items, using the public telephone excessively, and planning vacations during the wrong season" (p. 162).

Goodwin and Jamison (2007) reported that "Most studies with large sample sizes have not shown strong differences in rates of bipolar disorder by gender" (p. 185). The age of onset[4]—at 20 years (*DSM-IV-TR*, p. 360)—is also the same (Goodwin and Jamison, 2007, p. 124). There are, however, some differences in how men and women experience the illness. For men, the first and most prevalent episode is generally manic, whereas for women it is depressive (*DSM-IV-TR*,

[4] According to Goodwin and Jamison (2007), studies of the age of onset vary widely because of dispute as to what "onset" specifies. Symptoms are thought to begin before the age of 20, with the first hospitalization between 26 and 30 (p. 149).

p.385). According to studies, a higher ratio of women have bipolar II disorder and a higher ratio of men have bipolar I disorder (Goodwin and Jamison, 2007, p. 12). Moreover, rapid cycling more prevalent in women, and women are also probably more likely to experienced mixed symptoms (*DSM-IV-TR*, p. 385). Finally, according to Goodwin and Jamison (2007), women are especially vulnerable for developing manic episodes around pregnancy and menopause (p. 185).

Bipolar disorder also presents itself equally across social class and education level (Goodwin and Jamison, 2007, p. 182). Goodwin and Jamison (2007) reported that earlier studies showed that people in higher social classes were more likely to have bipolar disorder; however, people in lower social classes are diagnosed—Goodwin and Jamison (2007) wrote "mistakenly so"—as having schizophrenia while people in higher social classes are more likely to be diagnosed as having bipolar disorder (p. 182).

For diagnosis in the *DSM-IV-TR*, symptoms must not be caused by medication or treatments or other illnesses. Other illnesses which look like mood disorders include systemic lupus, thyroid disease, diabetes, multiple sclerosis, Lyme disease, epilepsy, syphilis, and HIV/AIDS (Fieve, 2006, p. 162). Physical illness often coincides with the disorder, because of the treatments, the disorder itself, and the effects of the behavior it causes (Goodwin and Jamison, 2007, p. 240).

Causes

In the second century AD, Aretaeus of Cappadocia, the first to link mania and depression together as one illness, said that both came upon a person for no reason (Goodwin and Jamison, 2007, p. 5). Accordingly, Goodwin and Jamison (2007) asserted, "we view manic-depressive illness as a medical condition, an illness to be diagnosed, treated, studied, and understood within a medical context. This position is the prevailing one now, as it has been throughout history" (p.

xix). In studies, bipolar's connection to genetics is becoming more and more apparent (p. 411). Goodwin and Jamison (2007) explained that genetics contribute to an episode in that they create "and underlying vulnerability" and that "environmental conditions—psychosocial or physical—contribute more to the timing of an episode than to" that vulnerability (p. xxi). Taylor (2006) wrote that stress and interpersonal problems are more likely caused by the illness than causes of the illness. Even though outside issues can contribute to the timing of the episode, such issues affect the timing only in the early stages of the illness (Goodwin and Jamison, 2007, p. 135). As the illness progresses, the episodes take on a life of their own (Goodwin and Jamison, 2007, p. 135; Mondimore, 2006, p. 8, 232).

Overemphasis on the social aspects of bipolar disorder and other mood disorders leads to false assumptions regarding writing and mental illness, i.e., that writing can cure it. Moreover, one of the biggest fears about having a bipolar student in the classroom is understanding what might trigger an episode. Valentino (1996), for instance, lamented the fact that students do not have to disclose their condition to teachers.

Treatments

In the context of discussing treatments, Goodwin and Jamison (2007) admitted that "we simply do not yet have an adequate understanding of the illness in all of its various forms and complexities including its interactions with *individual differences*, that is, differences in environment and in the patient's character and psychological and physical resilience" (p. 701). However, they made a point of saying that the scientific community has made a lot of progress; treatments for bipolar disorder have brought a lot of people into remission. Still, relapse is possible. It is possible that these treatments cause mania or hypomania, especially

antidepressants that are not used in tandem with a mood stabilizer cause a person to break into mania or hypomania.

The three major treatments for bipolar disorder are medication, psychotherapy, and ECT (electric convulsive therapy).

Medication

Goodwin and Jamison (2007) maintained that"[P]hysicians, ancient and modern, have for the most part sought cures for mania and melancholia not through talking and listening, but through direct actions of control: mineral baths, bloodletting, herbs, chains, vapors, bromides, opiates, warm waters, cold waters, and physical and chemical restraints" (p. 871). Modern pharmaceutical intervention for bipolar disorder began when lithium, a salt, was found to cause symptoms to remit. When lithium was approved by the FDA in the 70s, lives were finally, literally, saved. Depression stopped. Mania stopped. People who had bipolar disorder became exactly like the rest of the population, give or take your normal amount of psychological baggage (Caramagno, 1992, p. 32). Not only can it be safely said that lithium was a miracle, and it can be said that lithium changed how people saw bipolar disorder. According to Mondimore (2006), it led people to start believing there was a biochemical basis for mood disorders (p. 72). He wrote, "The fact that lithium made mania go away indicated that mania had at least some biochemical basis" (p. 72). In fact, according to Romero and Kemp (2007), because bipolar could be treated with drugs, "it has become a paradigm for pharmacological intervention in psychological disorders" (p. 134).

Today there are many more medications besides lithium, as not everyone with bipolar disorder responds to it. It can take years to find the right combination for a person, and, even with medications, there can be break-through episodes or slightly less harmful tides.

Furthermore, medications cause side effects which affect a person physically (tremors, weight gain, hair loss, etc.) and mentally (lowered self-esteem from altered appearance, loss of concentration, fogginess).

Psychotherapy

Goodwin and Jamison (2007) wrote, “Even the pioneers of psychotherapy, the psychoanalysts, tended to perceive patients suffering from bipolar illness as not very good candidates for psychotherapeutic treatment” (p. 871). They asserted that “The empirical evidence for the efficacy or effectiveness of psychotherapy for bipolar disorder remains limited for adults and is virtually nonexistent for children and adolescents” (p. 905). Others have agreed. Colom and Vieta (2006) wrote that “psychological treatments as add-ons to drugs may be appropriate for treating bipolar depression, but there is currently very little evidence indicating that such treatment is correct” (p. 223). And Mondimore (2006) explained that “no one today would even think to recommend counseling or therapy as the only treatment for bipolar disorder; to do so would constitute malpractice” (p. 142). Taylor (2006) argued strongly against the usefulness of psychotherapy in actual episodes, say that psychotherapy is useless because the disorder skews cognition anyway.

Goodwin and Jamison (2007) did, however, advocate both medication and psychotherapy, calling drug therapy “primary” because it enables patients to live free of “severe disruptions of manic and depressive episodes” (p. 904). Psychotherapy then fits in to “help patients come to terms with the repercussions of past episodes and comprehend the practical and existential implications of having bipolar illness” (p. 904). Such implications include coming to terms with having bipolar disorder; keeping to the drug regimen; lessening anxiety; and learning how to manage symptoms and triggers (Miklowitz, 2008, p. 426). Fawsett et al. (2000) wrote

that people need “the skills and awareness to both make sense of their illness and to develop proactive and reactive approaches to help minimize the impact of the illness (p. 105). Psychotherapy, according to them, is a haven; it helps the person distinguish between illness and normal living, depression and sadness, optimism and mania. It also helps people understand the meaning they assign to the illness—is it an identity or challenge (Fawsett et al., 2000, p. 105).

Although CBT (cognitive based therapy), one specific kind of therapy, has not been proven to cure bipolar disorder, it teaches self-talk, that is, substituting healthy cognitions for less than healthy ones. Because it emphasizes the verbal, CBT will be discussed later with regard to using writing as a tool for coping.

ECT

ECT is a treatment whereby seizures are induced under anesthetic, which is said to relieve depression. It is a highly controversial treatment in the respect that it can cause memory loss, usually short-term memory loss.

Trauma of Diagnosis and Treatment

Receiving a psychiatric diagnosis is significantly traumatic. The average person diagnosed with bipolar disorder is treated properly eight years after the onset of the illness (Goodwin and Jamison, 2007, p. 701). A person must go back and re-interpret those eight years in light of the illness. This may involve looking at the past in terms of biochemically-induced misperceptions and sometimes in terms of things—relationships, jobs, health, money—that might not have been lost if the problem had been solved earlier. For example, if a person has undergone several depressive episodes, he or she might find reasons for those episodes until the diagnosis, when he or she then reinterprets the episodes in terms of bipolar disorder.

Moreover, a psychiatric diagnosis is society's official stamp of "crazy," affecting a person's view of himself or herself as well as society's view of that person. The stigma that the individual already associates with mental illness or manic depression is difficult to swallow (Mondimore, 2006, p. 142). As with other psychiatric diagnoses, a diagnosis of bipolar may require a re-understanding the meaning of "mentally ill"; such a diagnosis may involve coming to terms with stigma, the stigma that that individual had previously placed on others and that which the individual will now accept or not accept to place on himself or herself. Hinshaw (2007) wrote that stigma transfers into the stigmatized as shame: "In other words, the demeaning attitudes of perceivers may well come to be internalized by the possessor of the devalued attribute in question" (p. 25).

Then there is the outside stigma. Thomas and Hughes (2006) are worth quoting at length here:

> The diagnosis of manic depression is not like a physical diagnosis. When someone is given the diagnosis of manic depression, it tells the rest of the world who they are, how they behave, what to believe about them and what to expect from them. And as long as they are who they are, it is a label that will define them for the rest of their life. They do not deserve the label, and they should not be blamed. Other people have worse problems, and live worse lives, and yet other people's sanity is never questioned. From the moment of diagnosis, the illness can explain that person's thoughts, their moods and their emotions and from the moment they are diagnosed, just in case they become unwell again, their judgement (sic) is never to be fully trusted again. . . .
>
> To be diagnosed as a manic depressive goes to the core of who you are as a person. It is difficult to feel good about a diagnosis that reaches into your very soul. Furthermore,

> there are no external signs to mark the condition out as special, to get the ordinary sympathy for illness or to provide even a hint of what you experience. Suddenly, medication becomes a permanent part of daily routine, doctors and psychiatrists become privy to every personal fact and able to judge each personal experience. (p. 228-229).

Fawcett et al. (2000) noted that being diagnosed with bipolar disorder "can leave permanent scars" (p. 3). These scars come from "feeling of loss and grief after the loss of real or abstract objects, such as job, . . . economic status, and loss of love relationships and family support" (Taylor, 2006, p. 222). They also include the guilt associated with the false perception of being able to control symptoms, a guilt that fades with psychoeducation. Also, "the loss of abstract objects includes grief for the loss of the healthy self" (Taylor, 2006, p. 222). Mondimore (2006) pointed out that another traumatic event is relapse, even when everyone is working against it (p. 142). In other words, breakthrough cycling and psychological immunity to medication can occur regardless of best efforts for reasons that are largely not understood.

Learning what the disorder is and what "normal" is can be a difficult journey. Treatment, too, is traumatic. Clark (2007) explained,

> Almost every narrative of depression includes a first encounter with medication, usually the first of many. In *Speaking of Sadness*, Karp shows, through the words of his respondents, that the process of accepting antidepressants into one's life is rarely a straightforward one (78-103).
>
> There is often resistance at first to the idea of relying on pills, especially for a "mental condition." The old stigmas are still powerful, even while doctors draw analogies with diabetes and high blood pressure, and the drug companies push Paxil and Effexor in the media, promising new birth and life. . . Identity is definitely at stake in taking

> psychiatric medications, as the brain with its defective neurotransmitters is the house of the self, the memories that make up a life's story. (p. 125)

Being diagnosed with bipolar disorder may involve looking at a future of hit-or-miss long-term medications and their side effects (e.g., hair loss, tremors, huge weight gains, tardive dyskinesia, memory and concentration problems), therapy, and understanding and acceptance of invisible limitations that require lifestyle changes.

In addition, as Hinshaw (2007) explained, "Side effects of the medication can offset aesthetics and cause the person to be even more stigmatized. Many people, for instance, twitch, have tremors, gain an ungainly amount of weight, break out in near uncontrollable acne, lose hair (in men and women), etc." (p. 32).

Comorbidity

Goodwin and Jamison (2007) cited studies saying that 65% of patients who have bipolar disorder have an additional disorder. It is not unlikely that a participant in this study may be suffering from (in order of prevalence) substance abuse disorder, anxiety disorder, panic disorder, social phobia, post-traumatic stress disorder, or eating disorder (Goodwin and Jamison, 2007, p. 224). Moreover, people with bipolar disorder tend towards the following physical illnesses "at a higher rate than the general public": cardiovascular disease, thyroid dysfunction, obesity, diabetes, and migraine headaches (Goodwin and Jamison, 2007, p. 240-245).

Conceptualizing Bipolar

Bipolar disorder has gone through several name changes in the medical community: a review of the literature follows the name from manic-depressive illness to bipolar disorder affective disorder to bipolar disorder to the less frequently used bipolar disorders.

In her memoir, Jamison (1995) wrestled with the name change:

> Obviously, as a clinician and researcher, I strongly believe that scientific and clinical studies, in order to be pursued with accuracy and reliability, must be based on the kind of precise language and explicit diagnostic criteria that make up the core of DSM-IV. No patient or family member is well served by elegant and expressive language if it is also imprecise and subjective. As a person and a patient, however, I find the word "bipolar" strangely and powerfully offensive: it seems to me to obscure and minimize the illness it is supposed to represent. The description "manic depressive," on the other hand, seems to capture both the nature and the seriousness of the disease I have, rather than attempting to paper over the reality of the condition. (p. 181-182)

Author James Fry (2006) put it more succinctly: "Personally, I prefer Manic Depression. Bipolar isn't quite right—the condition isn't really just about two poles, there are mixed states in between. Besides, why not give it a title that names the effects?" (p. 7).

In the 2007 edition of their acclaimed work on manic-depressive illness, Goodwin and Jamison (2007) broadened manic-depressive illness to include recurrent depression and bipolar disorder, to, in effect, emphasize the commonality among the disorders as being cyclical rather than polar.

In the end, the name does matter. Taylor (2006) wrote that

> Popular writers and news announcers simply describe the disorder as an illness causing people to experience extreme emotional lows and at other times wild euphoric highs. As with most generalizations, this fails to communicate the true experience, pain, and the cost of the illness. Brief definitions also invite people to picture a simplified problem

> controllable by choice. . . [F]or many, depressive and manic symptoms are seen as behavioral choices. (p. 17)

Walking Through Bipolar Disorder

There seems to be a number of people who either diagnose themselves or perceive no difference between the symptoms of bipolar disorder (whatever form) and their own "normal" personality traits or, ultimately, writing processes. The previous discussion should be helpful in understanding the degree and kind of suffering experienced by these writers. Further understanding might help one better understand the differences.

Of the biographies and autobiographies which describe mania and/or bipolar depression, there are several which are useful in understanding the disorder, or various permutations thereof, such as those written by Patty Duke (1992), Lizzy Simon (2002), Kate Millet (2000), Kay Redfield Jamison (1995), Jane Pauley (2004), and others. What has been most helpful, though, are those out there which attempt to guide the reader through the illness by relating it to the experiences of the other 90 to 99 percent of the population. Whybrow, in his 1997 book, *A Mood Apart*, wrote,

> Mania and melancholic depression are intensely personal illnesses. Although they stand as true aberrations of thought and feeling, extending the range of what we consider "normal" emotional experience, they remain accessible to all of us through empathic understanding and thoughtful dissection of such common mood states as profound grief and great joy. (p. xviii)

More useful yet is Taylor's (2006) walk through the moods themselves as follows:

> Imagine a time when exuberant energy caused a momentary lapse in judgment. Perhaps in excitement you embarrassingly overrated your work, claimed phantom skills. . . Now

> imagine all of these exaggerated thoughts, emotions, and behaviors coming together at once. The flood of ideas are welcomed until sleepless nights and unstoppable thinking turn self-assurance into fear and confusion. Unfinished thoughts start rapidly colliding, crashing like freight trains, and leaving you disoriented, irritated, and unsure of how to end the madness. . . (p. 23)

Taylor's (2006) exercise in understanding of depression includes the following:

> . . . picture day after day, week after week, finding no joy or peace in anyone or anything. Successes are either experienced as failure, or just added burdens, moral obligations, piled upon an already tired body. . . Yet no one perceives how hard you are working, how tired you feel, how stress hangs everywhere. . . You simultaneously experience a sense of heavy, anesthetizing dullness and psychic emotional pain that cannot be relieved. . . There is no room, no energy for discovering alternative ideas. . . A nagging awareness that there are no joys, no delighting colors and sounds, no wonderful smells and tastes, no answers no future, only burden and failure, hardships, pain, and death: death to stop the pain, death because the mind demands death. . . (p. 26).

But in the end, Taylor (2006) reminded us, "Bipolar disorder is easy to define, but difficult to explain in a way that effectively communicates its overwhelming destructive power" (p. 17).

Conclusions and Implications of Part I: Living With Bipolar Disorder

This section laid out the symptoms and major issues an individual with bipolar disorder must confront. An understanding of these symptoms and major issues not only helps in understanding the context in which these writers write, but such an understanding also contributes to the formulation of interview questions. Do writers with bipolar experience differences in their writing due to the seasonality of the disorder? Do they find that the disorder

might be cured by writing, even though studies in the field of psychology and mental health disagree? Can writers be talked out of suicide? Can writing cure a suicidal depression? Is writing dangerous? Does stigma play a role in their experience as writers in relation to how they relate to their audience?

The understanding of bipolar disorder as laid out here is that it has a biochemical basis and, as a syndrome, cannot be resolved with psychotherapy. Moreover, as the illness progresses, the episodes come on regardless of life stresses (even though many bipolar handbooks for patients advise ways to manage stress so as not to precipitate an episode). This is a vital point in that it addresses the fear that mania or depression might be triggered by outside causes, a question that brought to the participants in this study.

All-in-all, though, these symptoms, experiences, and treatments will affect a writer's practices and these practices have been hypothesized to affect a writer's experience of bipolar disorder, both of which will now be discussed.

Part II: The Writing Life of Writers With Bipolar Disorder

The previous section sketched the context in which individuals with bipolar disorder live their lives. Inside, they cope with the chaotic symptoms of a mood disorder while outside they come up against trauma and stigma. In this section, the focus is more on writers with bipolar disorder as *writers*.

In many respects, their lives as writers are the same as the lives of other writers. That is, because bipolar disorder has a cyclical course and can be treated with stabilizing medications, many who suffer from it experience periods, even long stretches of time, of complete normalcy. But the illness has an effect on writing as it would on every other aspect of their lives. Since Kraepelin's groundbreaking work on bipolar disorder which was published in 1921, studies in

the field of psychology and neuroscience have produced clinical pictures of connections between bipolar disorder and writing. With an eye toward areas where the results of this study might diverge, the following explains what theorists and researchers (including Kraeplin) have said about writing and bipolar disorder.

Writing By Episode

Writing with Mania and Hypomania

Goodwin and Jamison (2007) cited Kraeplin as having said that "many patients display a veritable passion for writing" (p. 74). He was "astonished" by "the number of documents produced by manic patients," even though "certainly they themselves do not count on their being read" (as cited in Goodwin and Jamison, 2007, p. 34). Moreover, symptoms of mania and hypomania change how a writer thinks, behaves, and feels about himself or herself and therefore no doubt change how a writer writes.

The *DSM-IV-TR* contains the observation that, "despite lack of any particular experience or talent, the individual may embark on writing a novel or composing a symphony or seek publicity for some impractical invention" (*DSM-IV-TR, p.* 357). Jamison (1993) identified a few parallels between the chemical-induced states of mania and the experiences of highly successful writers. In terms of thinking, Jamison (1993) drew parallels between creative and hypomanic thought in two respects: "fluency, rapidity, and flexibility of thought on the one hand, and the ability to combine ideas or categories of thought in order to form new and original connections on the other" (p. 105). The flooding of the brain with ideas facilitates creativity, she wrote, because the "sheer volume of thought can produce unique ideas and associations" (p. 105). Jamison (1993) continued that manics not only demonstrate a quickness of the mind and facility with connecting ideas, but they also have an ability to bring together both ideas that are relevant

to the others and those that are not, those which seem to "come out of nowhere" per se. There is also an ability to come up with "unusual types of solutions to set problems" (Jamison, 1993, p. 106). Citing creativity researcher J. P. Guilford, Jamison (1993) demonstrated that manic and hypomanic thinking processes are similar to those of creative thinking in nonbipolar individuals. Psychiatrists Carreno and Goodnick (1998) also have written that "it is believed that mood disorders, particularly bipolar disorder, enhance the complexity of thought patterns" (p.27).

The writer also experiences increased grandiosity and self confidence, distractibility, flights of ideas, urges to take risks and to indulge in pleasurable activities, and an urgent need for an audience, someone to communicate to. Manics feel they have something to say that seems unique and valuable to others if not to civilization as a whole. And these symptoms melt together. It is grandiosity that caused one patient to "record everything" because he had suddenly come into his own as a creative person and writer—

> Nothing was beyond me. My creative impulse had found full outlet and I had enough now to write to last me for the rest of my life. . . The major work which would be based on this material would be accurate, original, provocative, and of profound significance. All that had ever happened to me was now worthwhile. (as cited in Goodwin and Jamison, 2007, p. 39)

He was now also confident in writing in various genres and about various topics, explaining, "I would write a book on mental hospitals. I would write books on psychiatric theory too, and on theology. I would write novels. I had the libretto of an opera in mind" (as cited in Goodwin and Jamison, 2007, p. 39).

As his mind continued to move towards mania, his thinking got more bizarre:

> I made symbolic scrap-books whose meaning only I could decipher. I wrote a fairy tale; I wrote the diary of a white witch; and again I noted down cryptically all that was said or done around me at the time, with special reference to relevant news bulletins and to jokes which were broadcast in radio programmes (as cited in Goodwin and Jamison, 2007, p. 39).

Everything around him was important and, as neurobiologist Alice Flaherty (2004) wrote of her own experience, "flooded with meaning" (p. 11). Flaherty (2004) also wrote that indeed "manics write because what they are writing about seems vitally important to them, worth preserving" (p. 38).

Not only do people with mania find everything important and meaningful, but they remember things easily and fly from idea to idea (Flaherty, 2004, p. 38). Because writers can safely be said to enjoy writing. writers with mania indulge in writing as they might overindulge in anything that pleases them. Moreover, they are pleased more with words and sounds than they usually are—"the sounds and shapes of words entrance them," Flaherty (2004) wrote (p. 38). Kraeplin observed that patients with mania produced an inordinate amount of writing with "the pleasure of writing itself [as] the only motive" (cited in Goodwin and Jamison, 2007, p. 34).

None of these reasons to write is as motivating as the compulsive need to communicate. In mania, this takes the form of finding the social center of attention, interrupting people as they speak, or calling friends in the middle of the night. As translated into a writing behavior, this compulsion has been referred to as "hypergraphia" (Flaherty, 2004) and "logorrhea" (Nelson, as cited in Kantor, 1995). Like feeling the pressure to speak, manics sometimes feel the pressure to write (Flaherty, 2004). Most notable of the works on hypergraphia is Flaherty's *The Midnight Disease* (2004) in which she described hypergraphia as "an unbelievably complex psychological

trait" that arises "from complicated abnormalities of the basic biological drive to communicate" (p. 2). She explained that the same parts of the brain that cause a manic episode are those parts that affect the specific act of writing (p. 15). According to Flaherty (2004), changes in the limbic system that occur during mania cause excessive writing (p. 36). In her own experience with postpartum mood disorder after the death of her prematurely born twins, she recalled, "For ten days I was filled with sorrow. Then suddenly, as if someone had thrown a switch, I was wildly agitated, full of ideas, all of them pressing to be written down" (p.11, 12).

Besides the need for an audience, the pressure to write and the world filled with meaning, there is the constant barrage of ideas: "sometimes the racing thoughts and pressured speech lead to an outpouring of frenzied writing" (Mondimore, 2006, p 11). Goodwin and Jamison (2007) pointed to the "excessive energy" of mania that "translates directly into pressured writing and an inordinate production of written declarations, poetry, and artwork" (p. 34). And Kantor (1995) saw it as a inverted writer's block, an experience in which people write and write despite the fact that writing is not communicative and is rather useless.

Jamison (1993) also pointed out that the "abandonment of normal judgment and restraint" that accompanies mania can drive artists to go in directions they otherwise would not go. She called this "a form of forced voyage and exploration" (p. 114).

Writer's block might also occur. Kantor (1995) observed that "the mood disturbance can cause blockage directly, by making the creator too high to work, or indirectly, by causing bad judgment, of the kind that leads writers to feel that fragmentary works deserve publication. . . " (p. 42). Moreover, the drive to write may in fact overwhelm the writer. When mania becomes severe, writing can become confused and psychotic. Flaherty (2004) called hypergraphia "a writing problem in its own right" which can "benefit from treatment," which is likely to be

resisted (p. 41). This is because a core symptom of hypomania and mania is a sense of well-being and a denial of being sick.

Writing With Depression

Depression is an illness of isolation and sometiems extreme fear of incompetency or embarrassment in front of others. Moreover, with depression, Flaherty's (2004) "drive to communicate" dries up: "I was not really a blocked writer," she wrote, "I was no longer a writer at all" (p. 12).

During depression, cognitive difficulties in general make the possibility of putting sustained mental energy into something improbable (Jamison, 1999, p. 92). Memory problems can be an issue—people in depression have been known to "find their memory wanting" (Jamison, 1999, p. 92). And with what memory they do have, they feel sapped, losing much-needed working memory and the ability to make decisions.

Drawing from Kantor (1995)[5]the following are ways that the depression might manifest itself in the subjective experience of the writer**.** Kantor (1995) suggested that the writer might not want to write because he or she feels guilty about past behavior and punishes self by blocking (p. 28); the writer might be overwhelmed with grief (p. 29); or the writer might want to avoid criticism because he or she is extra sensitive and takes it much harder than usual (p. 31). The writer's self-esteem may flag—"in severe cases," Kantor (1995) wrote, "the artist feels personally worthless, believes his or her works are the flawed product of a defective person, then loses or tears them up, or withdraws from working entirely" (p. 32). Finally, the writer might not

[5] Kantor (1995) wrote in a much different context, but, I believe, his ideas are still applicable. Kantor (1995) located neurosis or conflict at the bottom of clinical depression in presenting reasons why a writer might experience writer's block. The current work, however, is grounded in the theory that the chemical precedes the dilemma, taken from Taylor (2006) and repeated often in Goodwin and Jamison (2007).

be able to measure up to the image of himself or herself that he or she had created (p. 32). The writer might also be overcome and blocked by the anxiety that accompanies depression.

Flaherty (2004) ventured that suffering triggers biological processes which "increase the desire to write," a biological need to express sorrow (p. 42). Brand (1989) derived from literature "that negative emotions move writers to composing or to expressing their emotions in writing, as easily if not more easily than positive ones" (p. 16). She asserted that writers may write in order to relieve their depression (Brand, 1989, p. 15). Writers write to feel better, she wrote, backing this up with quotations from writers (having bipolar or not) who felt relieved after writing (p. 10-15). Hawkins (1999) wrote that writing—specifically about the self—can be motivated by "the need to communicate a painful, disorienting, and isolating experience. Indeed, the need to come to terms with a traumatic experience often involves the need to project it outwards—to talk or write about it" (p. 10). Not only the need to communicate, but the sense of impermanence brought on by a chronic or fatal illness might also trigger the need to write. Couser (1997) wrote that illness "may stimulate. . . [an] autobiographical narrative of illness or disability—by heightening one's awareness of one's mortality, threatening one's sense of identity, and disrupting the apparent plot of one's life" (Couser, 1997, p. 5). And Frank (1997) wrote that "The body sets in motion the need for new stories when its disease disrupts the old stories. The body, whether still diseased or recovered, is simultaneously cause, topic, and instrument of whatever new stories are told" (p. 2).

Kantor (1995) wrote,

> Certainly, depression can enhance creativity in ways ranging from the pedestrian to the grand. As for the pedestrian, some artists write, and push to get published, as a way to enhance their self-esteem. As for the grand, depression can make for art whose greatness

> is the product of excess, dross made into drama employing the hysterical and masochistic 'romantic' touch. (p. 41)

Jamison (1993) noted depression also allows writers to prune their writing in that it "acts as a ballast" (p. 118). In fact, Jamison (1993) believed that the interplay of mood states make for a better product (p. 118), as is discussed below.

Interactions Between The States

The most well-rehearsed maxim regarding writers with bipolar disorder is that they have the opportunity due to their (biochemically enforced) change in perspective, cognition, and affect to see both sides of the coin and reconcile them. Jamison (1993) hypothesized the creation of writing in this way:

> [w]ork that may be inspired by, or partially executed in, a mild or even psychotically manic state may be significantly shaped or partially edited while its creator is depressed and put into final order when he or she is normal. It is in the interaction, tension, and transition between changing mood states, as well as the sustenance and discipline drawn from periods of health that is critically important; and it is these same tensions and transitions that ultimately give such power to art that is born in this way. (p. 6)

It might look like this: During a manic episode, the writers believes with utmost confidence that the writing is indeed good—if not earth shattering. Indeed, grandiosity is a common symptom of a manic episode. At extreme states in fits of delusions and psychosis, the writer might believe he or she is sanctioned by God. Even in a state of hypomania, the writer feels certain of the correctness and importance of his or her ideas. During a depressive episode, on the other hand, the writer is extremely critical and doubtful. What seemed vivid in terms of color and aspect is no longer so. If God is in the picture, God is cruel or dead. And any work that

has been produced is subjected to a critical eye, that is, if the writer is in a depression in which he or she is still able to work. The interaction of a state of abandonment and a conservative state then forces steps in the process the writer takes. Brand (1989) also stated that cognitive dissonance, brought on by conflicting emotions, has an influence on the drive to write (p. 16).

Qualities of Manic and Depressed Writing

Several qualities of the actual writing during manic and depressed phases are in the literature: content, handwriting, and linguistic changes.

Content

As Flaherty (2004) wrote, "Memory and writing are intertwined" (p. 61). The content of a depressed person's writing may depend on not only the power of working memory, but the ability to access memories that are stored in the brain connected to other mood states. Applying neuroscience to composition, Brand (1989) wrote that memory has at least two components, affect and cognition and that they work together in several ways. When an event happens, our thoughts are tagged with the accompanying emotion and organized in that way. When one wants to remember a thought, the emotion attached to it helps one to recover that thought. And emotion is more durable than thought: "it is the affective, not the informational, memory that provides the staying power. So effortless and automatically accruing are these feelings that they often survive long after people forget the stimuli. Such is the power of affective memory" (Brand, 1989, p. 30).

And so by that same token, strong, lasting, negative emotions might block memory. That is, working memory is reduced to memories with negative affect. That is, not only can the writer not concentrate, he or she might not be able to fully remember any memory that is positive. Jamison (1999) explained that "depressed patients are more likely to recall negative experiences

and failure, as well as to recall words with a depressive rather than a positive context" (p. 92). According to studies, it is the case that positive emotions allow for positive emotion-based memory recall and negative emotions allow for negative emotional recall (Goodwin and Jamison, 2007, p. 298). However, Goodwin and Jamison (2007) explained that although it has been the case in laboratory studies that positive memories are not likely recalled during depression, this is not always the case in real life. Citing one study, they wrote that "in intensive interviews regarding autobiographical events, severely depressed patients differ little from healthy controls in the richness of their reports of positive or negative events in their recent and remote past" (p. 298).

Content might also be set apart from writers who do not have bipolar disorder because of the experience of having the disorder. Jamison (1993) explained that "the dive, of journey underground, by definition provides a remarkable intensity and range of experience for those who take it" (p. 116) and that "many writers, artists, and composers have described the impact of their long periods of depression, how they have struggled or dealt with them, and how they have used them in their work" (p. 117). Furthermore, she pointed out that "profound melancholy or the suffering of psychosis can fundamentally change an individual's expectations and beliefs about the nature, duration, and meaning of life, the nature of man, and the fragility and resilience of the human spirit" (p. 117). "Research," wrote Jamison (1993), "has shown that observations and beliefs during mildly depressed states are actually closer to 'reality' than are normal mood states" (p. 119). Jamison (1993) wrote that this gives "credence to T.S. Eliot's view that 'Human kind cannot bear very much reality'" (p. 119). Flaherty (2004) also contended that mild depression may help the person "see the world more accurately" (p. 32). Sigmund Freud, in "Mourning and Melancholia," wrote that the depressed person is actually seeing the truth more

clearly: “it is merely that he has a keener eye for the truth than other people who are not melancholic” (as cited in Burns, 1999, p. 56).

Other content changes might parallel the changes that painters experience: “The content of manic paintings tends to be more sexual, filled with motion and bright portrayals of natural phenomena such as fires, waterfalls, and landscapes; in contrast, paintings done during the depressed phase tend to show a paucity of ideas, a lack of motion, and themes of death and decay” (Jamison, 1993, p. 127). Jamison (1993) wrote that “Manic patients tend to use vivid and highly contrasting colors; depressed patients, on the other hand, use primarily black and cold darker colors (when the depression begins to clear, the palette tends to lighten accordingly)” (p. 127). Furthermore, she wrote, “Manic paintings, usually produced rapidly and impulsively, often have an agitated or swirling quality to them; paintings produced by depressed patients are relatively barren, painted slowly, and exhibit less imagination” (p. 127). With writing therefore we might see darker imagery in depressions as well as darker themes. Manic writing might be agitated and filled with energy.

Linguistic Qualities

Andreasen and Pfohl (1976) wrote that linguistics can actually help one distinguish depressed and manic individuals. They wrote,

> [D]epressive speech tends to be more vague, qualified, and personalized, while manic speech is more colorful and concrete. . . [D]epressed patients tend to qualify more, to talk more in terms of a ‘state of being,’ and to talk more both about themselves and other people. Manics, on the other hand, tend to talk more about things then people, to discuss them in terms of action, and to use more adjectives to describe them. (p. 1366)

Although there is no proof that depressed writing leads to suicide, therapists might look at certain features; writing for therapy helps therapists both diagnosis and get an idea of whether the person is going to commit suicide (Mazza, 1999, p. 112).

Jamison (1993) pointed out how specific linguistic changes translate directly into poetry: "rhyming, punning, and sound associations increase during mania, and many patients spontaneously start writing poetry while manic (often without any previous interest in either reading or writing poetry)" (p. 108). She cited Kraeplin as saying "Artistic activity namely may, by the untroubled surrender to momentary fancies or moods, and especially poetical activity by the facilitation of linguistic expression, experience a certain furtherance" (p. 55). Flaherty (2004) also suggested that the manic fascination with sounds and shapes of words contributes to a high frequency of poets with bipolar disorder (p. 38). For individuals with mania or hypomania, "the sounds and shapes of words entrance them," and they tend toward "characteristic rhyming and puns (known as clang associations)" (Flaherty, 2004, p. 38).

> Goodwin and Jamison (2007) also pointed out that, based on some studies,
>
> Manic patients were more likely than depressive patients to exhibit pressured speech, distractibility, derailment, illogicality, loss of goal, perseveration, and a higher overall global rating of thought disorder. Depressed patients, by contrast, were more likely than manic patients to demonstrate poverty of speech. There were no differences between manic and depressed patients in ratings of poverty of content of speech, tangentiality, clanging, neologisms, word approximations, circumstantiality, echolalia, blocking, or stilted speech. When compared with normal subjects, depressed patients displayed greater poverty of content of speech, as well as increased tangentiality, circumstantiality, and self-reference. (p. 71)

Handwriting

Handwriting may get "larger and more flowery as the mania intensifies" (Flaherty, 2004, p. 30). Flaherty (1994) also noted that "during depression, people tend to write much less (and oddly, their handwriting often shrinks in size)" (Flaherty, 2004, p. 32). Kraeplin described this phenomenon in 1921:

> The handwriting of the patients may at first be quite regular and correct. In consequence of the excitability, however, it usually becomes gradually always larger, more pretentious and more irregular. There is no more consideration for the reader; the letters run through one another, are scribbled; more words are underlined; there are more marks of exclamation; the flourishes become bolder . . . " (as cited in Goodwin and Jamison 2007)

Writing and Treatment

Many artists face a dilemma in deciding whether they should take medication. The fear is not only pointed towards the loss of hypomanic behavior, but also depression. Kantor (1995) wrote, for instance, that "creativity can decline when depression improves" (p. 41). Jamison (1993) wrote that

> Many artists and writers believe that turmoil, suffering, and extremes in emotional experience are integral not only to the human condition but to their abilities as artists. They fear that psychiatric treatment will transform them into normal, well-adjusted, dampened, and bloodless souls—unable or unmotivated, to write, paint or compose. These fears have greatly intensified as a result of the availability of a wide range of highly effective mood-stabilizing medications.

She explained that some concern that medications will ruin creativity is unjustified, but that on the other hand, the fear is not entirely misplaced: "the short- and long-term effects on artistic

creativity of the major drugs used in the treatment of manic-depressive illness. . . remain unclear" (241). However, she explained later in that same work, "in the great majority of instances the effective treatments now available do not hinder creative ability. Indeed, competent treatment almost always results in longer periods of sustained productivity" (246).

Writing and the Whole Bipolar Experience

In her famous book, *Touched With Fire: Manic-depressive illness and the artistic temperament*, Jamison (1993) drew distinct parallels between bipolar activity and the creation of artistic work. While at no point did Jamison (1993) imply that to be an artist, writer, or composer must one have manic-depressive illness or that all those who have manic-depressive illness are naturally skilled in the arts, she explored how the illness impacts the work and lives of those who are already artists. In fact she began early on by stating, "That impassioned moods, shattered reason, and the artistic temperament can be welded into a 'fine madness' remains a controversial belief" (p. 3) and later pointed out that

> Clearly there are many artists, writers, and composers who are perfectly normal from a psychiatric point of view. The argument here is not that such people do not exist, for they obviously do. Rather, the argument is that a much-higher-than-expected rate of manic-depressive illness, depression, and suicide exists in exceptionally creative writers and artists. (p. 90)

Later, Jamison (1993) stressed the necessity of discipline and intellect in great artistic work. She cited Charles Lamb, "but the true poet dreams being awake. He is not possessed by his subject, but has dominion over it" (Jamison, 1993, p. 53). Jamison (1993) also wrote that "Changes or extremes in mood and experience alone do not guarantee good art, of course. If, however. . . they are coupled with imagination and discipline, the possibilities for creating lasting

and sustaining art may be greatly enhanced" (p. 117). Flaherty (2004) agreed: "Hypergraphia, although intriguing, is a neurological curiosity that when uncontrolled can lead to very bad prose indeed" (p.48). She does not, however, give an example of "bad."

Nancy Andreasen is best known for her Iowa Writer's Workshop study, which also helped further understanding of creativity and mental illness. In it, she matched writers with nonwriters to gage the number who have mood disorders (Jamison, 1993, p. 74). She found that 80 percent of the 30 writers she studied in the Iowa Writers' Workshop "met formal diagnostic criteria for a major mood disorder" and half met the criteria for bipolar disorder (Jamison, 1993, p. 75). In studying the families of such writers, she discovered that family members were also highly creative, but not necessarily verbally, leading her to conclude that mood disorders predispose people to be creative, but not necessarily to be writers (Jamison, 1993, p. 84). Andreasen (1982) cautioned not to connect art and illness, hypothesizing that romanticizing mental illness increases the frequency of it and that writers may feel that they need to have a mental illness in order to be good.

Still, to draw parallels between manic-depressive creation processes and creation processes of notable writers, Jamison (1993) studied the "occurrence of mood disorders and suicide in a consecutive sample of poets born within a hundred-year period," from 1705 to 1805 (p. 61-72). She used autobiographical, biographical, and medical records. Speaking of the 36 she studied, she said that a "strikingly high rate of mood disorders, suicide, and institutionalization occurred within this group of poets and their families" (p. 62). More than half showed strong evidence of mood disorders. One-third of the poets were likely manic-depressive; "Compared to rates in the general population, they were 30 times more likely to have manic-depressive illness" (Jamison, 1993, p. 62).

In another well-known study, Jamison (1989) tried to understand the "similarities and dissimilarities between periods of intense creative activity and hypomania," among other things (p. 125). The study involved interviewing British writers and artists who were chosen on the basis that they had "won at least one of several specified prestigious prizes or awards in their respective fields" (p.126).

Whether her 47 participants experienced affective disorders was derived from self reports. In structured interviews, she asked them "about history and type of treatment, if any, for affective illness; observed, if any, diurnal and seasonal patterns in their moods and productivity; behavioral, cognitive and mood correlates of their periods of creative work; and the perceived role of very intense moods in their work" (Jamison, 1989, p. 126). In a later explanation of her work, Jamison (1993) wrote that these "'intensely creative' episodes were characterized by pronounced increases in enthusiasm, energy, self-confidence, speed of mental association, fluency of thoughts and elevated mood, and a strong sense of well-being" (p. 77-78). Her study presented a connection between hypomania and creativity, and yet Jamison (1989) indicated that it was unclear whether they caused each other or were similar yet unrelated (p. 132); however, Jamison (1993) wrote that

> Although tendency has been to assume that creative periods lead to 'high' or elevated moods and that noncreative periods lead to depressed ones, these studies suggest that the reverse may be true. It may be that elevations in mood such as those caused by hypomania result in more creative thought; likewise, depressed mood and thinking may well lead to periods relatively bereft of creative work. (p. 108)

Another result of the study of accomplished British writers was that Jamison (1993) found connections between genre and frequency of mania, with the novelists and poets more

likely to experience "prolonged elevated states" than playwrights, "who often reported severe mood swings" (p. 76). Again, she said, "it . . . remains unclear the extent to which writers and artists are simply more sensitive than the general population to their own mood states, and therefore more able—and perhaps also more willing—to articulate and report them" (Jamison, 1993, p. 81).

On the other hand, it just might be that the high moods had to do with mastery of writing as a skill. In her study of emotions during the writing process, Brand (1989) studied "student poets" whom she immediately connected to poets with mood disorders or "emotional disturbance" (p. 173). Creating a emotional scale which included positive emotions (adventurous, affectionate, excited, happy, inspired, interested, relieved, satisfied, and surprises), negative passive emotions (ashamed, bored, confused, depressed, lonely, and shy), and negative active emotions (afraid, angry, anxious, disgusted, and frustrated) (p. 69) but not testing for mood disorders[6], Brand (1989) found that, as with other writers she studied, student poets had an intensification of positive emotions during writing, with negative passive emotions weakening and negative active emotions resisting change (p. 175). The skilled writers in her study (with skill level determined by the teacher) "felt more positive than their *unskilled* counterparts"; moreover, "when it came to negative passive emotional change, the . . . *highly skilled* poets felt less depressed and inhibited than there unskilled counterparts, and the . . . unskilled or moderately skilled felt more so" (p. 178).

[6] Brand (1989) introduced this part of her study by adding that its purpose "was not to determine if creative writing classes were a breeding ground for emotional disorder but to extend the general inquiry into a highly neglected subset of student writer, the poet" (p. 174).

Conclusions and Implications of Part II: The Writing Life of Writers With Bipolar Disorder

This section mapped out how bipolar disorder might affect writing according to research and other studies. Chapter Four discusses what the participants in this study have to say about how the disorder affects their personal writing processes.

Part III: Bipolar Disorder and Healing

> Then one October evening I opened the back door and heard geese honking overhead; looking up at them I knew that, to survive, I had to begin writing seriously again. (Clark, 2007, p. 126)

The writer with bipolar will most likely at some point experience the therapeutic nature of writing; however, it is disputable whether writing has a therapeutic effect on the actual disorder. Research suggests that verbal therapy does not work with bipolar disorder, yet the person with bipolar must deal with traumatic and difficult things above and beyond the episodes. Should the writer chose to write about him or herself, theorists have postulated and researchers have found that such writing may have a salutary effect on other areas of his or her life.

To begin to understand what exactly is healthy about writing for an ill person, it is necessary to unravel composition studies' current understanding of writing and mental health. Composition studies as a field knows very little about mental illness. In fact, both in Brand's (1989) *The Psychology of Writing* and Anderson and MacCurdy's (2000) *Writing and Healing* conflate emotion or personality with mental illness. In the case of Brand (1989), she classifies the poet as one with emotional chaos. Brand's (1989) misrepresentation of the issues confuses the difference between emotions writers experience because they write and emotions writers with a mental illness might experience. In Anderson and MacCurdy's (2000) book, trauma survivors are conflated with those suffering from PTSD. Anderson and MacCurdy (2000) perhaps

unwittingly conflated a trauma survivor and one who has developed PTSD (post-traumatic stress syndrome): “because we are all witnesses to, perhaps participants in, this apparently endless succession of virtual and actual encounters with great traumatic potential, PTSD has become a central, material fact of our time. We are all survivors” (p. 5). The fallacy here is a bit dangerous, but it parallels a persistent attitude about depression as in the blues and as in clinical depression, as discussed in Chapter Two. According to the *DSM-IV-TR*, the major psychiatric diagnostic manual, PTSD may include a disruption in interpersonal relationships, an impaired ability to regulate one’s emotions, dissociation, inability to sleep, “loss of previously sustained beliefs,” “hostility,” “social withdrawal,” or a change in parts of the person’s personality. Severe PTSD may include auditory hallucinations and paranoid ideation (p. 465). Romero and Kemp (2007) wrote that

> three conditions must be met in order to diagnose PTSD: First, a person must have experienced an event that involves actual or threatened serious injury or death. Second, a person must have responded to the situation with helplessness or fear. Finally, the person experiences three sets of symptoms as a result of the experience: persistently re-experiencing the traumatic event, either in dreams or flashbacks; avoidance of anything associated with the traumatic event; and heightened arousal, which can lead a person to startle easily and have difficulty sleeping. (p.130)

On the other hand, people with bipolar disorder have enriched emotions and go through devastating experiences which might be worked out in writing (see Comorbidity section below). People with bipolar disorder undergo trauma of diagnosis and dealing with the social stigma on top of any other disorder they might have. The possibility exists that writing might help people work toward recovery based on a review of literature on the subject by Davidson (2003):

> What recovery seems to entail is that people overcome the effects of being a mental patient—including rejection from society, poverty, substandard housing, social isolation, unemployment, loss of valued social roles and identity, and loss of sense of self and purpose in life—in order to retain, or resume, some degree of control over their own lives (Anthony, 1993; Deegan, 1996a, 1996b). (Davidson, 2003, p.38)

The composition studies conversation about writing and healing for the most part holds that writing can heal mental illnesses or at least emotional scars, and, therefore, in breaking from this tradition, the following information explains what might happen if the healing has to do with the trauma of diagnosis and stretch to recovery rather than the healing of the mental illness itself.

Ways Writing Heals

The seminal works on writing and healing have come from James Pennebaker, a research psychologist, who has dealt extensively the physiological impact of writing as a part of his study of expression in general. Also well cited by compositionists is psychiatrist Judith Herman's book, *Trauma and Recovery* (1997), which deals with the purpose of language in resolving some issues associated with the impact of traumatic events, especially in PTSD.

Below discusses how writing has been theorized and studied as a way to express pain, change the self, close and organize stories, transition one into the Kingdom of the Sick (Sontag, 1978), give agency, and help escape.

Express Pain

Part of how to understand the effect writing has on illness is through the empirical research of Pennebaker and colleagues who have demonstrated time and again how expressive writing can heal both mind and body (see Pennebaker; Lepore and Smyth, 2002). Although they do not deal with chronic affective disorders, they offer some insight into what happens

physically and mentally when one writes expressively, sometimes calling writing, "life changing" (Pennebaker, 2000, p. 3). One study conducted by Lepore (1997) examined students with depressive symptoms that were due to the stress of taking exams with high stakes. Lepore (1997) found that those who were instructed to write about their feelings were significantly less depressed at the end of the study. Oddly, it did not matter what aspect of the stressor (or trigger to an episode) individuals wrote about; writing about positive things was just as beneficial as writing about negative things (Lepore et al., 2002).

Pennebaker began his 1997 book *Opening Up: The Healing Power of Expressing Emotions* with this: "In short, excessive holding back of thoughts, feelings, and behaviors can place people at risk for both major and minor diseases" (p. 2). His studies continued and continue[7] to produce evidence that expression is good for one's health. In 2002, he summarized the bulk of his work, reporting that, "To this point, studies have indicated that writing brings about reductions in common illness visits to physicians (e.g., upper respiratory illnesses), reductions in blood pressure, reduced use of pain medication, and long term changes in immune function (which we frankly do not yet know how to interpret)" (p. 287). Lepore and Smyth (2002) followed up Pennebaker's studies with a collection which talked about expressive writing as a way to either ameliorate or cure cancer, high blood pressure, poor working memory, and other physical ailments.

One study done by Pennebaker and Beall involved university students who were asked to write 15 minutes a day on four consecutive days and from one of three angles: 1) just venting, 2) writing facts about a trauma, and 3) writing facts and emotions. They found that those who wrote about the facts and emotions surrounding a trauma had a fifty percent drop in visits to the health center and were overall healthier (Pennebaker, 1997, p. 34).

[7] Pennebaker was the keynote speaker at CCCC in New Orleans in 2008.

Being able to express greatly affected one's mental health. According to Pennebaker (1997), there is a difference between how one can cope with events considered acceptable to talk about versus how one can cope with events considered unacceptable to talk about. The difference lies in inhibition's affect on the psyche and physical health. This is easily extendable to being diagnosed with a stigmatized illness. He plays out this difference: "Dying in an automobile accident is socially acceptable; suicide is not. If a person's death was beyond his or her control, we can express our sorrow openly, without any hint of embarrassment. Usually, when someone commits suicide, we speak in hushed tones" (p. 21). By studying the spouses of individuals who died in accidents and those dying by suicide, Pennebaker and his colleagues came to the conclusion that it did not matter how the spouse died, but only "whether they talked about the death" (p. 22). Writing allows people to talk about unacceptable events where they would not otherwise be able to express them and, therefore, where they would be open to health threats. Pennebaker (1997) wrote that self-disclosing in writing works much like "talking to others, but without the social ramifications" (p. 197). This is especially important if the social ramifications, as they are in talking about bipolar disorder, might dictate economic and social well-being. Pennebaker (1997) pointed out,

> There is nothing magical about writing in a self-disclosing manner. It works much the same way as talking to others, but without the social ramifications. Therein are its strengths and weaknesses. You cannot be punished or humiliated by writing per se. (p. 197)

What Pennebaker (2002) concluded was that "when an individual has come to terms with an upsetting experience, he or she is less vigilant about the world and potential threats. This results in an overall lowering of defenses" and biological stress (Pennebaker, 2002, p. 287).

Pennebaker (1997) insisted that people who cannot speak openly about their lives—as is true with people with bipolar disorder—are open to illness: "living a lie is living a life of inhibition. People who are unable to talk about significant personal experiences are at increased risk for a variety of diseases" (p. 127).

Lepore et al. (2002) wrote that expressive writing works because it directs attention to the stressor and its emotional effects (both the stressor and the feelings it causes can be detrimental—we react to the stressor and to the emotion it causes) (p. 105). Because attention is directed to the stressor and the emotion, the person becomes as if immunized against that stressor writing increases exposure to it (p. 104). Lepore et al. (2002) call this "habituation" (p. 104).

Pennebaker (1997) suggested the reason that language is so powerful is the same reason that teaching forces one to learn what one needs to teach: one understands it when one can translate it into language. He wrote, "translating a phenomenon into language alters the way it is represented and understood in our minds" (p.96). Moreover, once language-based, one can put it away.

Change the Self

Writing has been understood to re-create the past, as Hawkins (1999) reminded us—"as most autobiographical theorists maintain, the past in any autobiography is not simply recorded but it is changed, reordered, and even re-created in the act of writing about it" (p. 18). It is interpreted rather than reported. To this, Warnock (2000) added a touch of magic—the future, too, might be changed. Drawing on Kenneth Burke, she discussed his idea of the "comic corrective." The comic corrective is the ability to make things pliable by putting them in writing. Warnock (2000) quoted Burke in saying that "it will thus be seen that, in playing the game of life, we have at our command a resource whereby we can shift the rules of the game" (p. 49).

Changing the rules of the game allows more possibility than previously there. Warnock (2000) explained that, “The comic attitude is the attitude of poets who understand that, in emphasizing language as figurative, they allow themselves to see things ‘other than they are’ and to entertain what is, what was, and what might possibly be” (p. 48). Words are revisable, changeable, and literacy gives us the opportunity to put life down, gain objectivity, and change it. Writing is more than cathartic; it is a tool for rearranging and re-creating in a new context.

Johnson (2000) traced the notion of opening oneself up to change and switching contexts to the early Greeks, for whom language, he said, was believed to have healing properties. He wrote,

> illness as the mark of moral impurity [as it was thought to be] and of a punishing invader was a signifier that could be altered by a steady stream of a different sort of signifier—sacred songs and chants. These words/spirits could expunge the other signifier or, by wrapping it in a new verbal context, could alter its meaning, inducing a purifying, cathartic, transformation of the sufferer. (p. 92)

Lepore et al. (2002) wrote that writing about a problem helps with “cognitive restructuring”—or, “changes in stress-related thoughts and appraisals” (p. 108). This can also be done deliberately, namely, with cognitive behavioral therapy (CBT). In his book advocating CBT, Burns (1999) explained how to use writing to restructure thought. He advocated using writing in specific ways, such as the “triple-column technique” where one writes the following headings and fills them in accordingly: automatic thoughts, cognitive distortion, and rational response (p. 62). As an example, an automatic thought might be “I can’t do anything right.” The cognitive distortion involved is that the thought is an overgeneralization. Therefore, the rational response (in Burns’s words) to the thought should be, “Nonsense! I do a lot of things right!” (p.

63). Putting this on paper allows looking at it "rationally" and in a different context, that is, one that places the defeating words up against an "objective" list of ways cognition can be distorted. Pennebaker (1997) agreed in the sense that writing can give you distance and perspective (p. 42).

What is interesting about Johnson's (2000) interpretation of the healer Sophists is that the facts that support his interpretation are ignored in Goodwin and Jamison's (2007) explanation of medical cures for bipolar disorder. Even though language for Johnson's (2000) sophists allowed for rearrangement and therefore healing, Goodwin and Jamison's sophists also employed physical cures such as I mentioned before: "mineral baths, bloodletting, herbs, chains, vapors, bromides, opiates, warm waters, cold waters, and physical and chemical restraints" (Goodwin and Jamison, 2007, p. 871). Yet, if language heals because it wraps a person in a new context, as Johnson (2000) and Warnock (2000) suggested, then it is likely that it heals traumatic experiences like diagnosis and exposure to stigma by introducing alternative interpretations of the these events and the life before it.

In agreement with Johnson (2000) but speaking from the field of poetry therapy, Gorelick (2005) wrote that "words are not abstractions: they carry bodily weight" (p. 121), thereby tracing the verbal cures back to the ancient Egyptians and Chinese (p. 119). Campo (2003) wrote that poetry has been used for healing throughout history and across cultures (p. 31). He cited the use of incantation and poetry in Native American cultures. He then talks about the ancient Egyptian practice of giving the dead *The Book of the Dead*, "a kind of guidebook to the afterlife, without which survival of the spirit was unimaginable" (p.32). As for the ancient Greeks, Campo (2003) points to Apollo, the highest deity, who was also the god of both poetry and healing, and the father of Aesculapius, who "was believed to have invented the art of medicine" and the Muses, who inspire all artists, including poets (p. 33). He also pointed to the Judeo-Christian tradition's

use of poetry in healing through prayers and Biblical poetry such as the Psalms (Campo, 2003, p. 34).

Warnock (2000) adamantly argued against seeing writing as "therapy"; for her, it was much more. Therapy, she said, had "connotations of help for those who can't help themselves" (p. 50). Writing, on the other hand, could revise life. Although this might be based on a limited notion of therapy or even writing therapy, she broadens the scope of therapeutic writing. According to Pennebaker (2002), writing *is* for people who *can* help themselves. He noted that "Across multiple studies, . . . individuals who develop good stories and *who are able to change their perspective* from one writing session to another are the ones most likely to show health improvements" (p. 289, italics mine).

More directly implying that writing can revise life and even heal mood disorders is DeSalvo's (1999) book, in which she repeatedly stated that writing can help one through a suicidal depression, a mood state that is common in bipolar disorder. Although she did in fact write a couple paragraphs explaining that bipolar disorder is a serious medical condition that cannot be cured by writing, she turned to Virginia Woolf and Sylvia Plath, two writers who are broadly thought to have suffered from bipolar disorder and explained that their suicides had more to do with their approach to writing than a biological problem.

Couser (1997) wrote that there are many reasons that people do not write about their life with a disability. One reason could be that they are psychologically unable in that they cannot reconcile their lives to the expected "comic plot" where good triumphs over adversity--"in many cases the culturally validated narrative of triumph over adversity may simply not be available" (p. 5).

Close and Organize Stories

In 2003, Judith Harris wrote that "stories exist to make order out of chaos, to structure and organize experiences into something separate from events that first induced painful and chaotic emotions" (p. 7). Pennebaker (2000) wrote, "the act of constructing stories appeared to be a natural human process that helped individuals understand their experiences and themselves" (p. 3). According to Pennebaker, writing a story allows us to simplify and shorten the experience so as to psychologically be able to handle it. But he did not mean this is a negative way. He wrote that "Another way to think about one of the functions of language is to consider it a tool by which to simplify our experiences" (97). Furthermore,

> A similar phenomenon occurs in our experiments when people write about the same trauma several days in a row. The description of the event is gradually shortened and summarized. Irrelevant issues and tangential impressions are dropped; central features of the traumas are highlighted and analyzed. The experimental volunteers have created a mental summary of their experience which, often, is psychologically less daunting. (p.97)

It is the shaping of a narrative that helps with health:

> On the first day of writing, they would often tell about a traumatic episode that simply described an experience, often out of sequence and disorganized. But day by day, as they continued to write, the episode would take on shape as a coherent story with a clear beginning, middle, and end. Ironically, participants who started the study with a clear, coherent, and well-organized story rarely evidenced any health improvements. (p. 103)

Pennebaker and Seagal (1999) wrote that adding structure and meaning to an experience through writing allows people to better manage their emotions (p. 1243). The story does not have to have a moral or ultimate meaning; rather, it need only get un-stuck. Theoretically, then, the

person stops ruminating. Pennebaker (1997) wrote that it is particularly important that "writing moves us to a resolution. Even if there is no meaning to an event, it becomes psychologically complete. In short, there is no more reason to continue to ruminate about it" (p. 103). This is the case with both trauma and love. Pennebaker (1997) explained that "In writing about love, as in the writing about grief, overpowering obsessions and emotions are more quickly understood and assimilated. Once we understand them, we are less driven to ponder them. Love letters, then, may be an antidote to love" (p. 131).

From another perspective, binding reality back together through a narrative is the important thing because the self is fragmented in the face of trauma. Couser (1997) wrote that it is difficult to make a coherent story out of bodily dysfunction: "how do illness and disability—which in extreme cases might obstruct or defy narration—get written at all? How does one make a (coherent) story out of bodily dysfunction? What particular challenges do illness and disability pose for personal narrative?" (p. 14).

Transition to the Kingdom of the Sick

Susan Sontag (1978) wrote that "everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick" (p. 3). Being diagnosed with bipolar disorder requires crossing into the kingdom of the sick. It means re-articulating one's life as someone who has the illness. It requires re-orientation. Judith Zaruches, a woman who suffered from chronic fatigue syndrome, described her loss of orientation when discovering her own (physical) illness: "The destination and map I had used to navigate before were no longer useful" (as cited in Frank, 1997, p. 1). For people with bipolar disorder, diagnosis disrupts the person's conception of how life goes. Not only does hindsight itself change—the world must be reinterpreted in terms of newfound knowledge—but the way to act within the new world as a

"well" person is equally difficult. Jamison (1995) explained: "As I gradually entered into the world of more stable moods and more predictable life, I began to realize that I knew very little about it and had no real idea of what it would be like to live in such a place. In many ways, I was a stranger to the normal world" (p. 168). Along the same lines of transition, Frank (1997) wrote that "the *personal* issue of telling stories about illness is to give voice to the body, so that the changed body can become once again familiar in these stories" (p. 2). Writing helps people situate themselves in the world, particularly if they are chronically or terminally ill and need to accept that they are now living in a new reality (Couser, 1997, p. 12; Hawkins, 1999, p. 2).

Give Agency

Theorizing about writing and healing has led some to think that writing gives a person agency over his or her life and circumstances. Pennebaker and Seagal (1999) wrote that writing allows sick persons the sense that they can exert control over their lives (p. 1243). Anderson and MacCurdy (2000) suggested that writing gives a person control over "that which we can never control—the past" (p. 23).

Quite literally, the person is given authorship which had been taken when diagnosed and had his or her previous life explained for him or her. Johnson (2000) wrote that "writing that heals is often writing in which the writer names, describes, and takes control of experiences in which the writer's powers of naming and controlling have been explicitly annihilated" (p. 86). "As trauma survivors," Anderson and MacCurdy (2000) wrote, "we share one very important characteristic: We feel powerless, taken over by an alien experience we could not anticipate and did not choose. Healing depends upon gaining control over that which has engulfed us" (p. 5).

These powers may have been annihilated in treatment, that is, when control is handed over (or forced in some cases) to the doctor. Hornstein (2002) explained,

> Psychiatrists have not simply ignored patients' voices; they have gone to considerable lengths to silence them. Patient narratives are filled with reports of their authors' being locked in isolation rooms, deprived of writing materials, having correspondence censored, or being threatened with violence for making their views public. (¶ 8)

Couser (1997) wrote that the privileged, official story is not that of the patient, but of the doctor—the doctor is thought to know better about the patient than the actual patient does (p. 18). He wrote,

> In order to be treated, then, patients generally must have their medical history "taken." In diagnosis doctors provide patients with an interpretation of their lives—an act that, regardless of what follows, may at least make sense of a baffling past. Diagnosis leads in turn to prescription, treatment, prognosis, all of which extend physician's authority over patients' lives. Thus doctors may both reinterpret patients' pasts and literally pre-script their futures. The process is collaborative but one-sided; patients submit their bodies to tests, their life histories to scrutiny, while doctors retain the authority to interpret these data. (Couser, 1997, p. 10)

Things can escalate, according to Couser (1997), to the point that patients are the field on which the battle is played out between the doctor and the disease, where eventually the patients themselves become the enemy anyway (p. 26-27). In fact, Frank (1997) equated living with a serious illness to being colonized by the medical profession which "claimed the body of its patient as its territory" (p. 10), thereby bringing postcolonialist theory to the study of illness and disability.

Writing and publishing personal stories wrenches back control. According to Hawkins (1999), illness narratives—usually overly emotional—are the flip side of the cold discourse of

the medical community, and a necessary flip side in that the two together tell the whole truth (p. 13). Illness narratives give the person a voice (Hawkins, 2000, p. 223). She wrote that "pathography restores the person ignored or cancelled out in the medical enterprise, and it places that person at the very center" (Hawkins, 2000, p. 223).

Writing gives the writer a place where expectations are not placed upon behavior. Pennebaker (2002) pointed out that writing allows one to please oneself:

> It is one of the few times that people are given permission to see where they have been and where they are going without having to please anyone. They are able to prioritize their goals, find meaning in their past and future, and think about who they are at this point in life. (p. 283)

Agency also entails reconstructing the self. Hogan and Hogan (2001) wrote, "For the sufferers of various forms of mental illness, writing a memoir represents a reclaiming of the self, a gathering of a fragmented self back into a narrative unity, if not a psychologically unified whole" (p 40). Caramagno (1988) cited Milden's explanation of a split of the bipolar self:

> When a patient has a major affective episode, his or her normal self disappears. The patient becomes someone foreign, another self. By definition, this self has a different affective organization from the normal self. There are different thoughts, behaviors, and personality traits . . .
>
> Who, then, is the real self for someone who has been up and down and in between? Is the real self who one is when one is euthymic [normal]? Is it possible or even necessary to construct a whole self out of an amalgam of the "self-in-episode" and "self-out-of-episode"? Can this integration ever achieve the same coherence of self-structure

> that the patient previously took for granted? (Milden, as cited in Caramagno, 1988, p. 16).

In his study of Virginia Woolf, Caramagno (1988) wrote that Woolf made herself whole through writing.

Help Escape

Writing is also widely thought to be a means of mental escape. Harris (2003) explained that "Freud saw in the creative writer a capacity for launching fantasy as a means of protecting the already vulnerable and often wounded psyche" (p. 60). For example, Harris (2003) gave Charlotte Perkins Gilman, who used writing "as a way to shield the injured ego, sending up 'papered' (as in textual) walls. And fantasy, even nightmarish fantasy, became Gilman's earliest strategy for distancing herself from realities she considered intolerable and too limiting" (p. 60). Dalsimer (2001) had a similar interpretation of writing as a tool for Virginia Woolf. She wrote,

> I wish to explore the ways that writing served Virginia Woolf in the period when she was becoming a writer, the ways it served her in the face of the 'sledge-hammer blows' that life dealt. From an early age, writing was as necessary to her as the very air she breathed: before finishing one book she began to envisage the next, to ensure that there would be no time when she was not working. (p. xvii)

Gilman and Woolf were not alone. Hedges (2005) pointed to Graham Greene as having said "I wonder how all those who do not write, compose or paint can manage to escape the madness, melancholia, the panic fear which is inherent in the human situation" (p. 7). And Jamison (1993) quoted poet Antonin Artuad as saying, "No one has ever written, painted, sculpted, modeled, built, or invented except literally to get out of hell" (p. 121).

Ways Writing Hurts

Pennebaker (1997) warned against using writing as a sole means of therapy: "Writing about your deepest thoughts and feelings should not be used as substitute for therapy. Much as talking to a friend, writing should be used as a form of preventive maintenance" (p. 114). In many ways, writing and speaking share the same healing properties, but, according to Pennebaker (1997), writing could be harmful in that with writing the writer does not have a listener who can ground him or her; he wrote, "Without consulting others, we can blow many of our thoughts and emotions far out of proportion" (Pennebaker, 1997, p. 197). Speaking, as in talk therapy, allows one to bounce ideas off someone else, but writing allows one to ignore audience. According to Pennebaker (1997), having friends allows for providing physical necessities if not there, as well as "advice and an objective perspective." But, friends are also good for "help[ing] people maintain a stable view of their world and of themselves" (p. 109).

Despite his studies and self-help book, Pennebaker (1997) admitted that he is not a therapist and that "It is very possible that writing about your own traumas or upsetting feelings may not be helpful" (p. 40). In a benign way, writing might not be helpful because a person might have no emotional awareness or understanding (Horneffer and Chan, 2006, p. 27). Moreover, Wright and Chung (2001) wrote that in their review of literature they found that "writing therapy is not always appropriate or beneficial. When the client's experience is pre-verbal, for instance, other expressive therapies would be preferred. When writing is associated with strong negative experiences, such as being criticized at school, clients are unlikely to want to try writing therapy" (p. 286-p. 287).

Others have speculated on how writing might be downright destructive. Some of this speculation is grounded in trying to understand why famous writers have committed suicide. In

trying to understand the suicide of Sylvia Plath, for instance, Runco (1998) hypothesized that her "large psychic investment" in writing, publication rejections (vulnerability to public scrutiny), writing-produced anxiety, "lack of immediate gratification," struggle with writing difficulty, and normal life stress were some of the contributing factors to her depression and subsequent suicide (p. 646). DeSalvo (1999) goes as far as saying that the reason Virginia Woolf and Sylvia Plath ultimately did commit suicide had to do with how they approached writing. With Plath,

> though she kept a journal for years, she didn't reflect upon how writing her courageous work made her feel. Nor did she connect the effect of her writing upon her feelings and her life. On March 28, 1958, for example, she describes how she wrote eight poems in eight days:. . . "I feel these are the best poems I have ever done."
>
> By the end of the week, though, she was. . . completely exhausted and suicidal. . . Indeed, Plath seemed to feel worse, perhaps because she didn't reflect upon the link between her feelings and the events in her life. Nor did she write about how doing her work made her feel. Nor did she understand how to care for herself as she wrote. Because Plath didn't witness herself working—didn't record her feelings about her creative process—she didn't connect what she was experiencing with her work. (p. 89-90).

DeSalvo (1999) asserted that, with Virginia Woolf, pacing was important. When Woolf wrote *To the Lighthouse*, DeSalvo explained, she paced herself and was fine, but when Woolf wrote *The Years*, she did not pace herself—she was "overworked, producing about ten pages a day"—and this caused an emotional breakdown (p. 98).

Speculations get even more bizarre. Kaufman and Sexton (2006) argued that, based primarily on the high rate of poets with mental illness, the only writing that is beneficial writing is that which constructs narratives; they thought that narratives help organize and make sense of

an event in a space long enough to allow a person's perspective shift from beginning to middle to end.

There is also the fear of not having support in case of emergency echoes in various fields. Such warnings are apparent in the modern use of poetry as therapy as early as 1925. According to Mazza (1999), Robert Haven Schauffler's *The Poetry Cure: A Pocket Medicine Chest of Verse* (1925) was one of the first to include a precaution "pointing to the potential dangers of indiscriminate use of poetry" (p. 6). DeSalvo (1999) cautioned without explanation that her readers seek professional help in addition to writing if necessary: "I personally believe it is essential for people wanting to write about extreme situations to have skilled professional support while writing or to attend a reputable support group" (p. 40). (This contrasts sharply with her advertising that writing to work through severe emotions "is cheap," requiring nothing but pen and paper on page 13.) She explained, "As David Aberbach has warned, writing, though it may be therapeutic, isn't therapy. But keep in mind that therapy isn't writing" (p. 41). Wright and Chung (2001) reported that some work in the field of writing therapy has leaned toward either having a therapist near or a safe space because the emotions associated with writing can be too much.

Pennebaker (1997) wrote that "writing. . . should be viewed as preventive maintenance" only (p. 197). Pennebaker (2004) expressed the fear that the writer might "Flip-Out," that is, "start screaming and ranting uncontrollably" (p. 13). Pennebaker (2004) has never seen this happen; although he has seen people become emotionally distraught, they quickly recover (p. 13). He also wrote that, over-analyzing a problem may make a person feel worse (Pennebaker, 2004, p. 14).

In a little-known essay in the seminal collection, *Poetry Therapy*, Burke (1969) wrote that there are other reasons that writing can be dangerous: “Whereas we begin with the (quite probably) sound assumption that the expression of the repressed is intrinsically therapeutic, there can be complicating factors that threaten this result” (p. 105). Writing thoughts down for an outside audience makes a person vulnerable to the audience (Burke, 1969, p. 105), a vulnerability that Pennebaker (2004) also located, to people who will not act in the best interest and might find and read those thoughts (p. 14). Pennebaker (2004) also asserted that using writing will change people’s coping strategies and, therefore, change relationships with other people, people that person may have previously needed to depend on but will no longer (p. 14).

Actual empirical, negative reports of expressive writing include the finding that people feel unhappy immediately after writing about unhappy events, even though the unhappiness resolves in the long term (Pennebaker and Seagal, 1999, p. 1244). Could further writing before a positive mood sets in increase the intensity of the negative mood? Lepore (1997) pointed out that there is a connection between negative mood and rumination (p. 1030). Some have said that the solitary, ruminating act of writing might contribute to if not trigger a full depressive episode (Andreasen, 1982), specifically because rumination itself has often been linked to depression (Kaufman and Sexton, 2006, p. 272).

Where writing gives the advantage of expressing emotion, “The most consistent disadvantage cited was the provision of a vehicle to promote resistance through intellectualization and avoidance” (Mazza, 1999, p. 12). Pennebaker (1997) warns against “using writing as a substitute for action,” as an “intellectual rather than self-reflective exercise,” “as a forum for uncensored complaining,” and as “an exercise in. . . self-absorption” (p. 194-196). Healing writing for Pennebaker (1997) is writing that tells a story.

But, when it comes down to it, Pennebaker (2002) asked,

> Is writing in a diary good for your health? You might think that we would know the answer to this question, but we don't. Are diary writers healthier than nondiary writers? I have never found this to be true—but, then again, people who take vitamins are not healthier than people who do not take vitamins. Like diary writers, vitamin users may actually be slightly sicker. However, both vitamin users and diary writers may be far healthier than they would have been had they not taken vitamins or written in diaries. (p. 291)

CHAPTER THREE: METHODOLOGY

Overview

In the Foreword to *Breakdown* (1959), George Stevenson writes "Why should a person wish to tell about his mental illness? More appropriate is the opposite question. Why shouldn't he? After all, he knows more about it from certain angles than anyone else."

This study aimed to better understand the perception of writers who have bipolar disorder about their lives and writing experiences. It differs from other studies of people with bipolar disorder in three important ways. First, this is a study that uses qualitative, naturalistic, grounded theory methods based on the work of Lincoln and Guba (1985) and Erlandson et al. (1993). The study depends on, for the most part, open-ended interviews as its main source of data collection rather than surveys and predetermined questions. Second, whereas other studies about writers with bipolar disorder tend to focus on the product of the writers, their diaries and work, and textual analyses of these writings, this study focuses on the people, the stories they have to tell, and their processes and practices. And third, all but two writers in this study are neither famous nor even known: they are average, everyday people for whom writing plays an important role. In this third instance, the study extends the work of composition studies on self-sponsored writers.

This study involves in-depth interviews of 24 participants who reported to have been diagnosed with bipolar disorder and who identify themselves as writers. The theories that were derived from these interviews were grounded in the respect that they came out of the interviews rather than being imposed upon them by a predetermined hypothesis. As the interviews progressed, I came to see patterns and more and more lines of inquiry, which I followed through additional interviews and hypothesis testing. I let the theories emerge, and I checked them against the data as they came up in accordance with naturalistic techniques.

The stories I collected from the interviews and other contact with the participants such as emails, letters, and casual phone calls, were gathered as a collection of stories rather than as collections of facts, as seen in both Jamison's (1989) study of accomplished British writers and their writing experiences and Andreasen's (1987) study of writers in the Iowa Writer's Workshop by which Andreasen (1987) judged the frequency of mental illness in those writers and their families (Jamison, 1993, p. 72-74). Furthermore, in composition studies, Brand (1989) used structured questionnaires and interviews to determine mood states in writers. This study's interviews were naturalistic and not standardized, because, as Patton (2002) wrote: "the open ended responses permit one to understand the world as seen by the respondents" (p. 21).

Other methodologies that this study positions itself against is that of literary criticism, which provides for the most part the study of famous writers' journals and more formal works as well as an occasional study of such writers. The current work was purposely focused on writers who are not necessarily famous because it is important, as argued by Gere (1994), to see how writing plays a part in the world outside of the academy. It also informs the field about writers who cannot make it as writers—that is, how bipolar disorder works both as a detriment and an advantage in their lives.

The participants, therefore, were initially 24 writers, and were interviewed one to three times each over the time span from April 2007 to January 2009. This amount of time accounted for changes in episodes which therefore accounted for changes in mood and perception. The dates and lengths of these interviews are in Appendix D. At the end of the study, the number of participants totaled 21. The three participants whose data did not make it into the study did not do so for the following reasons: one participant disclosed during the study that he had in fact schizoaffective disorder, which is a very different illness that privileges psychosis over mood

swings; one participant was not included because my safety was in question; and a last participant withdrew her information during a final member check.

Participant Demographics

The majority of the participants were women; that is, 13 were women and eight were men (see Appendix E for a table of participant characteristics). Most participants were between thirty and forty years of age. Two were in their twenties, six in their thirties, six in their forties, four in their fifties, and two in their sixties. Nineteen were white, one was Native Canadian, and one was of West Indian descent.

Besides four who were professional writers, five participants collected disability, and one other participant was and is still trying to get disability, a process that often takes years. As for other occupations, there was an undergraduate student, a graduate student in writing and one in counseling, a high school English teacher, and an English professor. Outside of academia, the study comprised a retired pastor, a retired and an active coordinator of a local affiliate of a national grassroots organization, a secretary, and a stay-at-home mom. During the study, the undergraduate student and both graduate students left school, and the high school English teacher was hospitalized.

Writers

I defined "writer" as a person who writes on his or her own time, by his or her own choice. As writers, four of the 21 were professional writers, that is, in addition to writing on their own time, they wrote for their livelihood. Two of those four wrote fiction, the third was a technical writer, and the fourth wrote for freelance projects as well as occasionally taught a course on writing/publishing.

But just because four were professional writers did not mean that they were the only ones who had been published. Those who had been published had been published in the following places: Two had published their fiction for a wider market; two had been published in books or pamphlets about artists who have mental illnesses; one had published a narrative specifically about her life and the effect the illness had on it; one had published an article in a psychiatric journal about her life with bipolar disorder; one had published a chapter in an edited collection about her illness; another had published a poem about his experience in a book; two regularly wrote letters to the editor, while two others only occasionally did; two kept online blogs and/or diaries; one wrote essays, some of which had been published in magazines; and one had published poems. Three kept private journals in which they wrote often, two had completed, unpublished manuscript, and three had unfinished manuscripts that they were spending time working on.

Bipolar

To be a participant in the study, an individual had to be clinically diagnosed with a type of bipolar disorder: bipolar I, bipolar II, bipolar not otherwise specified (nos), or cyclothymia. Individuals were clinically diagnosed with bipolar disorder according to the criteria laid out in the *DSM-IV-TR* (see Appendix A). Of the 21 participants, thirteen suffered from bipolar I, seven suffered from bipolar II, and one did not identify I or II and, therefore, was placed in the not-otherwise-specified category.

To further get an idea of the severity of the illness and, therefore, the effect of it on the individual and his or her writing, I relied on the data of whether or not they were on disability, since to be on disability, one must convince the government of the need, a convincing which often takes several years. Five participants collected disability.

Data from this study did not represent the experiences of people who experience depression without hypomania or mania. Because bipolar depression may have features different from depression (Burgess, 2006), I could not accept participants who had depression only, nor could I prepare myself by studying narratives written by people who suffered only from depression, such as William Styron's *Darkness Visible* (1990). Moreover, there is a harsher stigma attached to bipolar disorder than to depression partially because of the bizarre behavior that it tends to cause. In one case, it seemed that a participant clung dearly to her bipolar II diagnosis because bipolar I brought to mind "crazy."

I also differentiated between bipolar disorder and schizoaffective disorder and chose not to interview individuals who suffer from schizoaffective disorder. Schizoaffective disorder stands nearly half way between bipolar disorder and schizophrenia, causing mania and depression but more prominently, psychosis. In one case, a participant revealed the schizoaffective disorder only after the interview, which then had to be discarded.

Participants also had other mental illnesses. Goodwin and Jamison (2007) cited studies saying that 65% of patients who have bipolar disorder have an additional disorder (p. 224). Of the twenty-one, five reported having at least one other mental disorder. These included eating disorders, PTSD, postpartum depression, and alcoholism.

In speaking with several psychologists, I discovered that there are disparities in diagnosing the disorder. For my purposes, I asked for specific depictions so that I could gage by episode the similarities. In order to account for this, I asked directly what each episode was like so that I could establish an idea of bipolar versus other illness, and yet I found that depictions of the episodes were similar across participants and tended toward the descriptions discussed in Chapter Two.

The participants (and others who did not participate) in the study surprised me in that they were motivated to help and seemed to feel like they were contributing to the erasure of stigma or other positive causes which may ease the situation of others also living with the disorder. One potential participant wrote to me to ask that I represent people with bipolar disorder in a positive light.

Means of Selection

My object in selecting participants was to choose a number large enough that I could see some similarities among diagnoses and yet an number small enough that I could get a rich portrait of their lives as writers, as people with bipolar, and as writers with bipolar disorder. I stopped looking for participants when I had a wide range of writers who nonetheless exhibited many similarities such as employing the use of writing as a tool, and writing more than usual during hypomanic episodes and less than usual during depressive episodes.

Many, many people responded to my inquiry for participants. A few were memorable. One potential participant hoped to take part in the study but then, two weeks later, she wrote to tell me she no longer had bipolar disorder, that she was cured. Another potential participant was excited about the study, even offering me a piece of his poetry he rewrote from memory; however, when I called him, his caretaker told me that he had disappeared because he had not been successful in fighting his addiction to drugs. Additionally, a mother contacted me about interviewing her underage son, who she said, was in the hospital at the moment. Because of his age, he was not a suitable participant.

Although I responded to each interested person, I repeatedly turned down potential, eager participants who could not sign the consent form because they were not in treatment. Although being in treatment does not preclude experiencing strong and even overpowering symptoms and

episodes, I could not otherwise interview them without knowing whether I could possibly trigger an episode as some research tends to suggest. On the other hand, in keeping with other research, the conversations did not in fact trigger episodes in any participant.

Generally speaking, I looked at three venues to find participants: areas of the mental health community, areas of the writing/artist community, and areas that were general.

Mental Health Community

In terms of the mental health community, my first contact was with the local affiliate of the National Alliance on Mental Illness (NAMI), a large, grassroots organization which hosts support groups as well as educates the community on all kinds of mental illnesses. The two largest kinds of mental illness, however, were bipolar disorder and schizophrenia. The director at NAMI introduced me one participant; another I found in speaking to support groups when invited.

NAMI helped me through the internet as well. They let me use their listserv through which I put out a general call to people with mental illness, family members, and mental health professionals. From this general call, two people contacted me directly, one of whom learned about the NAMI listserv from a person at his church. Moreover, I contacted one writer I had learned about from NAMI's blog.

A second mental health forum I used was Depression and Related Affective Disorders Anonymous (DRADA), another grass-roots organization, but one which had recently gone defunct. Although the organization no longer existed, the support groups that it had once fostered continued to exist. I attended several meetings when allowed, from which I met six participants, four of which remained in the study. One dropped out at the end and another I had to remove after our first interview (see Deviations below). At one group meeting, I was given an old list of

group leaders across the state. I "cold-called" about fifty group leaders and asked if I could either come to speak or send information about my study. Out of the about fifty that I called, two asked for materials and three allowed me to come speak about my study. From this I met one participant whose group leader had passed on my information and another participant who was a group leader.

A third mental health forum was Depression and Bipolar Support Alliance (DBSA), another grassroots organization. I sent an email to the local affiliate's moderator and attended a support group, from which I found two more participants.

Another mental health group I contacted allowed me to make an announcement at one of their sponsored talks outside of the Baltimore area. The night I went had a packed room to see Kay Redfield Jamison speak. I found two interested participants from that talk.

I contacted yet another person after reading an essay about her experience with bipolar disorder and asked if she would volunteer. She agreed.

I also contacted mental health professionals themselves, getting a good idea of the key players in the mental health realm in Baltimore. One of them referred a participant to me.

I placed an advertisement in a magazine dedicated to publishing artwork and writing by people who have mental illnesses. The magazine is no longer in circulation, and the advertisement that I placed attracted one participant, whom I later had to drop from the study because his diagnosis was not bipolar.

Calls to Writers

I looked to writing communities, including students and professors at my place of employment. I found one participant in this way.

I posted advertisements, too, on a larger listserv of writers across the country. From the latter, I found participants from Connecticut and California. Initially I was not going to interview people except for face-to-face, but after receiving calls from other people in other states who seemed highly interested, I decided that it was worth it to get a larger variety of participants.

General Calls

I posted information in more general settings, too, such as listservs for my own college alumni and social networking sites, such as MySpace and Facebook. Furthermore, I sent emails to family and friends, asking them to pass on my information. To give an idea of how people react to those with the disorder, I received a forwarded email in which one of the members of the email chain had written that he knew several people with bipolar disorder and that "they are wonderful people!"

Finally there were those participants that contacted me after hearing about the study through word-of-mouth. These included two local participants and one in Canada.

Consent

Before the interviews, participants filled out and signed consent forms (Appendix C). The forms certified that the participant agreed to participation in the study and that he or she understood that he or she could withdraw at any time. Each participant also confirmed that he or she was active in his or her treatment beyond attending support groups; i.e., he or she was under the care of a psychiatrist and/or therapist.

Identity was hidden for all involved and their interviews were kept confidential. This was done in two ways. The first was to ask people when they read the transcriptions what they felt identified them too much; the second was to keep an eye out for myself for which kinds of things might identify them and erase those whenever possible or hide them when not possible. In the

latter case, I did not delete the piece of information until after the data was coded so that I would not lose vital information, such as things that would connect them directly to the character rather than allowing me to speak in generalized terms. A fictitious example is that I did not identify writers by gender or book title if they had published a book.

Identity was hidden not only for the protection of the participants but also because with their identities hidden, participants felt that they could speak more freely and free of the stigma associated with the illness, internal as well as external.

Interviews

Why Interviews

According to Lincoln and Guba (1985), "A major advantage of the interview is that it permits the respondent to move back and forth in time—to reconstruct the past, interpret the present, and predict the future, all without leaving a comfortable armchair" (p. 273). Reinharz (1992) explained that another benefit of interviewing is that interviews capture the experience of the participants rather than the researcher: "[I]nterviewing offers researchers access to people's ideas, thoughts, and memories in their own words rather than in the words of the researcher" (p. 19). Patton (2002) concurred that "the purpose of interviewing . . . is to allow us to enter into the other person's perspective" (p. 341). Using diaries/texts alone—or seeking out what poetry therapists, psychologists, diaries of famous writers, and literary biographers say—does not give us the insight we get from asking writers directly how and why they write. Of all these methods, only in-depth interviewing allows us to know the context in which the person is speaking.

Preparation

Naturalistic research, which is based on the principle that reality is contructed, involves developing shared conceptions of reality (Erlandson et al., 1993, p. 21), a task in which both researcher and participants share (Erlandson et al., 1993, p. 26). Although one cannot share conceptions of reality completely, the researcher must find overlap; moreover, "because these persons represent different constructed realities, a credible outcome is one that adequately represents both the areas in which these realities converge and the points on which they diverge" (Erlandson et al., 1993, p. 30). Erlandson et al. (1993) explained that "the researcher's goal is to get behind the data being collected and to see through them the constructed realities of the respondent" (p. 89).

In a previous interview project, I interviewed Don Ho, the famous entertainer of Hawaiian descent and of a different (nonmainland) culture, which taught me in practice the difficulty of getting into the experience of someone in another culture. To compensate, I spent several hours a day with him and did extensive research on the history and people of Hawaii. Therefore, to get closer to the reality of my participants, I began by working in tandem with Davidson's (2003) advice in *Living Outside Mental Illness*:

> Extensive, informal, and unstructured discussions with members of the prospective target population and/or other key stakeholders, review of areas of inquiry and potential phrasings of questions with the same parties, as well as conducting pilot interviews to test sample questions, are all essential steps in the process of formulating an interview protocol. (p. 66)

Along these lines, I talked to as many people of the bipolar population as possible. I sat in on support group meetings for 24 hours over two months and listened to their stories, especially the

wide range of differences and similarities. I also spent time getting to know the research on the disorder and reading biographies. Some more the face-to-face time happened through volunteering with NAMI, where I had volunteered for a year prior to the study's inception.

I spoke not only with people who have the disorder, but also care providers in the field. Some could identify for me the biggest names in psychology having to do with bipolar disorder and who could educate me more on the illness.

All of these preparations were especially helpful in my interviews so that I did not register shock or surprise about the graphic or outrageous parts of their stories. In fact, my preparation helped me monitor my own prejudices and the stigma I have in the past placed on others; I became very aware of how I was acting and feeling. For instance, I was embarrassed to find that, during one of my early interviews, I felt that I stood on more or less higher moral ground. Although this was a terribly negative thought process, it is in keeping with social stigma in that mental illness has often been thought of in terms of moral impurity or punishment (Johnson, 2000; for a detailed account of stigma, morality, and mental illness, see Hinshaw, 2007). With due vigilance and writing in my methods log, I became aware of this and tried to ground myself in focusing on my commonalities with the participant.

Building Rapport

According to Lincoln and Guba (1985), in naturalistic interviews, the interviewer and respondent are peers (p. 269). I approached participants in the least intimidating way, dressing informally and meeting at places of the participant's choice. The locations of the interviews, as specified in Appendix E, included coffee shops as well as some at the participants' homes. The participants also decided whether or not to be recorded. All but one was recorded for the first interview. For second and third interviews, two were not recorded.

During the process, I found myself building friendships with the participants. According to Reinharz (1992), building such friendships is neither uncommon nor poor methodology. Reinharz (1992) told the story of feminist researcher Ann Oakley who

> suggests that feminist interviewing involves commitment on the part of the researcher to form a relationship, and on the part of the interviewees to participate with sincerity. In another of her studies, more than a third of her interviewees continued their ties with her after four years: "four have become close friends, several I visit occasionally, and the rest write or telephone when they have something salient to report…" (p. 28).

Several of my own participants have kept in touch afterwards, and some continued to send me works in which they were published, even though the use of the works was for the projection technique (as described below). In one case, a man sent postcards not only describing his life, but expressing support for me as a teacher. The participants also seemed concerned with my well-being as a student—encouraging me to do well and complete the dissertation. In order to maintain these relationships, both for personal and professional reasons, I kept in touch long after the data was collected, sending occasional emails and holiday cards. In terms of professional reasons and in accordance with Erlandson et al.'s (1993) advice, I left the door open so that I could continue the study as long as needed and beyond.

Although I approached the interviews as building a peer relationship as opposed to a researcher-subject relationship, I was not always a peer in the eyes of my participants. The perceived expertise I had as an English teacher made several ask for feedback on their work. It also made them hesitant when talking about their processes. Brandt (2001) had written of her interviews of literacy in America that she wanted to escape the notion of writing teacher; therefore, she did not ask for participant work (p. 13). I, on the other hand, found it important to

have participant writing (see projection technique below) in front of us in order to ask more specific questions and collect richer stories. Still, I found the most salient example of the image of the writing teacher in participant descriptions of writing processes that are untraditional. Thomas, for example, stressed that he did not "prewrite" but he wrote "extemporaneously." The distinction was important to him. As I realized the effect my presence as an English teacher was having, I changed my questions to state outright that there are no right or wrong writing processes. I also avoided being perceived in my teacher role by setting myself up as a fellow writer, suggesting similarities in our processes. At the same time, knowing that I am a writer, editor, and writing teacher, they seemed to be more eager and excited about showing me their work or talking about it. One participant commented on how passionate I seemed to be about writing, which in turn, she told me, inspired her.

As part of rapport building, Lincoln and Guba (1985) thought it important to begin with a "warm up" (p. 269). This warming-up was informed by my experience working as a researcher in previous projects. For example, interviewing Don Ho, who was a proud, acclaimed Hawaiian entertainer, reticent to share the juicier parts of his life, taught me that building trust meant first breaking the ice, sharing something of yourself, being agreeable whenever possible, and asking as few as possible personal questions at the start. Fontana and Frey (1998) explained that unstructured conversation ("chit-chat") without taking notes or trying to direct the conversation is important "to establish rapport and immerse oneself in the situation, while gathering a store of 'tacit knowledge' about the people and the culture being studied" (p. 68). Reinharz (1992) echoed this when she wrote that trust needs to be present if participants (women in her case) are to divulge information (p. 29).

Questions

According to Lincoln and Guba (1985), naturalistic interviews are necessarily unstructured although they move towards structure in later stages (p. 269). Specifically, my interviewing was a cross between Patton's (2002) *informal conversational interview* and *interview guide*. Such an interview does not rely on predetermined questions, even though the researcher will begin with a set of memorized questions or issues to address. Patton (2002) wrote that "The *informal conversational interview* relies entirely on the spontaneous generation of questions in the natural flow of an interaction. . . .The persons being talked with may not even realize they are being interviewed" (p. 342). On the other hand, Patton (2002) wrote that because of its informal nature, such an interview makes it longer to get to the point where all the answers are obtained (p. 343).

I crossed this method with the interview guide, in which the researcher comes to the study with questions in mind and these questions are asked of each participant (p. 343). I developed a few broad, basic questions (see Appendix F) and memorized them as Erlandson et al. (1993) had suggested so that I could "take advantage of the situation when the respondent spontaneously drifts off into addressing a scheduled but as yet unasked question" (p. 90).

According to Patton (2002), "Being unstructured doesn't mean that conversational interviews are unfocused. Sensitizing concepts and the overall purpose of the inquiry inform the interview (p. 343). In this study, I let the conversation flow while I had my list of questions to fall back on to use in emergencies; on the other hand, an overarching conversational force was at play. That overarching force then shaped the interview. With the advertisements to participate, the participants knew my definition of a writer—one that writes but has not necessarily published—and suspected that I had postulated a connection between writer and bipolar disorder.

In some of the later interviews, I directly stated my assumptions that the two do to some extent play off each other.

Reissman (1993) suggested that interviews "give considerable freedom to both [the interviewer and interviewee]" (p. 25). When extraneous topics arose, I therefore erred, as Reinharz (1992) also suggested, on the side of staying with the participant with the belief that all topics will come back around (p. 25). Reinharz (1992) explained that "Interviewee-guided research requires great attentiveness on the part of the interviewer during an interview and a kind of trust that the interviewee will lead the interviewer in fruitful directions" (p. 24).

Reinharz (1992) wrote that interviewee-oriented work requires "careful listening" in order that the interviewer knows to introduce new questions (p. 21). Moreover, as Erlandson et al. (1993) have suggested, the researcher should not intrude on an interviewee's explanation, thereby inadvertently substituting his or her own thoughts and construction of reality (p. 93). The researcher should listen genuinely and interrupt as little as possible during the answer because the participant might be getting to a point in a round-about way. Partly due to this, I found it true that "because of the interviewee-guided nature of much feminist interview research, there frequently are large variations in the duration of the interviews within a single project" (Reinharz, 1992, p. 25). Interviewee-oriented or guided interviews gets subtleties otherwise not available: "One of the ways to get at these subtleties is to be interviewee-guided, which means focusing less on getting one's questions answered and more on understanding the interviewee" (p. 24). As Reissman (1993) further observed, "narratives often emerge when you least expect them" (p. 56).

For the 16 out of 21participants for which I had more than one interview, I went to the second interview after carefully combing through the first transcript and looking for idiosyncratic

areas that could be further explored, which helped paint a richer picture of that individual. I did the same with the third interview. This is in keeping with Patton (2002) who wrote, “Interview questions will change over time, and each new interview builds on those already done, expanding information that was picked up previously, moving in new directions, and seeking elucidations and elaborations from various participants” (p. 342). As Patton (2002) elaborated,

> the fluid and emergent nature of naturalistic inquiry makes the distinction between data gathering and analysis far less absolute. In the course of fieldwork, ideas about directions for analysis will occur. Patterns take shape. Possible themes spring to mind. Hypotheses emerge that inform subsequent fieldwork. While earlier stages of fieldwork tend to be generative and emergent, following wherever the data lead, later stages bring closure by moving toward confirmatory data collection—deepening insights into and confirming (or disconfirming) patterns that seem to have appeared. (p. 435)

When the second interviews took place, I had already drawn observations enough to ask questions in light of the new information that I learned. In honing and developing my questions as such and coming to and testing initial hypotheses, I followed the advice of Miles and Huberman (1994). After about ten interviews, I was able to conduct only one interview and still cover what I needed because my idea of what I wanted to ask had come clearly into view. (See lengths of interviews in the Appendix D.) Still, I also followed Patton (2002) in his suggestion that when the questions were cemented, one should go back and ask the other participants the same (p. 343). Initially, this was possible because the interviews were spaced out enough to allow me to formulate new hypotheses and questions. After I had coded the data thoroughly, I went back through the methods log and picked up the questions that I had not asked everyone. I then went back and asked them.

Although I had defined the boundaries of my study, I relied on grounded, emergent questions. That is, I approached the participants with the question of what I can learn from them, the basis of my research questions. Although the connections between writing and bipolar disorder have been elsewhere hypothesized, I did not bring that question into the study in any specific way (e.g., saying that bipolar disorder causes creative writing). I entered the study with the mindset that writing may or may not affect bipolar in a specific way and vice versa.

Chase (1995) distinguished between stories and reports, stories being chronicles of experiences where reports are more fashioned toward what the interviewer is thought to expect. She explained, "If we want to hear stories rather than reports, then our task as interviewers is to *invite* others to tell their stories, to encourage them to take responsibility for the meaning of their talk" (p. 3). The danger of participants not taking responsibility is that it results in getting stories that are meant to please the interviewer rather than stories about the experiences of the interviewee. For example, I found it very important to let the participants guide the conversation as much as possible and make the introduction of questions seamless. As Reinharz (1992) wrote, "Interviewee-guided research requires great attentiveness on the part of the interviewer during an interview and a kind of trust that the interviewee will lead the interviewer in fruitful directions" (p. 24). Sometimes, though, the interviewee went into histories that did not directly relate but which were still large parts of their lives. For example, I learned of Susan's complicated relationship with her late mother, Tess's extrication from her birth family, and Robert's strained relationship with his father.

The work of the interviewer, then, includes careful formulation of questions that invite the other's story. That is, I aimed for questions which elicited what makes an individual's life experience interesting rather than questions that might be an affirmation of any theory.

Moreover, Davidson (2003), in speaking of his research in collecting stories of experience of people with schizophrenia, wrote, “What we are looking for most in narratives, . . . are rich, descriptive details about a person’s subjective experiences in the context of his or her everyday life. We are unlikely to elicit this kind of detail by asking vague or general questions” (p. 65).

Dependence on Context

Everything that surrounds the interview—the interviewer, the context, the purpose, how the story is told—necessarily affects the story with which the researcher later comes in contact. Ellis (2004) wrote that “Ideally [in traditional methods] the interviewer should not interfere with or change the story that is told” but that, since interviews happen in context—especially in the context of the speaker speaking to a particular audience (the interviewer in a specific time at a specific place)—one cannot dismiss the impact of the interviewer on the responses. I entered the interviews ready to record not just the interview but the context, the dynamics of the interactions, and my own reactions, but later felt it was more important to let the person know that my notes were open to him or her throughout the interview. Still, I used a note pad and paper to record the context, the participant’s nonverbal cues, and my reactions to the interview to the extent that the participant was not made uncomfortable, while an Olympus DS2 digital recorder recorded the interview. At any time, the participant should have felt that he or she is able to see those notes. The notes were also vital because the digital recorder sometimes malfunctioned and because one participant refused to be recorded.

Projection Technique

To enrich the interview, I used what Patton (2002) described as a “projection technique,” through which the participant “reacts to something other than a question” (p. 394). I asked

participants to bring a recent or favorite piece of writing. Pieces of writing included personal journals, articles, poems, books. This was intended to elicit what they thought of the role of writing in their lives. Three interviewees, Jessica, Julie, and Mary, wrote something in particular for me. I then interviewed these three participants about the documents, asking about their writing processes and general thought processes in creating them. In this way, the writer could focus more on the process of creating the piece.

Brandt (2001) found in her study of literacy that it was better not to ask for pieces of writing: ". . . the disapproving teacher looms large enough still in many people's memories and was best, I thought, left alone" (p. 13). I found the disclosure of being a teacher and the asking for pieces of writing to be helpful in that people were more apt to talk about their literacy experiences and that they offered pieces of writing of which they were most proud and eager to talk about.

A couple of things took me by surprise. I was not just allowed—I was asked—to keep chapters and borrow whole journals for months at a time. I was even asked to comment, critique, edit, or demonstrate my comprehension of their work by repeating back to them what I had read or solving a mystery if it was presented to me (as did Thomas). Once, I went to my study-designated PO box and found a 334-page hardback book filled with writings by people with mental illnesses in which one man had published a small essay. Another time, there were two books written by another man's mother, and another time a small poetry collection.

Notes and Transcriptions

As close to the actual interview as possible, I transcribed the recordings using a foot pedal. (See lengths between interviews in Appendix D and a sample transcription in Appendix K). I copied the transcripts folder and I downloaded the files into Express Scribe software to

transcribe using the foot pedal. Then I went through the transcripts and adjusted them by broadening the margins. I put 2 inch margins on each side in Times New Roman 11 in order that I could get a view of the larger picture as well as to save paper if I could.

The initial transcriptions captured every "um" and "like" and later I found this too overwhelming, both for me and for the participants to have to read. At first I left out the chit-chat, and then I put the chit-chat back in, and then I took it out again to streamline. There were several reasons for my wavering. Initially I had wanted to keep in the chit-chat for context, since Atkinson (1998) suggested making those parts which are transcribed as complete as possible, with pauses and intonations indicated, because how something is said indicates how individuals may want to be interpreted (p. 55). Although I began my interview transcriptions by transcribing each pause and "um," I changed my technique in following with Brandt's (2001) interviews on literacy in which she wrote that she did not have the linguistic training to merit such transcriptions.

In some cases I deleted all but the episode descriptions and writing information based on what might identify a person. I also ultimately took out what was irrelevant so as not to overwhelm, since they were not getting paid for the interviews.

Member Checks

Lincoln and Guba (1985) wrote that member checking is vital. As Hatch and Wisniewski (1995) noted, "In order for the work to be well done, researcher and participant work closely together to come to a shared understanding of the participant's story" (p. 117). And Erlandson et al. (1993) asserted that "No data obtained through the study should be included in it if they cannot be verified through member checks" (p. 31). I conducted member checks continuously

throughout the interviews and until the end. As tentative conclusions were drawn, they were member-checked.

I member-checked each interview transcript with the participant by mail, email, or phone. In contacting them, I told them that we needed to agree on the perception of how the interview happened. Participants made changes when things seemed too personal; for instance, one interviewee who later decided not to participate had experienced abuse as a child and did not want that added.

In one case, the participant chose to take out what he thought was irrelevant, but which was good data. I called him to ask him why he took it out, and he told me he was being helpful but that I could put it back in.

After I wrote up the individual stories, I returned to the participants with the questions that Clandinin and Connelly (2000) suggested: "Is this you? Do you see yourself here? Is this the character you want to be when this is read by others?" Except for three participants whom I could no longer find, all of the participants said that yes, the stories sounded like them. One participant said that he was "transfixed" in reading it. Another—the one who corrected the transcripts according to what he thought I would need—corrected the story to suggest only what he thought I would need, although he said that I could use the story as I had written it. The exception to those who did approve it, was that one participant felt that her story was too personal because, for one, it included her experience being mistreated in the hospital, and, as a result, she dropped out of the study.

Researcher's Reflective Journal

I kept a journal for several purposes. I recorded the notes of the interview in case of digital recorder malfunction and in order to capture the context and nonverbal cues when

possible. I also kept track of my communication with participants and with mental health professionals who gave me advice on the study, like the encouragement to ask for symptoms of individual episodes rather than taking bipolar as a whole or even their diagnoses at face value. As I was transcribing and analyzing the interviews, I kept notes about what seemed interesting or what patterns were emerging, both individually and cross-case. This was especially important in analysis because it recorded the necessary change in coding systems that I went through. Moreover, as I was transcribing, I put in the journal what happened and what my thoughts were on the coding/analysis that I was doing.

The researcher journal also allowed for an audit trail. Erlandson et al. (1993) explained that an audit trail must be maintained so that readers will be able to discern what influenced the researcher in his or her final conclusions in terms of documents and processes. Therefore, all data was collected and saved "that provides documentation (through critical incidents, documents, and interview notes) and a running account of the processes (such as the investigator's daily journal) of the inquiry" (p. 34). Specifically, this documentation included tapes, transcripts, participant writings, researcher journal, and all email interactions.

Deviations From the Original Plan

Although there were more women in the study than men and middle class more than upper or lower class, this study remains transferable because bipolar disorder affects people equally across gender, class, cultural, and education lines (Goodwin and Jamison, 2007, p. 182).

Although I meant for communication about the study to be uniform, I ultimately used several types of fliers (Appendix B) because some people told me that they knew people who wanted to get involved but did not want their names out there. Also, for many, and I had to

explain “writer” as someone who has a close relationship with writing but is not necessarily published.

Patton (2002) warned against not writing up the story immediately after the interview (p. 383). Although I did not do this, I did carefully transcribe my notes and the interview tapes while at the same time keeping a researcher journal on my reactions.

I realized in interviewing my first few participants that I could not positively assert that the mental health worker who diagnosed the disorder had diagnosed it correctly nor could I assert that this diagnosis is the person’s only or final diagnosis and, therefore, how much of the bipolar illness was affecting the writing. For this reason, I asked about specific mood states, such as depression, and compared the answers across the board on what that experience was like.

My original plan was to have two interviews of an hour each. The lengths vary considerably, which, according to Reinharz (1992), is natural in interviewee-guided research (p. 25). Moreover, I was concerned in some cases that I would not be able to get another interview and, therefore, those interviews ran long. In others, where the interviewee was more accessible, the interviews ran two or three meetings.

Analysis

In naturalistic studies, analysis begins at the beginning of fieldwork, or in this case, interviews. As a method of analysis, I constantly revised my interview questions to fit the study or to explore something that I had not anticipated. I revised the questions 1) by reflecting on the individual interviews, 2) reflecting on the literature review, and 3) reflecting on the interviews as a whole.

As Patton (2002) wrote,

> Such overlapping of data collection and analysis improves both the quality of data collected and the quality of the analysis so long as the fieldworker takes care not to allow these initial interpretations to overly confine analytical possibilities. Indeed, instead of focusing additional data collection entirely on confirming preliminary field hypotheses, the inquiry should become particularly sensitive to looking for alternative explanations and patterns that would invalidate initial insights. (p. 436)

An example of this revising was the issue of point of view. Early on, a respondent (Thomas) told me that similarities among writers who have bipolar disorder is that they will not write in the first person about themselves. Anticipating this to be an emerging theory, I conducted more interviews with an ear for which point of view the participants wrote the most in: first, second, or third. I initially thought this to be a gender issue; as I followed up, the men said they wrote in the third person and about issues other than themselves and the women said they wrote about themselves and their experiences. But upon closer analysis and interviews with a woman who wrote fiction professionally (Lisa), another woman who refused to write about herself (Mary), and a man who only wrote about his experiences (Robert), I realized that the issue was not so much an issue of gender as an issue of whether the purpose of writing is to escape. That is, those who did not write about themselves frankly thought it a bad idea to write about the feelings and thought processes involved in the illness either because they did not want to keep records of it or because they anticipated the writing would make them feel worse.

I began coding according to Miles and Huberman's (1994) advice of starting with a start list that "comes from the conceptual framework, list of research questions, hypotheses, problem areas, and/or key variables that the researcher brings to the study" (p. 58). With the start list, I went through and assigned categories to chunks of meaning, following Miles and Huberman

(1994) (p. 57). I added new codes when categories did not fit my codes. Eventually, my coding system was bloated, and I tried to whittle it down to 50, following the advice of Miles and Huberman (1994) who wrote that the mind can usually hold about 50 to 60 at once (p. 58). Then, using these codes, I drew an initial concept map in order to better see how they related to each other. After transcribing and re-reading the interviews as well as compiling the literature review, I drew three overlapping circles—life experience with bipolar disorder and life experience as a writer, with the middle circle being the overlap. My map showed that there were two major areas I had either consciously planned to and had implicitly decided to explore—what that particular participant's writing life/literacy journey was like and what his or her journey as someone with bipolar disorder was like. A third, middle area also emerged which showed where the two intersected—how the writing and bipolar affected each other. My map allowed me to whittle the codes down by the fact of whether what I had coded was pertinent to the study or what level of pertinence they were.

I then clustered my coding system according to those three areas and began re-coding the transcripts. Again, my coding system grew. I had managed to develop codes, for instance, for writing with depression, depression's affect on writing, whether writing in a depressive state caused deeper depressions, and whether writing cured depression. To simplify and create a final coding list, I coded for depression and the act of writing as two separate but more general codes. In this way, I could combine the codes to answer questions that I had developed, such as what was the affect mania had on writing (MAN + WRIT-ACT) or what was the affect mania had on the perception of the writing (MAN + PERC + WRIT-ACT). Wherever the two codes coincided, those places would have the answers to my questions. For instance, if a section described a manic episode and described the act of writing, I could then tell what the act of writing was like

in that manic episode. If a third variable defined that same section of text, for instance school work, I could tell what it was like to write during mania in school (MAN + WRIT-ACT + SCH).

From my interviews, there was no way of knowing whether the episode caused the writing or the writing caused the episodes. The scholarship, too, is divided on this point (see Chapter Two). I then, to interpret the data, put them together in those different combinations to show whether and where they co-existed, which was more accurate than which caused which. This is the concept that Lincoln and Guba (1985) called *mutual simultaneous shaping*: "everything influences everything else, in the here and now" (p. 151).

Another reason for my bloated scheme was that I found many, many reasons that people write and each of these ways found itself into my coding scheme. I moved therefore into a pattern code (or meta-level code) rather than a descriptive code (Miles and Huberman, 1994, p. 71). I was careful to, as Miles and Huberman (1994) warned, not force the pattern codes but where necessary I left the descriptive code (p. 72). This, for instance, was the case in participant mentions of Kay Redfield Jamison, spirituality, and hope, none of which fit neatly into a larger pattern code. In the meantime, I also found that the criteria for certain codes had more nuances than I thought. I therefore noted these in my methods log for later review.

I put the codes together as I had laid out in my formulas by paying attention to certain combinations of codes that could help me clarify my questions and develop hypotheses that I could then test.

After I had conducted my interviews, I continued to analyze the data according to Patton's (2002) advice,

> In essence, when data collection has formally ended and it is time to begin the final analysis, the investigator has two primary sources to draw from in organizing the

> analysis: (1) the questions that were generated during the conceptual and design phases of the study, prior to fieldwork, and (2) analytic insights and interpretations that emerged during data collection. (p. 437)

I had all this information in my researcher journal. I then classified the information in my journal into further questions, conclusions, and methods.

"Questions" were questions that I derived as the study went on. These created my final list of questions which I went back and asked the participants at the conclusion of the study. They are listed in Appendix G: Final, Directed Follow Up Questions. "Conclusions" were conclusions that I had come up with throughout the study, specifically those main lines of thought that I had followed. These, too, informed the new list of questions where certain topics had not be adequately explored.

Conclusions were found under the following headings: processes, reasons for writing, directed writing, concerns (writing causing episodes/ writing controls episodes), writing about the self/ writing outside the self, intersection of learning to write and bipolar, what is a writer?, intersection between being a writer and having bipolar, and audience concerns.

"Methods," of course, were the methods that I used as I proceeded with the study.

Ethics

According to Lincoln and Guba (1985), ethical interview practices are overt: "the respondent is fully and completely informed not only of the fact that an interview is taking place but of the purpose of that interview and how the resulting information will be used" (p. 269). This was accomplished via email correspondence and consent forms.

One ethical problem I ran into was the expectation of being a therapist. Davidson (2003) explained such an instance in his interviews of people with schizophrenia: "The intimate and

potentially therapeutic nature of the person's disclosure does raise unique ethical issues for qualitative research" (p. 68). This was an issue specifically with co-morbid illnesses. I avoided this by—whenever possible—bringing the interview up a notch to a less personal level, sometimes inserting a question to move on from the issue, and not offering advice. If I knew of resources such as support groups, I did inform the person of the resources I knew.

So as not to put people in the way of harm, I wanted to find people who had made an effort to manage their disorder. This, however, left out a large population—I did not foresee the event of some who were not under the care of a doctor or therapist because they are in rebellion against the mental health establishment. Also, just because they were under the care of doctors and/or therapists did not mean they were stable or that they and their doctors could manage the illness. Taken as a whole, I found that their mood states were at nearly all points of the bipolar spectrum, from near balanced to hypomanic to near manic to mildly depressed to severely depressed. They were also influenced by treatments for bipolar disorder, such as ECT (electroconvulsive therapy—formerly known as shock therapy) and psychotropic medications.

CHAPTER FOUR: INDIVIDUAL CASES

The following section describes what life is like for each individual participant. They are roughly grouped by the kind of writers they are: the inspired (amateur), the journal writers, the pathographers, the paid professionals, and the advocates.

The Inspired (Amateur)

Although Gregory and Robert had poems and articles published, they were still amateurs in that writing was not their main occupation; that is, amateur in this title is to suggest people who write as more than a hobby but who are not paid professionals. In the cases of Tess and Gregory, for instance, they wrote and wrote often but did not earn a wage for it and were on disability. Thomas, Robert, and Chris saw themselves as writers first and foremost. They were dedicated to their craft, but again, did not earn livings as writers.

Thomas

Thomas started writing in the second grade with a story about a family named Stone. He did not show it to anyone, he no longer has a copy and no longer remembers most of it, but he clearly remembers some details, such as what influenced it (monster movies) and what the Stone family did (fight werewolves and vampires). The next time he wrote something significant was in fourth grade. It was a play about the Dewey Decimal system. This time he showed it to his teacher, and he was crushed that his teacher did not want to use it for the class. Even though he got a good grade in English that year, he said the instance "sort of dampened my idea of writing for a long time." With the exception of 7th grade poetry, he did not pick up writing again until he was about 27 and in college writing short stories.

Although early on Thomas did not get positive feedback, he actively sought feedback as his life went on. He began to share his writing widely with family, friends, and his church community. At the time of the interview, he had written a couple-hundred page manuscript and was shopping it out to publishers.

Thomas's life and work is heavily influenced by his spirituality. In my first contact with Thomas (over the phone), he told me to write God at the top of a sheet of paper and write down all the adjectives I would use to describe God. His first major episode involved "chas[ing] this one priest and this one minister around for a couple of days, telling them to get people to pray more" until it escalated to a terrifying hallucination of a white light and "a voice asking . . . whether I wanted to come or not." He told me that he then "passed out and a couple of hours later . . . [he] was in the hospital, talking with the little nun . . . [who] said, 'You just had a profound religious experience. There's probably something more going on: Consult a psychiatrist.'"

Although Thomas's life is greatly influenced by religion, he is not zealous. Rather, he offers it, as he offers his writing, as a gift. The genesis of his now book-length work was a small story written for members of his family for Christmas in 1994, and recently, he wrote a play for the children at church. When I asked him the point of the book that had come out of the small story, he told me,

> I think everybody needs faith. . . . But some people have real trouble finding faith in their life. . . . And this book helps anybody say to themselves, "you know, if this character Leon can go through all of this and come out the other side as [Jesus], one of the greatest figures that's ever lived," you know, "maybe I have a chance of coming through this and being good myself."

On his own list of adjectives about God, he must have the word, “understanding”; although his book is an allegory, he thinks on one level people might find it blasphemous.

It is hard to discern how much the hypomania helps him write. He mentioned writing between three and seven a.m., but on the two separate occasions we talked, he mentioned two different causes: the lowered level of medication during the night and that “things are so quiet . . . [E]verything is where it should be in the middle of the night.” However, somewhere “between baseline and hypomania, and even into hypomania a little bit,” he said, “the thoughts just flow. It’s like somebody opened up an area of your mind where creativity exists and just let it out. To be free.” This feeling he described as “unbelievable.” The writing is “beautiful, beautiful, beautiful writing.” Thomas feels it is possible to write yourself into hypomania and ultimately mania. He said that in mania he composes thoughts that are, upon later reflection, “jibberish” and that “don’t follow one another.” He continued, “it doesn’t make any sense, it’s broken, it’s disjointed . . . [and] when you’re doing it, you think that you’re writing the greatest thing that has ever been written. And, it’s very humbling when you go back to read it, and it’s just so broken up.”

He told me that he doesn’t “deal with [writing] very well when I’m depressed.” He said he is overtaken with apathy and does not want to try. If he sits down to the computer and actually wants to write, he’ll get more depressed. He told me, “when I’m depressed, I don’t want to have a thing to do with the keyboard. I just, you know, I’m very much filled full of apathy, very strong apathy.” He said that the only creative thing that he can do in a depressive state is to read the Bible.

Thomas drew a difference between writer’s block and a block due to depression. Writer’s block he contrasted against creative, free-flowing, extemporaneous writing where “thoughts

follow one another as if almost like they come out of thin air." He's written most of his work extemporaneously, including his book manuscript. With writer's block, he said, it's usually a matter of which way to turn with his story. He can walk away and come back later and write. Depression block, as I have discerned through this research, is "when it just comes to a screeching halt.. . . I can't get on top of it for some odd reason. And that's frustrating." In this case, he said that medication is what in fact keeps him able to write. He stays on top of his illness, working with his doctor so that he is neither overmedicated or under-medicated. When he can write, he knows that writing is what he has to do to keep himself happy.

Thomas spoke about great writers who were actually able to write during "dark times," such as Edgar Allen Poe and Abraham Lincoln. When I asked him what other similarities he sees among people with bipolar disorder, he told me that the pieces of work will be done in the third person: "It is easier to be creative in the third person and . . . people who are bipolar really don't want to write about themselves and their stories because it is too depressing." But he said that I would find people who were not "capable of seeing above the disorder into another area of life that is far more rewarding than the mental illness." He said, "writing fiction enables me to step outside of myself far enough to realize that I'm capable of doing more than just living the illness."

Writing allows him to "play God," to "create [his] own little world" in which he has full creative freedom and is not judged. He said that writing keeps him healthy. He explained how much writing meant to him and what getting published would ultimately mean:

> I find that I feel normal when I write. And I think it's the normalcy of my feeling that keeps me writing. Not only is it good to be creative, being able to do something that's

> interesting and maybe not everybody in society can do, but it makes me feel like I'm just like everybody else. . .
>
> I'm hoping I could get my book published because it would culminate all the years and stories all the years that I've written, I mean that . . . what it would mean is that I'm just as good as anybody else in the world [tears in eyes] at living, rather than a person who suffers from mental illness, barely holds a part-time job, and even though maybe married to the most beautiful woman he's ever known, still does not feel adequate in his own marriage because of his illness. That's what writing does for me, and that's why I hope the book gets publish. Because it will do something for me. That will validate who I am for myself.

Publishing would allow him to see himself as a writer, as someone who can make a high contribution to society, despite the fact that he has a mental illness.

Robert

Robert has always had an aptitude for language. His mother had an intense interest in writing—she wrote books and taught writing—so Robert said he "didn't have a chance." He was bound to be a writer. He told me that "she was like an in-house resource." When asked if his parents encouraged him, he said, they "encouraged me verbally in the sense of drama," and he was in several school plays.

Robert's history with language has usually been in speaking rather than writing, but he said, "Writing well and speaking well [are] intimately connected." In elementary school, he put together a neighborhood newspaper which was copied with a hectograph. In high school, his SATs were "off the charts." In college, he majored in public speaking because he knew he wanted to go into the seminary. And, after the seminary, he routinely drafted sermons. Now in

"active retirement," he has taken on a different kind of writing. He enrolled in and completed a course in writing where writers are paired with mentors who offer detailed feedback. He has since successfully sold some manuscripts.

His recent writing has allowed him to take on another title—it helped him break with his identity of being a pastor (which he had been for thirty years) so that instead of "Pastor" he became "Mister." This came at a time where he was unable to preach because of an adverse reaction to lithium. Although he still preaches, writing has allowed him to look at himself in a new, yet still productive, way.

Most of his adult life, he has been writing sermons. He often talked about his "manuscripting skills" that enabled him to be an effective preacher. He told me that "very little of substance can be put together extemporaneously." Revising his sermons, he was able to exercise more control over what he had to say and how he said it: "As I would revise manuscripts or sermons, I would find that I was in a sense controlling myself more and more. I wasn't just spouting off." The more he manuscripted, the more "I condensed, distilled. . . my messages, the more and more they became effective and in a sense the more and more they helped me."

However, drafting became more difficult sometimes in manicky states because he would be "so heavenly-minded that I was no earthly good." He said, "Now that would be the extreme. My head would be in the clouds, my mind would be racing, the typical hypomanic [symptoms]."

When Robert is depressed, it is a struggle to write, but because he was a preacher, he said did not have the choice. He said that he would say to himself, "well, I'm going to write you down, I'm going to manuscript you down. I'm going to preach you down," and thereby use

writing as a tool. But sometimes the depression would be bad enough that he would just have to go extemporaneous at the pulpit.

I asked him whether the message he was trying to get across was changed by his illness. Robert told me about unction liberty anointing, where "the Holy Spirit takes you beyond in where you have been in your preparation." However, it is not an ecstatic change or change in personality:

> Proper Orthodox doctrine says the Holy Spirit works through the natural personalities, the styles of writing, of human authors. The Holy Spirit does not obliterate those distinctions. So when it comes to preaching, you don't become a different person, but there is a persona guide that comes alongside.

He said that the bipolar gave him more empathy and strength: "It sounds crazy, but I became a better preacher for having been bipolar—the more I wrestled with my condition, the more I was able to be an empathetic preacher which made me a better preacher." It also allows him to reach out to other people with mental illness. He said that he talks about mental illness in a veiled way—"in terms of emotions, how you feel, the real you inside. . . " and "I would talk about mind issues, which, because your mind uses your brain, would actually be brain issues, too, which are sort of mental health issues/spiritual issues."

In the 1973, Robert had a breakdown and was put in a "good" psychiatric hospital and on lithium, which pulled him out of a psychotic state in an absolutely dramatic fashion and enabled him to go back and finish his graduate degree. On the side, he told me, "you haven't lived 'till you've been in a state mental hospital." When he was diagnosed, he found that it made sense all the way back to his childhood.

Now, he reflected that when he is depressed, as for "creative writing, or my personal writing, it's a struggle. . . I have to struggle. It's more satisfying once I conquer it, but man, I can sweat bullets sometimes." During depression, he also effectively uses literacy to keep himself going:

> I have memorized a lot of scripture over the years. And when I didn't feel, I mean, absolutely felt horrible—and you can feel absolutely horrible when you're depressed—I would bring to my mind the scripture over and over. . . This is true even though I feel horrible. And so I don't think it is too much of a stretch to say, "look, . . . this is the real McCoy, this is what God says is true, no matter how I say it isn't true." And really, depression is a false thing, especially if the chemistry is wrong in your head. You're altering a reality if you're depressed. You're not really seeing reality as it is.

Sometimes instead of repeating it in his head, he would write it; he explained, "sometimes we just say something to yourself orally, it's not enough unless you write it down, as well as saying it. And I think that's helpful with depression, another way to use your writing." He said that writing is also helpful because it has allowed him to be "an active listener to himself." Writing his feelings down has helped him gain the distance needed for self-therapy.

Chris

Chris has been making up stories since he was five or six, which he would dictate to his uncle or grandmother. In the sixth grade, a teacher encouraged him by singling him out from the rest of the class. Freshman year in high school, he wrote a play. At the time of the first interview, he was taking graduate classes at a local university. At the time of the second interview, roughly six months later, he had to drop out because of money concerns.

When I asked him why he writes, he said "because I'm just compelled. . . I guess a narrative that goes on in my head a lot when I see things and I guess a passion for the sound of words. . . what I tend to do is just have a line, just kind of blasting in my head." Shortly thereafter in the interview, he took a pen and jotted down an idea that had suddenly come to him. Even in his worst times, he writes when he can. He writes always in his head all the time and puts in on slips of paper: "I come home with stuff scribbled on a piece of paper in my pockets all the time. . . And I have a bulletin board at home that's literally covered. So much so that I don't know what's on the bottom." The board is covered with scraps of paper, probably 17 layers thick. Indeed, Chris writes because he loves writing: "Everyone I know is like, well, 'why don't you write for money?' And I kind of tell them to go fuck off, because you don't write for money." He said of writing, "I've realized that over the last year that it just is the only place my heart is, so."

According to him, his process is scattered. He'll start something in one notebook, put it down and follow a different train of thought in another notebook. He doesn't tend to revise; however, when he thinks of coming back to a piece it becomes an entirely new piece. He described a basic writing practice of putting down "whatever was kind of flowing at the time," which is the way that dictates the form of the writing (poetry or prose). He described his writing as "mainstream fiction," some poetry, and some essays when he is angry or interested enough in something.

Although he was going to graduate school for writing at the time of the first interview, he had not published anything and had a fear of his work being rejected. He has strong opinions of what should and shouldn't be workshopped in class, saying that people should not bring to workshop self-centered poetry that only has meaning pertinent to themselves. Still, his school

audience was very supportive of his writing, especially in graduate school where all of his professors except one told him he should publish: “I’ve always done well, I’ve always been one of the better writers in my classes. I’ve always been encouraged by my professors and mentors and stuff. . . ” When I asked about his family, he told me that his mother was overly supportive and his father is overly critical and accused him of plagiarism at one point. Still, Chris said that he tends “not to like anything I've written,” regardless of his mood, although this has been recently changing while being in graduate school. At the same time, at the time of the second interview, he was about two weeks shy of his 30th birthday, and he was depressed that he hadn’t done some great work yet. A lot of the time around this milestone birthday, he fought the self-talk that said “it’s too late. I’ve squandered all my time that I had to do this.”

At the time of the first interview in May 2007, he had suffered from depression for about five years—which put the date somewhere in his early to mid-twenties—and had been diagnosed with bipolar disorder for a year and a half. He went to see a therapist afterwards and learned some coping techniques such as cognitive based therapy, or CBT in which one learns how to substitute negative self-talk with positive (see discussion in Chapter Two). After four or so months of medication and therapy, he went on a “three month bender” of partying and reckless behavior “all over the place,” “interspersed with serious bouts of lying in bed for two days at a time and not wanting to leave the house.”

At the second interview, he was weaning himself off medication because he could not afford it. He was, however, practicing good mental health habits that “they tell you to do in the hospital,” including “positive interior monologues” like that which is encouraged with CBT. He had been off his medication for four months. When I asked if he had been writing, he said he had recently started again:

> I've been managing to get by without any major episodes, but the one thing that I've been really avoiding is writing. The two times that I tried, I got in a pretty depressive state where I would just give up really early. I haven't been able to sit and focus for more than maybe fifteen minutes at a time. I was at a point where I was writing for at least an hour a day pretty solidly, and I definitely want to get back there. Last night for the first time in probably four months, I managed to write for an hour. And it was good, it was a pretty positive experience. There was a lot of dropping the pen and pushing the notebook away and laying down on the couch and constant, "no, you can't do this"—I had to give myself positive reinforcement over and over again.

I asked him why he talks himself into writing when he is depressed, and he told me, "Because it's what I'm constantly thinking of all day when I'm doing something else." But sometimes when he sits down, everything else crowds out the desire to write.

He told me that after he tries to write, he "feel[s] pretty down, really low sense of accomplishment, a lot of negativity bouncing around in [his] head" including, "you can't do this" and "if I was any good at this, I would have done it before." He winds up staring at the blank computer screen if he tries to work on the computer. So he handwrites most of his work—"notebooks are scattered all over the place. I have the tendency to get more done when I'm writing on envelopes or the back of like a credit card application. . . It seems like that little confined space makes me feel a little better because there's a page that's filled up very quickly." He said he writes his best when there are strict parameters and guidelines.

It is the sense of worthlessness that comes with depression that also slows down his writing. He said that "frustration is usually a sign that things are good." Otherwise, the worthlessness stops him: "Sometimes I have the inability to handle it, that I'm not good enough

for it." Episodes actually distract him too much from writing. In the four months off the medication, he had ideas and chunks but he was having trouble devoted time "strictly to writing."

What really sticks out with him is that he was depressed when writing because it wasn't as good as he wanted it or because he could not write. When I asked him if this were the case, too, for student writers, he replied that people who are used to writing don't find it dangerous, but people who are not used to expression are naturally going to start very close to themselves and later distance themselves and, therefore, "channel all that shit" onto the page. It seems to him and to other male participants that distancing oneself (although sometimes using one's life) is the mark of a safe or experienced writer. He does not think it is dangerous to write because he says he would never let it get to that point, although "I don't think it would ever get that bad."

> In relation to depression, he said when he does write, his perception is clearer, usually just some of my best writing as far as what I've observed and being able to transcribe things in that sense. . . Of course, they're all drab and horrible, but yeah, it always seems like I'm better at perception, really, when I'm depressed.

Still, he told me, "it is never whole. . . I might be better at getting down lines or specific descriptions or paragraphs or a good characterization for a short story. But I don't have that energy and coherence, I guess, to put together a structure."

He said it is hard to both read and write when he is depressed. When he is stable, he writes directly after reading.When he is in a manic state, he can't read a book—there's a sense of "constantly escaping the last moment." In manic phases he finds himself "wrestling with something" for a "good eight hour bout." He would "abandon it for four days while I drink and do as many drugs as possible." When manic, he told me, "I write a lot of I guess puzzle pieces

that I have to put together later. . . and sometimes it's really fun to work on that stuff and just try to make correlations between them," which might be because in mania, it is easier to go off on a tangent and get sidelined by associative thinking. "Sometimes," he said, I'll get. . . story ideas just out of that, just trying to make the leap between two things I've written." While manicky, he also jumps from project to project, does a lot more stream-of-consciousness and unconventional writing, and play with time and point of view. In fact, he said, he tends to write more in second person. He explained why:

> It's like you're talking to your audience, and your audience is part of your fiction. It's a manipulation thing, and I think when I'm manic I'm just on fire and very ego-ridden, too. And it feels like I'm pushing things around and controlling things the way I want, which probably isn't true in the slightest, but. . .

As for drawbacks from being a writer with bipolar disorder, he says he psychs himself out when in a depressed mood and writes "garbage" when manic, the latter being "okay because at least I write something." However, he told me, it is harder to get emotionally invested in what's coming out. Also when he is manic, he tends to jump from project to project, sometimes abandoning them for years. On the other hand, when he is depressed, he has found that he "[scraps] completely good ideas of stories, completely. . . completely erased them. Completely destroyed them, you know, with no evidence left of them whatever." At the same time, since he has already written them, he sometimes resurrects them in different forms, as in turning prose into poetry.

One of the better writing times in his life was the three-week time period when he would journal for a half hour and write fiction for two hours. Occasionally he does write on a disciplined schedule. At the time, he was "pretty stable" on medication and going through

therapy. He told me “things weren’t exactly perfect, but I had a goal in mind. I was working toward something and it felt good. I was very stable.”

The states themselves have interfered with his learning to write or improving his writing because it made him reluctant to do anything besides going to class. When he gets depressed, he talks himself out of things. He’ll say to himself that he knows nothing about writing but then he will go to workshop classes and realize how much he does know.

When depressed, he writes about characters who were going through hard situations, such as abandonment by a loved one or a relationship that “quickly dissolves.” He tends to write about people who “blame the universe for their problems” and “don’t realize they need to make a personal fix,” a core feeling of depression. He told me that it is easier in first person—in such an ego-centric state—to become the character with the problems than someone on the outside looking in. The writing itself, and especially writing about such topics “through depressed eyes” does not make him more depressed. At one point, he did write a character that was too depressed and, therefore, too dull thus needing something else to make him interesting.

He had not written about the illness but said he “most definitely will.” His stories would only be indirectly related to bipolar disorder—“with sort of a twist and a theme that would . . . mostly be mental illness.” He believed that “a lot of authors” have bipolar disorder, although he does not personally know of one. He thinks he would write it because “it’s important for the general public at some point to understand that this is a commonplace thing, this is part of everyday life.”

He told me it is

> a stigma to take medication . . . A lot of people are afraid that medication is going to make them someone different . . . [but] I think that’s not necessarily true once you find

the right combination of medication. It allows you to be more yourself than you've ever been before.

When it comes to journaling, he does not do it at the time but feels like he had to because his therapist told him to: "I've tried many other times, and it's always just my mind races faster than I can write stuff down and it just irks me." He did admit that it helps, but his idea of journaling is writing a writer's process journal rather than writing about what was happening in his life. He explained that "I think that's more productive. Cuz otherwise you're just trying to write down what happened to you and that's boring because you already know it. It's more fun if it were something that you're making up, I think. Twisting the world the way you want it."

Tess

Tess began writing at the age of twelve, but because she lived in an abusive home, her parents wouldn't buy her paper. She learned to write very small—as small as four millimeters. At 13 she started writing her first novel. She showed it to her teacher who really didn't respond and she finally got rid of it about four or five years later. In retrospect, the novel was a way to explain to herself her family situation, for "the reason why they behaved the way they did. For that matter, the reasons why I behaved the way I did." She wrote not by encouragement but because "it seemed necessary": "I was never told that I would make a good writer or anything like that. I just started doing it." Even at the time of the interview, Tess was writing "because it has to be done." Since her first novel, she has written seven more manuscripts and fifty-one scripts for a television series she is involved with creating.

At the time of the interview, Tess was 45 years old and had broken ties with her abusive family. She lives in Canada with her sister and eighteen cats, so as she told me, the keyboard can

get furry. She is on disability, which allows her the freedom of being a full-time writer and artist and more control over her moods.

She identified four rather than two major moods, including a crash depression, mild depression, hypomania, and hypermania. In a "crash" or deep depression, she told me, "I can't move, I walk into walls, I'm blank. I'm blank except to ask myself what in the hell I think I'm doing." A mild depression she describes as having her head in a vise, but here writing is possible. In fact, she told me she "writes *a lot* when I am depressed." A hypermanic episode would be when "my sister comes home and finds me on the ceiling." The most productive state is hypomania, in which she is descriptive, organized, and prone to humorous observation.

In addition to the medication she takes, writing controls her cycles. Writing helps her avoid "real breakout phases." She said writing works better than medication, although she would not give either up: "that would be disastrous." Although she appreciates the medication, recalling for me the first moment antidepressants worked for her at which time she could see the world in focus and color, she does not take all of what has been prescribed for her. She doesn't want to be over medicated because she feels it would make her sleep all day and it would hamper her creativity. She does not go to a higher level of medication because it makes her so foggy—"I would sleep too much. . . you get this idea that you get so fogged out you get so detached from everything. . . You're not doing it. Maybe it's doing itself. Wow! Look at that: there are words appearing on the screen." In fact, if there were a cure for bipolar disorder, she wouldn't take it because "there is a certain kind of truly magic energy in mania and even to a certain extent in mild depression." Because she resists medication, there are days when her episodes get pretty bad. She said there have been days where her sister would have to come and "pull her off the

ceiling," and there have been times when she has had problems with people, such as two of her bosses whom she had "cold cocked."

She is a rapid cycler, changing multiple times per day, even sometimes in ten-minute increments. What she likes about and feels is useful about writing is not only the expression but "it's discipline," by which she means, the organization of writing. The discipline of writing helps her organize her thoughts and, therefore, life. An example of discipline is the format of the writing; for example, she was given feedback on how to write a script for a TV show. However, the discipline does not refer to a writing routine at a certain time of day to write; rather, it refers to the structure of the genre she uses. For example, she sent a script to one TV series, one whose editor took her under her wing and showed Tess the specific format that such scripts must follow. Although Tess does not have a writing schedule, she writes when she has something to write and that "is most of the time." She does not keep a private journal (gave that up a long time ago), but she blogs about personal things on a friends-only website. And in the meantime, she paints, too.

Through feedback, she has learned to write well. She has created an internet community to work getting together a TV series. This production group gives her feedback on her drafts. She has written scripts and mailed them to producers, who have also given her feedback. Still, she does not depend on validation, but rather knows she has written something good when she wants to read it herself: "I enjoy other people's compliments, but, if it is something that I wouldn't ever look at again, I don't care what anybody else thinks." She has destroyed a couple novels since the first one—"a hundred thousand word swatches." Her perception of her work remains solid, despite mood changes.

Still, the disorder shows up "at every level" of her work: "I can see exactly what kind of phase I was in at the time. I'm looking at one right now. I was in a real manic phase—my sense of humor just got completely out of control." She says she can write while she is mildly depressed but she knows as she writes it that "it's crap." The illness, she told me, makes people better writers because

> I know for myself—I experience two trains of emotion at any one time. One is the phasing and the other is I think what most people would call "what it's supposed to be." You know, you're having a good day so you feel happy. But you're having a depressive phase. . . And I think that makes a bipolar person a better writer because you have a better experience of all kinds of emotions.

Moreover, she told me, because of the bipolar, "I understand how [other people] feel. I'm not sure they understand how I feel." She also said that people with bipolar disorder demonstrate a self-centeredness, self-awareness "that is a little different from most people's common awareness of themselves." At the end, she told me, "It seems that every bipolar person I know writes. At least on some level."

As for writing for advocacy, she wrote letters to "various mental health services" that she is familiar with that people should read Patty Duke's book, *A Brilliant Madness*. She said that "it is [what] many, many people need because it does have that personal side." She said, "the best part about it is that you can look through this book, and you can see yourself." She wrote asking that they *apply* it so that people can get the help they need. She said, "it's important that people need to know for themselves not only what's happening to them, but what the options are." To Tess, such writing allows people to see that they are not alone.

Gregory

Gregory wrote his first poem in preschool, but tended along the way toward the visual arts. He started focusing on writing as a craft as early as high school—"so that's when I began reading a lot and began focusing on writing as a craft as opposed to just something that I just had to do in classes. And then I paid aesthetic attention to language above and beyond just semantics." He does not consider himself a writer as much as artist first, writer second, partially because he "kind of fell into becoming a writer." However, he has always been interested in language: "I've always been keyed into language and interested in speaking different languages and interested in issues of translation where the rigid framework of language falls out and you are kind of like stuck in between two notions of meaning." After high school, he started moving toward poetry. As an adult, he told me, poetry "just kind of landed on me. . . and so it was exciting for me, and I just realized that you can do a lot more with language than grammar and syntax allow. And you can explore yourself and other people's minds and preferences that are like subtle preferences of language." He told me that he had written fiction and nonfiction but that the move into poetry had brought him away from that:

> For me, I was really sort of like flexing aesthetic muscles when I was getting into poetry and once I started exercising that aspect of writing, it became increasingly difficult for me to do sort of analytical and theoretical writing and so my fiction and nonfiction kind of went to the wayside. . . And now I even have trouble reading and paying attention to and holding serious train of thought to fiction or prose that classical/syntactical/grammatical, along those lines. I do well with magazine articles, but getting into longer, longer works of prose is tough. And maybe that has something to do with being bipolar also. I'm sure it does.

In the past decade, he started to shoot and edit video—"most of the stuff I do is kind of a transition from writing into seeking a wider audience through video." He found himself only writing for other poets, and for Gregory, this "professional applause" was not what he wanted. Therefore, he started writing for a wider audience; but, when he speaks of poetry and audience, he says that even though he tries not to write for an audience,

> I mean, to a certain point, [the audience] is myself. But then you know, you give birth and it's out there and it's on its own and it's doing what it needs to do. So that's kind of the crux there is that you want to pay the right amount of attention to something but you want to know when to show up and when to get out of the way.

He has bipolar II and fluctuates "between mania and normalcy without too many dips into the depressive state." His depressive episodes happened earlier on in this life and he feels like he's come out of that. He doesn't tend to slip too much into depression or get blocked by it. He feels like he maintains a drive to be happy, to stay away from the depression and that drive "was realized through creative efforts." As for mania, the episodes fluctuate "between clear perceptions of myself and others" into grandiosity and all the negative consequences of mania. At the time of the interview, Gregory had been diagnosed for nearly ten years. The episode that caused him to be hospitalized and diagnosed did not allow him to continue for his second masters. He told me, "it was such a realm of creative freedom that my mind expanded rapidly there, and I had an episode."

After that first episode, Gregory said that each consecutive one "has been kind of a revelation in self-discover/spiritual discovery" and "it's given me a lot of sort of emotionally-charged, spiritual realizations." He told me that mania "gets me through the tough times. . . I'm way more creative and productive in those times." This mania also fuels his video work for

nonprofit and underfunded organizations. He explained that these projects "offset a little bit of the costs and take those emotional drive that I've gotten and the energy that I've found in those episodes, and it has allowed me to translate that into an active way to be, like environmentally dialed in and working for good causes versus just to put food on the table." As for medication, he told me "I'm on a manageable amount that doesn't cloud my thinking, so. . . I'd say it provides stability for my everyday life, and provides me an outlet to maintain better control over my creativity." In addition, he keeps himself healthy and creative by playing soccer—"for me, playing soccer allowed me to succeed and be highly creative as a person and an athlete without the aesthetic expectations of poems or films or something like that."

His writing is not intentionally therapeutic, but, he said, "I don't deny that you write a poem and it gets picked up and somebody reads it and sometimes they read it at the right time and the poem is talking deeply to them." When I asked if it was therapeutic for him personally to write, he told me:

> There have been some poems and stuff that I've worked on that have been beneficial to my well being and I would say they're therapeutic. I don't know what would be untherapeutic about it, because, unless one looks at art that's—I really don't like the word harmful--things that people put out there that, like, they'll grab the spirit and wrench it around rather than giving it a good push in the right direction. And so, I think that one of the nice things about writing poems is you're not going to come out and be damaged goods by it. It's mostly a positive experience. And if that's going to be construed as therapy, that's great.

Nothing about the practice itself, he said, could be harmful to him.

The Journal Writers

Janet, Jessica, Jane, and Julie are first and foremost journal writers, albeit with differences. Janet keeps a thorough and full journal, handwritten. Jessica and Julie only journal when they need to; and Jane journals online and considers such journaling as a way to connect with other people for support. In addition, Janet shared a dialogic journal with nurses in the hospital.

Janet

Janet kept everything she had written in school from a young age and every journal. She enjoyed writing in English classes in school. One college course in literature stood out to her because her teacher, who would chose one student essay a week to read out loud, read her essay to the class.

Janet told me she has been journaling for a long time, and that she can see evidence of her episodes in how and what she journals. She said she's "on and off" with journaling and that it "kind of comes and goes with the bipolar." When I asked what drives her to write, she responded, "unexpressed feelings. Just kind of getting them out. Getting them out of your system. . . it's like cathartic." Moreover, the illness directly causes her to write: "if I'm kind of hypomanic, then I'll write lots and lots and lots. It wouldn't be unusual for me to write in the journal every day and write like four or five pages. But if I'm either really depressed [or manic] then I won't write any." She said she usually journals right before she goes to sleep at night and then if she cannot sleep, which in some cases has to do with the hypomania.

She pointed out some differences in the journals because of the episodes. She believes that her writing is at its best during hypomania because she can express herself clearly. But, she said, "then the hypomania . . . feels so good you want to continue that and then you can just get

thrown into the manic, or on the opposite hand, actually." She found it amusing that once, in a manic stage, she pasted pictures and flipped the book upside down. In mania, that is, her thought processes rejected order, but she was intent on creating something. Although her writing might have given her signals that something had changed, she was oblivious to those signals: "And when I looked back, I said, maybe I should have figured out that something was happening. Because—at the time it didn't even dawn on me: I just kept writing upside down." She did not realize that she had done this until after she had returned from the hospital where she had checked in for a manic state.

Medication also directly affected her writing because it caused tremors. She said, "I just mainly—the writing—not being able to write legibly, really bothered me, plus."

When she is in a manic state, her writing becomes very disorganized. She will also write about whomever she has fallen in love and has become fixated with at the time. When she writes about the person she is obsessed about, she writes a lot. The writing does not stop the thought, which goes in a circular pattern. In psychotic states, it is impossible to write, and she tends to paint instead because it requires less logic. In a heavily medicated state, "my writing would be all kind of slurred." Lithium bothered her because of the tremors (she mentioned this first) and then because she had an allergic reaction to it.

At several out-patient hospitalizations, the staff used journals to communicate with the patients on another level. The patients would write their concerns and thoughts and the staff would make comments as responses. In the journals, the patients would set goals for the day and write whatever they felt like writing. They would use composition books "and our therapist would read over them and make comments. . . And I thought that was helpful." An example of using this, in Janet's case, was when she was afraid of getting tardive dyskinesia, and the nurses

told her they would look out for signs. The journals allowed the patients to do reality checks, ask questions, and express their feelings.

With journaling on her own, she can look back and see what it was like to be sick earlier and how she got through it: “even if you think you’re feeling a certain way right now, you can look back and say, it could have been worse, you know . . . I’m productive right now, even though I’m depressed.” She said that it brings it back to her, takes her back in time and lets her remember.

She has considered writing a memoir because she thinks she has some significant experiences to put together in a book. She recounted several stories to me of things that have happened over the years and suggested the title be what she had heard in an ad for a sitcom: “dangerously bipolar.” Still, she described her writing as “introspective” and said she has never tried to get published: “I have the feeling it would probably be a good idea first to go to like a struggling writers workshop or something. . . to get an idea of what to do.” To become a “writer,” she said,

> I think I’d probably have to be more disciplined. That’s one thing that—I can’t say that I’m very disciplined about stuff. . . And I think people that are writers, that are established writers, they really have to sit down and say, “Okay . . . I’m going to sit down every day from 10 am to 4 pm at the computer or with my pen and paper and I’m going to write, no matter what.” And I think that’s really—besides having talent, they have to have a lot of discipline.

Jessica

The major point that Jessica wanted to convey is that writing can be helpful, but that the danger in writing is the possibility of rereading what has been written; that is, the act of writing

is not dangerous, but the rereading of that writing can cause a spiral into depression or kick of an obsessive reread. Her advice to other writers with bipolar disorder is to simply not reread.

Although she says she wrote a poem in eighth grade, Jessica mainly started to write in high school because there was "a lot of trauma" in her life. But there was another influence: her creative writing class in tenth grade. The class forced her to write a journal every week, and she believed that her best work came out of that journal. She felt her strong point was that she "brought up a lot of emotion in what I had to say. I was able to put words together that a lot of people may not have been able to." She began writing poetry and recently a piece of fiction about her recent stay in the hospital.

Jessica did not know that she was good at writing until people—her family and her teachers—started telling her she was. She was even published in her school's literary magazine. Her sister, she said, was the writer in the family, which did not leave room for her to be a writer. But her tenth grade teacher said she wrote really well. Strangely, this embarrassed her, and she was ashamed to tell her sister. Reflecting back, she said, her family is full of writers.

She has been diagnosed not only with bipolar but with PTSD, OCD, and generalized anxiety disorder. She said that writing became a release of energy and an outlet when she needed to purposely try to feel better. She sees writing and bipolar disorder connected in that writing allows the person to release some of the pain. She said, "You should, I think, always feel good after you write something"; however, in November of 2004 it made her feel worse:

> It's when my thoughts got way too obsessive and all I could do was write. And I just wrote for hours and hours and hours. And really disturbing thoughts came out . . . [it was] very manic in the way of writing, but it was like very, very depressed. . . I just wanted to

> die. And so I wrote like how I didn't think that I should be feeling the way I did. . . And I was like writing about how I saw myself dead and that was a tough piece of writing.

She learned, with a new therapist, that she did not need to read what she wrote. So she writes, closes the book, and it is done. She might date the piece so she can see what is happening if she wants to see it later. She imagined that posterity would read it and say, "Wow. This shit was fucked up." Her mood at the time of the obsessive writing was mixed, causing her to continually write but have a strong amount of negative energy. Still, it was not the act of writing that made it troublesome, only the act of obsessively reading it. She kept it in her trunk for awhile and "those thoughts were on paper, and I would just read it and read it and read it, and I wouldn't let myself move forward." She focused mainly on reading as the dangerous part of writing—

> reading your own words forces you to accept what's happened. . . writing it makes it real because it's your emotions [that] become tangible. . . then reading it makes it that much more realistic. And hopefully you get a better understanding of yourself as a writer, as a person, and as someone with an illness.

She said that the writing allowed her to talk about what was going on inside that she didn't understand or have a name for.

When I first interviewed Jessica, she was in a severe depression, undergoing shock treatments. She said that, at the time of the first interview, she was severely depressed and unable to journal: "It's just that I don't have the energy to write. And I feel like I could just stare at a piece of paper and have a pen in my hand and nothing will come out." At our second interview, Jessica was more energetic. She told me that it is easier to write when she is feeling okay. She had brought a piece of writing written for me used to commemorate her stay in the

hospital and the friendships she had made there. As a matter of audience, she prefers to and finds it easier to write about the illness for people who have it; others might listen but not understand. She imagines herself one day writing her memoirs, but she thinks of her audience as people with the illness or those having been in psychiatric institutions because she does not see how it would be interesting to other people.

A victim of sexual violence, Jessica uses writing as a form of advocacy, writing speeches for Take Back the Night. She is proud of her speeches. She excitedly told me about her love of speech-writing, especially in that she can motivate people through it. For Take Back the Night, she writes about her life story while encouraging others to come out with their own stories. She revises each time she prepares it. When she first started writing speeches, she prepared an elaborate speech of her sister giving her eulogy in speech class in high school and said she had people in the room in tears.

Julie

Julie started writing in 1990, as an adult. She started writing because of the torrent of emotions the illness brought. Her life "wasn't going very well," and she was "very suicidal" and "wanted to blame everything on God. She had already been four days in an institution for trying to commit suicide. But at that time, she said, she "didn't know about writing yet." At the hospital, they didn't tell her about using writing as a tool; rather, she told me, "I just picked up a book one day, and I said, I want to write." Although she liked English in school and remembers clearly one very warm English teacher and a poem she wrote and, although she tried to take a correspondence course on writing, Julie had very little training in writing nor did she have a habit of writing whether it be poetry or prose. She feels that she would have to go to school to improve her writing further.

Still, she wrote. Initially, she found that writing allowed her to struggle to find reasons for why she was feeling what she was feeling and acting the way she was acting. She was not yet diagnosed with bipolar disorder at that point, which would only take place six years later. Writing, then, served the purpose of helping her explain her feelings:

> It kind of almost rationalized it to make it okay about going out or quitting a job, and it was everybody else's fault; it wasn't my fault. Or, you know, mixed states as far as who was to blame, and like I said, it was a lot of God. It was a lot of God. I still struggle with some of that.

Another reason she initially wrote was to speak to her mother and cry out for help. Her mother found one of her initial journals, in which Julie had "blamed everything on God." She said that there "was a part of me that wanted her to find it, that I put it in a place where she would have easy access" and that "in a sense I know that what was going on in my life just really wasn't right. I was out of control." She was simultaneously writing for God, for herself, and for her mother. And writing made her feel "so much better." She feels the same way today. After writing, she feels "refreshed." She sees "power in writing" in the fact that it does give her a much-needed outlet.

A part of wanting to write is that "I didn't want the world to think I was nuts. I felt like I was nuts, and I didn't want the world to think that. So I didn't. . . divulge to really anybody that I was journal writing." She is especially ashamed of her stay in the hospital—

> I could not believe that's what had happened. . . And being in there with a bunch of other cuckoos, you know? But "god, I must really be nuts, because I'm in with a bunch of other people. . . " Did I write about that experience? Not that I can recall. I think it was such a deep seated experience and I was embarrassed.

On the page, she can express herself without judgment or dealing with possible stigma. She can also express herself without fear of ruining her self concept. Writing has also allowed her a place to cuss and use language she doesn't find appropriate to use. "When I get the mania or depression, my language really changes. And so in a journal I was able to do that instead of verbalizing it to people—because it's wrong." She says there are a lot of four-lettered words and she gets very sarcastic and "vicious." She abhors such language so much that using it embarrasses her and she sees the use of such language as the least favorite characteristic of her writing.

Writing is also useful because it spares other people—"And that's what the journal writing helps me to do. So that I don't act out on other people . . . at this point in my life so I don't act out on my boss." These days she writes for her husband to verbalize what he needs to know, like when she is feeling suicidal—"Sometimes I'll tell him, look, you need to read this because. . . this is where I am right now in my life, and I really don't mean to be." She thinks it would be difficult for her to say to him and hard on him to hear what she is thinking. She also writes for her therapist to say "hey, this is what I was feeling"—"I just want to be able to remember it and describe that feeling at the moment." She mostly writes when in an episode—minor or major—almost as if she is driven to write. When she is manic, she can "probably write forever and still never have a conclusion. . . after awhile it would even become repetitive."

Afterwards—after most of the journal-type writing she does—she throws it away. She explained to me that that is now the past: "if I kept [the journal-like piece she wrote for me], it would eventually be trash because then it's on to the next part of my life. And to read it over and over, I think I would dwell on it." Rather than keep them, she uses them as stepping stones to move on. She told me, "But. . . if I kept that, it would eventually be trash because then it's on to

the next part of my life." She says when she writes to her husband, he reads it and then she takes it back and destroys it. In other words, Julie sees writing as always transitory. She writes on the fly without planning or much editing. She told me "There's no point [in editing]. I mean, I might go back and scribble like, that's not what I meant to write. . . But when I'm done writing, that's it! That's it and then I go on to the next part of my life." She can move on because "now I've gotten a lot of the scary thoughts out, I got a lot of the anxiety out, I got a lot of the. . . angst out of my system." At the same time, she worries about audience: "Sometimes I want to write more stuff, but it could become repetitive, which I really don't always want to do. . . [because] I don't like sounding like a broken record." The exception to throwing journal writing away is when she is writing in a hard-back journal, which she can't throw away until it is done.

She appreciates how she can be descriptive, creative, and detailed. Her favorite piece at the time of the interview was the piece she had written for me about how she felt—

> I felt proud after I wrote it, like wow, I really hope that she tries to get it and understand what a bipolar person goes through. . . When I went back and read it, I said this is something that I think that someone who's not bipolar. . . could really get a better understanding of what goes on in somebody's head.
>
> In describing what exactly she wanted to say to me in her writing sample, she told me
>
> And that these are scary thoughts not only for the person reading them I think but for the person experiencing them. And not having any control. There is no, you know, "well, I wake up today and I'm depressed because it's raining out and I have to face the storm and get wet. You know, and then in two hours when I'm all dried, that feeling goes away."

Jane

Jane is a bright, hard-working, and motivated young woman who at the time of the interview was nineteen years old. She is an avid reader of history, politics, philosophy, science and a little bit of fiction. She enjoys reading anything by people with bipolar disorder, especially Kay Redfield Jamison. She has a library at home of 450 books.

When she was in the third grade or so, Jane would go to school early with her mother who was at the time an elementary school teacher. Waiting for school to start, she would write stories about her stuffed animals. She said the stories were "really, really bad. . . and they got ridiculously long. . . like single-spaced fifteen pages." As she grew up, she said her classmates would make fun of the amount she'd write in response to school assignments: "I was always notorious for writing books, as they [my peers] would say. I got made fun of it." In ninth grade, she started keeping a public blog on LiveJournal. She would write about personal experiences and said she was also into politics at the time. In the tenth grade, she was assigned a paper about her life, where she was then and where she hoped she would someday be. She wrote the paper with gusto: "I was really optimistic about the future. . . I was really career-oriented and that kind of stuff and I just kept writing, like I had all these great ideas." The paper turned out to be 58 pages, and Jane told me her teacher did not like it because it was too long.

In the twelfth grade, Jane's writing directly intersected with her illness. At that time, she continued her public blog, writing what "appealed to a variety of audiences," while being treated for depression and OCD. Zoloft, a popular antidepressant, flung her into a hypomania that slowly escalated into a mania, which she suffered from her freshman year in college. She said that in hypomania, she "was insanely irritable, everything was pissing me off." She said she wrote about everything. A high-achieving, well-rounded student who participated in both track and student

government, she became disproportionably irritable about issues at school and politics. A teacher at her school found it, printed it, gave it to the principal, and like that, Jane was suspended. Her parents became very upset and did not understand the anger in her. She reasoned that her suspension contributed to a subsequent depression because "up until that point of my life I had always been perfect and I had never gotten in trouble, and it just threatened that whole kind of—'ohmygosh! I'm a bad person!'" She fell from an all around excellent student with a 4.0 to suspended and, because of her behavior, was not allowed to be part of the National Honors Society.

At the time of the interview, restricted-public blogging was her main kind of writing; she said that she hadn't felt like writing "other junk lately," but that that had nothing to do with her bipolar disorder. In fact, she uses the blog to write about her eating disorder. She said she's lost friends over the content: "and a lot of people are so annoyed with that because I'll post, like, how many calories I consumed or something and they're like, 'Jane, you're sick.'"

She continues to journal online. But she takes an approach with her journaling that makes it a support device. She said,

> I write about the progress of my illness or whatever, because I have online friends who read it who have bipolar, eating disorders, or whatever—and so they comment, you know. . . And I like them reading that. I like reading their journals. It's kind of like we have this support system.

The act of writing about her illness, too, is helpful. When she was in the hospital, she said that people were encouraged to write—"everyone had their own little journals and writing and stuff." She has learned, "when I get like a desire to. . . hurt myself, it sometimes it is like well maybe if I write about it, then that would help me not do that, or call a friend or something. . . I'm really

trying." On the other hand, she feels writing has sometimes been harmful to her because when she rereads her stuff, she becomes more convinced that her "life sucks." Overall, she said, "[writing] is not always a good thing, but usually it is. . . because it helps get it out."

The bipolar directly also affected her academics. She said that writing under the constraint of school "was awful" because of the deadlines she must stick to. Her first semester in college was especially tough in terms of writing:

> I couldn't complete papers and stuff because I had gotten so depressed, like I would just lay around in bed all day or whatever. . . I'd get to the computer and I'd just sit there and watch a little—you know the little thing on Word—that line just blinks and I'd try to type, and I'd get a sentence in maybe like a half hour or something. Then I didn't like it . . . it was so frustrating and it was like, go back to bed!

She later told me that this was not the same as writer's block: "It's just when I'm depressed. I'm not really getting it—it's just I don't feel like doing it." She told me, "Eventually I couldn't get any type of schoolwork done at all. I eventually had to drop out because I was just so behind." She had a month's worth of work to do by Easter break.

That initial semester at college marked her first episode that threw her out of function. It happened yet again at another school she tried. Since then, she has tried to work with the illness:

> But when I'm manic, I can get so much done. It's like—now I learned, because I went to the community college this past semester—and what I've learned was I can take advantage of this mania and get so much done. So when I get that syllabus when I go to [new college] this fall, as soon as I get that syllabus I'm going to try to get as much done as possible, like, that's—you know—try to get ahead. And that's what works. So. Coping skills.

She said you could see the cycles in her writing through the way it would change. She said not only that it might be irritable but "sometimes it'd be more creative and stuff like that. Or even funny and clever." At the same time, she does not believe that the disorder affects creativity.

Jane seems to be torn between keeping and throwing away her stuff. She was mad when her sister came and deleted all of her journal entries. On the other hand, she said that she might be excited about something that she has written but days later change her mind and rip it up.

Although she also writes poetry and short stories, she does not like to share them, telling me that, "That's my stuff." Still, she writes poetry when she is depressed (never when she is manic). One day she hopes to write a memoir, and she recounted to me some of the stories she would include.

The Pathographers

Annie, Erin, and Melissa wrote narratives of their illness. Annie's narrative was published, and Erin's and Melissa's were not; however, all three wrote about their lives with a public audience in mind.

Annie

When I asked her when she started writing, Annie gave me two beginnings, which are telling in their order: the first beginning was when she started using writing to help her through and help her to diagnose her bipolar and the second beginning was her English classes growing up. She would "express myself, try to make it fictional, but it was really nonfictional." In the first instance, she intentionally used writing to deal with her disorder. She began writing when she began keeping secret journals or write things and burn them so "wouldn't have to tell anybody

how I really felt." She had read about keeping journals in a book about people with mood disorders, so she considers this "treating myself." She told me,

> And I would look at the symptoms. And I would say, maybe I really don't have this, maybe I do have this, and I would make notes of it. And then I would compare what I'd write in my journal and go back and date it, and I would see mood swings of the type of writing. . . So I started comparing and sort of watching that. But I still thought I could manage on my own.

"It was really strange," she said, "it was really strange analyzing it."

Early on, she would channel the mania into getting work done. She said that she would be up all night writing a budget or completing a paper that was due in three weeks in one week. But then she got worse and was unable to channel the mania. Her thoughts began to race and her writing started to get more intense.

Looking at her journals, she noticed that there was writing that was "really calm, [and] another type, it's really emotional and angry." Her handwriting, too, began to change. In mania, "the thoughts were going so fast. . . I couldn't get it out. And I would just be scribbling, and I couldn't read it." It was rushed, scribbled. Depressed handwriting was slow—"really slow, like I really don't give a damn." She stopped herself at this point in the interview and said to me, "If I go too fast then let me know, because sometimes I go too fast and just don't stop." Characteristics of the handwriting change include "the size of it. I would write more in print sometimes, I would write in cursive. And every time my signature was different also. I mean, I can honestly say to this day, it's just been maybe a whole year since I've had a consistent signature."

After years of suffering from the disorder, experiencing a heightened eight months of mania, and nearly being disowned from her family, she decided to check into a mental hospital. When she got out, she began to write a book: "basically, when I came out of the hospital, I kind of went through the journals, and I picked out the parts that I thought were significant, that are the changing points, the significant points that changed my life." It was so difficult to write that she hasn't read it. Once she finished writing it, she didn't even go back to make changes because she couldn't. She told me that,

> when I was going back through to do this, to get the information from it, it was hard. Because it was like a different person. And since I have put this out, I never read it. I would skim through it and look at certain parts, but I can't read it. It feels like it is a different person. But I wanted to help somebody else, but I just can't relate to it any more. I'm like, that was somebody else in a different life.

It was also difficult to write because she had disassociated from that life. She had to be very careful because remembering those times caused her to want to go back to them. When I asked her if it was ever dangerous to write, she said, "I think when I started talking about the rock bottom of where mania took me. You almost miss the mania. I almost missed that lifestyle." The lifestyle she described to me was one of complete abandon, in which she eschewed all responsibility and became a call girl.

Compiling her journals and her memories, Annie wrote the book to help others dealing with similar situations. She said, "I just wanted people to hear the story." She referred to the writing as composition studies would consider audience-centered. Unlike Kay Jamison's book, she told me, hers is easy to read. She speaks on the level of a peer rather than a mental health professional and notes how Jamison is in a unique position as a writer, a psychologist, and one

who deals with the disorder. Annie wrote her easy-to-read, little book because she wanted to help people with the disorder and knows that concentration is often difficult. She said, “I know from my own experience—I would not sit there and read a long book. I just wanted something with a quick answer, somebody I can identify with, and a quick fix.” Also audience-centered was the typeface, courier [courier]: “It’s just straight and narrow to the point. . . because I wanted to keep it personal. I wanted to make anybody feel like a connection, that they weren’t isolated the way that I felt like I was isolated.” She hopes that it brings them out of a feeling of isolation, which enables them “to get treatment and comply with treatment. They are not ashamed. Acceptance, education, and support. They find a support system. But when you’re in isolation, you lose so much. You’re really killing yourself.” She said that she wishes she had something like it when she herself was in the hospital so that she would have an example.

Annie prefers writing because it hides her face and people can listen to her words. She told a story of a woman who overheard her co-workers talking about bipolar and the woman turned to them and said that she had the disorder. Annie said she would never say what that woman said. But when I pointed out that she had essentially done so in writing a book, she raised the issue that as long as the audience does not see her face, she’s okay. What is really interesting about her book and her podcasts is that she feels that she is faceless to the audience: with her writing, “I get to be me. I guess people get to hear me, they get to see words without putting a face to it. Because sometimes when I’m talking and I’m making a speech, you know, you see someone in there and they’re making a speech, you pay attention to how they look and their body actions and stuff. But when it’s on paper, you develop your own image, so they get to feel me out on the inside, what I really am on the inside and not just on the outside. And that’s kind of how bipolar is. It’s on the inside, you want to see that inside. Not just how we look on the outside.”

When she was writing her book, she still had episodes:

> I was almost to the point of covering myself in the basement, but I was more on the couch, staring at the computer, staring at the papers surrounding me, because I never put it away. I always left my notes all around because I knew I had to keep going. . . [with mania], I was like, "I'm going to write a book and then I'm going to have an organization and I'm going to do all these great things!" You know, everybody told, me "no, it's not." But a part of me, I knew what I was capable of, but the way it came out, I made it larger than life. Instead of saying, "oh, I'm writing an informational book," I may have come out, "oh, I'm writing a best-seller."

In terms of taking medication, she said, "Sometimes it was foggy, because you're zombie-like. You couldn't focus—I mean, I hate using the word focus over and over again, but you were—it wasn't clear. Your thoughts honestly were not clear. You felt isolated. Isolation. When I first started taking the meds. During the whole thing, while I was taking the meds and writing the book, I felt like I'm the only one in this world that's feeling this." But at the same time, she said, "I was able to keep my thoughts on one thing."

When I asked her how she got through her episodes and wrote, she said that she would take breaks, shut down for a couple of weeks, and remind herself that it was a necessary project. When I asked if the depression itself affected the writing process, she said, "it took a lot longer, sentence structure, the words—I couldn't get the words out. I tried to make it as basic as possible, but I still couldn't even find the basic words to come out when I was depressed. I felt like this was a waste of time. I felt very flat, if it makes sense. The writing was just so dreary. It felt like you were sitting in the alley. . . just pouring your thoughts out." Other times, she would

get ideas from strong emotions she was having, jot them down on anything (a napkin, maybe) and put them in the book.

Mania, on the other hand, was quite different: “When I was manic, I wanted to put so many different things into the book: I wanted to make it so long, I wanted to talk about every adventure in depth, I wanted to go into descriptions, vivid descriptions, vivid actions. . . I wanted just to go into detail, every detail so much but I wanted to do it very fast. I didn’t want to take over a period of time to do it: I wanted it done that day.”

Annie used her emotions and memories of emotions as writing fuel. Her process was as follows:

> Okay, I would, be flipping through the journals or whatever and I would just build this emotion up, build this emotion up, and then I would just sit in front of the computer and just start typing. And I didn’t have anything labeled, separated, nothing. I just had a hundred and seventy pages of just typed stuff. And then that’s when I went back through it and circled, yes, this goes with this, this goes with this, this. Something of it made no sense. So I would build emotion up from the journal and from the people around me, from the stigma that was around me, from my treatment I was receiving. If I was depressed, then I could reflect back more on my childhood. If I was manic, I would focus more on the mania.

It is interesting here that she would use the mania and depression to get her in touch with past memories.

Jamie

Jamie loved reading as a child: “When I was a little kid, my mom would say, ‘lights out,’ and I would be sitting with a flashlight or sitting at the window, you know, by the moonlight,

reading and reading." She liked to write stories, too, and remembers being in a special accelerated program as a child (six or seven years old) and writing a short story that turned out to be very long. She confessed to writing sentimental poetry around the age of 12. She did a lot of writing in college when she was part of a band. An important moment in writing for the band was when she wrote a song that was very near something she had written as a young child. The original poem that she had written as a child was so much a part of her that she wrote it from memory for me.

As for feedback, she said that her teachers "all loved [her] stuff" and thought she "was a great writer." She even credits her success in graduate school to her writing skills as opposed to her mastery of the material. In school, she would edit or tutor people with their writing. She likes writing because she likes language and because it is therapeutic. She told me,

> If I knew I had a lot of emotions about an event that had happened to me, but I was kind of all in a jumble about them, I'd write it all down when I felt a little calmer, and I would show that to them the next session and say, this is what happened, sort of. Instead of just describing it verbally, the writing I had down would be more powerful than any verbal description I could give about it.

She also uses writing as a tool to gain perspective: "if I'm really upset or really having some acute feeling and later on I look back and say, wow. I was feeling really bad and now I can look at it from a different perspective because I feel much better now and it really gives me insight." She also likes to write about herself and how she processes things. She thinks that even the worst writing is valuable because it is a tool for self-understanding and a record of the illness. She regrets the one time she destroyed her writing, a journal that she was afraid her sister would read: "And I really regret that now, because I could find some excellent material. I can still remember

the stuff, but I would love to have some of my original writings from when I was that sick." She said that the only other time she destroyed her writing, she had already made a back up of it. Even the parts of her memoir that she has taken out, she saved in another file. "I'm just saying, even if it's bad writing, it's still a valid. . . record of emotions, and I think that is valuable."

The strong emotions that she does have play a part in her opinion of herself as a good writer; she feels that the bipolar directly affects her work as a writer. The bipolar contributes in that the hypomanic phases tend to be inspirational. She suspects that her writing process has to do with her being bipolar. Inspiration flows only when she's between normal and manic. It's not that she can't write when it doesn't flow, but that she can't write with gusto. Those days when she is struck by inspiration, she writes a lot and other days she revises. She feels that bipolar influences the way that she sees the world, that her writing is enriched because of the depth of emotion and then being able to come back and write about it—she quoted Wordsworth to me, "poetry is emotion recollected in tranquility." She appreciates her strength in writing to describe the feeling tone of an event, to effectively communicate emotion.

She sees a huge link between volatile moods and creativity. In fact, when I asked her if there were similarities between her and other bipolar writers, she told me that emotion "probably influences things"—"I think there's probably the same quality of sometimes the muse really strikes and you have a lot of energy and want to write and other times, it's kind of difficult."

Although she said that she writes when she's hypomanic as well as depressed (in the latter case, for catharsis), she did tell me that there are parts of the spectrum that make it impossible for her to write. She said, "I would say, if, now it hasn't happened in so long. . . but if I were so depressed I was really like, like almost like catatonic. . . then I won't be able to."

When she recovered from her first time in the hospital at 17, she felt she was having a spiritual experience and her poetry was an outlet to express that sense that she had a positive relationship with God as opposed to her previous feeling that he was punishing her. She also expressed her experience in terms of energy. Since she was as young as eight, her energy was always in a negative direction, she was hurting herself from headbanging to cutting, but after that first recovery in the hospital, she became very creative. She told me "I remember once I was like very keyed up" and was saying that she wanted to hurt herself, and they told her, "no, you're not going to do that. Now, why don't you sit down here and write about it for twenty minutes" (She thinks she heard this from a nurse as opposed to an expressivist therapist too.) She said that she'd feel a bit like she had hurt herself once she had written: "because I feel very peaceful and as though I had something that needed to be expressed and now it's been expressed. . . The way people probably feel after expending a lot of energy in doing sports. . . Well, I've let it out." Later she said, "the energy's going to get out one way or the other—it's good to get it out the right way." She found that this worked and even used it in her art therapy groups, having participants write for catharsis. Some, for instance, might write a letter to someone to express their feelings but not send it.

In addition to writing, Jamie got into painting during her first hospital stay. At that point, she started creating abstract paintings and has done so since. When I asked her if her writing also changed, she said that perhaps it did get more image-based. But what seemed to happen more was that she would write during hypomanic states, writing a 50-stanza poem while in the hospital. She would put the poems and pictures together: "I would do a painting and then I would write a poem about it. Or I would write a poem and then I would illustrate it by a painting. I

haven't done that in awhile, but as a teenager and young adult, I did that all the time." She would also take the combination and give them to people as gifts.

She is working on her memoirs. She started writing stream of consciousness, but it became a coherent narrative. She said she abandoned writing her memoirs when she went back to school for her master's in counseling, but she would like to take them and turn them into a novel. She doesn't want them to be recognizable as her experience. She told me that

> when I first started this last year I was planning first to write a memoir on me—not a tell all—I wasn't trying to expose anybody. It's just sorta like I was telling my story. It's become less important for me to tell my story as me.

She initially feared that it will harm her professionally as a counselor. She said, "Believe me, if I could, I would love to work somewhere I could be open about things, but I'm not sure that's going to happen." She was also worried about her family's past being revealed. She hoped to write a second draft where she could take some of the original draft and use it as a journal entry but create a piece that is in a more distant, third person, as if she were watching the character. In the end, though, she wrote for a psychiatric magazine, coming out as having bipolar.

When I asked her if it was possible to get the distance to write it from a third person point of view, she said she has so many years of therapy under her belt that it is possible. When I asked whether or not writing about such states can throw her back into them, she said that writing about something that is depressing does not make her depressed: "Just because I remember doesn't mean it hurts me now."

Erin

Erin "first started writing poetry when in college in response to what I was reading, pretty much." She said she had written little when she was a child and, in the fifth grade, was

discouraged by a teacher who didn't believe she wrote the poem she had written. Because her teacher didn't agree with it, she didn't even show her parents. The reading that inspired her in college included that of Virginia Woolf, Dante, Andrienne Rich. Woolf in particular affected her writing by "her language—the fluidity of her language and the cyclical nature of her themes." She showed me specific poems that were influenced by Woolf. In general, she loves to write because it can be used "as a form of expression, basically. You can be less literal." She said of writing, "It's like working with a piece of clay. You don't know what you're going to get until it's formed." When she writes, she said, "I feel like I'm trying to tell myself the truth about things. And I guess maybe that's what keeps me writing is that I think that at some point I will tell myself the truth. And I never really seem to get there."

She said that "a lot of writers take some of the most powerful events in their lives and try to—a lot of times it's a painful thing—they try to sort through it, in their writing. You know, it's therapeutic." To compose a poem, she starts with a word or phrase that is sing-songy that sticks with her. And she "tries to build around that." She said she doesn't like to outline—instead, she goes with the feeling. She journals and then melds it together.

Within the span of three interviews, Erin changed her mind slightly, showing that perception does change from interview to interview. In the first, Erin was mildly depressed and working on a series of vignettes which have to do with her illness, "pretty directly: The main character in the vignettes is struggling with bipolar disorder and each vignette has to do with how it affects relationships and important aspects of life." She started the vignettes because of a hospital stay, which was powerful because she had ECT. Furthermore, the stay was notable for her because it was the first time she realized that hospitalization was necessary. She said that in the hospital, she was encouraged to and did a lot of journaling. She was trying to take them and

"intertwine them into some semblance of order." When I asked her what it felt like to write the vignettes, she said she felt "vindicated." She explained,

> I feel like I can resolve things, like all the problems that I had with my partner. I feel like I can write about it kind of comically a little bit. And metaphorically. And it takes the edge off of everything that really happened. And I guess maybe that's what I do with my illness, too. I try to look at it with humor and humility.

By vindicated she did not mean proving herself as a writer. She has submitted several pieces for publication, and although they have not been published, she told me that published or no, she will still see herself as a writer.

In her second interview over marshmallow sandwiches, she told me in response to my questions that it was hard to differentiate herself from her illness. Having the chance to interview her directly after a round of ECT treatments, I asked what it would be like to write at that point, and she said she might have enough concentration to put something down, but that she hadn't really thought about it. And yet, in terms of words,

> They don't come to mind as readily as they normally would. And it's very frustrating. It's difficult to articulate things on a level that I think—like I think my mind is at a certain level and my ability to articulate isn't up there right now. And so, I'm up there frustrated, trying to think of words to—you know?

The third time we met, Erin had just been released from the hospital. She had checked herself in for depression, but while she was there, she tried to kill herself with a pen. Another patient found her and got the nurses.

She told me that with bipolar disorder, moods are cyclical and "you come to some sense of some returning state of being that brings closure to what you write. I think it's natural for you

to have some heightened sense of something and then some resolution in that." The resolution, she said, is like a reconciliation of states, a place of normalcy. She said, "What I'm trying to say is that if you were to. . . write in some circular pattern, there'd be a rise and a fall. And you would come to some standing agreement, or some misunderstanding that. . . " Still, she told me, "I think however with me personally, it's not as distinct. I think I hit the lows more than the highs. So it's not as equal."

I asked her if she can write about a mood but not fall into it. She told me yes because she didn't think she would be able to write without maintaining some logical sense consciously worked on not becoming depressed.

Depending on her mood, she told me, "words come to me in different ways and I'm able to articulate them in a certain sense. . . My gray moods bring a lot of gray language and when I'm manic, things come to me at a quick pace. And have very little punctuation."

When I interviewed her in a depressed state, she told me that she is pretty much always depressed. She described depression as "screaming inside. . . in incredible agony. . . [about] nothing in particular." She thinks that while she is in a depressed state, her language is not only gray but her characters are a little bit too melodramatic and without humor. She doesn't write when she is severely depressed because "I don't think it matters at that point. I don't think I'm ever going to want to re-read anything. . . I don't think anyone's going to want to hear what I have to say. . . I don't think in fact whatever it is that I'm thinking, I know I don't want to hear again." In a lighter depression, she is still unlikely to write: "It's a little painful to have some angst and agony and try to put it into words."

On the other hand, when she is close to mania, "it just comes out." She described her highest manic phase as no sleep, no memory of, not present in myself. She finds it later

interesting to read what she had written in mania: “When I write in that frame of mind, it’s nice to go back and see what other realm I was in. . . ” In mania, the writing is frantic, scribbled, and illegible. Her journals when manic “are like mush. There’s no. . . substance to them when I’m manic. It just—the pen keeps moving and it doesn’t make any sense.” She also said that she is “all over the place and [she] can’t keep up with the pace of thought.” Interestingly, she told me, “I think that having bipolar affects your writing. I don’t think it’s what drives you to write, though.”

She might have written her college senior project in a high hypomanic state. This was her favorite piece of writing, and she had to defend the significance of it in a little essay. She told me, “in that brief little essay that I had to write, everything in the world was connected, and it was beautiful and had the utmost meaning, and everybody appreciated that meaning.” Strangely, when I asked what her professors thought, she told me, “They bought it! I tell you, when I read it now it sounds like such bullshit. But. . . They were on board with me. . . They thought that I had, like, captured it all. I got an A, I got an award.”

In a medicated state, she said, “I think that if I’m manic, [writing] calms me to a state where I’m able to record my thoughts. It puts me in a state that I can actually write. And when I’m depressed, I’m not so sure that it helps me when I’m depressed. I’m not so sure that it lifts me up enough to put me in a state where I’m able to write.”

Interestingly, she rebelled slightly against the idea of discrete states:

> There are places in between those states that I think aren’t necessarily controlled by the medication and aren’t necessarily controlled by the illness. I think there are some places that are natural, that, I mean, you can’t just go, “Oh here she is: her normal self today! She’s not manic! She’s not depressed! She’s actually writing as herself!”

When I asked what it was like to write under the constraints of school, Erin responded that deadlines were helpful: “Didn’t always stick to them, but they help.” Sometimes she could force herself to write if she was depressed and had to write for school. When I asked how she overcomes a mild state and writes, she said, “medication,” and then, when pressed, she said that she can pull herself through mild state if need to write something. She said,

> I couldn’t follow a deadline to save my life. I could not produce on the regular standard schedule . . . My production was flighty . . . it would come to me in spurts, and I had to take what I could get and work with that . . . I think what I learned to do was take advantage of opportunities where I was able to produce and capitalize on what occurred at that time. Like I was able to write in spurts and then utilize my time effectively to revise. . . I was always needing an extension. I always needed extra time. . . And you know I wasn’t diagnosed at the time. It wasn’t clear to—my professors had no concept of it. I didn’t tell them, “Oh I have bipolar disorder and therefore, you know, it’s hard for me to make this deadline.” You know, I didn’t pull that kind of thing. . . but I think they knew that there was something kind of not quite right. So they usually gave me a little leeway.

As an English teacher, she said that if she herself had a student with bipolar disorder, she would “be more sympathetic to them” and “cut them a little more slack, and pay them a little more attention.”

She said that as a member of the bipolar community, “I think at heart I’m trying to prove that we can do something other than cause harm and hatred and pain.” She lamented stigma, saying that “when I hear of somebody doing something psychotic, I always think to myself, please don’t be bipolar." She has a keen sense of the stigma people with bipolar disorder are up

against. Finally, she said, “I think anything good someone with bipolar disorder accomplishes helps fight against the stigma, be it writing, be it. . . I don’t know. Anything.”

Erin was intrigued by the study because it goes toward her own question of “does being bipolar affect how I write?” She isolated some parts of her writing that came from her illness, including being “all over the place,” not being able to “keep up a pace of thought,” and having some really strange thoughts that she doesn’t know what to do with. When I asked what her options were in terms of what to do with her thoughts, she said she could,

> revise a million times and add to it and try to make it cohesive, or I can just let it be. Just let it be as a healing process. . . Something makes me want to make something of it, and I think—this is really grandiose—but I think that I feel like I have something to prove. Like if someone’s going to say that I’m ill, damnit, I’m not gonna take it. You know? I’m going to do something. I think there are people out there that have done that, but I feel I need to do it, too.

She intended to write about herself: “Not that if I wasn’t bipolar I could pull it off and write something worthwhile, you know, but the opposite in fact. . . Because I’m bipolar I have something that needs to be said, and I just haven’t said it yet.”

Melissa

Melissa said she started writing because she was miserable, misery she attributes to a then-undiagnosed mood disorder. She believes she has been depressed on and off since she was twelve years old. Although she was told “for your insurance forms, we’ll put anxiety and depression,” she was never officially diagnosed. A mother of toddler twins, she said she was diagnosed with four different kinds postpartum disorders first before she was diagnosed with bipolar disorder. Actually being diagnosed “put everything in context” for her.

Of writing poetry growing up, she said, “I think it helped me relax. And I think it helped me find out more about myself.” She said that it was easier when she was younger to write in either end of the spectrum, but now it is hard to write at all when she is depressed. She found it interesting that I asked whether or not it did any harm because she had never thought of it that way: “Sometimes. Sometimes I think it made me sad. Or feel lonely, but it was almost cathartic to feel those feelings, I think. . . I never thought about that.” She then quickly interjected that it would alleviate her symptoms by “defining” what she felt. She told me, “I would be so caught up in a cloud of feeling that I wouldn’t know what my thinking was. It would help me articulate my thinking.”

The writing “is all emotion. It’s not like I’m articulating or thinking, like when I was a kid. It’s just the feeling. It’s like delving into a rainbow almost. All color.” She said,

> I think I had less adult responsibility to ground me, and so I had more time to just focus in on just me. So I could like, I could get caught up in the feeling and then find my way out of it into the thinking stage, but as an adult, it’s more just, I’m just like huddled down in the feeling. And it’s almost like I’m trapped in a bubble, and I can’t think my way out of it when I’m not medicated. My process is all feeling. I’m like coming, trying to get myself out of the color, you know? I’m just trying to like, find my way out, you know? Or telling my story.

Feeling stuck in the color, she saw writing as “driven by instinct. . . like purging energy, which is almost like an instinct.” As for how the illness enriches her emotion,

> I feel like it’s almost a gift. . . to be able to feel something that deeply . . . I feel everything, all the time. And I feel like, I love that . . . Sometimes, though, it’s

overwhelming because I am just such a conduit that I almost don't know how to censor—or like, block it.

These days, in a manic state, she said that her thinking is fast and her talking is fast: "I can't keep up with my own thoughts." This makes writing frustrating for her "because I can't type as fast as I can think. And it's choppy."

Although she sees herself as a writer, she won't say that she is. "I think I'm a great writer," she said, but she is down on herself for not having finished college, not having published anything yet, being mentally ill, and having insecurities about the manuscript she has in fact written. Even if her book would be published, she feels she would still not consider herself a writer. As for not having finished college, she thinks she is nothing and therefore not possibly a writer. Being mentally ill makes her feel "less than" with everything. At the same time, she said she has taught herself a lot and it was obvious in that simple conversation that she is very well read. Although she may not consider herself a "writer," she said that even her moods do not change her opinion of her writing: "I always feel good about my writing."

The piece she brought to show me was the manuscript she wrote after her children were born, while she was very sick, "at the height of my craziness." She "just wrote everything I remembered, every crazy moment I remembered. And then I would go back and connect the crazy moments together with transitions." While she was writing, she was doing little else besides taking care of her babies:

> When I put the babies down for naps. I'd stay up 'till 3 o'clock in the morning when I was manic. Sometimes I'd stay up all night, sleep all day. Put the babies in the bed with me and nurse them and sweet sleep. Get up, type some more, when the babies woke up,

feed them, nurse them, put them down for a nap, go do some more. Just this whole like mama bear and then go type, you know?

At the time, she doesn't remember eating—"I don't know how food got into the house"—or doing any sort of self-care, such as taking showers, sleeping (most of the time), or brushing her teeth. She also didn't remember actually leaving the house. She was depressed for most of this, could barely do anything, and yet she was able to write. Usually she can't write when she is depressed.

When it comes to journaling, she said she feels like she should but she doesn't. She feels that way because every therapist she's ever had has told her to and because she thinks "I'm more functional when I do. . . cuz I think it helps me clear my head." The therapists never gave her guidelines.

When I asked about what she does to improve her writing skills, she and her partner read Strunk and White's *The Elements of Style* a lot when they are editing each other's stuff. In fact, the book is in the bathroom.

Her partner also writes, and she edits her partner's stuff. They have done a number of collaborative workshop presentations and have begun but not finished other manuscript ideas, but have slowed down since they've had kids.

The Paid Professionals

Mary, Carol, Susan, Lisa, and Kevin all wrote for a living in some capacity. Mary and Susan also did some editing. Lisa and Kevin were fiction writers.

Mary

Mary started writing as a kid, probably about five years old. She studied writing in college and ultimately took on work in writing. At the time of the interview she had been writing professionally around 25 years for various profit and nonprofit organizations. She sees herself as a writer "who happens to have bipolar disorder." Writing is her trade. It is also a tool used to create a gift, to make money, to get something that she wants. As a child, she would write plays for her classmates and herself. She saw the plays that she wrote as a child as a form of manipulation to get out of class. She writes when there is an assignment or a birthday coming up—with the birthday there is the necessity of having a gift to give. As an adult, while in a manic state, she feels she used writing to manipulate her lover into staying with her. Her direct way of manipulation was writing love poems. When she is sick, writing is "also a distraction for me and distractions are very helpful with the depression. . . When I'm manic, or at least, zealous, I get even more of a kick out of the accomplishment of writing, and having the framework enables me to accomplish it that much more quickly." Writing is also a way to find comfort. She finds "comfort in organization and order."

Writing is less of "pouring out" of emotion as a solving of a formula, coming up with the precise words and putting them in the precise places they should be. She looks at writing in a "formulaic" way, which gives her "pretty immediate satisfaction." By formulaic she meant

> the organization of it. The rules. I really like grammar and language and not formulaic in a rote way, but here's a puzzle, here are the steps you take to write a marketing brochure or to write a certain form of poetry. And it makes me feel pretty immediately accomplished when I finish an assignment or finish something that I want to give as a gift.

The mania affected her earlier on in life: “I think it was a strong influence. I do think I’m creative and have some good ideas. I think that the mania served me well in some cases. In being able to come up with things almost out of thin air.” In her writing sample, she wrote, “I’ve written books and plays and musicals since early childhood when overly zealous, and continue to write funny poems for people’s birthdays.” As a professional writer, she comes against deadlines, and says she writes “well under pressure, except when. . . manic or pretty neutral.” She sees some impacts of the disorder on her writing. When manicky, she doesn’t pay as much attention to the organization and order—“I’m thinking faster, everything seems to be moving faster, and so I’m paying less attention to the formula then.” She described her writing in a manic state as faster: “The ability to think is faster when I’m manic. The interest in coming up with the perfect word is stronger. The ability to write under a pressured deadline is greater. Just a bit more than when I’m ‘normal.’” When she is manic, she is also more creative. Moreover, “I think the manic-driven and the normal period in writing is more organized and is more creative, and that I’m more clever in terms of style. A more precise and effective vocabulary.” When she drafts during mania, she sometimes writes it in her head first and then puts it to paper. She said she might put down a bullet-point list, which is much more drafting than other participants. In this way,

> a first draft is nearly a final draft. I might go back and tweak a few things, thought I don’t—I try to schedule things and then part of my process is to put things off. A lot of the freelance work is very fast turn-around; so it’s not a matter of being able to schedule it; it’s a matter of doing it immediately.

In addition, love sonnets come out within a half hour to an hour. Assignments themselves can make her manic because they put pressure on her. On the other hand, she told me,

> part of my disappointment in the book was that I don't think it's good and I think that was really impacted by being so depressed that it was laborious to write and I wasn't thinking very straight. And it did occur to me in the middle that well, I could drink and get manic and do a much better job. But, you know, then realizing that if I did that, I would just pass out. And I wouldn't get anything done.

Mania, however, does her a disservice because "my behavior over the past has been deplorable." It has caused her to risk her job and her marriage.

In addition to manicky periods, depression, she said, "has fueled poetry writing." Still, the product of writing in a depressed state "gives the feeling of lethargy. . . the rhythm is slower, it's spacier. It's not as organized. The thoughts aren't as clear." Moreover, "And then things are very slow and confused when I'm writing when I'm depressed. Confusion and inability to focus and concentrate are definite impacts on writing of the depression."

The most recent example of depression affecting her writing had to do with a book proposal which had been accepted:

> So I was very excited about that for awhile and then when I got into the thick of it, I realized that it was a lot harder than I thought it would be. I think, in terms of a project, it's been. . . definitely been the hardest thing I've ever done. . . in my life because it brought up a lot of emotion about feeling inadequate and feeling like a fraud.

By "fraud" she explained, "That people think I'm good at things, but I'm really not. That I'm faking my way through life. . . And, as I wrote to you, I still don't feel very good about the book, and at every turn, I've waited for someone to say, 'this is horrible.'"

When I asked her what similarities or differences she might have with other writers who have bipolar disorder, she focused on her reaction to her depression: "I don't feel depressed and

then the need to emote and have a release" and, therefore, don't "have the great American novel in me." There was the sense that the disorder for others creates this dark genius with writing, partly because of the benefits of the writing. She said, "I think Dostoyevsky was horribly depressed and look at what he created, so that's not me. At times, writing, except at an earlier, an easier stage in my life. . . I'm older now, I'm 48, I'm tired. I'm tired of being depressed." She told me that she is too depressed and tired of having the disorder to write about it.

She always got good feedback, even at a young age, but the feedback high only lasts so long. A poet, she took an independent study in college with a professor who used to write "perfect" on some of her poems. Her term papers were also graded highly. When telling me about the praise she's gotten, Mary several times started hedging: "you know, who knows what [seeing the word "perfect" on poems] really means, whether that's a true validation or legitimate or whatever. I tend to dismiss praise, I think." Validation is getting oral or written feedback, "but that feeling dissipates pretty quickly. I think I'm a good writer, and I think I'm good at a number of things, but very quickly I don't believe in myself again." Her confidence as a writer often wavers.

She hasn't written about bipolar, and she doesn't journal. She sees journaling as unproductive: "I've been told by doctors and my husband has suggested that, you know, journaling is so good because you can look back and see how you felt. Not necessarily something I want to remember."

Carol

It wasn't until she was an English professor that Carol had realized that she has always written, but she didn't start personal writing until she had been diagnosed in 1997. She came from a family of story tellers. Her father wrote for a newspaper and her mother and aunts wrote

letters to each other of professional quality. Her mother loved to read. As a child, she wrote her own made-up versions of Westerns because that was a form she liked a lot. At age 11, she wrote a poem that her teacher didn't believe she wrote because it was so good. She always got positive feedback from her teachers. She was part of her high school creative writing magazine. At one point in high school, her father published her in the college creative magazine he was working with because he didn't have enough entries. Carol found reading a solace and writing as a way of escaping her "slightly dysfunctional family."

Being an academic, for whom writing is part of the job, she does not usually consider herself a writer. She writes often, such as conferences presentations, articles, and references. In fact, before she had a hypomanic writing episode during which she wrote, she said she would have also said that writing is not affected by the disorder, since she had done the usual professional writing. But then with the presentation of this episode, she said, "it's conceivable that [the medication] might have prevented this more imaginative kind of writing." The exception was during a hypomanic writing state: "I think probably the first time I thought of myself as a writer in that way was when I wrote these pieces and that was everybody's reaction." In other words, the feedback she got helped her see herself a writer.

When she did write when she was hypomanic, it was swift and easy. The writing since then hasn't stopped, but the inspiration has. When I asked her about inspiration, she told me of some especially good writing she did in a hypomanic state—"the only thing that came absolutely wonderfully at the start were these childhood memoirs that I wrote just a few years ago now." Her lithium intake had been lowered. She told me that "those pieces came into my mind almost whole, without me having to do anything else except write them down." She said,

> Well, I would write for the length of one of the memories, whenever they came along. Seems to me that this all happened within the space of a couple of weeks at most. And it would be—I think it would probably be not more than an hour, and hour and a half amount of time because they were short. Each one of them was about two and a half pages or so. They're circulated around one memory or focal point. So, probably—but I actually don't know for sure, but I think that's about right. About an hour and a half.

This process contrasted sharply with her normal writing process where she will "pace up and down, sit around, type up four different things, erase three, etc."

The doctor upped her lithium level and the inspiration stopped. She described it as "the really nice easy flow of the images just coming together with good words to tell them. . . stopped." She was then afraid to touch them again because the same flow would not be there—"I still really like the pieces, but I guess I had this uncomfortable, slightly uncomfortable feeling that if I sit down to try to write another piece that goes with them, that either none will come or that it will be much harder to do it."

She also identified a down side to hypomania: "The first thing that happens with hypomania is that you can really concentrate. And then it tends to start spiraling out of control on the other end. Yeah, so you get real focused first, and then you start getting a real scattered effect."

When she is depressed, she told me

> It felt a lot harder and I think it was probably a lot harder to get things done. It seemed to affect concentration . . . So, in other words, a task that might only take me twenty minutes when I was feeling normal might take me an hour or something. It was hard to keep things together.

She told me of an instance when she wrote when she had a terrible depression spiral down quickly into psychotic symptoms. She had sat down and "written a whole bunch of stuff really fast," probably, she said, her whirling thoughts. And her husband threw it away so she would not see it later. She said she didn't know what it said—"But I guess you wouldn't want to—you can't exactly say that you'd want to have the authentic manic depression in its full blown whatever, just like that. Nobody would be able to read it anyway."

As for writing being dangerous, she said, "But I don't think writing has ever been dangerous to me as something that would set something off. It's like when I did start doing these much faster-flowing pieces of writing, they came as an outgrowth of what was already happening. They didn't trigger it." Says that writing about manic depression is therapeutic not only in a cathartic way but because it causes people to open up and share similar experiences.

I mentioned how some participants found it useful to write to get beyond the illness and Carol told me that she is more stable on lithium and prozac, but that "it's all still me. And the crazy parts are still me, too. So I guess I don't know if you can ever really get beyond it."

Susan

Susan started writing young and has always been entranced by words. She was the only one in a family of five kids who did not go to kindergarten, and she remembers clearly being afraid that she would not learn how to read. She has been a professional writer for 20 years and a fiction writer since ninth grade.

In high school she had a friend who later became a published writer who was supportive both with writing and depression. The friend suffered from depression and had good doctors, "so it was kind of like the rest of us, by relationship and osmosis, got what she was getting." She also encouraged her to write more—

> I did a tremendous amount of journaling back then, and very, dark, very expressive. You know if you're a word freak, you'll just delve into the language of wherever you are, and like go on at length sometimes to get just the right words that you mean, or maybe even need to find them.

In high school she went to England to study music, and when she was there, she suffered from extreme, suicidal depression. At the time she did some writing that explored her feelings about her relationship with her father and step mother. She showed one of her English professors, and "he didn't discuss it with me. He just said, 'some very interesting stuff.' And I felt like a pariah." At that time, she wrote mainly poetry as well as some journaling:

> [It was] strictly autobiographical, not even an attempt to fictionalize it. And that was a real solace. I guess in a way I felt like, if something happened to me, it would be a record of who I was and how I felt.

Her mother had breast cancer when she was nine. She has written a lot about that time, but when I asked if it was helpful, she said "yes and no." Then, "actually, yes it did, but it wasn't adequate, because I just plunged into extreme depression around that age" and she used music to distract her (rather than writing). In speaking about one particular piece about her mother that she couldn't find to show me, she rewrote the past to make it more palpable, changing a fight she had with her mother into an opportunity for them to spend quality time with each other. But rather than the writing altering the feeling, she could not write it until the feeling had altered, until she had seen her mother from a grown perspective. With the piece that she showed me, which was about her relationship with her father, she told me that it was a good outlet but did not allow her to put the problems to bed. Writing has not made an episode worse, either, even in rereading. "It's brought me compassion for myself and sadness and validation."

She has never destroyed anything she's written "no matter how vacuous or pithy or self-indulgent." Rather, she keeps it all in her journals upstairs, both longhand and typed. She seemed to feel the need to write longhand because "it's a much more emotional thing. To me. Just the act of writing." It also expresses one's personality. It is especially expressive of mood states: in mania, she told me, "it would be more expansive" in terms of her "ascenders and descenders. And certainly the language is over the top." With depression, she described her handwriting as "certainly laterally compressed, if not vertically. I'd probably always choose a black pen, although I often wrote with a fountain pen when I was depressed. You know it was melodramatic."

But the writing that she got most excited about where the skits or "little comic entertainments" she has created for twelve-step conventions. She puts them together specifically for the small variety shows they have. She said that "It is very easy for me to do that. And a lot of it—it's along recovery things." She writes about depression, suicidal feelings, suicide and dealing with these things through entertainment. This she says is cathartic not only for her but for the audience. Still, "I don't really think of that as writing!" Why? "Cuz I just popped it out!" And because she does not find them to be meaningful in contrast to, for the example she gave, Arthur Miller. Her definition of a writer is someone who has "some experience that you feel is worth trying to commit to paper."

> She only sometimes considers writing work. With her professional writing, it's largely effortless because. . . the stakes are different. If I don't express something most efficiently with the exact vocabulary that I want, I'm not going to be crushed. And I'll write it and a lot of times I'll go back and the way I want to revise it will come to me. But I never revise my [personal, journal] writing. I might rewrite something as an

addendum. I might say, well, this is how I really think it is or whatever. But to me, it's like the thoughts and words I put down are sacred.

The words are so sacred in fact, that she dates not only the days but puts "afternoon" or "later that afternoon" next to entries. She revises, on the other hand, fiction and poetry. She also revises her stories, especially of her mother—not the "essence" but the "expression." But, she told me, "most of my experience of pieces are just—I would say all of those are done in one fell swoop."

She does not believe that depression gives any more depth of experience for writers than does any other intense experience. She said that the medication doesn't affect the writing, but the impulse to write. "I'm unquestionably a happier, more stable, more capable and competent person on medication." Of Kay Redfield Jamison's connection between bipolar disorder and creativity, she told me, it "too closely linked to the thought that if I take medication, I won't be who I am, I'll lose my creativity. . . [it is] irresponsible in the message it can give to people who are struggling and suffering without medication and know that it's an option but reject it because they don't want to be artificial."

Writing, she told me, enriches experience, giving it another dimension not only for the audience (as compared to movies) but for the writer (as compared to memories).

In terms of the stigma surrounding the illness, she discussed how 32 thousand people per year kill themselves in the US but that that fact is usually hidden. She related to me a discussion about suicide she had had with a very compassionate friend. She told her friend, "I want my obituary to read that, if I kill myself, I want it to read that I committed suicide. And she just thought it was an outrage. And I said, no. I want people to know that unfortunately I succumbed to something that I fought successfully for many years."

Kevin

Kevin is a professional fiction writer. His story of his illness directly intersects with the beginning of becoming a writer. When he was about twelve, he started having his first episode of depression around the same time he met a friend who wrote for fun: "And what saved me was I went to school one day and I ran into this kid out of nowhere. . . and he said to me, 'are you a writer?' And he said, 'I write these stories, like *Lord of the Rings*,' and I thought this friend 'was insane. Who writes for fun?'" At that point, Kevin started writing, but it did not touch the depression.

As a child he tried to come up with reasons he felt so bad and reasons why it would clear up. He told me that today the point he tries to get across in his writing is that, "We formulate all these, all these reasons for things and yet, usually the actual reason is right there in front of you. And I've always wanted to be able to say that to people."

He does not write about his own personal experience with the illness directly. In college, he wrote about himself and his depression and it turned out poorly. They were

> unbelievably depressing, kind of self-absorbed pieces, and I didn't necessarily notice it at the time. But they did not help me at all. It was not as if I was cleansing my soul by writing these pieces. In fact, I was kind of sullying it. I was recalling all of these times and moments and moods and you tend to recount your entire life as this kind of horrible, crusty, blackened space and that nothing has ever been good and if you ever felt like it was good, you were lying to yourself. And all of that. So. That the kind of stuff I was writing back then. I don't think it helped.

When asked to give an example of writing that makes him feel better, he concentrated not on catharsis or personal change, but on how a job that made him write about other people helped him. In this sense, it was helpful as with other people as a distraction and a wake up call:

> I was still having major problems with depression and then it was this new kind of thing in the mix which was this kinda high energy, high though—it wasn't horrible at all. But it wasn't pleasant either. . . In the midst of all that, I started working at this place. . . it was my job to go out and interview the famous and unknown people of [city]. It was incredible . . . And I would record their stories. . . And while I was doing that, I just gained so much respect for people who put up with so much. . . never expected to be noticed for it all. . . And I thought, "I need to learn to deal with things this way, somehow." And I wanted to move beyond it at that point, and kind of look to others through my writing and ideas and stories, and, so, I very purposely did that. And I think that has been a wonderful thing to have done. . . And I think it also gives you a purpose in that you want to celebrate individuals who aren't you.

Although he doesn't write about himself, he uses the highs and lows of bipolar to imagine his characters and empathize. He sees the ability to empathize as a benefit.

When I asked about detriments of being a writer with bipolar disorder, he said there is "no beauty in depression," and moreover that "When I'm depressed, my writing goes down the drain. I can barely formulate sentences much less come up with poetic word usages or anything like that." He described writing in such a state as "Pushing ahead and knowing everything is crap that I'm putting together, yet it usually is." He said, "It is so, so difficult in those times." Worse, "I have wasted. . . two years" out of his writing life of 15 or 16 years "just depressed and unable to get things done."

In mania, he perceived himself to be "a genius with words," who "for all intents and purposes. . . practically was." His favorite work is a book that he wrote in about a month rather than the typical year to three years. He said he was clearly manic while writing it. Reflecting on the mania, he told me that "it is sad when that genius goes away. . . But what accompanied that was also the frustration, impatience, fury at things around me." His manic states are not always cheery but rather tend to make him be "work-efficient," "intelligent," "acidic," "acerbic," and "incredibly uncomfortable." They could be described as mixed: "I would be so energized and so ready to explode some days and other days I'd just be absolutely pulverized, unable to rise, unable to do any more. And I did no work. I did no work." In this state, he has written angry editorials that are published in a local newspaper, and they sound different from his usual writing. Although he will often write editorials while not in that state, they tend to be angry, furious when he is.

With medication, he said, he still feels "a tug," but "I think if I was not on medication, I would not be here, probably." As for writing on the medication, he said that lithium makes him a little duller "as the day goes on," so he likes to write in the morning. He said he will write in the afternoon if needed but that it "usually just not as good." When I asked if he liked lithium, he told me that "I think your short term memory is not as sharp—it's spongy. I do sometimes [find that even coming up with words is difficult]. But at the same time, I've been so tortured by that. . . it's a huge relief. It's a huge relief."

As for the other bipolar states:

> I got used to writing—I got used to there being a very simple kind of regularity to my life. Meaning, I would get depressed. I would pass through a period of relative normalness and then depression. And I would always at the top of that curve would

always try and grab onto that and stay there. And I would always tell my wife, “I’m not budging off this.” It is a state of mind. . . ”I could stay here.” And I never could. It always cycled back around.

I think [cycling is] a great plus for my writing—especially now that it’s somewhat harnessed. Is that you write a book, and you write passages over a period of a year to a year and a half, two years--this very long period of time--and in that period of time you wake up and every few days you feel different: you approach the world in a slightly different way. And certain things bother you more that day than other things and certain things seem new for the first time. And, whether it be a pan down in the kitchen or something else. And I think that constant change, that never ending kind of cycle of newness, oldness, and all that is wonderful for a book, because it begins to create layers that nobody would expect or nobody imagines that they’ll get and yet they’re there because you come one day and you’re feeling good, you come the next day and you’re not feeling as good but the passage requires it, somebody feel good in it, but maybe you can write something in that undercuts it just a little and creates a little more depth and emotion and all to it. And then the next day you come back and you know, you just bought a leather chair and—I don’t know. But it’s true: these things are all over time.

As for early feedback, when in college he told his mom that he wanted to be a writer, she responded, “Maybe you should do something else.”

He does destroy pieces or at least try to. One complete manuscript that later got published he tried to burn but his wife stopped him. He was manic and was feeling that “bigger and better things awaited.”

The stories that he has lately told have to do with mental illness in some way or another. “What I want to do is make people familiar with these issues, but not just make them familiar: get in their heads a little bit.”

He uses writing to escape: “when I’m really depressed, I can at least escape for a time in some other place. I don’t have to be myself 24 hours a day or anything like that. And that has been wonderful.”

Lisa

Lisa knew she would be a writer all her life. When she was in second grade, she had a teacher especially encouraging who passed her love of writing onto her students. She entered contests, the first being in second grade. Lisa doesn’t write poetry for publication now, but writes it for herself. She writes poetry for herself but only writes fiction for public. She never got negative feedback. Now she is a published fiction writer.

Bipolar disorder did not make school difficult; however, she credits her teenaged hypomanic periods for honing her writing skills in that she would stay up late “writing and writing and writing” in her journals. Now that she is a professional writer, she no longer journals. Because she was an English major, she took poetry and fiction writing workshops, but she feels they have no affect on her writing today. She taught herself about writing by reading books about writing and taking a extension course at a university for a certificate in literary fiction.

She first considered herself a writer when she was working seriously every day—sometime in her early 30s. She had started writing seriously in her late twenties. She does not wait for inspiration; she believes in writing a little bit everyday. She knows something is good when she finds an “aha” feeling.

She went public about her illness, deciding to stop being secretive about her illness because she wrote about how one of her characters had the disorder. She wanted to help overcome the stigma in the world. One of her points is that there is a form of bipolar that is not the severe form of bipolar I. She feels like she has helped her audience by coming out as having bipolar. She felt like talking about it in the form of fiction was an easier way to bring it to people, like "slipping a pill in with sugar."

I asked her what drawbacks she would see to coming public with the disorder. She said she worries about getting a regular job in terms of employer prejudice and the hiring process. She had been worried that people would treat her differently. She said that some people say "weird things to [her] face but not with intentional maliciousness," and, if they do have prejudices, they don't tell her.

The effect of depression on her writing process depends on whether it is mild or severe. When it is mild, she can write and the schedule is actually good because it is a structure in life. When the episode is severe, everything is hard. I asked if she writes during depressive episodes. In a depressive state, she "doesn't feel alive," and writing is like "pulling teeth." Her whole system slows down. She reads the same paragraph over and over and over. She says she is OCD, so that has a lot to do with it. As for writer's block, she doesn't allow it in her thought process. She never thinks she gets it. But she says depression is separate from what writer's block would be.

When she is hypomanic, she can write and write well. She sees her hypomania as a generation time whereas revision requires a normal mood. For revision, she needs to be in a logical, grounded state of being. She feels great at first because she feels like ideas are flowing, everything is easy, but then "the price is too big." I asked her if, when she writes during a

hypomanic state, she needs less revision. And she said, that it is true that she needs less revision. She said she cannot sleep, has rushing ideas, makes random connections, has heightened creativity, feels that everything seems important and critical, and feels like her entire nervous system is on precipice. She said she gets on sensory overload. She goes to bed, pulls covers over her head to shut things out.

When I asked how the switch in mood states affects her writing, she explained that her disorder involves rapid cycling, but that she cycles a few times a year rather than a few times a day. She said yes, her perception of her writing changes according to the episode. If it is a depressive episode, she feels the writing she has done is trash and she often dumps it in the journal she keeps for each book. She does not destroy her work. When she is hypomanic, her work appears wonderful.

She feels she can get in touch with her emotions easily, which is both a drawback and a benefit of having this disorder. It is a drawback because she can incite an episode. If she writes too much and doesn't stop to take breaks, she can trigger a hypomanic state. This she says is also from the OCD—but not stopping to come up for air leads to bad things, such as scattered thoughts, sensory overload, and insomnia. It is in fact difficult not to fall into depression when writing about a character who has depression. When she writes, she internalizes the emotions of her characters. When she wrote about her character that was depressed she "dug down into that place to write the depressed scenes" and sometimes the depressive feeling stays with her, especially because she writes everyday.

I asked if the book that is her favorite, the one that was written in less than two months, might have been written because of the illness. She said probably, since she wrote it in the spring and spring is traditionally symptomatic for people with bipolar disorder. In the fall she tends to

be more depressed, less creative than the spring. The other reason she wrote it so quickly was that it was already in her head. She worked for long, intensive periods.

The Advocates

Bill, David, and Lawrence all used writing to advocate for social change. Most of the time, their outlet involved editorials and letters to the editor, with Lawrence's focus on writing to international organizations about world issues. But even Lawrence's unpublished manuscript had to do with social change.

Bill

Bill writes mainly poetry, and when he gets the urge, letters to the editor. Other than for school assignments, he only has been writing really the last ten years, long after he was diagnosed with bipolar disorder. A lot of his poetry had been written during outpatient hospitalization—a type of hospitalization where people go during the day and come home in the evenings. Generally within occupational therapy groups, other people would be making "knick-knacks," and he would read the paper or write. Part of it was out of boredom: "There are only so many birdhouses you can make." When he was writing in the hospital, he said that some of the time he was hypomanic, but most of the time he was closer to baseline. Therefore, poetry comes to him even while he is not hypomanic.

Some of the connections he makes in his poetry, however, might originate in hypomania. What struck me in discussing his poetry was his ability to tie together seemingly disparate ideas or dates, such as that of Columbine, that of Pope Benedict's election, and that of the eve of Hitler's birthday. He said that when he is hypomanic, he makes random connections: "I mean they still make sense when I'm not so much up there, but. . . when I consider them later on, it's

like, ‘Wow! I really grabbed that out of nowhere.’ If I express it to somebody at the time it hits me.” His sister, for instance will say, “You’re there again!”

Hypomania fuels his letters to the editor. When I asked him what his mood is like when he writes these letters to the editor, he said it is “super aware of stuff going on around [him]” and that he gets “kinda charged. Kind of on the way up, if not there.” He gets so charged that he doesn’t edit his letters to the editor so that he gets “it out there immediately or someone’s gonna either beat me to the punch or they’re gonna be ready to print responses to the story.” He said he feels better when he walks away and comes back to it, but that he usually doesn’t do so.

For him, bipolar itself is useful because it “helps [his] imagination—at least the expression of it” and he probably feels “a greater motivation than somebody who doesn’t deal with the same levels of ups and downs. He suggested that there might be similarities in writers who have bipolar disorder in terms of being “vociferous” and on “the flowery side.”

A bipolar state is not necessary for him to write. In fact, hypomania can make writing difficult; it can even be a hindrance: “Generally—if I’m in the mood to write, I’m not all the way over the edge. Usually when I’m kinda over the edge, I’m just scribbling down ideas for stuff I’d like to do, or making lists. I mean, it’s certainly fairly clear ideas. It’s just something I never come to a conclusion of.”

Even though he gets charged up—excited and driven—he keeps the tone pretty even. He told me, “I don’t get angry, and I try to keep it from being flowery. If I feel it’s something that I’m really arguing, I try to keep it pretty even keeled.” He writes about anything that attracts his attention. Lately, in one piece, he came out as having bipolar disorder. He said,

> it was more of a complaint about the use of. . . the word bipolar. [It] was used to describe. . . some kind of policy that was kind of polarized, but it could easily be and rightly be

> seen as polarized, but to say "bipolar" is kind of stigmatizing. . . most people don't understand bipolar and the little that they know of it, they think it's, you know, it's. . . all about violent tendencies.

Bill does not journal. He said he's "not driven to journal because. . . it'd be so much stuff that I wouldn't want anybody else to see. . . I just wouldn't want anybody else to get their hands on it. And. . . it's. . . you know, it's the risk you run." The kind of writing he does is not dangerous because the worst that could happen is that the writing would not being considered.

David

David mainly writes for advocacy, arguing for rights for and understanding of people with mental illness. Much of what he has written has been in the capacity of the head of a local affiliate of a national organization on mental health.

He started writing in reaction to stigma, stigma placed upon him by the same people who once took care of him—he had gone to work at the psychiatric hospital where he was a patient and found there to be implicit and explicit prejudice. He said, "Somebody wrote an article in the newspaper that insulted me, so I come back with a letter to the editor at some point in time about prejudice and respect and things like that." From then on, he kept writing and was encouraged by his therapists and friends to go further. Although he said he changed some people's opinions, he said that there is still a large amount of work to be done:

> That's why I write. I want people to know about the stigma we put up with. The emotional pain we put up with. And just about any other issue that comes along that we put up with. I want people to realize how unfair it is, how painful the illness is—it's not something that we can just get out of—and it can be a blessing and it can be a curse.

Otherwise, he writes for pleasure—"It gives me a lot of pleasure to write, especially a poem that's moving or touching. And having it published so people can see it and comment on it." David has written songs and poems, many of which deal with mental illness. Many, of course, deal with other topics. He has written funny rap songs and light-hearted pieces that contrast from his role as advocate.

He has written for therapists and added that "most of my writings are therapeutic to me. If not all." Like the others, his interpretation of my question of whether writing is dangerous was different from what I thought it might lead to. He said it has been risky to write because "I've written on some very controversial subjects that perhaps instilled a little anger in different people, but that's the name of the game. . . " When I pressed him for whether it made him feel personally worse, he responded,

> I have written things that make me feel worse. And didn't know what I wrote them for, wish I hadn't. Some of the things were left unseen. Some of them people did see and. . . but you can't take them back. But basically everything I've written has been good but I have written some things that I wish I shouldn't have.

He doesn't write when he's very depressed, and his writing is not successful when he is manic; rather, it can be slightly dangerous in the same way: "That's one of the things I do when I'm in an elevated mood: overreact to little things, things that wouldn't bother me, [bother me] when I'm in a manic state [and] they really tick me off." He said that he has learned to "sit on things for awhile and especially have somebody read it back to [him] and see how it sounds."

Still, writing on depressing subjects can make his depression worse: "I think if I'm writing sometime in the depth of depression, it can actually pull me down farther." For instance, about the book he is writing about his own experience, he told me, "When I'm writing about

something that's very upsetting, very frightening, whatever, I'm experiencing that right as I'm hammering that out on the screen, what I went through."

However, he said he writes when he's a little, not a lot, depressed—"I'll write out of my melancholy state to express what it's like." He feels the need to express at that point. These pieces tend to take the form of poems. Conversely, "when I'm in an elevated mood, I write some funny rap stuff or something like that." He thinks a lot of things come out when he is in a lightly elevated state: "I usually write when I can't sleep. And so that indicates that my mood's a little elevated." He said that when he is lightly gone in either direction, you can find him at his computer. Although he is prolific, he doesn't like to force himself to write. He says the quality of the writing is better when inspiration strikes him.

He says that people like things in every mood that he writes. The disorder itself makes it easier to write, he thinks. "Associations come fast when I'm writing poems, rhymes, just you know fall into place." However, his writing usually has the purpose of furthering rights and understanding: "the illness itself gives me a need to express what I'm feeling and what I think other people might be feeling and I want to communicate it to everybody I possibly can."

Lawrence

Lawrence remembers clearly as a young adult wanting to be a "paperback writer"; when he saw his mother and stepfather during a vacation from his Peace Corps service, his stepfather asked him what he wanted to do and he said, "write mystery novels and be a drug agent and follow the heroin trail." He started writing in high school, writing diaries there, which he continues to keep. He said nobody told him to keep a diary, he just "thought it'd be a good idea." He told me, "I guess in the back of my mind, I knew people kept diaries, so." He has journals that he has written from the late 1970s as well as the ones he kept while in the Peace Corps back

to 1969 to 1971. The earlier ones, he told me, are lost. Writing diaries made him feel less lonely in high school and later in adulthood.

In addition to the journals, he'd "been writing down what authors had written about writing," thereby in effect learning about writing with famous writers as teachers. These writers include Hemmingway, Conrad, E.M. Foster, John Gardner, and John Brain. He's read a lot of books about writing, and although he writes "in spurts," he had learned from them that it is better to write piece by piece, perhaps 500 words per day. Of the top of his head, he cited *How to Write A Novel*: "when you write you've got to make people see," and he paraphrased Conrad as saying "you've got to make people feel, see, and hear." If he could give advice to writers, he would say, "believe in yourself and what you've got to say," because he has fallen into depressions while writing in which he has had many doubts about his ability and worth.

Having been raised in a multilingual environment, with Polish parents and a father in the British Air Force in Libya until they immigrated to the United States, Lawrence did not get off to a good start in his high school writing classes. His parents had been planning to come to the States and had not spoken Polish to him so that he would not have what they thought would be a linguistic handicap. When they eventually did come to the United States, he was put in the 7th grade in a military school. After finishing the 8th grade, he changed schools and the school year was two months in but he was put in the 10th grade instead of the 9th grade because of his fluency in French had impressed the headmaster. But he knew a little amount of English. Therefore, he struggled academically. He flunked composition as well as math because he didn't have a chance to study 9th grade algebra. But when he started writing in journals in high school, he wrote in English because he had "left the French language behind." Interestingly enough, French does not creep into his writing.

In 1973, he started writing a novel based on his Peace Corps experience. Some of the scenes, he told me, were based on his actual journals. Another large part of it was based on his studies about the issue he addresses in his book. At the time he started it, he wanted it to be a short story. He had always "admired writers and their effect on society," thinking that writing instead of fighting was a better way to address and solve issues. He said,

> I always thought writing was something I could do. It was kind of something that I had in me, that I wanted to write a book. And so that's why I started writing about the Peace Corps and the things I had experienced and saw about hunger, poverty, and underdevelopment with the hope of changing people's attitude toward the less fortunate. I felt there was a good story.

At the time of the interview, the book was 319 pages, and he had not touched it in five years. He also hadn't revised it at all. He said that part of the reason he hadn't touched it is that he was hospitalized several times. In the hospital, he was never encouraged to write, "except by one exceptional therapist."

He has not tried to get his novel published, but he has had 17 letters to the editor published out of 35 or so which had been sent in. All that were published were written over the course of three years. One of these letters was written in one draft. He typically writes more than one draft.

In 1973, for seven weeks he was hospitalized for the first time. He had begun to "lose my sense of reality." He was diagnosed paranoid schizophrenic and then later, in the 1980s, bipolar. He had gone through six different diagnoses before bipolar disorder. At that point he started learning more about the illness. I asked him if he resisted the diagnosis and in particular resisted it because of the stigma. "No," he told me,

> I was just maybe in denial that I had a mental illness. . . I had survived many years and I'd been able to get out of the jams that I was in and I always hoped that I would be able to do the same. It was a shock to me that the problems I had were so debilitating to my mental health that I had to be hospitalized.

He continued to journal through the roll of diagnoses. He also wrote papers for school, as he had gone to graduate school in 1975 for Agricultural and Resource Economics, but he didn't complete the degree. He had been working as a Resident Manager, getting only $120 per month and a free apartment in addition to working a part-time job. He said he had no way to see a doctor or buy medications and started to deteriorate mentally. Soon after, he spent four months homeless in Washington, DC. While he was homeless, he tried to read some, including Orwell's Down and Out in Paris and London, and he kept a diary and "read about a hundred books." In that diary, he described the "life around me and my thoughts, my fears, hopes, and frustrations."

He continued his diary through yet another phase in his life, being arrested because he had a knife in Kentucky Fried Chicken. He doesn't remember much of it; he blacked out. The cops shot him twice, and he wound up in a hospital for the criminally insane for three years.

The journals had several functions for him. He had been put in the States and made to learn the culture, had gone through his parents' divorce, and had been left on his own at 17 when they went to India to work for the US government. He said that journaling "was a way to organize my thoughts and feelings, to keep myself sane. It became a way of getting back my sanity. . . help[ing] me organize. . . thoughts that may be disturbing. I'd have feelings of suspicion, feelings of worthlessness." When I asked what did happen when he journalled, he told me,

> Sometimes when I start writing, I get more anxiety or I feel some paranoia. Sometimes when I start writing, there are moments when I feel increased tension and anxiety. I try to keep writing to put things right again. . . When I'm able to explain to myself in writing what's going on, I may make myself feel better because it doesn't look that bad after all.

I asked him what it was like to write in episodes. He told me that in a high manic state he doesn't write at all. But in a hypomanic state, he writes furiously: "Postcards, letters, to the BBC, White House, about world affairs, comments on what I heard in the news. Mostly very angry type of writing. Made me feel better." It connects him to the world, making him feel like he is "participating more in the affairs of the world, doing something to try to make things better in the world. Attributing thoughts to. . . solutions of problems and I feel on top of the world." At this time,

> some types of thoughts come out that normally wouldn't come out. [And] I wouldn't be bold enough to write down. The kind of stuff that's not in the mainstream of political thought and so I'm afraid that what I have to say is too radical, too upsetting of the status quo and that the authority, the police will come after me.

On the other hand, during depressive episodes, "I haven't been able to write much in the past year. Being depressed, I haven't been able to write much. . . When you're depressed you don't feel like doing anything." He doesn't force himself to write when he is depressed, and only writes when he has to. In a depressive phase, he recently "started a short story. . . and it's got about four pages. I haven't been able to add to it. I've been thinking about how to structure it, how to continue it. And I think I've found a formula, but I haven't been able to actually sit down and start writing."

He wants to start writing again, but feels like it's best to do it in the morning when he feels the least depressed.

As for medication interfering with writing, he said it has in the past but doesn't currently. With some, "you don't want to write. You forget what points you're making." It also has affected his ability to read. But now, "Geodon [a medication] actually. . . make[s] me be able to focus my attention a lot longer."

When I asked about drawbacks to being a writer with bipolar disorder, he said simply that mental illness has made his life itself difficult, so that it would naturally make his writing difficult, too. But, he later wrote to me,

> there is disorder, strife, and violence in the world and these affect me. I write to bring my agitated mind to a less disordered state that the disordered environment brings about, maybe if I didn't have a bipolar disorder, I wouldn't feel the urge to write—it's difficult not to be confused when there is so much confusion and conflict around you.

His writing overall has been for humanitarian purposes, for advocacy. A newer piece of fiction has to do with mental illness. He said he planned to use his ten years of experience working with the mentally ill and the issues that come up. I asked if the character will have mental illness and he said no. When I asked why not, he said, "because it might complicate things a little. . . I haven't thought about it much, really. . . but that's a good point. If he had a mental illness, it would be true to life, because the character's based on me."

I asked how he would deal with creating a manic character if he is not manic at the time, and he answered, "You don't need to be manic. I know what manic—I know what it's like to be manic. I've lived it. . . I can mimic it."

If he were to offer one piece of advice for other writers, he would say, “Believe in yourself and what you’ve got to say.” This is because he’s had “a lot of doubts,” and he has lacked self-confidence. He told me,

> Recently, in the last year, every time I try to finish, I have lots of doubts about the worth of what I have to say or what I’ll end up writing and that lack of self-confidence is very depressing. Or maybe depression gives me a lack of self-confidence. I don’t know. . . [E]very time I’ve been thinking of picking [his newest work] up and writing it, I get these feelings of unworthiness. . . It stops me. And I don’t know how much good is going to come out of me.

When this happens, he actively tries to overcome the thoughts—“instead of writing the story itself, I’ll journal or note down my feelings at the time or try to get out of the depression by the reading that I’ve been doing. It’s a lot easier to read than write.”

He knows it is a good piece of writing when he feels good about it, either in writing it or rereading it. The 17 letters he has published are “pretty good letters. . . very good pieces. And they’re not small letters; they’re pretty big pieces in terms of ideas.” It is only after that that he thinks of his audience: “Afterwards you realize that somebody may see it in a different way because people have different ideas, ideologies, political beliefs.” Still, he thinks it is important to be “true to yourself.” He does get feedback from friends, but is not known as “the Writer” in his circles. He wrote me that he’s “known more as an intellectual and/or philosopher.”
He didn’t get good feedback from his writing teachers to the extent he had wanted.

Lawrence told me that he always liked writing, and then he stopped himself and said, “No. I [always] liked books.” Reading actually helps him with depression. He told me, “One of the things I’ve been able to do a lot in the last three months is read. . . mostly nonfiction. And

that keeps me focused and learning." He reads what interests him and which are normally world-wide or country-wide problems. He has a big library, which he tends to add a lot to when he's manicky.

He is most proud of the way he structures his sentences and the points he makes. He is least proud of his "ability to write sometimes, to get [his] thoughts down, feeling of ignorance sometimes."

After our interview, Lawrence was kind enough to keep in touch, sending postcards about political issues and wishing me well with my project.

CHAPTER FIVE: MAJOR THEMES

In what follows, the major findings from a cross-case analysis are discussed. These themes include manic writing and depression block, drafting, characteristics of the written product, romanticization of bipolar disorder, deliberate tools, confronting stigma, healing genres, dangerous writing, writing despite the illness, and writing for school.

Manic Writing and Depression Block

Participants in this study experienced two forces that came with depression and mania respectively. One, which Flaherty (2004) named *hypergraphia*, and a second which I call *depression block*. Hypergraphia is hypomanic writing, involving writing much and often. Yet writers do not just write much. They write with more energy and gusto. They write as if they are only a vehicle for the words they produce; it has been described as that which "just comes out of me." There is an increased interest in whatever topic they choose and that interest and inspiration make writing come easily. The pen, they report, seems to move on its own, but not as quickly as the thoughts behind them. Thoughts press to be written down and everything at nearly the same urgency and pressure. There is no telling what is irrelevant. Irrelevancies are as important as those facts which are relevant. There is never enough detail. Word choice is of the utmost importance—a word must be the precise and perfect word.

There is also a feeling of all one's faculties working together, or, as Carol said, "It was the feeling of all things, like your knowledge or words, your memory about your life, your analytical skills, and everything was all flowing together to make it come out to be just about as complete and good as it could be."

Concluding is difficult. The writer may not be able to accurately put a finger on what is important since everything seems important. Whether or not certain things take precedence over others is unclear, but it is clear that most things rise in importance.

Writers who find writing pleasurable will over-indulge as they will with any other pleasurable activity while manic. As they write and like what they write, they write more and more. Mary said she gets a kick out of writing well, which makes her only want to write more. Still, they are not always in love with what they've written. Kevin decided in a manic, grandiose state that his draft could be much better. So he took what he had out to the back alley and told his wife he was going to burn it. She did not let him, and, happily, the book got picked up by a publisher shortly afterwards.

On the opposite end is *depression block*, which is a block grounded in the symptoms of depression, symptoms that include apathy, anhedonia, low energy, feeling of worthlessness, lack of concentration, inability to make decisions. Blocked by depression, writers might not feel motivated to write; they might even have no feelings at all about writing; they might find a pervasive numbness has replaced the drive to write; they might find no more pleasure in it; they might find no energy to even pick up a pen or even sit up straight (let alone slump) at a computer; they might feel like they are worthless as writers, thinking "what's the use?"; they might not be able to concentrate enough to make a coherent statement or "keep things together"; and they might not be able to problem-solve. The inability to concentrate makes, as Lisa said, "everything hard." Similarly, they might feel unworthy to face the task, thinking, as Chris does, "I'm not good enough for it." Lawrence said that writing is so difficult when he is depressed that he does not "force" himself to write. Kevin said that he lost two full years of his nearly16-year writing career to depression.

Depression can also make writing painful because writing forces one to look at his or her thoughts. Erin said, “it’s a little painful to have some angst and agony and try to put it into words.” Annie explained that sometimes while writing her book, “I felt very flat . . . The writing was just so dreary it felt like you were sitting in the alley—a dark alley and just pouring your thoughts out.”

It seems that lighter forms of depression do not cause blocks and may even be helpful for some writers. David said that when he is lightly depressed, he likes to express how he feels, and Tess said that during a light depression she writes a lot. There is also Mary, however, who said that she does not have it in her to emote any more.

A mixed episode, somewhere in the combination of depression block and hypergraphia, is a volatile place where negative thoughts spill out. Only Jessica reported such a feeling, and she found the piece to be dangerous to her in the long run because she would take it out and reread it over and over and over.

Drafting

The amount and kinds of drafts that are produced change drastically from mania to depression or vice versa. Manic writing involves few drafts, often only one, whereas depressive writing involves multiple drafts, that is, if the writer has the energy to follow through.

In mania, writers overtaken by hypergraphia write quickly and efficiently. The draft that they produce is often so good—or is often perceived to be so good—that they are reluctant to go back and make changes. Carol will not touch a draft she wrote during hypomania for fear of ruining it. Thomas adamantly told me that he will neither prewrite nor edit.

Often, then, there is little planning. Mary, for instance, said at most she makes a bulleted list. Others jump right in until it is finished. Chris said that in a manic state, he works on a draft

for eight hours straight (and then spend the next four days drinking and partying). Thomas will stay up all night writing and writing, and Lisa actually credits hypomania for nights up writing and writing, teaching herself to write.

A lot of times, these late night or all-day drafting sessions involve creating pieces rather than whole drafts. Chris, for example, comes up with character sketches or lists of character names: “I have files with just pages of one blurb after another,” he said. Jane writes down all the random things that pop into her head.

And just as starting and continuing is easy, manic writers have a difficult time wrapping things up, concluding.

Depressed writing does not come so easily, if it is not blocked altogether. It is tedious and slow. The writer will stare blankly at the blank screen. There will be a line and then that line will be erased. Jane told me, “I’d get a sentence in maybe like a half hour or something.” In light depressions, some writers, like Jamie, like to line edit.

The effects of medication, too, must not be overlooked. Writers are equally enabled and disabled when drafting with medication. Writing while medicated may be difficult, especially if that writing is by hand and that medication is lithium, which causes severe tremors. Writers who experience tremors have to draft on the computer, whether or not that works best for them. Several start out writing by hand, including Jessica, Jane, and Chris, making it necessary to adapt to the computer or not write at all. Tess described her experience with medication as feeling so detached from her writing that the words appear on the screen all by themselves.

Characteristics of the Written Product

Visuals

Often, if the writer likes to paint or sketch as well as write, those paintings or sketches appear on the page along with the writing. If the writer solely writes, there will be no artwork, but the great majority of participants accompany their writing with art, even if that writing is only in their journals. Sometimes the drawing or painting would take over completely.

Other visual differences with the writing include handwriting changes. Annie said that she could pinpoint an episode by its differences. She described her manic handwriting as "very rushed, very scribbled." Erin said that in mania, the writing is "frantic and illegible." Chris said that his writing is "all over the place: big letters, little letters, drawing in between." Susan, whose writing is self-characterized as melodramatic, said that when she is depressed, her handwriting changes—"certainly laterally compressed if not vertically." Erin noticed another visual difference in the pace of thought in the actual written product: there is very little punctuation.

Topic and Form

When he is manic, Chris tends to write "unconventional" and experimental fiction, and he plays with things like time and point of view as well as stream-of-consciousness. For the most part, people write what they usually write from state to state. Lisa and Kevin continued to write fiction and those who journalled the most, continued to do so. David wrote poetry at all points on the bipolar spectrum except for the extremes. A few who used the subtle changes from mania to depression to their benefit. Annie said that when she was manic, "I would focus more on the mania" in her story. Likewise, if she was depressed, she would concentrate on the more depressing topics like her relationship with her mother when she was a child.

In a depression, the writing is personal; in a mania, the writing is more public. Whereas depressions bring journals and personal letters, manias bring about letters to the editor, editorials, postcards, or letters to top officials. When Lawrence is manic, he starts "writing furiously. Postcards, letters to the BBC, White House, about world affairs, comments on what I heard in the news. Mostly very angry type of writing. Made me feel better." When Thomas is depressed, he writes letters to his godfather.

Point of View

Chris tends to write in first person when he is depressed because his thoughts are focused inwards, he is more introverted. Chris tends to write in second person when he is manicky because second person is "a manipulation thing": "when I'm manic, I'm just on fire and very ego-ridden, too. And it feels like I'm pushing things around and controlling things the way I want, which probably isn't true in the slightest, but it feels like it."

Most other participants said that they write in the first person, about themselves, when they do most of their writing. Having been asked directly about the idea that some had expressed how people with bipolar should not write about themselves but about outside themselves, one participant in particular responded that it is not possible to write outside the self.

Romanticization of Bipolar Disorder

There is a persistent belief that bipolar disorder fuels creative processes. This belief is no more apparent than in the writer's decision to take or not to take medication. One such example is Tess. She keeps herself on a low dose of medication because she believes that there is "magic" in the creative process of mania, and "to a certain extent" in mild depression. She also

recognizes, however, that her episodes can get out of control, and so she credits equal parts medication and writing with her stability.

Another group of writers writes with their medication, feeling that medication makes them stable enough to be productive. Susan said that medication affects "creative impulses" but not creativity itself, and that considering to not take medication is dangerous: "Why should I biologically or neurologically punish my brain and body when I've been healed in so many ways?"

In the current study, participants found bipolar disorder to have both benefits and drawbacks, with more drawbacks over all. In fact, contrary to popular thought, they identified a normal to hypomanic range for productive work, a range lower than otherwise written about.

Benefits, then, included the following: an enriched experience which contributes to a certain depth of writing; an addition of humor/cleverness; and an intense creativity, especially in the connection of seemingly disparate ideas.

What participants felt they got from bipolar that improved their writing was the ability to describe rich emotion because they felt what they considered to be richer and/or stronger emotion than others might have. One strong point of Julie's writing according to her is that she is good at description. Another example of enriched description is in Chris's experience: Chris told me that he seems to have "a really keen perception" when he is in a depression and that it creates "some of the best writing as far as what I've observed, and being able to transcribe things in a sense . . . of course, they're all drab and horrible, but it always seems like I'm better at perception." Jamie, too, said she was good at describing her feelings. However, Susan pointed out that bipolar disorder gives depth to writing "as much as any other profound experience. But

it's not in a class of its own. You know, climbing Mount Everest would, too. It would involve a lot of struggle, hardship."

Jamie quoted Wordsworth and said that she felt a depth of emotion that enriched her writing when she reflected back on that emotion or else when she reflected back on and edited what she had written during that time. Melissa highlighted the fact that she feels she can feel emotions more intensely than other people. Kevin told me, "I think when you are bipolar, you've experienced higher highs and lower lows than most people. And I think they're accessible that way." Lisa said that, as a writer with bipolar disorder, she can get in touch with her emotions more easily. But she did not see the impact of the interaction of mood states on writing.

Tess said,

> I really do think that a manic depressive person makes a better writer because—I know for myself, I experience two trains of emotion at any one time: one is the phasing and the other is I think what most people would call "what it's supposed to be." You know, you're having a good day so you feel happy. But, you're having a depressive phase. Do you know what I mean? And I think that makes a bipolar person a better writer because you have a better experience of all kinds of emotions. That's a personal assessment.

Robert said that bipolar gives him empathy and has helped his parishioners because they know he has "walked in their sandals." Kevin also told me that cycling into depression gives him more empathy and that the cycling itself gives him the ability to have a wider range of perception.

Tess said that she is "prone to humorous observation." Both Tess and Mary used the word "clever" to describe their writing. Mary described the normal and hypomanic moods as contributing to a more organized, creative, and clever style.

Erin said that when she wrote about her writing process and the world her senior year in college, “in that brief little essay that I had to write, everything in the world was connected and it was beautiful and had the utmost meaning, and everybody appreciated that meaning.” Bill showed me work that brought together ideas that one would not easily connect in a normal state, such as a poem that connected the midnight ride of Paul Revere, the Pope’s coronation, and Hitler’s birthday.

Both deep depression and high mania make writing impossible. Lawrence was adamant about the notion that one cannot write while in an episode.

Reflecting on work done in mania which was thought to be good at the time, participants said that it was not good. Writing for them seems choppy, moody, “all over the place,” not making sense. In mania, the participants reported that they tend to really like what they have written but that they go back to it and consider it garbage. Lisa said that her perception of her work while she is in a hypomanic state is that it appears wonderful. Thomas also talked about his perception of writing while he is actually in a manic mood: “when you’re doing it, you think that you’re writing the greatest thing that has ever been written. And it’s very humbling when you go back and read it, and it’s just so broken up.” David told me that when his mood is manicky, he thinks he’s doing good writing, but when he looks “at it at some other point, it’s not good.”

At the same time, there is some work that they like so much that they do not want to go back for fear of ruining it. This is, however, what it is like if the mania is not extreme, or else it falls into dissolution. David, who tends to write poetry and lyrics during episodes, “crank[s] out some pretty good newspaper articles” when he is in normal range. In terms of perception, though, some participants said that they always perceive their work to be good.

Participants also discussed both not being able to write in an episode or not being able to write well. Hypomania itself can be less than euphoric—it can cause downright irritability or volatility. It can also be a stepping stone to a more severe state. For Lisa, she is on sensory overload and has to go to bed, pull the covers, and shut things out. At first, everything is easy and then, she said, "the price is too big." In terms of writing, the increase in intensity of what would otherwise cause writing benefits has an adverse effect on the written product. The clarity becomes incoherence and the connections become more and more "out there." The work has no substance, makes no sense. The writer becomes frustrated as his or her thoughts move too quickly to record them. Jane, for example, says she gets depressed when it gets frustrating because the thoughts come too quickly and she loses some. The writer cannot keep to one task. Manic logic tends to be tangential. The effect on writing is both a bringing together disparate ideas—especially those that don't usually follow each other—and an inability to follow through with one train of thought. As the episode progresses, the logic is more and more incoherent. Thomas said that it "is broken; it's disjointed; thoughts don't follow one another." Mania, in its upper stages, disables logical connections and sometimes creates psychosis. Eventually, there is an inability to write—Janet said, "I couldn't even get my thoughts together that much to write anything."

Whereas participants did not see writing as productive during high manic or low depressed states, they did find what they'd written (if they'd written) in those states useful for not only reflecting back to see where they had been but also for using snippets in their writing. Moreover, that which is recorded in journals during a manic or depressed episode can be useful as "emotion recollected in tranquility" when the writer has reached an euthymic state.

A Deliberate Tool

These writers used writing as a consciously chosen, deliberate tool, a means to an end they are already aware of. They saw writing as powerful and useful. The distinction between referring to writing as a deliberate tool to one of many specific ends as opposed to talking about writing's effects is that in the situation of the deliberate tool, participants knew writing was there to help them. Writing is a tool specific to writers like painting is to painters. Whether this could be applied to nonwriters is uncertain. Individuals chose to write because it is an identity that they need, because they want to understand themselves better or to cope, and because they want to communicate with others, escape, advocate and educate, control episodes and help someone else.

As writers, Thomas and Robert found that writing helped them heal because it allowed them to forge an identity that went beyond the illness. In Thomas's case, this meant that he could identify himself as someone other than a person with mental illness. In Robert's case, because he was no longer able to be "pastor," he needed to find a new identity and being "writer" filled that void.

To understand herself better, Annie would write journals and then go back and date her entries and compare her handwriting and moods. In doing this, she better came to terms with the fact that she was ill.

As a coping mechanism, written expression was used to replace the outlet of self-injury; Jamie likened the feeling of release involved in self-injury to the feeling of release involved in writing. Jamie said that when she writes during a state, she finds that she afterwards feels the same way as she might after hurting herself: "I feel very peaceful and as though I had something that needed to be expressed and now it's been expressed." Jane also said that writing is a tool that she uses to keep her from hurting herself. She said, "when I get the desire to hurt myself, . . .

sometimes it is like, well, maybe if I write about it, then that would help me not to do that . . . Like I try all these methods before—I try to *think* before I act impulsively."

Julie used writing to verbalize feelings she could not express to anyone else for fear of being judged. When she first started writing, she said, "the feelings that I had were so deep that to verbalize them to anybody I figured they'd think I was nuts." She said that she had to express herself in writing because growing up, she didn't have anyone she could express it to. Jessica said that writing is a way to cope, to release the pain and hurt. She said that people should feel better after they write. This seems to be the main reason Jessica writes: When I asked her why she didn't write earlier in her life, she said, "I never saw it as an outlet."

Writing was used as a tool to bring one out of an episode, one which failed. Lawrence journalled about feelings of worthlessness, deliberately trying to overcome that worthlessness.

Writing was also a tool for communicating to others when there was no better way. Julie communicated how she was feeling to her husband or therapist; Annie used writing to communicate to her husband in the absence of good communication skills; and Jamie used writing to keep a record to report about her illness to her therapist. Julie specifically wrote so as to protect others from her anger and discontent. Thomas found written communication to be healing because he always ended on an up-note when he wrote his godfather.

Writing also helped individuals communicate with doctors and nurses, yet none of the participants were given guidelines and rarely was the method taught in any way, with the exception of Jamie who used what she learned about writing and healing for an expressive therapy class she would later teach, in which, for example, she had them write letters to people with whom they had a conflict.

Writing has also been a tool for advocacy and education. Erin hoped that someday her writing could make a change: “I think that I feel like I have something to prove. Like if someone’s going to say that I’m ill, dammit, I’m not going to take it. You know? I’m going to do something. I think there are people out there that have done that. But I feel like I need to do it, too.” David, who for a long time worked as the head of a local nonprofit, wrote for advocacy often.

Writing was used as a tool for helping others. Annie said that by writing her book, she wanted to help somebody else that might be going through what she went through. Annie wrote to help people feel less isolated and therefore more apt to comply with treatment and not be ashamed. Both fiction writers wrote about the illness in part to help others, and since their books have been published, they have received letters from people about how much they have helped.

Thomas found that writing fiction helped him move away from being a person with the disorder. When he showed me some lines of autobiographical writing, Thomas explained that he could not write very much because

> I was in a very low—a complete low is when I wrote that. And it’s only that long because I was incapable of writing any more and the only thing I knew to write about at that time was the illness. I wanted to be autobiographical and found that I couldn’t be and writing fiction enables me to step outside of myself far enough to realize that I’m capable of doing more than just living the illness.

Moreover, Thomas said, “I think [writing beyond the autobiographical] is something that you’ll find in the writings of somebody who’s bipolar. That they may be writing in the third person, but they are definitely writing in a way that makes them feel normal.” Some writers were intentionally choosing to not write about themselves. This was what Kevin referred to as learning

the right way to write. He said, “I’ve responded to that fact by writing in specific ways. I’ve no intention of making depression worse.” By specific ways, Kevin means that he started writing about other people. At a job where he had to go around and record people’s stories, he realized that he wanted “wanted to move beyond kind of just myself, way beyond it at that point, and kind of look to others through my writing and ideas and stories and so I very purposely did that.”

Most other participants did not necessarily look for escape. They said that they write in the first person, about themselves, when they do most of their writing. Having been asked directly about the idea that some had expressed how people with bipolar should not write about themselves but about outside themselves, one participant in particular responded that it isn’t possible to write outside the self.

Confronting Stigma

Participants expressed several ways that stigma be confronted and expelled. One of them is to make writing as specific as possible—a deep description—so that a reader might get a good understanding of what a person goes through. Julie was proud of the piece she showed me because she was happy that she expressed the feelings she wanted to, “I wanted to be helpful even though I was going through an episode.” She tried to communicate to an audience that did not have bipolar disorder by being as detailed as possible in her description of her thoughts. She told me that she wanted me to get a better understanding of what goes on in somebody’s head:

> And that these are scary thoughts not only for the person reading them I think but for the person experiencing them. And not having any control. There is no, you know, “I’m depressed because it’s raining out and [because] I have to face the storm and get wet. You know, and then in two hours when I’m all dried, that feeling goes away.”

Another strategy to confront stigma is to write fiction through which the writer can put himself or herself in a character's head and thereby create empathy for the character in the reader. Kevin and Lisa both wrote fictionalized accounts of the illness to encourage awareness. Because the illness is so stigmatized, they allow the reader to learn about it first hand, through the characters' heads, so that, as Lisa said, the audience takes "a pill with sugar." In his fiction, Kevin takes care to have people experience the mental illness:

> What I used to want to do was really make people familiar with individuals who have these issues, but not just make them familiar: get into their heads a little bit. You know, why are they doing what they're doing? People still care about them—all this stuff that basically make them human.

David wrote often and much about his illness as the head of a local affiliate of a grassroots mental illness organization. He continues to publish often because he believed that there is much work that has to be done in creating awareness of mental health.

Jamie, who originally intended to change her text to avoid the negative impact of stigma, wound up writing for *Psychiatric Services*, a journal for mental health care workers (psychiatrists, psychologists, counselors) that features first person accounts of mental illness. She found that coming out as having bipolar was more important than protecting her privacy.

Healing Genres

Insights on writing and healing are arranged under three rough categories: journals, autobiography or pathograpy, and fiction. This organization highlights that participants chose specific forms of writing for specific reasons; for example, fiction writers chose writing fiction over writing journals because it helped them distance themselves from their feelings.

Overall, participants did not believe that writing cures bipolar, but they did find that writing served some healing purposes. Unlike deliberate tools, these kinds of writing seemed beneficial in retrospect; that is, the writers were driven to write, and, not until later reflection did they know what they gained.

Journals

Participants reported several effects of journal writing. Four results are empathy, the ability to organize thoughts, catharsis, and insight when they look back. The results are that journal writing does not make one better. It might continue ruminations and allow a person to rationalize their thoughts and behaviors in unproductive ways.

Participants found that journaling did allow them to gain empathy for themselves. Susan in particular expressed this notion. Susan said, “I can look back at that 18-year-old and think, you know, you just didn’t know, and neither did they.” For Melissa, writing helped her understand her thoughts and feelings.

Participants were divided on whether they saved their journals or destroyed them. Those who destroyed them explained that they would not feel like this forever or want to look back. Mary explained that she had found a letter written to her brother when she had been depressed and that it was an awful experience to read it. Those who saved their journals exhibited a kind of fascination with their thought processes, particularly their thought processes around having the disorder. Some expressed keeping it for “posterity” while others indicated how important the journals are by explaining that they did not revise them—they would make an addendum but not revise.

There was also a separation between those that wrote public journals and those who wrote private journals. Public journals included blogging but also journals that were left around

for people to find them. As for leaving journals to be read, Julie would leave her journal around so that her mother would find it. Jane and Tess both journalled online for friends and internet "friends" to see it. Jane saw such journaling as a support group in that she can write about her eating disorder and bipolar and her friends write back and encourage her: "I have online friends who read it who have bipolar, eating disorders, or whatever—and so they comment, you know, it's a support thing. That's the difference. And I like them reading that. I like reading their journals. It's kind of like we have this support system."

Some participants did not journal because they did not feel it would be productive. Some did not want to record their feelings, some did not want to have the journals as available to obsess over later (in one case, the participant's husband destroyed what she had written so as to protect her from this kind of rereading/obsession), and some felt that writing about the self would only make things worse for them. Some did not force themselves to write when they were depressed, at which point writing was difficult.

Autobiographical or Pathographical Writing

Pathographies are the most popular form to write in. Fourteen out of 21 planned to write or have written either a pathography or an autobiography that highlights the illness. There is a great appeal to write these, and as the literature on pathographies suggest, there are a few healing benefits to them. One reason is to rewrite their lives with a new plot, that is, to adapt their conception of their life stories in light of their new diagnoses. By constructing a narrative of the self, the writers get better understandings of themselves. Such writing works like journaling.

Jessica was planning on writing a story about her recent hospitalization to commemorate it and share with other people with bipolar disorder. Kevin wrote his autobiography to talk about his own struggles with the illness. Lawrence would like to write his autobiography of living with

the illness. “That’s something I keep thinking about,” he said. Jamie has started writing her memoirs. Annie wrote her story so as to help people feel less isolated and therefore more apt to comply with treatment and not be ashamed. Erin felt that writing her memoirs (in the form of vignettes) would help her validate herself. She said when writing her vignettes, she felt “vindicated” against the problems in her life. “I feel like I can resolve things. . . I feel like I can write about it kind of comically a little bit. And metaphorically. And takes the edge off of everything that really happened.” Erin explained, “I think because I’m bipolar I have something that needs to be said, and I just haven’t said it yet.”

Unlike journaling, public pathographical writing gets feelings out there so that the writer no longer feels as if he or she is hiding the illness, such as Annie does. By constructing a narrative of the self, a writer better understands himself or herself.

Fiction

Some participants felt the need to write beyond themselves, saying that writing about themselves would take them to a dark space. Such writers found it helpful to either write about other people or to write fiction. Fiction writing necessitates authorship/agency, something many people with illness do not have, a lack of agency discussed by Couser (1997) in his book, *Recovering Bodies*. Couser (1997) wrote that the privileged, official story is not that of the patient, but of the doctor—the doctor is thought to know better about the patient than the actual patient does (p. 18). The phenomenon of gaining agency was discussed by Thomas in his explanation that writing allows him to “play God.” This agency allowed him to feel like he could do something as opposed to being disabled.

Two participants found that the discipline of writing can help them control their episodes or get on top of them. By discipline, Tess was referring to the necessity of sticking with a form of writing. Robert, on the other hand, used writing to (try to) control his mind.

As with journal writing, fiction enables exploration and explanation of symptoms. Tess said that she wrote a book at age 13 to explain to herself why she and her family acted the way they did, even though the explanation did not take mental illness into account. It was a fictional story about a family with a ghost in the basement, and she said that the writing "didn't teach me anything about what was actually happening in the world."

Dangerous Writing

Ways that writing was reportedly dangerous were surprising. Some suggested traditional danger: that writing could cause an episode of depression if, for instance, they are writing fiction and have to get in the mind of a depressed character; or if they are writing about a mania, they might miss the manic lifestyle; or if they are writing in a hypomania, the writing might escalate them to a mania. But, for the most part, writing was not reported as psychologically dangerous, i.e., causing an episode; rather, writing was considered dangerous in that wilder pieces could ruin a reputation, in that having the writing to reread might cause obsession, in that writers grow upset with themselves while depressed because they cannot live up to their conception of themselves as writers; in that writing provides a piece of writing that they can obsess about when the illness is bad; in that writing provides a space to rationalize their actions and experiences in an unproductive way, especially prior to diagnosis; and in that it becomes increasingly obvious how bad life really is for them as they write. Moreover, if put out there in public, the writing might cause the writer to fall prey to stigma.

If a person is writing with mania, that person could write irritable things that, upon returning to an euthymic state, regrets what was said, even though he or she could not stop while in an episode.

Jane said that writing has hurt because "I realize, sometimes I'm like—I'll reread it and I'm like, 'oh my god, my life sucks!" Jane said that writing "is not always a good thing, but it usually is because it helps get it out." Jessica said that the danger in writing is in the rereading. She wrote a piece that she obsessively reread, which made her feel worse. What made reading worse was not that she wrote, but that she obsessively reread what she wrote and did not let herself move forward. She told me that "reading your own words forces you to accept what's happened. And that's probably one of the toughest things about writing." She said that one thing writing does is "enables you to accept what the truth is."

Kevin writes editorials when he is manicky, though, he said, "They sound different than I typically sound." He said that he writes editorials when he is not an episode but that the "angry, furious" editorials do tend to come out of this state.

Writing for these participants was no more dangerous than writing for any other person who has to deal with a trauma. In fact, David said that even though he sometimes gets down when writing, he doesn't get any more down than anyone else recounting their experiences.

Stigma was another danger. Annie said that she needed to be careful when including certain aspects of her life in her book because she did not want what was said to negatively impact the future of her husband and children. Although she said she revised the book minimally, she said that she did spend time on the part about the mania because of her concern for her family. Julie wrote initially because she did not want to express her feelings and have other people think she was crazy.

Jamie told me during our initial interview that she had written her memoirs and was trying to fictionalize them so as not to ruin possible chances at jobs, especially because she wanted to be a counselor. At our last meeting over a year later, Jamie told me that not only had she decided to write the story as it really was as her memoirs, but that she had also published an article about her illness in a leading psychiatric journal.

Participants gave a number of ways that they write which, if writing is dangerous, might be what makes it not dangerous for them. Chris said that writing might not be dangerous because he is so used to writing that he has the ability to distance himself. Jamie said that she has been going to therapy so long that telling her story no longer makes her upset. Finally, Lawrence said that it is impossible to write in an episode, and therefore there is no danger.

Writing Despite the Illness

The results of this study are not transferable to all people who write. The individuals in this study identified themselves as writers, an identity that few students take on, and this necessarily alters the outcome of the study. Although they reflected on their school years, they reflected from the point of view of people who are intrinsically motivated to write and who practice writing often. This is a problem when it comes to understanding dangers and health benefits. Conversely, students may not reap the same health benefits because they might not know how to employ writing as a tool for health.

For all of the participants except for Julie, the beginning of their writing lives and love of writing did not coincide with the onset of their symptoms. One might argue that the writers wrote because they exhibited signs of cyclothymia, which has smaller but still present waves than does full-blown bipolar disorder, but even so, the fact remains that these participants wrote regardless of the disorder. Jane wrote, for instance, as a kindergartener at her mother's computer before

school, and Mary would write plays to get out of class. They wrote and read even through negative feedback as well. Thomas wrote in second grade, received what he perceived to be negative feedback, and resumed writing fervently later in life, and Tess had no feedback at all and yet showed an early passion for writing so much so that she, in the absence of available paper, modified her handwriting to a very small size.

What sets them apart from others who have bipolar and do not write, is a love of writing. This love is evident in their answers to "why do you write?" Answers included Kevin's "I love words. I love the poetry of words. Man, there is a—there's a way that words can fit together that in certain circumstances they should fit no other way"; Jamie's "I enjoy the challenge of putting words together, like finding the right word, getting to turn the phrase so its sort of musical"; and Tess's "I write because it has to be done."

As writers they needed to develop strategies to continue to write when the episodes forced them not to. For some participants, it is nothing short of impossible to write during extreme manic or depressive states. The fact that these writers try to write when their physiology is telling them not to shows a dedication to writing. At the same time, some—like Thomas and Mary—believed that it is possible for the very talented to be successful at writing in such states.

These writers do certain things when they are faced with depression block; although, it seems that, at certain levels, if the symptoms of depression get too bad, there is nothing that can be done to make them write. Lawrence tries to overcome his feelings of worthlessness by journaling. When Lisa is mildly depressed, the writing schedule she set up for herself allows her to write. She said that sometimes she could force herself to write if it was for school. She said she "didn't always stick to them, but they help." When manic, Chris said he "writes garbage but that's okay because I was writing something." Even though bipolar makes writing difficult (he

"psychs [himself] out" when he is depressed), he still writes when he can. Chris said that sometimes he has to talk himself into writing. When asked why, he responded that "it's what I'm constantly thinking of all day when I'm doing something else."

Writing for School

For the great majority of participants, with the exception of those below, bipolar did not affect writing for school, or at least did not have a profound enough effect to be remembered. For example, Chris did not have symptoms of the disorder until he was in his twenties and therefore his bipolar did not affect him in school. Carol's bipolar also did not start until later on in life.

Erin said that she needed deadlines and could make herself write. When pressed, she could pull herself through and write something. Jamie found that she'd write for class if she had to, but she preferred her work when she did it when she was inspired. Jane said that when she had dropped out of a university and started community college, she said she learned to ride the waves:

> Now what I've learned was I can take advantage of this mania and get so much done. So when I get that syllabus when I go to [a new college] this fall, as soon as I get that syllabus, I'm going to try to get as much done as possible, like try to get ahead. And that's what works. Coping skills.

Still, even with her plan and "coping skills," Jane was unable to continue that fall.

Above all, the advice the participants had for teachers was to educate themselves so that they could recognize bipolar. The participants did not suggest trying to act as therapist or suggesting writing to heal. They also asked that students' differences be kept in mind, and that lessons would be geared to accommodate the most amount of students. Erin, a high school English teacher, said that if she were to have a student with the disorder in her classes, she

"would be more sympathetic toward them" and "cut them a little more slack, and pay them a little more attention." Jessica suggested that teachers be more understanding, and Lawrence suggested that they not "robotize the class," by which he meant teachers should account for the differences in the classroom. Annie had much more to say: "allow for openness and creativity" and "accept style beyond the norm." She continued by saying, "look beyond the person and information provided and wonder what they are trying to say to you. If they do say something, be educated enough to work with them to pass classes or refer them if needed to [appropriate] resources." Kevin said that, if teachers know students have bipolar, teach them to ride the waves. He taught himself that. "I would talk to them about waves, finding a balance, when to edit."

CHAPTER SIX: CONCLUSIONS AND IMPLICATIONS

Introduction

Through an extensive review of the clinical literature on bipolar disorder and a qualitative, naturalistic inquiry into the lives of 21 writers with bipolar disorder over a three-year period, this study offers space to rethink practices and commonly held assumptions about mental illness, writing, and writers. Very little is known about how students with bipolar write, what the negative and positive aspects are, and what the disability means for the classroom. Less is understood in composition studies based in empirical data about how writing might heal, how it might be dangerous, whether writers are writers and better writers because of bipolar disorder, and whether teachers can deter a writer with bipolar disorder from using writing as therapy.

The clinical literature on bipolar disorder places it as a biochemical, medical illness, one that is treated by medical means. As a departure point, this placement has dramatic ramifications for composition studies. It affects both literature on emotions and composing, such as Alice Brand's (1989) *The Psychology of Writing: The Affective Experience* and literature on writing and healing, such as Anderson and MacCurdy's (2000) collection. Seeing bipolar disorder as a biochemical illness necessitates re-seeing composition studies theories and literature that do not differentiate among mental illness, life's ups and downs, and working through trauma.

In her book, Brand (1989) conflated mental illness with emotions such as depression and excitement in describing the reactions of writers to both clinical and nonclinical depression in her description of what motivates writers to write. Brand (1989) combined testimony about the power of emotions on writing from people who were experiencing normal "downs" and people who were experiencing clinical depression, and, thereby suggested the powerful effect mental illness has on writing. She wrote, "Authors are more widely known for their drive to write their

way out of another group of negative emotions, the withdrawing, inhibitory ones represented by unhappiness and depression" (p. 12). But clinical depression is more than simple negative emotion, and the life of one of the writers she cited—Lord Byron—has been studied extensively by Kay Redfield Jamison as an example of one suffering from bipolar disorder. Later, Brand (1989) wrote, "Nowhere in the annals of literature is emotional disturbance more visible than in writers of creative work. The emotional history of poets is especially notorious. In and out of public attention is the poet suicide: …A positive by-product of affective disorders is, of course, creativity…The purpose of Study 5 was not to determine if creative writing classes were a breeding ground for emotional disorder but to extend the general inquiry into a highly neglected subset of student writer, the poet" (p. 173-174). However, in literature which discusses bipolar disorder as contributing to creativity and literary creativity, scholars and practitioners like Jamison are careful to say that not everyone with high creativity necessarily has a mental disorder, and mood disorders do not make writers.

Writing and Healing

When speaking of bipolar disorder and writing to heal, there are two kinds of healing to consider: healing the bipolar itself and ameliorating the consequences of having the disorder. Both of these will be reviewed below in the terms used in the second chapter's review of literature and the findings of the in-depth interviews.

Express Pain

Pennebaker and colleagues have written extensively on how expression—written or verbal—can have a salutary effect on mental and physical complaints. In 2002, Pennebaker summarized the bulk of his work, reporting that, "To this point, studies have indicated that

writing brings about reductions in common illness visits to physicians (e.g., upper respiratory illnesses), reductions in blood pressure, reduced use of pain medication, and long term changes in immune function (which we frankly do not yet know how to interpret)" (p. 287). What Pennebaker's studies lack, however, is an in-depth look at two things broached by this current study: are the benefits just as good for those who see themselves as writers and are they just as good for those who have a clinical, biochemical, mood disorder? The participants in this study did say that writing is a tool for catharsis, and two participants went as far as to say that they used writing to express their pain in lieu of hurting themselves, and yet they continued to suffer from the disorder. For others, catharsis is not present simply because they cannot write when faced with depression block.

Change the Self

Writing has been understood to re-create the past, as Hawkins (1999) reminded us—"as most autobiographical theorists maintain, the past in any autobiography is not simply recorded but it is changed, reordered, and even re-created in the act of writing about it" (p. 18). This is important because those with bipolar disorder who are recently diagnosed require a way to understand their life in terms of the diagnosis. Recreating and changing the past might be helpful for those suffering from trauma, but for those who experience a biochemical disorder, the past is irrelevant. Moreover, changing the past is what Warnock (2000) cited Burke as dubbing the "comic corrective." For them, words are revisable, changeable, and literacy gives us the opportunity to put life down, gain objectivity, and change it. Writing is more than cathartic; it is a tool for rearranging and re-creating in a new context. Participants did not find that writing served to change their perspectives. Participants talked about when perspectives changed, but not in the context of writing changing perspective; rather, they talked about how writing reinforced

their perspectives, allowed them to rationalize their feelings and behaviors, oftentimes for the worse. The ability to put life down and change it—to employ the comic corrective—as discussed in Warnock (2000) was lacking because the ability to manipulate a mood state is mostly not possible.

Close and Organize Stories

According to Pennebaker, writing a story allows us to simplify and shorten the experience so as to psychologically be able to handle it. Pennebaker and Seagal (1999) wrote that adding structure and meaning to an experience through writing allows people to better manage their emotions (p. 1243). The story does not have to have a moral or ultimate meaning; rather, it need only get un-stuck. Theoretically, then, the person stops ruminating. But if the person is suffering from depression, ruminating will not stop; moreover, if the person is suffering from mania and is clenched in the jaws of obsession, again the ruminating will not stop. Such emotions cannot be managed with literacy.

Transition to the Kingdom of the Sick

Susan Sontag (1978) wrote that "everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick" (p. 3). Being diagnosed with bipolar disorder requires crossing into the kingdom of the sick. It means re-articulating one's life as someone who has the illness, and writing may help him or her accomplish this.

Give Agency

There are two ways that writing may give agency to a person with bipolar: one, if the person were to write fiction and be able to, as Thomas said, "play God"; or two, if the person can successfully write his or her pathography.

Quite literally, the person is given authorship which had been taken when diagnosed and had his or her previous life explained for him or her. Johnson (2000) wrote that "writing that heals is often writing in which the writer names, describes, and takes control of experiences in which the writer's powers of naming and controlling have been explicitly annihilated" (p. 86). "As trauma survivors," Anderson and MacCurdy (2000) wrote, "we share one very important characteristic: We feel powerless, taken over by an alien experience we could not anticipate and did not choose. Healing depends upon gaining control over that which has engulfed us" (p. 5).

These powers may have been annihilated in treatment, that is, when control is handed over (or forced in some cases) to the doctor. Hornstein (2002) explained,

> Psychiatrists have not simply ignored patients' voices; they have gone to considerable lengths to silence them. Patient narratives are filled with reports of their authors' being locked in isolation rooms, deprived of writing materials, having correspondence censored, or being threatened with violence for making their views public. (¶ 8)

Couser (1997) wrote that the privileged, official story is not that of the patient, but of the doctor—the doctor is thought to know better about the patient than the actual patient does (p. 18).

Writing and publishing personal stories wrenches back control. According to Hawkins (1999), illness narratives—usually overly emotional—are the flip side of the cold discourse of the medical community, and a necessary flip side in that the two together tell the whole truth (p. 13). Illness narratives give the person a voice (Hawkins, 2000, p. 223). She wrote that "pathography restores the person ignored or cancelled out in the medical enterprise, and it places that person at the very center" (Hawkins, 2000, p. 223). This could be the reason that most participants wanted to write a pathography.

Help Escape

Hedges (2005) pointed to Graham Greene as having said “I wonder how all those who do not write, compose or paint can manage to escape the madness, melancholia, the panic fear which is inherent in the human situation” (p. 7). And Jamison (1993) quoted poet Antonin Artuad as saying, “No one has ever written, painted, sculpted, modeled, built, or invented except literally to get out of hell” (p. 121). But writing did not appear to enable the writers in this study to escape when they were in the grips of depression or mania. Those who spoke of escape spoke in terms of writing fiction, but only when the person is well enough to overcome depression block.

Talking Oneself Out of It

Neither depression nor mania can be talked out of, which is the essential flaw in writing and healing literature, even that which is suggested by psychologists. In David Burns’s book on cognitive behavioral therapy, Burns (1999) gave specific steps on what to write and how to write. For Burns (1999), words on paper work to displace negative or dangerous thoughts. But for the participants, this was not the case.

Theorizing about writing and healing, however, might be helpful with the trauma of having a mental illness and the need to move toward recovery, recovery from such things as internalized stigma and loss of agency as a mental patient.

Dangerous Writing

Another ramification of seeing bipolar as a biochemical disorder is a new look at dangerous writing. Writers with bipolar disorder are sometimes thought to be overly dramatic and childish. Writing is also thought to be dangerous for them, a thought supported in the work

of DeSalvo (1999) and elsewhere. If bipolar episodes are brought on largely internally, then it is possible that writing that appears dangerous is the result and not the cause of an internal upheaval. DeSalvo (1999), who has carefully studied Woolf and Plath, believed that there are right and wrong ways to go about writing, with the wrong way leading to suicide. DeSalvo (1999) wrote that Woolf did not pace herself and, therefore, became mentally exhausted. Kevin and Lisa, both professional writers, had times where they did not pace themselves, but they were no more the sicker for it; in fact, they reported that their moods were slightly elevated. If they were to get sick, it is plausible that they would have become ill because slightly elevated bipolar moods tend to crash into depressions, as is generally the case with bipolar II. Such a situation could have been what happened to Plath and Woolf.

It is entirely possible that episodes precede their manifestations; i.e., it might be less that writing is dangerous than the episode is dangerous. As the illness progresses, the episodes come on regardless of life stresses (even though many bipolar handbooks for patients advise ways to manage stress so as not to precipitate an episode). That is, as the illness progresses, the episodes take on a life of their own (Goodwin and Jamison, 2007, p. 135; Mondimore, 2006, p. 8, 232). Therefore, whether writing can be dangerous is really a question of whether the episode itself will be dangerous. One surprising finding in this current study was that participants found writing to be dangerous in ways other than causing episodes. They found it to be dangerous for reasons including that highly irritable writing might fall into the wrong hands, that they might become prey to stigma, and that because they might later obsess over what they had written.

Literary Genius

The current study sought to interrogate the connections drawn between bipolar disorder and literary genius. Jamison (1993) wrote that the transition between mood states allows for

highly creative thinking in manic states and critical thinking in depressive states, two kinds of thinking that are vital for artistic work (p. 6). The combination of mood states possibly leads to good writing because depression "shapes and prunes" that which is done in manic states (Jamison, 1993, p. 6). Contrarily, the participants in this study found that depression blocked them and manic writing was usually not fruitful.

Jamison (1993) also saw a benefit to experiencing the depths of despair (p. 114). Such experiences, she thought, could add depth to one's work. The bipolar helps the writing inasmuch as it is a powerful experience from which to draw; for these writers, the bipolar itself does not help them become better writers. Susan said it best when she said that a writer suffering from depression has experienced something profound in a way that anyone could experience any other situation profound; the profundity is not unique to the depressive or manic states.

Still, the depths of despair and the higher moods fueled the participants' perceptions that mood fuels productive writing. What participants felt they got from bipolar that improved their writing was the ability to describe rich emotion because they felt what they considered to be richer and/or stronger emotion than the outside world. Jamie, for instance, kept referring to "emotion recollected in tranquility," explaining that it is not that she is more creative during episodes but that she has the episodes to write about. There was also the fact that writers did not see benefits in either extreme, but that if anything they could pull from journals that were written while in an intense episode (most likely mania).

Not everyone with a mental disorder or bipolar disorder to be specific is creatively gifted, and, this study goes so far to suggest, having bipolar does not necessarily mean one is a writer. Bipolar does not lay claim to making writers. Part of what contributes to the myth that bipolar causes someone to be a writer is that the processes in the brain that spur mania are also thought

to spur hypergraphia (see Flaherty, 2004). But those in this current study showed that they saw themselves as writers first and then as individuals with bipolar disorder; by which is meant that they practiced writing and enjoyed writing long before their symptoms hit and that they actually tried to write despite the disorder, e.g., when blocked by depression.

A danger in romanticizing bipolar is that writers in a depression block who cannot write might entrench themselves further into that block by believing that great writers could write under the same circumstances. It is even less healthy that teachers of writers add to the mystique.

Romanticizing bipolar disorder also lends to the notion that medication stifles creativity, a thought with which that the participants in this study did not agree. Most participants found that they did better on medication, that medication allowed them to be more creative and that the creative juice from mania came in recalling manic episodes, not in the manic times themselves. Also, depression stopped writing. Kevin he said, "I see no beauty in depression. I know some people who actually see some kind of glamour or excitement in this idea of being depressed or a person susceptible to depression. I see nothing in it. There's no—there's no beauty in it at all." It was also the case that participants felt more creative in mild manic episodes, but felt more productive in the space between normal and mildly manic. This has important ramifications for placing medication in the context of writing. From these interviews, one might conclude that the writer draws sustenance from normality.

Stigma

In the face of stigma, writing, according to Julie and Annie, also allows for anonymity. Julie wrote to me so that I could better understand where she was coming from. Jamie, who originally intended to change her text to avoid the negative impact of stigma, wound up writing

for *Psychiatric Services*, a journal for mental health care workers (psychiatrists, psychologists, counselors) that features first person accounts of mental illness. She found that coming out as having bipolar was more important than protecting her privacy.

The Classroom

In "The Unrecognized Exceptionality: Teaching Gifted Adolescents with Depression," Gardner (2003) talked about how depression is a hidden illness. She said that teachers who are properly educated on depression can help students with the illness continue to learn, that is, they can make accommodations so that students continue to learn. She recommended that, "when we work with depressed students, we need to begin thinking seriously about adjusting our requirements. . . .We need to take a hard, honest look at our assignments and what might be necessary to complete, given the medical circumstances, so that students can be assessed fairly" (p. 32). What, then, actions can be taken to accommodate such students? Teachers might "cut students a little more slack," according to Erin. And yet the problem with such a question is that the first episodes of bipolar—episodes, not diagnosis—usually occurs in the late teenage years and is not diagnosed until the late twenties. In other words, students in the classroom will not understand which accommodations they need if they have either not come to terms with or have had enough experience to understand the illness. Moreover, they will not be on medication enough to stable their thought processes. Students might also have the additional challenge of struggling with self-blame for their depressions or have a host of difficulties due to their mania, including not being able to concentrate, sit still, maintain linear logic, or even choose from a number of topics. Accommodation, therefore, means understanding the unique writing processes, including hypergraphia and depression block.

In the meantime, difficulties may arise with group workshops and peer response. Not responding well to criticism is something a teacher might look out for in a workshop-based classroom. It is possible that with inflated self-esteem and irritability, students might not take criticism well. There is not very much that a teacher can do in this situation except understand that a student's failure to productively participate has less to do with group conflict or something else within the teachers control than with mental illness.

The following suggestions are based on the current study:

Understand writing processes to help a writer with bipolar to "ride the waves."

Writing processes change significantly with bipolar states. Kevin suggested that teachers be able to help students "ride the waves" of bipolar disorder. Jane tried to ride these waves herself, but failed several times in her attempts at college. For students who have rapid-cycling bipolar disorder, whose mood states alternate quickly, there is only a small window within which students will be able to write coherently, and that window is a stable state or a state between stability and hypomania. For those who are suffering from a light version of depression, it might be necessary to require frequent, small writing projects to account for a variety of mood shifts. If the student has a registered disability, extended deadlines may be helpful, as this is something that some participants took part in, and something that Jane could have used in her attempts at college. At a presentation of preliminary results of this study at CCCC in 2008, some teachers expressed fears that there are too many accommodations made that lead to a less educated/less qualified graduate; however, the same argument might be taken up with any other disability.

Reactions to assignments and group work might be caused more by the disorder than by what would seem like the stimulus. Tess said, "I experience two trains of emotion at any one time: one is the phasing and the other is I think what most people would call 'what it's supposed

to be.' You know, you're having a good day so you feel happy. But you're having a depressive phase." The ramification is that there is a necessity of knowing that a writer can have some anxiety about his or her writing both because that writer feels anxious for whatever reason and because depression has an anxiety component. Knowing about writer's block and anxiety might help the teacher help students—and research on writer's block is useful in this way—but students might be anxious because they are going through depressions, not because of the task at hand. The writer might be apathetic about the writing assignment that he or she was just previously excited about but only because he or she is going through the depression.

Measures should be taken to allow for both quick-draft manic activity and slowed-draft depression activity. Whole drafts might be destroyed due to either mania or depression. In terms of mania, students might abandon a project completely for greater things, just as Kevin did when he tried to burn his manuscript in a celebratory manner over champagne, even though this was not a finding for all of the participants. They might also destroy them during a depressive state when writer confidence is down, although this, too, was not true with most participants. On the manic end, writers may be unable to narrow down topics or gage when something is adequately developed. They might not be able to whittle down and focus on a topic, seeing as they might believe that everything has the same weight, each idea is equally important and each idea is necessary to include. They might not be able to conclude their thoughts.

Recognize signs of bipolar disorder to refer a student to appropriate help.

Recognizing the signs of bipolar disorder might be helpful in referring students to resources. Just as talking therapy does not work with bipolar, so won't talking students out of an episode. Understanding suicide, too, is an important step. Most importantly, reflecting on and

understanding one's own stigma-heavy opinions about mental illness, which may include that mental illness is a weakness, will help a teacher be more compassionate.

Explore what might be helpful for the unique needs of a writer with bipolar disorder beyond the classroom.

What the teacher can do is give students tools. This includes talking about audience so as to avoid reputation-ruining irritable writing. It includes teaching students to sit on writing that has been written in a severely irritable state. It includes strategies for narrowing topics. Some students may require more deadlines so that, if depression hits, there is extrinsic motivation; this, however, was only suggested by one participant. Another thing is that students should be taught about self-expectations as writers. Students might also be taught to abandon writing that might be dangerous. Even with these lessons given, the student may not be able to effectively employ such strategies.

Evaluate advice for disturbing writing—what writers can and cannot do.

Comments in the margins of disturbing writing should take into account the clinical literature on the illness. Although suicidal individuals may or may not have bipolar disorder, fifty percent of individuals with bipolar disorder will attempt suicide at least once. Literature on suicide shows that people who consider suicide are not able to envision alternatives. Teachers should be aware that simple notes in the margins—such as Valentino (1995) suggested—will not dissuade suicide.

Educate yourself.

One of the biggest fears about having a bipolar student in the classroom is not understanding what might trigger an episode. Valentino (1996), for instance, lamented the fact that students do not have to disclose their condition to teachers. The fears of Valentino and

others is dangerous because it reinforces stereotypes of fear and does not take an in-depth look at what really happens.

Conclusion

This study makers a new starting point in a conversation about writers and writing with mental illness. It follows articles such as Valentino (1996), Gardner (2003), Ohrstrom (2005), and Richmond (2002) in that it tackles the reality that students with mental illnesses are in the classroom; however, it lays new ground in suggesting that maybe writing cannot heal, maybe it is not dangerous, and maybe some of the advice we give ourselves as a field is counterproductive and dangerous in its own right. Up until this point, we had only scratched the surface when it comes to mental illness and writing, and, I would maintain, we still have not gone deeply enough.

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APPENDIX A: DIAGNOSTIC CRITERIA OF THE *DSM-IV-TR*

Criteria for Major Depressive Episode, Manic Episode, Mixed Episode, and Hypomanic Episode
Source: American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders.* (4th edition, text revision). Washington, DC: American Psychiatric Association.

"Criteria for Major Depressive Episode (p. 356)

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
   Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions of hallucinations.
   (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (i.e., feels sad or empty) or observation made by others (e.g., appears tearful). Note**:** In children and adolescents, can be irritable mood.
   (2) markedly diminished interest in pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
   (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (as indicated by either subjective account or observation made by others)
   (4) insomnia or hypersomnia nearly every day
   (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
   (6) fatigue or loss of energy nearly every day
   (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
   (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
   (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
B. The symptoms do not meet criteria for a Mixed Episode
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
E. The symptoms are not better accounted for by Bereavement; i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation."

"Criteria for Manic Episode (p. 362)

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).
B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
    (1) inflated self-esteem or grandiosity
    (2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
    (3) more talkative than usual or pressure to keep talking
    (4) flight of ideas or subjective experience that thoughts are racing
    (5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
    (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
    (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
C. The symptoms do not meet criteria for a Mixed Episode.
D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).
    Note**:** Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder."

"Criteria for Mixed Episode (p. 365)

A. The criteria are met both for a Manic Episode and for a Major Depressive Episode (except for duration) nearly every day during at least a 1-week period.
B. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hypothyroidism).
    Note**:** Mixed-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder."

"Criteria for Hypomanic Episode (p.268)

A. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood.
B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
    (1) inflated self-esteem or grandiosity
    (2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
    (3) more talkative than usual or pressure to keep talking
    (4) flight of ideas or subjective experience that thoughts are racing

(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.
D. The disturbance in mood and the change in functioning are observable by others.
E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.
F. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar II Disorder."

APPENDIX B: ADVERTISEMENTS

Email 1

Hi. I'm a doctoral student in English at Indiana University of PA, and I am conducting a study of local writers who have bipolar disorder. I hope to capture the experiences of writers who have coped with this illness. To participate, writing must play a significant role in your life, but having published is not a prerequisite. Participation in this study would involve two one-hour interviews and a writing sample. If you are interested or have questions, please contact Lauren DiPaula at 443.504.9959 or zbbm@iup.edu. Also, please feel free to pass this notice along to anyone in the area who might be interested. Thank you. –Lauren

Another Email:

Dear On Our Own representative,

I have been several times referred to On Our Own as an important resource for the study I am conducting for my doctoral dissertation in English. I was hoping you could help me get the word out to local writers who have bipolar disorder that I am seeking to learn more about their writing lives. The only requisite for being a "writer" is that writing plays an important role in their lives.

The study requires one or two one-hour meetings to talk about writing and illness experiences. What I take from these conversations will help me construct narratives, to figuratively draw portraits of my participants' experiences.

I will not use any data without the participant's approval. I will also delete any information that could identify that individual.

Those who are interested or who have questions can contact me, Lauren DiPaula, at 443.504.9959 or zbbm@iup.edu.

Thank you. –Lauren

For those of you who do not already know, for my doctoral dissertation I'm searching for writers who have bipolar disorder in order to learn more about their writing lives. The only requisite for being a "writer" is that writing plays an important role for them.

The study requires one or two one-hour meetings to talk about writing and illness experiences. I will not use any data without the participant's approval. I will also delete any information that could identify that individual.

Those who are interested or who have questions can contact me at 443.504.9959 or zbbm@iup.edu .

Thank you. –Lauren

Fliers/Email 2

Writers with Bipolar Disorder

I'm looking for writers* with bipolar disorder willing to participate in a study for my dissertation in English. As a doctoral student of writing and writers, I am looking for first-hand experiences of being a writer with bipolar disorder.

Should you choose to participate, we will meet two times for an hour to talk about your writing and illness experiences. In addition, we will talk about whatever piece of writing you choose to bring, desirably one that speaks of your illness, your writing, or both.

What I take from these conversations will help me construct narratives, to figuratively draw portraits of my participants' experiences.

I will not use any data without your approval. I will also delete any information that could identify you.

Please do not hesitate to contact me with questions. I am available at 443.504.9959 or L.T.DiPaula@iup.edu or by mail at P.O. Box 10001, Baldwin, MD 21013.

Sincerely,

Lauren DiPaula
PhD Candidate in Composition Studies
Indiana University of PA

* All writers are welcome, published, degreed, or not.

Fliers/Email 3

Writers Who Have Bipolar Disorder
Research Project

For my doctoral dissertation in English, I'm interviewing writers who have bipolar disorder. The only requirement for being a "writer" is that writing plays a significant role for you. The study involves one or two approximately one-hour interviews during which we will discuss your illness and writing life. I will not use any information without the participant's approval, and I will remove names and identifying information.

If you are interested or would like to have more information, please contact me, Lauren DiPaula, at 443.504.9959 or L.T.DiPaula@iup.edu or by mail at P.O. Box 10001, Baldwin, MD 21013-9998. If you know someone who might be interested, please pass this information along.

Thank you.

Magazine Advertisement

I'm a doctoral student in English at Indiana University of PA, and I am conducting a study of local writers who have bipolar disorder. I hope to capture the experiences of writers who have coped with this illness. To participate, writing must play a significant role in your life, but having published is not a prerequisite. Participation in this study would involve two one-hour interviews and a writing sample. If you are interested or have questions, please contact Lauren DiPaula at 443.504.9959 or zbbm@iup.edu. Also, please feel free to pass this notice along to anyone in the area who might be interested. Thank you.

APPENDIX C: CONSENT FORM

Dear Sir or Madam:

My name is Lauren DiPaula, and I am a doctoral student at Indiana University of Pennsylvania. I am conducting a study that intends to capture the experience of being a writer who lives with bipolar disorder. I hope to better understand the effect of the disorder on writing and the effect of writing on the disorder.

Participation in this study is voluntary and confidential. Should you choose to volunteer, I will meet with you two times for approximately one hour each and collect one piece of writing that you believe best exemplifies how bipolar disorder affects you and your writing. At the meetings, we will discuss your life as a writer with bipolar disorder.

At any time, you may withdraw from the study. Should you wish to withdraw, simply communicate your wish to me in person, by mail, by phone, or via email, and I will destroy the data that you have contributed. No piece of data will be used in the final project without your written approval. You will be asked to review this data. The data which you do approve will be used in the dissertation and may also be used as part of conference presentations.

What you tell me and the documents you provide will remain confidential unless you give me explicit written permission in reviewing the transcripts of our conversations. I will make all attempts to hide your identity; your identity will not be disclosed. I will change confidential information such as your name, the name of our geographic location, and any other indicators of whom you are or where you are from. I will not use any of this confidential information in my final project.

This study will take place over a two month period of time. There are no known risks associated with this research. Although the conversations may involve disclosures about bipolar disorder, at no point should they be mistaken for therapy. This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the Protection of Human Subjects (phone: 724.357.7730).

If you are willing to participate in this study, please sign the consent form on the next page and promptly return it to the address given. If you have any questions, you can contact me via phone 443.504.9959 or email (L.T.DiPaula@iup.edu) or Donald McAndrew at 724.357.2201 or email (Donald.McAndrew@iup.edu).

Thank you!

Lauren DiPaula
Doctoral Candidate in Composition
Indiana University of PA
P.O. Box 10001
Baldwin, MD 21013-9998

Donald A. McAndrew
Professor
English Department
421 North Walk
Indiana University of PA
Indiana, PA 15705

Appendix C (continued)

CONSENT FORM

I have read and understand the information and consent to volunteer in this study. I understand that all information will be completely confidential and that I have the right to withdraw at any time. I have received an unsigned copy of this form to keep in my possession.

I also confirm that I am active in the treatment of my mental illness, either by being under the care of a therapist or psychiatrist.

NAME: _____

SIGNATURE: _____

Please return this form to Lauren DiPaula at P.O. Box 10001, Baldwin, MD 21013-9998.

If you have further questions about the nature and purpose of the study, please contact Lauren DiPaula at 443.504.9959 or L.T.DiPaula@iup.edu.

APPENDIX D: SUMMARY OF INTERVIEW DATES AND LENGTHS

Participant	Interview 1	Minutes	Interview 2	Minutes	Interview 3	Minutes
Annie	10/01/07	70	12/06/08	60		
Bill	8/13/07	77	12/1/08	56		
Carol	11/03/07 (phone)	62				
Chris	5/22/07	44	11/14/07	26		
David	10/21/07	54				
Erin	05/04/07	57	06/14/07	32	02/02/08	30
Gregory	10/28/07 (phone)	57	01/05/09 (phone)	60		
Jamie	4/22/07	37	5/19/07	19	12/22/08	36
Jane	6/15/07	70				
Julie	08/26/07	57	1/11/09	30		
Janet	05/04/07	44	09/28/07	30		
Jessica	04/11/07	23	05/20/07	37	01/05/09	35
Kevin	06/13/07	82	12/07/08 (phone)	35		
Lawrence	09/28/07	77	12/15/08	45		
Lisa	11/12/07 (phone)	45	11/16/07 (phone)	30		
Mary	05/17/07	42	05/24/07	30	12/03/08 (phone)	30
Melissa	11/9/07	43	12/09/08	17		
Robert	10/22/07 (phone)	69	10/29/07 (phone)	102		
Susan	09/14/07	126	12/17/08			
Tess	08/29/07 (phone)	72				
Thomas	04/16/07	18	05/08/07	40		

*Interviews not otherwise specified were conducted in person.
*does not take into account email communications

APPENDIX E: SUMMARY OF PARTICIPANT DEMOGRAPHICS

Participant	Bipolar Type	Male or Female	Age range	Disability?
Annie	I	F	30s	No
Bill	I	M	40s	Yes
Carol	II	F	50s	No
Chris	II	M	30s	No
David	II	M	60s	No
Erin	I	F	30s	No
Gregory	II	M	30s	Yes
Jamie	I	F	30s	No
Jane	I	F	late teens	No
Janet	I	F	50s	No
Jessica	I	F	20s	Pending
Julie	I	F	40s	No
Kevin	II	M	40s	No
Lawrence	I	M	60s	Yes
Lisa	II	F	50s	No
Mary	I	F	40s	No
Melissa	I	F	30s	No
Robert	I	M	60s	No
Susan	II	F	50s	No
Tess	I	F	40s	Yes
Thomas	I	M	50s	Yes

APPENDIX F: INITIAL INTERVIEW QUESTIONS

Tell me about when you first started writing. When was it? What was it?

What kind of feedback did you get growing up?

What, to you, validates your writing?

Does anyone in particular support your writing today/ what keeps you going?

What drives you to write?

What does it mean, in your opinion, to be a “writer”?

When were you first diagnosed? How?

Describe for me your deepest or most recent depression . When was it? What were the symptoms?

Describe for me your most intense or most recent mania. When was it? What were the symptoms?

Describe for me you most intense or most recent mixed state. When was it? What were the symptoms?

What is your favorite piece of writing? What was your process in writing it? How did bipolar disorder play a part in that process, if it did.

How has depression/mania/mixed states affected that and other projects?

What point of view do you write in? (Do you think this is significant?)

What kinds of writing do you prefer doing? (Personal, nonfiction, fiction?) Do you think bipolar plays a role in that?

Describe a difficult time you have had with writing, connected to the illness.

Does your illness affect what your writing looks like?

Who do you write for and why? Have you faced any problems in writing about the illness, if you have?

Has your writing ever been connected to advocacy?

Does medication affect your writing? Example.

What aspect of your work are you most proud of and why?

What aspect of your work do you feel needs the most improvement?

Give me an instance of a bad experience with writing? One that made your illness worse, if there is one?

Drawbacks/benefits to being a writer with bipolar disorder.

Who have been your influences?

What inspires you to write?

Do you identify yourself with any other writer/s who had bipolar disorder? Did something in their writing stand out to you? Did reading these writers help you? Did you learn about writing from these writers/how?

Do the seasons/time of day affect your writing/ how?

Referring to a specific piece:

- Why did you choose this piece?
- When did you write this piece?
- What were you thinking just before you wrote it? feeling?
- Why did you write it?
- Who is your audience?

What similarities or differences do you think you have with other writers who have bipolar disorder?

APPENDIX G: FINAL, DIRECTED FOLLOW UP QUESTIONS

Which form of bp have you been diagnosed with?

What is a writer? Are you one?

For you, is there overlap between being a writer and having bipolar? Where?

What conditions need to be there for you to write?

How does it feel to write in a manic episode? In a depressive episode?

When you are well, what is your opinion of the writing skill and written product you did while manic or depressed? What does the product of writing during mania or depression read like?

What topics do you tend to write about when you are manic? Depressed?

Can writing affect or change an episode?

Do depressive states make it easier to delve into depressing topics? do you get more depressed in recalling it on paper?

Do manic states make it easier to delve into manic topics? Do you get more manic in recalling it on paper?

Can writing cause an episode? Can it make you more depressed? Can too much creative freedom cause an episode? Can writing a lot cause hypomania?

How does a certain piece of in-progress writing change if your mood changes?

When you are manic or depressed, what is your opinion of your writing skill? What is your opinion of the written product at that time?

How are writer's block and depression the same or different? How are inspiration and hypomania the same or different?

What are your revision habits? How do or don't they change depending on episode?

Do treatments affect your writing and how?

Have you ever destroyed your work? For what reason? Was an episode involved?

What role does stigma play on your writing?

What are the differences/similarities between you and other bipolar writers (famous or not)?

If you journal, what are your journal-writing habits? How often do you journal? What kinds of topics do you write in your journal? Is it a public journal (blog) or private journal?

If you plan to write your autobiography about the illness, for what reasons do you want to write it? Who is your audience and why? How does what you say or how you say it change based on the audience?

How did bipolar disorder affect learning to write?

How did it affect writing for school?

What would you recommend for teaching writers like you?

If you were to give writing advice to someone else with bipolar disorder, what would you say?

Are there certain times of year writing is easier for you? More difficult?

APPENDIX H: START LIST OF CODES

BP effect on person
- Mania. . . . . .PERS-MANIA
- Hypomania. . . . . PERS-HYPO
- Mild/moderate depression. . . . . PERS-MDEPR
- Clinical Depression. . . . . PERS-DEPR
- Mixed State. . . . . PERS-MIX
- General States. . . . . PERS-GEN

Writing effect on BP
- Mania. . . . . .WRIT-MANIA
- Hypomania. . . . . .WRIT-HYPO
- Mild/moderate depression. . . . . WRIT-MDEPR
- Clinical Depression. . . . . WRIT-DEPR
- Mixed State. . . . . .WRIT-MIX
- General States. . . . . .WRIT-GEN
- Trauma/Prob . . . . . WRIT-PROB

BP effect on writing
- Mania. . . . . MANIA-WRIT
- Hypomania. . . . . HYPO-WRIT
- Mild/moderate depression. . . . . MDEPR-WRIT
- Clinical Depression. . . . . .DEPR-WRIT
- Mixed State. . . . . MIX-WRIT
- General States. . . . . GEN-WRIT
- Perception of writing. . . . . BP-PERCEP

Normal process. . . . . NORM-PROC

Audience
- BP. . . . . AUD-BP
- Public. . . . . .AUD-PUB
- Other. . . . . .AUD-OTH

How started writing. . . . . START

Feedback—Positive. . . . . .FEED-POS

Feedback—Negative. . . . . FEED-NEG

Self-Reinforcement. . . . . SELF-REINF

Types of writing done
- Autobiography. . . . . AUTO
- Stories. . . . . .STORY
- Poetry. . . . . POET
- Social commentary/ Editorials.. . . . . PUB

Reasons for writing with bp
- Self-therapy, catharsis. . . . . .THERA-CATH
- Self-therapy, problem-solving. . . . . .THERA-PROBS
- Self-therapy, distraction. . . . . THERA-DISTR
- Directed therapy. . . . . THERA-DIRECT
- Advocacy. . . . . .ADVOC
- Money. . . . . MONEY

APPENDIX I: FINAL LIST OF CODES

EDUC = education
SEAS = seasonal effects
SUI = suicide
ART = art
ADVOC = advocacy
TREAT = treatments
RESU = results of writing
SPIR = spirituality
PATHOG = pathography
SELF-PERC = self perception
READ = reading
OTHMI = other mental illness

DESCR = description of writing
DESCR-LANG = description of language
DESCR-CONTENT = description of content
DESCR-HAND = description of handwriting
DESCR-FORM= description of form
ENR = enriched emotions

TL = writing journey timeline
RELA = relationship with writing
BPW = other bipolar writers characteristics
SAVDEST = saved or destroyed

WRIT-ACT = the act of writing
DFTS = drafting
PHYS = physical act of writing

<u>REASONS</u>

SCH = school
JOUR = journals
REAS-BP = reason is because the person has bp
RESS-IND = reason is indep of bp
DB = depression block
HG = hypergraphia
DIR = directed by doctor or therapist

<u>GENRES</u>

GENR-PO = poetry
GENR-PR = prose
AUTO-B = autobiography

<u>OTHER PEOPLE</u>

STIG = stigma
AUD = audience
WSUP = writing support
BPSUP = bipolar support

<u>TOPICS</u>

AUTO = self
FIC = fiction
TOP-NFOTH = nonfiction but not about bp
TOP-SOC = social issues
TOP-BP = about bp

APPENDIX J: COMBINATIONS OF GENERAL CODES SO AS TO ANSWER QUESTIONS

Cluster One Questions

For all intents and purposes *Episode = meds & ECT*

- Episode + act of writing = how do write in episode
- Episode + result + act of writing = how do feel because of writing? Or effects of writing on the psyche.
- Conditions + act of writing + episode = how write despite episode
- Episode + Topic = kinds of topics in episode
- Episode + genre = kinds of genres in episodes
- Episode + reasons + act of writing= reasons to write in a particular episode
- Quality + episode = quality of writing either from the perspective of the episode or looking back
- Art + episode= use of art in episode (must specify if art is used at other times)
- Episode + save/destroy + (nearby text) = reasons for destruction or saving (hints to valuation?)
- Writer identity + episode = sense of self as a writer in the episode (may indicate a fluctuation)
- Episode + seasons/times of day + act of writing = effect of seasons/times of day on episode and/or (therefore) writing
- Directed writing = who directs writing? Why? Does it help? What are the directions? How does it play out? Are their similarities among participants? What kind/genre/topic?
- Journals (+ Episode) = what do they write? when do they write? who is the audience? Is it always in an episode?
- Suicide + act of writing = how closely connected the two are
- Episode + revision = whether or not the writer revises during a specific episode (best done if there is also a revision + NORM for comparison)
- Timeline + episode + start writing = was starting to write connected to the illness? Did he or she write more because of the illness? Is sense of identity as a writer tied up in the illness? Which kind of episode incited the writing?
- Episode + WRITED = Effects of episodes on formal writing education
- Description of writing + Episode = episodic description of language
- Perceived similarities among writers with bipolar = understanding of where they think they differ from larger writing population

APPENDIX K: SAMPLE TRANSCRIPT

This meeting took place as both a second interview and a member check.

Lauren: Alright. Um. I just wanted to go over the transcript and see places where we can elaborate and places where it's better just to—well, places that you want to change. And that's why I brought the red pen, so you can cross out…I changed your name, and I changed the name of your wife. I made her Beatrice…

Thomas: (chuckles) okay

Lauren: But I made the—just the Trice part.

Thomas: (flipping through pages)

Lauren: I was wondering why you didn't give that piece to your parents.

Thomas: I had a very bad childhood.

Lauren: Oh okay. Alright.

Thomas: (flipping through pages)

Lauren: I was also wondering—if I may, I'm sorry for interrupting—um, if you could describe the energy in a depressive episode.

Thomas: The energy in a depressive episode. Okay. (exhale)

Lauren: I have specific questions…

Thomas: I would have to say, it's the *lack* of energy in a depressive episode rather than the energy of a depressive episode: it's negative in nature.

Lauren: And how does it change—for you, does it change perception?

Thomas: Well, you go through levels of depression. You go through ambivalence to hopelessness to suicidal and then if you break through to depressive psychosis, which I've been in before.

Lauren: Right. Um, how would you characterize your lowest—well, your lowest depression would be the psychosis.

Thomas: Yes, most definitely.

Lauren: How would you characterize your highest mania—psychosis. (laughs)

Thomas: It breaks through to psychosis. But, before it does, it is extremely euphoric and you find a lot of joy in all areas of life. It's like happiness just smacks you in the face. And, it gets going so fast that you start moving with it—you become very fast in nature. You speak fast. Your motions are fast. Your thoughts are fast. And if it's left unchecked, it too breaks through to psychosis.

Lauren: Ok. And we've discussed whether or not you write during these episodes.

Thomas: Uh, depression..

Lauren: No.

Thomas: No, but the mania I have written in. Um, most of it makes no sense. It, uh, the ideas are so incongruent that when you come out of it and you go back to read it, you're like, you know, what is this jibberish? Um, most of my writing takes place when I'm between baseline and hypomanic. That's where most of it takes place—that's legible and has a following to it. A beginning and an end, and the middle achieving the end. But, um, in mania, no it doesn't make any sense, it's broken, it's disjointed, thoughts don't follow one another, and when you're doing it, you think that you're writing the greatest thing that has ever been written. And, it's very humbling when you go back to read it an it's just so broken up

Lauren: (unintelligible)

Thomas: Yeah. It's not very good. I don't have any samples of that. If I did, I'd give them to you.

Lauren: Ok. Ok. Thank you.

Thomas: (flipping through pages) Yeah, like right here (indicating the text), between baseline and hypomanic, you're very creative.

Lauren: OK

Thomas: But if you go into extreme mania, and you try to write, it just doesn't come out.

Lauren: So you did say you got a publisher? Oh you got a literary agent.

Thomas: Oh, I have a literary agent that wrote me back and said, "submit it online."

Lauren: Ok. Submit it to her?

Thomas: Yeah, just the query.

Lauren: Ok.

Thomas: Yeah. (flipping through)

Lauren: What page are you looking at?

Thomas: five. (flipping through) Yeah. Extemporaneous writing is really cool. (flipping through)

Lauren: Yeah. I like how you—the name you gave for it. Now the writing that you gave me of the chapter, that's all extemporaneous?

Thomas: Uh-hm

Lauren: Completely?

Thomas: Yes

Lauren: And it's coherent?

Thomas: Yeah, I know.

Lauren: That's incredible.

Thomas: Oh. Thanks.

Lauren: What were you thinking before you sat down to write the chapter on Nod?

Thomas: Well…

Lauren: to be so…

Thomas: Well, the book has…let me see, 1,2,3,4,5 chapters and one little expose that I call an interlude in the writing—the ch—the three pages are called "interlude." But what I was thinking of when I sat down to write Nod was just where I wanted the main character Leon to go in a natural progression to what I considered to be the end of the book. Where would he go next? And he had found in the forest at the end of Nod he's back in the forest with, um, Marrion. I thought the—Nod is a place in the Bible. It's where Cain went after he slayed Able. And I wanted Leon to go to Nod and confront various problems that just general people have in life, like there's pride, there's gluttony…

Lauren: Right

Thomas: I'm a glutton. (pats belly)

Lauren: (laughs)

Thomas: And there's several others that he confronts. And then in the end, because it's a spiritual piece of writing, the various negative aspects…[TAPE DIES]

Lauren: Alright.

Thomas: That's stop. Or is that record?

Lauren: That's record. So we lost a lot. You discussed your book, and then we talked about creative process. Alright. So I guess the next thing to do is just to go back to the transcripts.

Thomas: Well, you know, when you're being creative, thoughts follow one another as if almost like they come out of thin air. You'll think of something to write and then the next thing will come along—the next thought will just appear. And that's where writing is probably it's most fun, is when you realize you're creating something that either has never been seen before or where it may have a common theme. The way it's conveyed is not the way you've ever seen it before. And that's when writing is a lot of fun: when thoughts just follow one another. It's drudgery when you have a thought and you can't link it up to the next thought. And I guess that's what they call a block but I think every writer, you know, experiences both the freeness, the free-form of having thoughts just follow one another quickly sometimes and being able to put them on paper and then other times, there've been many times I've sat down at the keyboard with the full purpose of wanting to writing something specific that I have in mind and writing the first paragraph of it and then just saying, no, this isn't any good, I'm not going to do this today, and walking away. And there're other times when I've sat down and I thought I'd walk away where I've written twenty or thirty pages. And…there's no way of telling which way it's going to be.

As I said in our first interview, I like writing at night. In the middle of the night, because things are so quiet. You don't get interrupted by cars outside the window, or television going when my wife is watching tube, and I like spending time with her anyway and it's just everything is where it should be in the middle of the night. And it's easier to be creative at that point in time.

Lauren: Um, if you could tell me in a sentence or two about your process of coming up with the final chapter again.

Thomas: (breath) When I first wrote it and I was thinking about how to end the book. I thought ending the book the way the book began, with the fable of the animals and the evil being and instead of having the God known as Marrion coming out and quieting down the animals, I thought having Leon come out an do it: he'd be entering into his own life as being a god and he'd be helping other spirits along. I thought that would be good. I also thought that maybe having Leon come out to a group of people all arguing between themselves and him stepping out and saying, from now on, you know, you're going to speak in different dialects and you'll only understand the dialects you're in. But I said, you know, that's also sort of contrite, it bases itself on that first chapter and I don't think I like that. And then, I thought of the idea of Leon becoming a god in a completely different context than what Marrion had shown as being a god. And I said, well how—what can I do to give Leon his deity and have it be different? And I thought about maybe having Leon go to a specific village and just noticing people and I said, no it's already done in the book. And finally, I came up with the idea, that you know, Christ entered hell and came out of it and opened the doors of hell for everybody. You know, you no longer had to go there when you died, you could go somewhere else. Well, if that's the case, then Leon has to be Christ. You know, it follows. So then came the idea of laying the lines with the spirit in the

temple as having the conversation where he's called Noel, which is, you know, a Christmas statement.

Lauren: Oh!

Thomas: And you know, so.

Lauren: That's where that…I see.

Thomas: Uh-hunh—"oh I see!"

Lauren: I didn't get that the first time!

Thomas: The light comes on! The light comes on! (laughs)

Lauren: So you came up with the name, Leon, long after…

Thomas: No, I came up with the name Leon when I first started writing it.

Lauren: So you had some inkling he was going to be Jesus

Thomas: I had some inkling that he was going to be a powerful spirit, not necessarily Jesus at that particular point in time. But you know more or less just being allegorically linked to something beautiful, like Christmas. And, um, my father—I sent the first chapter out—that story

Leon—to twenty-four people. My father was the only person to pick up on Noel.

Lauren: (laughs)

Thomas: My father's a pretty bright guy. And he says, "What's this about Noel, Edgar?" (laughs) And I just sort of smiled and said, "I don't know yet, Dad, it's just what I called the character." But, um…

Lauren: You said something about CS Lewis and pissing people off.

Thomas: Yeah. CS Lewis wrote a lot of interesting stuff. You know, a lot of people know him best for his, um, six book series, The Narnia series that he wrote. But he also wrote a book that's really interesting called The Screw Tape Letters. And The Screw Tape Letters are a book about a couple of demons and there's a lead demon and a demon that's following in the lead demon's orders. And they see this guy who's leading an exemplary life, you know, he's done everything right, everything's good. And the two demons decide they're going to wreck this guy's life. And it's based loosely on the book of Job in the Bible. But, it's almost comical what these demons go through to try to ruin this guy. And in the end they don't succeed, but, The Screw Tape Letters is a good book. And he has another one called um, Until We Have Faces. And that's a spiritual allegory about being in the negative side of life and coming to find Christianity. And gaining a new person in yourself. And basically a face is what CS Lewis is analogous with it. The person

and a new face. That's a pretty good book. But, um, all of his books are a little edgy—with exception for Narnia and they're sort of edgy to a certain degree, but he takes a lot of it off so that they can be read to children, but they're really written for adults, the Narnia Series.
Lauren: You were saying because of that you weren't so afraid…

Thomas: Yeah, yeah, I sat there and I said, here I am. I'm going to write a book that's sacrilegious as far as most people would be concerned, you know, basically giving the idea that Christ went through various gyrations in heaven before he came to earth. And, um, you know, I figured, well, you know, the ending is what it is. It's the only ending that truly fits the writing. And I said, uh, I can't leave that, you know, I haven't. It was easy to, you know, write the last chapter, given the fact that Leon's name was Noel, you know. I finally said, what can we do with Noel? And, um, then the idea of having him go to hell came to mind. And I actually—I actually wrote that last chapter about a month and a half ago. I woke up in the middle of the night and wanted to go do some writing. And I sat there and I said I gotta end this thing with Leon, you know, you got him walking into the light: what are you going to do with him then? I just started writing and then, next thing I know, he's Jesus.

Lauren: (laughs)

Thomas: (laughs) you know, I started at three and about eight o'clock in the morning when my wife was getting up, I was just finishing. And, um, I took a copy of it off and I handed it to her and she read it and she said, "Yeah. This cooks."

Lauren: nice. Alright. (shuffles papers) back to this [transcript]

Thomas: I know why my printer isn't doing that: it needed new ink cartridge.

Lauren: Oh. (laughs) Just in case we didn't get it. I think, the other thing we talked about: how would you characterize your lowest depression.

Thomas: Lying in bed, hearing voices in my mind, beyond wanting to hurt myself.

Lauren: Beyond. As in passed?

Thomas: Yeah…you go..

Lauren: As in wanting to and then going passed it…

Thomas: You go past the idea of suicide. Not eating. Not cleaning myself. And, basically waiting for life to change somehow and not thinking that it will, but, you know, hope itself is pretty much dead. And you don't know what's going to happen next. The thing about being in an extremely deep depression is is even though you may not be able to think it, sooner or later, life is gonna convey a change in your life that will change where you are—it'll either be going to the hospital and being medicated to pull you out of it. Or, it will be, something catastrophic happening within your life circle that pulls you up out of it. In one case, I was in a very severe

depression. My mother came home and said she had breast cancer, and I was immediately out of the depression—something larger than myself had happened. Um…

Lauren: What about mania?

Thomas: With mania it's fun to a certain degree, you know, and when it spirals out of control, um, you hear voices and instead of going, I wish these things would leave me alone like you're in depression, when you're in mania, you follow them: you think you're talking to God. At least the first time it happened to me, I thought I was talking to God. And fortunately it spirals into such incongruity with normal life that somebody finally puts a finger on you and you end up in the hospital, if you're lucky. And…

Lauren: And as far as writing is concerned, you were saying something about you thinking your writing is good when you're in mania…

Thomas: Yeah, but when you go back to look at it, it's just jibberish. The thoughts don't follow one another. When you're between baseline and hypomania and even into hypomania a little bit, um, the thoughts just flow. It's like somebody opened up an area of your mind where creativity exists and just let it out. To be free. And it's just. It's unbelievable when that happens. You're able to just basically write—the story Leon came that way. I sat down at the computer knowing I wanted to write something as a gift to the people and I started off and I don't have—I have an electronic copy of it here today—but it's just beautiful beautiful beautiful beautiful writing. And, um, like I said, it's full of symbolism because it ties to things later in the book, but, at the time I was writing it, needless to say I didn't know I was writing stuff that I was going to play back on for—

Lauren: Right

Thomas: But it was just great. Um, between baseline and hypomania is where most of my best effort comes. And the more I write, the more I write, the closer I get to hypomania.

Lauren: Oh.

Thomas: Yeah. Yeah—the more creative you get, the more the ideas flow and the more upbeat your your nature becomes.

Lauren: So you're saying that writing can create hypomania?

Thomas: Oh yeah. Yeah, it can. The writing. If you start off with a lot of creative thoughts and you start writing—it can actually lead to mania, too. You can write yourself right out of sanity.

Lauren: I never thought of that.

Thomas: Well, that's the truth.

Thomas: Alright. What's on the next page? Oh. Now we're just talking about my illness.

Lauren: Yes.

Thomas: Oh. I see. That's not fun. (turns page) Yeah, still talking about the illness. (turns page) That's not fun…(turns page)

Lauren: St. Augustan's is St. Augustan's.

Thomas: Hm?

Lauren: St. Augstan's (indicates)

Thomas: Yeah. Ok. Thanks. (turns pages)

Lauren: I couldn't figure out what Beatrice was getting for Christmas.

Thomas: Diamond earrings.

Lauren: Oh. The sparkles. The glitter. But I thought…

Thomas: Read it over again, now that you know.

Lauren: Okay, I'll read it over again. That makes sense with the penguins.

Thomas: (turning pages) Yeah, I still agree with that. Writing about yourself is as depressing as it can get.

Lauren: Can writing also make you more depressed? If it can spiral you into mania?

Thomas: You can't write when you're depressed. I mean, people—great people—who've written when they're depressed are like, you know, Edgar Allen Poe wrote a lot of stuff when he was in dark times. And he-uh-he used heroine and alcohol to medicate himself through those dark times as he wrote. And Abraham Lincoln did a lot of great writing when he was in dark times, you know, there are people who've been able to—for me, when I'm depressed, I don't want to have a thing to do with the keyboard. I just, you know, I'm very much filled full of apathy, very strong apathy.

Lauren: Can the keyboard actually make you depressed?

Thomas: Yeah, when you sit down, yeah. If you want to write something. About the only thing I can write when I'm depressed is is I've been in correspondence with my godfather for many many many many years, and um, I can sit down at the keyboard, though I don't anymore—he asked me to write only handwritten letters to him, but I can sit down with a pad of paper and write him a letter when I'm depressed. But that's really about the only writing I can do when I'm in a depression. Um, I think I can write him when I'm depressed because I know that he will write me back and let me know what he's seeing in my writing. And it's therapeutic in nature for

me when I'm depressed. But writing itself—no, I don't deal with it very well when I'm depressed. And I, I don't think it's that I can't write when I'm depressed, I think it's the fact that I don't want to even try. You know, apathy is just that deep. (turns pages)

Lauren: What about if you are writing something depressing to your godfather? Would that make you more depressed?

Thomas: (takes breath) No, because the reason I write him is is you know it's the old adage of physician, heal thyself. And when I write him I may write and say, you know, I'm not really feeling too good right now. Things are not as happy as they could be, you know, I worry about this person or that person in my life worrying about me. And then I'll follow it up with a thought like, you know, but you know, I've been worse. Things have been, you know, more confusing than they are right now. And I can see that I'll come out of this at some point in time, you know, and, I'll basically follow up the negative with something positive, you know. My family have always said that I have the ability to be positive moreso than most people. I have—my father's very pessimistic. Uh, and my brother George is very worrying in nature. And I don't ex—I don't really show those two sides of my family's personality too much when I'm depressed, I try to pull myself out of it.

About the only thing that I find that I can do when I'm depressed that's somewhat creative in nature is that I can read the Bible. And uh, I find that uplifting. And I read basically the New Testament, but from time to time, I'll go back and read Job or I'll read Genesis, the first few chapters of Genesis, that things are being created and life is new for mankind and and, you know, I'll start to pull out of it. Sometimes I'll read them several times.

Um, with the second major depression I ever went through, um, I was drinking beer to make myself feel undepressed, which is stupid because beer is a depressant in nature, but here I am drinking beer. And one morning I got up and I said, you know, the only thing I know to do is um, I guess I should pray but I don't know how to pray. So I got in my car and I rode to a Christian bookstore and I bought a copy of the Catholic Missile, 'cause I knew there were prayers in the Catholic Missile. And I went home and I sat in my chair with my beer and opened up the book to the prayers and I said my prayers and drank my beer. And, um, after a couple of days, I stopped drinking the beer and was just saying the prayers, and then one—it was a Sunday morning I woke up and the depression was gone. And I said, great! Lemme have a beer! Celebrate! And I didn't—fortunately I didn't slide back into a depression, but, it was the beginning of the end of starting to use substances like beer and marijuana and scotch and what-not to help me through negative aspects of my life. And, after I used the prayers as a method of gaining stability mentally for myself, I didn't realize it was the prayers that had brought me to a place in my life where I was no longer depressed. You know, I didn't even think about it. I thought to myself, well good, it's gone. Let's celebrate! And that was sad because it happened again, and again. And, uh, depression's no fun. I've never enjoyed myself in a depression.

Lauren: Ok. (flips papers)

Thomas: Jibberish.

Lauren: Yeah, it's a lot of jibberish. (flips papers) Wait. This right here's jibberish? On page 14 at the bottom?

Thomas: Well, you mean where I was talking about the seven deadly sins?

Lauren: That's not jibberish. (pause) Because it has to do with your book, right?

Thomas: Here you go. Up above it. Yeah. This is it. Yeah (unintelligible) is the seven deadly sins. Yeah. That's cool.

Lauren: Ok.

Thomas: Because that's basically what I based it upon: the different things that mankind falls prey to.

Lauren: Alright. (pause) why a spiritual allegory? Why not another creative piece?

Thomas: I think everybody needs faith. You know? And some people can find faith in their church life. Other people can find faith in being a husband or a wife or a mother or a father, you know. But some people have real trouble finding faith in their life. And I wanted to write something that, if somebody read it, they would say to themselves, you know, that's got a pretty positive attitude to it. I think I'd like to (pause) read more of that.

Lauren: Right.

Thomas: And, um, I think everybody needs to have something that they can base their life upon. To a certain degree. And this book helps anybody say to themselves, "you know, if this character Leon can go through all of this and come out the other side as one of the greatest figures that's ever lived," you know, "maybe I have a chance of coming through this and being good myself." Or "better being the person that I am." And, um, there's so much—you see Leon go through all these things and come out as Jesus. But at the same time, you see the different characters in this book going through various things and coming out the other side of whatever it is they're going through and coming out better off than what they were before they started. I mean, even to the degree of the people being in Gomorrah with Ace in the temple saying, "My, my, we have a lot to talk about," even those people are going to have to face who they are themselves, even if it is with the devil. You know, so, I think that has to do with it. You know, I wanted to write something that the everyday person could pick up and say, "wow, that's really interesting." And I think I've done that, you know, I think I've done that.