



Research paper

In their own words: A qualitative focus group study of resilience in bipolar disorder

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ABSTRACT

Background: Bipolar disorder (BD) is a debilitating mood disorder. Empowering people to live well in the context of their illness represents an ongoing clinical challenge. Resilience research offers potential opportunities to address these complexities, yet debates regarding its definition and operationalisation limit interpretations of findings and future study designs. Including the voices of patients in this debate is crucial to understand resilience from a nuanced, multidimensional perspective.

Method: We aimed to understand how patients with BD experienced resilience. Four focus groups including a total of 39 people with BD were held. Data was analysed using reflective thematic analysis.

Results: Four central themes and twelve subthemes related to resilience in BD emerged: (1) illness course – subthemes: chronic illness stages, tools and knowledge via lived experience, and pressure of successful stability; (2) self-awareness – subthemes: accepting diagnosis, embracing inevitable downfalls, self-exploration; (3) coping and growth strategies – subthemes: emotional first-aid kit, routine and available resources, and cultivating optimism; (4) support networks – subthemes: positive support outlets, communication and disclosure of needs, and stigma and rejection.

Conclusions: The themes and subthemes highlight the need to assess and address resilience in BD given the unique challenges faced by people with this chronic condition. The insights from this qualitative study provide opportunities to redefine currently limited definitions and measurement of resilience in this population.

1. Introduction

Bipolar disorder (BD) is a lifelong mental illness marked by debilitating mood episodes of mania, hypomania, depression and periods of euthymia and subthreshold symptomatology (Vieta et al., 2018). BD is a leading cause of global disability affecting approximately 34 million adults (WHO, 2025), thus representing a substantial healthcare economic burden (Singh et al., 2025). Early onset is frequent in BD yet reported delays in diagnosis of up to 10 years prevent appropriate treatment in the early stages of illness (Fico et al., 2021). Aside from clinical symptomatology, functional and cognitive impairment are also prominent in BD across multiple illness stages, affecting prognosis

(Bonnin et al., 2019; Kjærstad et al., 2023; Miskowiak et al., 2026). Functional impairment affects autonomy, occupational and educational achievement, cognition, and interpersonal relationships (Sanchez-Moreno et al., 2017). Similarly, cognitive impairment is linked to poorer functional outcomes with approximately 50% of patients reporting persistent cognitive impairment, and no current pharmacological treatments are available to target it (Keramatian et al., 2021; Solé et al., 2022; Torrent et al., 2011). Beyond the clinical presentation, BD also affects various areas of life; people with BD also report lower quality of life (Gutiérrez-Rojas et al., 2008; Ishak et al., 2012) reduced life expectancy (Kessing et al., 2015) and greater physical health problems such as cardiovascular disease, stroke, and metabolic syndrome

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(Nierenberg et al., 2023). As no complete cure for the disorder currently exists, a core clinical goal is to help people living with BD to do, feel and live better within the context of their illness (Vieta and Torrent, 2016).

A paradigm shift involving mental health promotion is considered an effective approach to help people live better with their illness (Clougher et al., 2025). A core aspect of living better includes resilience which may contribute to the ongoing clinical goal of improving the overall well-being of individuals with BD (Clougher and Amoretti, 2024). To date, debates concerning resilience as a trait, an outcome, or a process persist, highlighting ongoing conceptual limitations and a lack of consensus regarding the definition of resilience (Denckla et al., 2020). Trait resilience explores inherent characteristics for coping with adversity yet does not account for intra-individual variation and shows limited predictive validity in longitudinal studies (Bonanno et al., 2024; Hill et al., 2025; Masten et al., 2023; Rutter, 1987). Outcome resilience focuses on positive adaptation in the presence of adversity, frequently equated with the absence of psychopathology (Feder et al., 2009). This dichotomous approach may be overly simplistic and categorically excludes people with mental health conditions as resilient individuals. Furthermore, a generalised outcome measure is potentially reductionistic as it fails to capture the heterogeneity of resilience across different populations via a one-size-fits-all uniform metric. In contrast, process-oriented resilience offers a more nuanced view of resilience by adopting a dynamic, multidimensional approach that considers variability in different contexts. As such, this highlights the need to consider domain-specific fluctuations which likely vary across different populations. Nevertheless, a comprehensive systematic review (Wolke et al., 2025) examined 193 longitudinal resilience studies found that only 33% provided an explicit definition of resilience; 6% (trait), 19% (outcome), and 8% (process). Consequently, resilience research remains fragmented and non-conclusive, warranting further investigation.

Examining resilience within clinical populations, such as BD, reveals additional layers of conceptual complexity. The APA Dictionary (APA Dictionary of Psychology, 2018) defines resilience as a process and outcome of successful adaptation to adversity through mental, emotional, and behavioural flexibility while adjusting to external and internal demands. Further factors include adapting well to serious health problems by bouncing back with personal growth and coping strategies, environmental factors, social support, and individual development (APA, 2012). Nevertheless, the APA definition was not specifically coined to encompass the unique, chronic experiences of BD, compounded by the resilience literature which has focused on post-traumatic stress disorder (PTSD) and major depressive disorder (MDD) (Denckla et al., 2020). Furthermore, many of these studies (Fincham et al., 2009; Marulanda and Addington, 2016; Min et al., 2015, 2012; Wartelsteiner et al., 2016) employ a dichotomous approach (high vs. low resilience), or use control groups without mental health disorders as a primary comparison, potentially limiting insights into the ongoing process of resilience within chronic clinical contexts. Consequently, the current literature appears to lack a specific focus on the role of resilience in BD, representing a significant gap in the extant literature.

In BD, comprehensive reviews of resilience are sparse; (Chan et al., 2023) explored resilience and BD in a systematic review restricted to studies in the English language, whereas Imrana et al. (Imrana et al., 2022) conducted a meta-analysis focused broadly on mood disorders. As such, both studies offered limited insight in inferring conclusions beyond their individual study objectives. These limitations were addressed in a recent BD-specific systematic review and meta-analysis of resilience compared to clinical and non-clinical populations (Clougher et al., 2025), finding that BD was associated with lower resilience when compared to controls, greater resilience in comparison to schizophrenia, and no differences with MDD. All included studies ($n = 21$) used a variation of self-report tools to measure resilience; only one scale was specifically designed for use in BD. Nevertheless, Clougher et al. (Clougher et al., 2025) did not synthesise the resilience definitions across studies, thus failing to address a marked limitation across the

literature, revealing further complexities in resilience research and BD.

As such, understanding definitions and measurement of resilience in BD represents a core clinical challenge. One possible solution are qualitative studies that explore people's lived experiences which may be overlooked in quantitative studies (Clougher et al., 2025). To our knowledge, only one qualitative study exists with a specific focus on resilience in BD (Echezarraga et al., 2019), however, the sample was restricted to 65 years of age and 'high' resilience scores, ergo excluding elderly people with BD who may have specific needs in terms of resilience (Montejo et al., 2024) while also reinforcing the conceptualisation of resilience as "positive adaptation". As such, qualitatively exploring resilience with a more representative sample is warranted (Nkire et al., 2024) as current quantitative approaches fail to capture the unique knowledge offered by people with lived experience. Given the fragmented nature of the results to date, perhaps we have forgotten to ask the very people we aim to help what they think resilience is (Clougher and Torrent, 2026).

The present study aims to qualitatively understand resilience through the lens of people diagnosed with BD. Together, results will address the notable gap of resilience research in BD by including patient voices to address the persistent methodological challenges in the extant literature.

2. Methods

2.1. Research design

Focus group methodology (Morgan, 1996) was used in this study. While informed by existing resilience literature, an interpretative epistemology using an inductive design (Braun and Clarke, 2006) was preferred to capture the subjective experiences of resilience in BD, providing a methodologically flexible approach to the analysis, to develop themes from the collected data. A checklist for reporting qualitative data (Braun and Clarke, 2021) can be consulted in Supp. 1.

2.2. Participant recruitment

A purposive sampling strategy was used to recruit participants via the Bipolar and Depressive Disorders Unit at Hospital Clínic, Barcelona. All participants were receiving ongoing treatment at the time of participation and had consented to participate in research studies. Participants were contacted via telephone and offered to participate. Inclusion criteria were: (1) diagnosis of BDI/BDII according to DSM-5 criteria, (2) six months euthymia at study entry based on psychiatric records, (3) ≥ 18 , (4) fluent Spanish or Catalan, (5) provide informed consent. Exclusion criteria were: (1) inpatient in the previous six months, (2) unable to attend, (3) unmet inclusion requirements. The study aimed to recruit between five to ten participants across four groups to reach saturation of emerging concepts from iterative rounds (Hennink et al., 2019; Krueger and Leader, 2002).

2.3. Guide for focus groups

No specific guide was developed to avoid overstructuring the groups, ensuring that analysis was based explicitly on participant feedback rather than pre-existing frameworks. Facilitators used a presentation to introduce the study objectives, the research team's background and study motivations, to promote therapeutic alliance. Further, the APA definition and Connor-Davidson Resilience Scale (Campbell-Sills and Stein, 2007; Connor and Davidson, 2003) were presented as references for standardised views.

2.4. Procedure

Four 90-minute focus groups were held in a dedicated group therapy room. Participants attended a single session and no repeat interviews

were conducted. Sessions were facilitated by CT (PhD, female), a senior researcher and psychologist, and DC (MSc, male) a PhD student and psychologist. CT facilitated active participation while DC took field notes to supplement the audio transcriptions. Co-authors rotated attendance in sessions as observers. The researchers had no prior relationship with the participants before the study commenced. All focus groups were audio recorded, transcribed verbatim, and all participants provided written informed consent.

2.5. Data analysis

Focus groups were transcribed and analysed using reflexive thematic analysis approach (RFA) (Braun and Clarke, 2021). RFA aims to identify and report patterns that emerge in a dataset based on participants' contributions, which are then interpreted by the researchers to explore their meaning from a critically relevant standpoint, while remaining aware of how individual experiences and perspectives could influence the conclusions obtained in the data analysis. The original 6-step framework can be consulted in Supp. 2. To maintain data integrity and participant anonymity, transcripts were not returned to participants. A participant with lived experience has co-authored the present paper to ensure that participant voices were represented both in the active data collection phase as well as the preparation of the final manuscript.

All transcripts were read by the research team to address any errors identified during transcription. Transcribed data were coded using an open coding method to allow for the interpretation of emerging themes by DC, who read all four transcripts. Qualitative data were coded and analysed using NVivo qualitative research software (Version 15; Lumivero). To ensure the rigour of the findings, CT and SA independently read and coded the transcripts. Team meetings were held to share coded data and discuss the emerging themes and subthemes as part of a collaborative reflexive dialogue. The researchers used illustrative quotes from the data to provide evidence for their interpretations. The final analyses were discussed among the research team to accurately represent participants' insights. Data collection was concluded after the fourth session as data saturation was achieved. To prioritise the collective lived experience and ensure the highest level of participant anonymity, quotations are presented as a collective narrative without identifiers, emphasizing the shared experiences of resilience identified.

2.6. Quality assessment

Team meetings were held to discuss illustrative quotation selections, patterns within the data and the diverse range of participants' views. The team also engaged in reflective dialogue regarding their own beliefs, values, and preconceived assumptions throughout the research process to reduce biased interpretations. The Consolidated Criteria for Reporting Qualitative Research Checklist (Tong et al., 2007) can be consulted in Supp. 3.

2.7. Reflexivity statement

Our culturally and professionally diverse team informs our approach to the data. CGD has lived experience with BD and is a proactive member of the Catalan Bipolar Disorders Association. Their personal and professional insight was vital to highlight experiences that may be overlooked by those outside of the community and was consulted throughout the writing process from study conceptualization to manuscript revision. Further, they also revised all results and citation selection to ensure that they were appropriately aligned and reflected the lived experience of people with BD. The lead author (DC) is a clinical psychologist and PhD student with experience in private psychotherapy practice, informing the rationale for the study itself. AMA and KM are psychologists and research group leaders with international experience providing cross-cultural perspectives. CT and SA are experienced clinical psychologists

with expertise in BD and psychological therapies; both served as supervisors to the lead author. EV and DH are leading psychiatrist experts in the field of BD and mood disorders, helping to address the complexities of understanding the BD context. We used reflective notes and in-depth discussions to ensure that all perspectives were considered and included. All authors acknowledge that these personal and professional experiences have likely shaped their interpretation of the data and informed the analysis presented here.

3. Results

39 individuals participated across four focus groups. Sociodemographic data are provided in Table 1. Supp. 4 provides full recruitment process.

The RFA revealed four main themes and 12 subthemes provided in Table 2. Each theme and subtheme is described alongside verbally transcribed evidence. Frequency was not treated as an indicator of importance, as both themes and subthemes were developed and analysed based on their relevance to the research question and their contribution to understanding participants' experiences. Additional illustrative quotes can be consulted in Supp. 5.

3.1. Theme 1: illness course

3.1.1. Overview

For resilience in BD, the illness course, included various factors that are important in feeling resilient internally. Participants considered mood episodes as part of an ongoing, chronic disorder, rather than a lack of resilience.

3.1.2. Subtheme: chronic illness stages

Chronic illness stages encapsulates the idea of resilience as an ongoing, fluctuating process based on the illness stage, which inevitably changes along the course of illness:

"Resilience often depends on the phase of illness. I don't think we can control whether or not we have more episodes and a lot of the time it's about holding on through them."

Current definitions of resilience may lack inclusivity in BD as they do not account for symptoms in changing mood states:

"People who suffer from a disorder become more resilient because we repeatedly face the different phases such as depression, whereas people without the disorder don't."

Actively adapting one's mindset to mood state is a central part of resilience as "resilience is more about giving it your all to try to adapt." Importantly, giving it "your all" to adapt as part of resilience depends on various factors:

"Adapting depends on your physical, emotional, and mental condition...on how you use different strategies for resilience, to face new challenges and new obstacles."

3.1.3. Subtheme: tools and knowledge via lived experience

Tools and knowledge via lived experience referred to the learning curves that allow people to feel more resilient:

"We have to be able to think about the past. If you think about

Table 1
Sociodemographic characteristics of participants.

Participant characteristic	N (%)
Sex	
Male	16 (41.1%)
Female	23 (58.9%)
Age in years (mean $\pm$ SD)	47.78 $\pm$ 13.29
Bipolar disorder (type)	
Type I	21 (53.8%)
Type II	18 (46.2%)
Time since diagnosis in years (mean $\pm$ SD)	11.94 $\pm$ 7.60

Table 2

Resilience themes and subthemes identified in bipolar disorder.

Themes	Theme Description	Subthemes
1. Illness course	Related to the broad range of factors that are important for feeling resilient within themselves over the course of the illness. Participants detailed the characteristic highs and lows of BD, highlighting a need to consider mood episodes as part of an ongoing, chronic disorder, rather than symbolising poorer recovery or a lack of resilience.	1a. Chronic illness stages 1b. Tools and knowledge via lived experience 1c. Pressure of successful stability
2. Self-awareness	Refers to capacity to reflect upon illness and allowing oneself the necessary time to do so. Captures the idea that there are different ways of feeling resilient according to the level of self-awareness.	2a. Accepting diagnosis 2b. Embracing inevitable downfalls 2c. Self-exploration
3. Coping and growth strategies	Explores the concept that dedicated time to coping and growth strategies is essential to promote flexibility. Describes the active approach that people with BD can take in terms of the resilience process.	3a. Emotional first-aid kit 3b. Routine and available resources 3c. Cultivating optimism
4. Support networks	Highlights the positive and negative aspects that interpersonal relationships and society can have in shaping resilience. Describes a bidirectional approach: how people with BD interact with their environment but also how their environment interacts with them.	4a. Support outlets 4b. Communication and disclosure of needs 4c. Stigma and rejection

overcoming a specific situation, when that situation happens again, it's an opportunity to identify resilience".

Nevertheless, some participants also reported that equally as important about remembering past events was the ability to "forget...the experiences...you learn from them, analyse them...then forget" as a way of being resilient. Another noted "resilience is not a specific or finite situation in time, but a constant that is experienced over time". Participants further mentioned that resilience could depend on certain situations, questioning whether one "could be resilient when facing one type of input, but not against another". Similarly, resilience was related to the experience of years with illness rather than the presence or absence of episodes:

"Experience to me is related to the years. Everything that you live until this very moment...that's what gives you experience, to fall."

3.1.4. Subtheme: pressure of successful stability

The pressure of successful stability—reaching and maintaining stable mood—affects resilience as participants felt that episodes are not a sign of reduced resilience:

"There's this point of view that you have to face it head-on...and you can't turn away from it, and on top of that, it has to make you stronger. Stronger? It destroys you."

The process of intent to adapt and be resilient was more important than a successful result or outcome:

"Success...we try to adapt! You can give it your all, but maybe you still don't achieve it. But even if you don't achieve it, you are still resilient."

3.2. Theme 2: self-awareness

3.2.1. Overview

Self-awareness was identified as an important aspect of resilience as it allowed people with BD to reflect upon their feelings of resilience in the context of their illness.

3.2.2. Subtheme: accepting diagnosis

An important part of resilience in BD was the acceptance of the diagnosis. Many described a sense of confusion of "not knowing what it means" upon receiving the diagnosis and the time it takes to "accept it". Many participants stated they were incorrectly diagnosed prior to receiving the BD diagnosis making it difficult to "recognise" the disorder. Moreover, acceptance appeared more important than the diagnosis itself:

"At the start, they tell you the diagnosis and you don't believe it... Then I was wrongly medicated and it took time to get the medication right...years....I didn't accept it, wasn't conscious of it. Maybe a year ago, my whole world was going to hell, and feeling that danger, particularly for my family, I accepted the diagnosis. Accepting it, made me more resilient. Now, as soon as I notice high energy, I know how to stop myself. But I couldn't do that without accepting the diagnosis."

However, experiences diverged regarding how the label itself impacted resilience. While acceptance can help to "interiorise living with BD as part of your daily life", participants were vocal about highlighting resilience in terms of before and after diagnosis. Diagnosis thus represented a point of tension in the data as it was considered both a facilitator and a barrier to feeling resilient:

"Sometimes, at the innate level, I feel less resilient, but receiving the diagnosis made me more resilient. It may seem a bit ambivalent, but it feels like a natural aspect to me."

3.2.3. Subtheme: embracing inevitable downfalls

Participants considered embracing inevitable downfalls as part of the resilience process that can be present at different times:

"Attitude is really important to seek resources. Going through a bad spell, without the tools that you need in the moment, but knowing that time helps."

Participants also stated that downfalls in BD and knowing that it passes, could also be part of resilience:

"More than not giving up, it's actually about letting yourself be defeated...but then getting back up again."

Moreover, during specific periods of the year participants knew they would feel bad, making it increasingly difficult to live a normal, daily life, despite efforts to do so. Accordingly, participants stated the need to adjust the definition of resilience:

"The resilience definition...the idea that it is a process and an outcome. There are always setbacks and relapses. It's hard to consider it as a result, let alone a success! There's a good chance you'll relapse again. You have to go back to work. You'll face challenges with that same issue again. I don't know...I'd like to know why it's also considered a result."

3.2.4. Subtheme: self-exploration

Self-exploration was as an aspect to consider in the resilience process involving "introspection and self-knowledge". Participants mentioned that "personal maturity" was important to know what situations needed to be faced via a balanced approach to both self-awareness and self-exploration:

"Sometimes being too attentive you end up overwhelmed from introspection, but at the same time if you never shine a light inwards then things can also go by unnoticed. Not too much, not too little. You have to try strike a balance."

Self-exploration was further linked to resilience:

"Resilience....it's a bit like opening doors, no? The doors lead you down a path to a better place...Feeling stress can be a sign that we are alive. But it has to be managed properly. I have experienced many traumas which also open doors...we have to look inside to find the right doors."

3.3. Theme 3: coping and growth strategies

3.3.1. Overview

The idea that resilience required dedicating time to coping and growth strategies encompassed was a fundamental part of the resilience process for people with BD to build their own individualised coping mechanisms.

3.3.2. Subtheme: emotional first-aid kit

Having an emotional first-aid kit as part of resilience, in terms of having "emotional flexibility" was important. There was a unanimous agreement that BD affected all participants' emotional regulation and a need to actively regulate emotions. Identifying triggers for emotional reactions is important to "detect" signals of upcoming challenges. Further, participants considered the emotional first-aid kit essential to deal with difficult and challenging daily life experiences:

"Challenging daily life experiences can trigger stress...leading to emotional behaviours but also some mental flexibility in moments of instability. I believe we try to avoid stress in order to achieve mental, emotional and behavioural flexibility."

Conversely, opinions diverged as while some sought stress avoidance, others found that facing stress helped participants feel more resilient:

"I need stress to adapt. Stress gives me more energy and allows me to focus on one thing. I don't see it as a negative thing."

3.3.3. Subtheme: routine and available resources

The need to acknowledge routine and resources available to them is part of actively participating in the resilience process. Routine was considered as an overall self-care approach to feeling resilient:

"In hypomanic phases, with the right tools...mindfulness, food, sleep habits, medication, your environment, everything is more under control, and for me personally, that makes it easier."

Resilience also needs to include the actions that people with BD when they know that they need support:

"Resilience is knowing when to pick up the phone. People eventually stop calling, that's life. But the loneliness...It's impossible. People might be there from time to time, but it's not the norm. It depends on what point of your life you are in. Some have children, some don't. People are busy. So, you must maintain the contact and take care of the friendships."

3.3.4. Subtheme: cultivating optimism

Cultivating optimism was seen as a resilient attitude towards living with a chronic mental illness. Having a sense of humour was "fundamental" in terms of living with BD:

"In terms of resilience, I know people with the illness that have a great sense of humour and explain really intense, difficult things to you, but laughing and almost joking around. I don't mean that they find it funny, but they have a comical outlook on it."

While BD was no laughing matter "seeing the bright side can help take the edge off" and increase feeling hopeful, although there was some hesitation about what provided hope. One participant mentioned that having a religious faith provided them with "a sense of community".

Nonetheless, other participants saw feeling hopeful from a more internal, agnostic state:

"I feel like you have to have, I don't really use this word, but faith....or....hope that something will change inside of you."

3.4. Theme 4: support networks

3.4.1. Overview

Support networks refers to the positive and negative aspects that interpersonal relationships and society provide for people with BD as part of resilience.

3.4.2. Subtheme: support outlets

Participants highlighted the importance of identifying actively pursuing positive support outlets as part resilience, mentioning the benefits:

"Having someone support you nearby, friends, family member allows me to detect when I am unwell and it's always been really helpful for me."

Experiences diverged regarding family support, revealing disagreement in the data. While most agreed that having a support network was important, participants also highlighted the flip side:

"Everyone has their own life story. My husband knew from the very moment I showed symptoms; he took me to the emergency department, and they diagnosed me. My husband is in contact with the psychiatrist, I take my medication, an anti-depressant, and when I am climbing the walls, my husband takes that medication off me. I have a son who doesn't accept the diagnosis. He was 9 when I was diagnosed, and he didn't understand anything, and he still feels that way. That's why I mention family – some understand and some don't".

Positive support outlets also included were the support of mental health professionals who understand BD:

"When I was diagnosed, I was supported by the public mental health service. They gave me a booklet about BD, with really easy to understand language and it felt really accessible for people who are not in the field. It helped me so much, and that evening when I left the clinic and was reading through the booklet, well, even though I knew it was a lifelong disorder, I felt like my spirits were lifted".

Other participants mentioned the importance of connecting well with professionals:

"It's so important to have a good mental health professional, one who does it because they like what they do, because if not, we experience the opposite effect. I hope it doesn't happen to many people but being diagnosed by someone who, while they may have advanced studies, shows no empathy, there's no connection...it's challenging. But if you get the right professional, my goodness, it's like a door opens and things start to change both inward and outwardly."

3.4.3. Subtheme: communication and disclosure of needs

Reciprocal communication and disclosure of needs was an important resilience aspect for many participants in terms of feeling understood and developing communication skills to explain their experience:

"There are times in BD, when we feel more euphoric, when we don't listen to what people are telling us. So, resilience is the ability to listen, even when we don't like it, especially when they mention our mood is changing. That's when we understand we need to take medication or reach out to the professional who helps us to...all because the people in our environment have noticed it. They are

more sensitive to our changes, and we have to be able to listen to them.”

Feeling listened to was another aspect of resilience for participants:

“People without the disorder don't understand us...it's really hard, they love us...but it's not the same. They understand 80% of what's going on... when there is hypomania and I need more stimulation they might try and cut off certain activities because they are afraid of what might happen...there has to be trust and understanding.”

Some participants disagreed, highlighting a divergence of experiences in terms of communication:

“At first, they don't understand you. They know you are sick, but they can't really understand it...”

3.4.4. Subtheme: stigma and rejection

Protecting wellbeing in the face of stigma and rejection was also an important aspect of resilience in BD. Ongoing stigma and rejection contributed to the resilience process:

“I hid my diagnosis because of stigma. During episodes, people didn't understand what was happening and viewed it as inappropriate behaviour...jumping to mistaken conclusions.”

Participants suggested that stigma could be more subtle, even in what, from a societal standpoint, would be considered safe environments like the family:

“In my family, nobody really says anything. Nothing said, nothing said. Do they know? They know. Very rarely it might come up in conversation, but in general it's a topic that nobody brings up.”

4. Discussion

The present paper aimed to understand resilience according to the lived experience of people with BD. Four themes were identified: (1) illness course, including subthemes chronic illness stages, tools and knowledge via lived experience, and pressure of successful stability; (2) self-awareness, including subthemes accepting diagnosis, embracing inevitable downfalls, and self-exploration; (3) coping and growth strategies, including emotional first-aid kit, routine and available resources, and cultivating optimism; (4) support networks, including support outlets, communication and disclosure of needs, and stigma and rejection. Revision of the four themes revealed a pattern of aspects that could guide resilience research in BD.

Insights underscore the need to reconsider current resilience definitions as a process to reflect the chronic nature of BD, in line with previous qualitative work from (Echezarraga et al., 2019). Participants' accounts of resilience while facing ongoing adversity align with research refuting its conceptualisation as the absence of symptoms or stability of mental health in the face of adversity as a benchmark for recovery (Denckla et al., 2020; Feder et al., 2009). Crucially, participants prioritised the *attempt* to feel resilient over successful adaptation outcomes. From this perspective, episode frequency is not a sign of failed resilience, but an opportunity to engage with the resilience process. Furthermore, self-awareness, diagnostic acceptance and the actively navigating the illness emerge as primary indicators of resilience. This mirrors the multisystemic process approach (Ungar et al., 2023), highlighting that resilience definitions in BD must account for the availability and accessibility of the tools required to regain well-being as part of a lifelong process. Considering our results within the context of recovery-oriented frameworks, such as the BD-specific POETIC model (Jagfeld et al., 2021), is warranted given the potential conceptual overlap with resilience. Convergence is evident regarding optimism (our results) and hope (the POETIC model). Nonetheless, while hope in the POETIC model often points towards the ultimate goal of recovery, our results suggest that optimism is concerned with maintaining a positive outlook,

regardless of current symptomatology. Clear divergence is also observed; while recovery-oriented frameworks focus heavily on factors tied to the journey of personal recovery, our study examined resilience independently of recovery, capturing how an individual engages with the process of resilience. As such, it may not be that people with BD are less resilient per se, following traditional binary outcome approaches or recovery-oriented frameworks, but rather that a more nuanced perspective is required. Facing adversity as part of a lifelong illness is, in itself, a demonstration of impressive resilience capacity rather than a lack thereof. Thus, while the POETIC model shows clear clinical utility for promoting personal recovery in BD, resilience may be better considered a distinct construct that can promote patient insight irrespective of recovery status. If we focus on resilience as recovery, we may run the risk of falling into the trap of associating recovery with greater resilience, as has historically been the case in outcome-based approaches or current ongoing conceptualisation challenges (Clougher and Torrent, 2026). Future research is necessary to better discern the boundaries between these concepts.

Our findings highlight the importance of considering social dimensions when defining resilience. Relational reciprocity (i.e., listening to others vs. being listened to by others) was fundamental for many individuals. Support networks were not solely considered as close friends and family; many mentioned the importance of mental health professionals in line with research on the therapeutic alliance improving patient outcomes (Fisher et al., 2016). Conversely, stigma and rejection could hinder resilience as participants described hiding their diagnosis for fear of judgement. Disclosure is associated with stigma (Schofield et al., 2025) which has been linked to a reduction in help-seeking behaviours (Perich et al., 2022). Thus, the disclosure of the disorder may influence the cost-benefit of sharing and negatively impact resilience, reiterating the importance of positive social support as a protective factor in BD (Studart-Bottó et al., 2023). Together, a notable disconnect is observed between the internal (fear of stigma) and external (presence of stigma) demands, indicating a need to review current resilience definitions which suggest that people with BD should adapt to these demands, focusing on how individuals view and engage with the world, and perhaps failing to account for how the world engages with *them*. Accordingly, although the element of social support is aligned with previous qualitative work on resilience in BD (Echezarraga et al., 2019), our results suggest the importance of considering both the positive and negative aspects of social support particularly how it may contribute to stigma, which advances preceding studies. This also reflects evidence from qualitative work on resilience in schizophrenia: patients also felt that involving family was challenging as it could diminish their autonomy, while social engagement could be associated with both stressful interactions and relief (Sumskis et al., 2017). Additionally, in the case of depression, qualitative results showed that individuals valued existing relationships in addressing stigma but also suggested a need to focus on individual feelings of internal resilience (Boardman et al., 2011). Thus, going beyond a unidirectional view of social support—traditionally positioning the patient as a passive recipient—and emphasizing bidirectional interactions encompassing support networks and societal stigma could contribute to a new paradigm for resilience in BD.

As our findings frame resilience as a process, a corresponding adaptation for its measurement in BD may be warranted. Resilience is commonly measured via self-report tools, prone to bias and, often, not designed for psychiatric populations (Cajada et al., 2023; Ishak et al., 2012). As people with BD experience lower life quality and reduced life expectancy (Gutiérrez-Rojas et al., 2008; Ishak et al., 2012; Kessing et al., 2015), it is plausible that they self-report lower resilience based on other illness related factors, not necessarily because of the disorder itself, which is likely influenced by both pharmacological and psychotherapy treatments (De Prisco et al., 2023) and the themes identified in this paper (e.g., stigma, relationship with healthcare professionals). Further, measuring resilience is generally compared to controls without a mental health diagnosis. This was a concern for participants who felt

more resilient than people living without the disorder by facing ongoing adversity that controls do not. Consequently, comparing resilience in people with and without BD may be a futile approach and future research should aim to deviate from arbitrary, binary outcome markers (i.e., high vs. low) that fail to capture the nuanced complexities of resilience in BD. Adapting resilience measurement to the specific context of BD via improved methodological approaches may result in better measurement tools.

While our findings underline the need to adapt resilience definition and measurement, it is noteworthy that cognition and functioning were not identified as part of this process. Their absence represents a potential divergence from the extant literature which has established their importance in recovery (Bonnin et al., 2019; Keramatian et al., 2021; Torrent et al., 2011). Cognition was mentioned indirectly for increased resilience in terms of accepting cognitive trade-offs, suggesting the sacrifice of certain cognitive capabilities. Furthermore, functioning was not explicitly mentioned, as participants focused on the attempts to achieve emotional wellbeing. We interpret these findings as an opportunity to bridge the gap between lived experience of resilience and clinical outcomes. Resilience could be defined as a process trajectory, whereby factors such as cognition and functioning could be viewed as fluctuating measurable outcomes of this process. Importantly, this would shift the research focus to modifiable mechanisms of resilience to be targeted in psychological interventions, promoting a transition from a deficit-based focus (mental disorders viewed as less resilient) towards a multisystemic, process-oriented perspective that acknowledges BD patients as resilient, surviving and living with the illness. Identifying an individuals' internal and external needs to improve overarching clinical features, may potentially allow people to live better in the context of their mental illness rather than in spite of it (Vieta and Torrent, 2016).

Overall, this study addresses gaps in the definition and measurement of resilience via the lived experiences of people living with BD. To our knowledge, this is the first qualitative study to explore resilience solely from the patient perspective, independent of traditional clinician-led frameworks. This approach allows people with lived experience to define and interpret resilience autonomously while considering the impact of their diagnosis, bridging a critical gap in the extant literature which heavily relies on clinician- or researcher-derived frameworks (Clougher and Torrent, 2026). Ultimately, promoting this patient autonomy fosters active engagement in the treatment process, aligning with the goals of person-centered approaches and encouraging informed decision-making regarding their own care (Pons et al., 2020). Further, the inclusion of 39 participants with near-equal gender distribution represents a robust sample size for qualitative inquiry. Combined, this allowed for a nuanced exploration of resilience in BD, enhancing the transferability of findings. Nonetheless, certain limitations must be acknowledged. First, the use of focus groups may have introduced self-selection bias, as participants likely had a pre-existing interest in resilience. Additionally, the focus group format can lead to social desirability bias (Bergen and Labonté, 2020) or the groupthink phenomenon (O-Sama and Shaukat, 2024), where the desire for group cohesion and harmony may outweigh critical analysis or limit the contribution of members who felt less confident speaking or disagreeing with certain aspects mentioned. To mitigate this, each session was led by an experienced clinical psychologist who attempted to ensure that all participants had the opportunity to participate equally and were fully informed prior to participation. Additionally, the sample only included people in euthymia, therefore limiting insights to this illness stage; resilience may have different meanings depending on the mood stages similar to that seen in other illness aspects (e.g., insight) (Choudhury et al., 2021).

To conclude, using an inclusive, patient-centred approach, our study highlights a need to broaden the definition and measurement of resilience in people living with BD, who remain underserved in collaborative care (Mongelli et al., 2020). To do so, we suggest a paradigm shift to consider resilience as a process in this population. The concept of resilience must strive to include the importance the illness course rather

than reducing resilience to the absence of symptoms or maintenance of stability, thus reflecting the complexity of living with BD. Resilience research must also include self-awareness in coexistence with the illness, that encourages the flexibility to accept the diagnosis and the inherent mood fluctuations as part of its definition. Similarly, we must aim to acknowledge that resilience is not limited to one point in time; for people with BD, dedicating time to coping and growth strategies is a vital, ongoing process. Consequently, we recommend longitudinal designs over cross-sectional studies (Vieta and De Prisco, 2024) to allow for richer insights into the fluid nature of BD and the resilience process. Furthermore, an essential part of resilience in BD must account for the interaction between the individual's internal world and how they interact with it, avoiding locating the tendency to locate the 'issue' solely in the person. While people with BD adapt to the world around them, the world around them also reacts to them which may impact actively engaging with the resilience process. Overall, this shift may offer more valuable insights into how people with BD actively attempt to cultivate resilience within the specific context of their illness. A more nuanced understanding could drive the research agenda to treat resilience as a process in the context of BD, ultimately contributing to the development of more precise, clinically oriented measurement tools and the development of effective resilience-promoting interventions.

CRedit authorship contribution statement

Derek Clougher: Writing – review & editing, Writing – original draft, Software, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Diego Hidalgo-Mazzei:** Writing – review & editing, Software. **Kamilla Miskowiak:** Writing – review & editing. **César García Díaz:** Writing – review & editing, Conceptualization. **Anabel Martínez-Aran:** Writing – review & editing. **Eduard Vieta:** Writing – review & editing. **Silvia Amoretti:** Writing – review & editing, Writing – original draft, Methodology, Conceptualization. **Carla Torrent:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization.

Ethical considerations

Ethical approval was received from the Ethics Committee at Hospital Clínic Barcelona (HCB-2023-0751). Participants were made aware of their right to take part and voluntary withdrawal of data at any time. All data were anonymised ahead of data analysis and manuscript submission.

Declaration of Generative AI and AI-assisted technologies in the writing process

No AI tools were used to support the writing of this work. The present manuscript was prepared, written and reviewed by the authors, who take full responsibility for the content of the publication.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.jad.2026.122436>.

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