

# *Self-Management Strategies Used by 'High Functioning' Individuals with Bipolar Disorder: From Research to Clinical Practice*

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**Introduction:** Bipolar disorder (BD) is a complex mental illness that results in substantial costs, both at a personal and societal level. Research into BD has been driven by a strongly medical model conception, with a focus upon pathology and dysfunction. Little research to date has focused upon strategies used to maintain or regain wellness in BD. Here, we present results from a qualitative study of self-management strategies used by a Canadian sample of 'high-functioning' individuals with BD. The aims of the present paper are two-fold: (1) To provide a description of the self-management strategies identified as effective by this sample of high functioning individuals and 2) to explore these results from a clinical perspective. **Methods:** High functioning (determined as a score of either 1 or 2 on the objectively-rated Multidimensional Scale of Independent Functioning) individuals with BD type I or II ( $N = 33$ ) completed quantitative scales to assess depression, mania, psychosocial functioning and quality of life, and underwent either an individual interview or focus group about the self-management strategies they used to maintain or regain wellness.

**Results:** The specific self-management strategies that individuals enacted are contained within the following categories: (1) sleep, diet, rest and exercise; (2) ongoing monitoring; (3) reflective and meditative practices; (4) understanding BD and educating others; (5) connecting to others and (6) enacting a plan. These strategies are discussed in the

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context of current treatment interventions and research findings, offering clinicians a broad range of potential techniques or tools to assist with their efforts to support individuals with BD in maintaining or regaining wellness.

**Conclusions:** The strategies adopted by a sample of people coping well with their BD show remarkable overlap with the targets of existing adjunctive psychosocial interventions for BD. The clinician can use this information to motivate clients to engage with such strategies. The present findings also serve to remind the clinician of significant individual differences in the personal meaning and concrete application of superficially similar strategies. Copyright © 2010 John Wiley & Sons, Ltd.

**Key Practitioner Message:**

- People who function well despite a significant history of bipolar disorder identify a range of strategies that are critical in their wellbeing.
- Key wellbeing strategies are: (1) managing sleep, diet, rest and exercise; (2) ongoing monitoring; (3) reflective and meditative practices; (4) understanding BD and educating others; (5) connecting to others and (6) enacting a plan.
- These strategies constitute ‘tips from the experts’ that can be offered to clients to increase hopefulness and improve engagement with psychosocial interventions.
- Clinicians will be familiar with these strategies as elements of existing psychosocial interventions—the present qualitative data provides significant cross-validation of the importance of these behaviours.

**Keywords:** Bipolar Disorder, Self-Management, Wellness, Clinician, Qualitative

## INTRODUCTION

Bipolar disorder (BD) is a chronic psychiatric condition typically characterized by recurring episodes of depression and mania (a distinct period of abnormally elevated, expansive or irritable mood) or hypomania (the subsyndromal counterpart to mania) (Goodwin & Jamison, 2007). Marked variability can occur between individuals with BD in terms of the type, number and length of episodes experienced, the severity and type of symptoms encountered, and the degree of recovery attained between mood episodes.

Outcome in BD has traditionally been determined by the assessment of objectively measured clinical information, such as rates of relapse or degree of symptom reduction on clinician-rated assessment scales. More recently, however, there has been increasing emphasis upon the need for additional forms of assessment to measure treatment outcome or recovery. For example, Keck (2004) has suggested that ‘Functional outcomes are more meaningful measures of response to treatment for BD than are scores on various psychiatric

rating scales’. Psychosocial functioning describes a person’s ability to perform the tasks of daily life and to engage in mutual relationships with other people in ways that are gratifying to the individual and others, and that meet the needs of the community in which the person lives. Most (e.g., Altshuler et al., 2006; Kauer-Sant’Anna, Bond, Lam, & Yatham, 2009; Miklowitz et al., 2007a) but not all (Michalak, Yatham, Kolesar, & Lam, 2006) existing research into psychosocial functioning in BD has used quantitative research methods. Of these quantitative studies, the majority have examined psychosocial functioning in individuals who are symptomatic or experiencing a mood episode; scant research has examined functioning in inter-episode or well individuals (e.g., Leidy, Palmer, Murray, Robb, & Revicki, 1998; Maina et al., 2007).

To our knowledge, only one previous qualitative study has examined the self-management strategies used by people to *stay well* with BD (Russell & Browne, 2005). The results of the study identified two main themes—a ‘stay well’ concept and ‘strategies to stay well’. Common strategies used to stay well included: acceptance of diagnosis, mind-

fulness education, identifying triggers, recognition of warning signs, sleep and stress management, making lifestyle changes, treatment access support and stay well plans. While the study provided some useful initial data, it also had some methodological limitations. For example, participants in the study self-identified as having maintained wellness for a 2-year period with no concomitant objective assessment and no clinical information collected.

We set out to expand upon this body of literature via a qualitative study examining the self-management strategies used by high functioning individuals<sup>1</sup> with BD. To avoid some of the limitations of the Russell and Browne (2005) study and our own previous qualitative research (Michalak, Murray, Young, & Lam, 2007), we committed to: use a carefully screened sample of participants, collect detailed quantitative data on symptoms, psychosocial functioning and quality of life (QoL) and utilize rigorous qualitative analysis techniques. Our objectives for the present paper are to: (1) describe the categories of self-management strategies identified as effective by a sample of individuals with BD who are 'high functioning' and (2) to explore clinical implications of these findings by synthesizing them with existing quantitative knowledge about strategies in adjunctive psychosocial interventions for BD.

### Participants

The study was completed by a total of 33 participants with BD (63%,  $n = 20$  female, age mean = 41.1, SD = 13.3) (Table 1). The sample was drawn from residents of British Columbia, Canada.

### Recruitment

Calls for participation were distributed via a number of channels, including: newsletters from the Mood Disorders Association of British Columbia, the Canadian Mental Health Association and other community mental health organizations, community newspapers, networking, public talks and education events and a range of websites. The advertisement invited people with a diagnosis of BD type I or II who felt that they were functioning

well with their condition to contact the researchers. Recruitment continued in this manner for 18 months, after which time an analysis of the characteristics of the sample indicated a preponderance of female and BD type I participants. Purposeful sampling was then used to selectively recruit for male participants, and individuals with BD type II (see Suto et al., 2010 for further details concerning the study methods.). Ethical approval for the study was granted by the University of British Columbia Behavioral Research Ethics Board committee (Table 1).

### Screening

Potential participants were screened over the telephone with the Mini-International Neuropsychiatric Interview (MINI) (Sheehan et al., 1998) to confirm diagnosis of BD and the Multidimensional Scale of Independent Functioning (MSIF) (Jaeger, Berns, & Czobor, 2003), which facilitates the assessment of functioning across work, residential and educational domains and has been validated for use in BD (Berns, Uzelac, Gonzalez, & Jaefer, 2007).

### Inclusion Criteria

Participants were required to have a diagnosis of BD type I or II, be 19 years or older, fluent in English, have a global score of less than 3 on the MSIF and not be in an episode of illness that would render participation in a qualitative interview or focus group difficult (e.g., severe depression or florid mania, based on clinical judgment). It is important to note, however, that individuals who were experiencing a mood episode but were still functioning well remained eligible for participation as we hypothesized that people who were maintaining their functional status despite high burden of symptoms could have important insights into self-management strategies for BD.

### Quantitative Methods

Hypomanic or manic symptoms were assessed via the clinician-rated Young Mania Rating Scale (Young, Biggs, Ziegler, & Meyer, 1978) and depression symptoms on the clinician-rated Hamilton Depression Rating Scale (HAM-D 29) (Williams, 1988). Self-report measures included the Quality of Life Enjoyment and Satisfaction Questionnaire (Endicott, Nee, Harrison, & Blumenthal, 1993) and Social Adjustment Scale (Weissman & Bothwell, 1976).

<sup>1</sup>Our research also samples from people who are not functioning well with their BD—a comparison of strategies amongst high versus low functioning individuals will be the focus of a future report.

Table 1. Demographic and clinical characteristics ( $N = 32$ )

Variable	Score
Sex	
Females	20 (62.5%)
Male	12 (37.5%)
Type	
Bipolar I	25 (78.1%)
Bipolar II	7 (21.9%)
Mean age (SD)	41.1 years old (13.3)
Mean # of depressive episodes (SD)	14.79 (15.94)
Mean # of manic episodes (SD)	8.3 (18.40)
Mean # of hospitalizations (SD)	3 (4.64)
Mean HAM-D score (SD)	8.03 (9.20)
Mean YMRS score (SD)	2.45 (3.00)
Mean Q-LES-Q % max score (SD)	
Physical health domain	68.69 (19.88)
General feeling domain	70.96 (15.43)
Work domain	82.73 (13.76)
Household duties domain	72.00 (23.04)
School/Course domain	74.44 (25.18)
Leisure time activities domain	77.77 (16.46)
Mean social domain	78.96 (16.44)
Overall-general domain	73.54 (20.20)
Satisfaction with medication (median [range])	3 (3)
Overall life satisfaction (median [range])	4 (4)
Have a job	16 (51.6%)
Work for self	14 (45.2%)
Volunteer work	13 (41.9%)
Mean SAS score (SD)	1.76 (0.44)
Mean SAS T-score (SD)	55.31 (13.46)

HAM-D = Hamilton Depression Rating Scale. YMRS = Young Mania Rating Scale. Q-LES-Q = Quality of Life Enjoyment and Satisfaction Questionnaire. SAS = Social Adjustment Scale. SD = standard deviation.

### Qualitative Methods

Participants were offered a choice of individual or group formats for the qualitative interviews. Interviews were conducted by one of the three primary investigators (S.H., M.S., E.M.), all of whom had significant expertise in qualitative research methods, lasted between 60–90 minutes and took place in participants' homes, at the university and/or over the telephone. A semi-structured interview guide was used to ensure that all participants were asked similar questions (e.g., what strategies have you found most helpful in managing BD? How do friends, family and co-workers affect your ability to stay well?). All interviews were audio recorded and transcribed verbatim. As is common in qualitative traditions, data collection and data analysis happened concurrently (Maxwell, 2005; Richards, 2005), and thematic analysis (Braun &

Clark, 2005) was used to compare, contrast and categorize the data into themes (both within and across transcripts). The data were coded, organized and re-organized several times as categories were developed, and an exploration of the relationships between and within subcategories led to the development of an initial coding framework and preliminary themes. The research team met to evaluate the initial coding framework and to synthesize the categories and concepts into themes. Data were coded according to these themes, whereupon coded data segments were again reviewed to determine their fit with each theme. QSR International (Americas) Inc., Cambridge, MA, USA (NVivo<sup>QSR</sup>) (Bazeley, 2007), a qualitative software programme, was used to manage the data and facilitate data analysis. Analytic meetings were held to discuss and monitor coding consistency to address the analytic validity of identified themes (Morse &

Richards, 2002). In addition, the research team met to ensure that the findings were internally consistent and supported by the data from the participants' interviews (Sandelowski, 2000). Therefore, emergent themes are supported by direct quotes from the participants as to enable readers to evaluate the interpretations.

## RESULTS

The self-management strategies presented here comprise actions, routines and processes that participants initiated to cope with BD and get on with the job of living. The importance of these strategies is that they arise from participants' experiences and are considered effective by people with BD who are functioning well. The strategies illustrate the beginnings of a self-management approach to living with a chronic mental illness. The strategies are: (1) sleep, rest, diet and exercise; (2) ongoing monitoring; (3) reflective and meditative practices; (4) understanding BD and educating others; (5) connecting with others and (6) enacting a plan.

### *Sleep, Rest, Diet and Exercise*

Participants identified getting sufficient and regular sleep as one of the most important strategies for maintaining or regaining wellness. Their description of sleep as a lynchpin to health indicates the critical role that sleep plays for people with BD. Some participants emphasized the benefits of sleep and naps on a routine basis whereas others described the association between sleep and rest to symptoms of mania and depression. One person explains:

*I guess another boundary that I set is sleep. That I make sure that I get to bed by 10:30–11:00 every night. And a routine is really important. So I think those kinds of things. And I wouldn't say that I've been absolutely symptom-free but managing, learning to self-monitor.*

Waking rest was also useful to many participants and usually involved lying down or watching TV. This strategy enabled people to meet social and work responsibilities. This focus upon sleep/rest hygiene is hardly novel but its importance lies in the regularity of the practice, which was also true for participants' dietary choices.

Attention to diet and nutrition as a self-management strategy involved choosing healthy foods, eating regularly scheduled meals and taking vitamin supplements. Incorporating these actions

into routines gave structure to participants' lives and helped many of them feel balanced and in control. The ability to eat well and regularly was associated with stability whereas more erratic patterns or excesses reflected shifts in mood, as Robyn explains.

*When I'm down I don't eat heavy foods. I eat lighter foods, I eat more meals, smaller meals, higher energy meals, quicker to digest meals. The worst thing when you're depressed is to eat high fat foods, fried foods, and sit there in a big puddle of fat, with your stomach bringing you down even more.*

Most participants identified adhering to a self-defined good diet and proper nutrition as part of functioning well. They monitored the overuse of potentially mood-altering substances such as caffeine and sugar. Although not strictly part of diet, several participants described either avoiding alcohol or decreasing the amount they drank, and eliminating the use of recreational drugs such as marijuana.

Exercise was a popular wellness strategy that participants used and they emphasized the importance of finding the right type of exercise. Participants described a wide variety of activities including: Tai Chi, dance, yoga, exercise routines, walking, snowboarding and swimming. Two participants indicated that exercise occurs through their work; one person taught dance classes 5 days a week and the other person referred to many years of teaching yoga. Exercise often involved activities outdoors and the location itself had a salutary health effect. The emphasis on outdoor activities is not surprising given the many options in British Columbia, the temperate climate of Vancouver and the active lifestyle that is culturally and socially encouraged. One of the older participants described the how regular exercise affects her wellness.

*Walking by the sea is something that I try and do three . . . you know a few times a week . . . I went out just for half an hour this evening to catch the sunset, so walked fifteen minutes west and then came back. I consider that a very important part of my overall balance, is the walking.*

One of the younger participants recounted numerous outdoor activities she did, and again, regularity and setting played a big role.

*A fair amount of cardio, I used to run the marathons to help keep my mania down. Now I just*

*do cardio at the gym and I mix it up, do different ones. I still do some running, do some cross training, the elliptical, whatever you call it . . . I do the aerobic cycle . . . at least three times a week . . . [for]at least a half an hour and about forty five minutes of weights.*

Overall, participants were acutely aware of the impact that the right sleep, rest, diet and exercise choices had on their lives. These strategies are inexpensive, within one's control and reflect common sense. As one participant concluded 'Exercise regularly, get enough sleep, and eat health balanced diet . . . It sounds really boring and it's in every magazine but being active really works for me.'

### **Ongoing Monitoring**

This set of self-management strategies reflected participants' strong motivation to stay well and assume responsibility for their wellness. Participants described the importance of learning to pay close attention to their moods and involvement in activities, in order to judge when to make changes. Understanding personal behavioural patterns and warning signs requires self-awareness and was a more common strategy among individuals who had lived with BD longer than those more recently diagnosed. Self-monitoring and being vigilant ('I'm always looking at my mood') prompted participants to adjust their activities to avoid getting overwhelmed: 'I keep myself in check . . . so I try to just keep myself calm and always think before I act.' For example, individuals would spread tasks out over the week, cancel social engagements if necessary and maintain some unscheduled time. Several participants spoke of being less critical of themselves for past actions and recognizing the importance of self-monitoring. Max describes changing his expectations.

*I will just become more diligent about exercise, eating right, more sleep, and trying to . . . I guess reassign priorities. So that if I have a lot on my plate of things I wanted to get done, get rid of a few of them, one way or another, get rid of a few of them. So you that can focus on what needs to be done and accept the fact that you're not going to get as much done as you would like to.*

The description of symptoms or the recognition that something was wrong varied across the participant group. Some individuals sensed physical

changes ('It's like a motor slowly turning off in my body'), whereas others observed their activity level for warning signs: 'If there are over 9 things on my "To-do" list, that's a danger sign . . . if there is no "To-do" list, that means I'm heading for depression'. The use of prescription medications and the ability to monitor the dose or initiate as-needed medications played a key role in maintaining wellness for the majority of participants. A few individuals remained well without taking medications; however, many more described making small changes after recognizing an increase in their symptoms. This is reflected in one participant's comment, 'I've learned my early warning signs [and] I make minor adjustments.' Some participants consulted with their psychiatrist, either in person or by telephone, before making any medication changes. Regular self-monitoring and adjustment requires considerable effort but has its rewards, as one individual describes:

*To me it's an ongoing basis where it's like a ship that's always righting itself, you know. Or when you're driving, you're sort of correcting as you're trying to drive in a straight line. So those were the things that I see, and then I make minor adjustments and hopefully I don't have to make major adjustments because I've been always making these corrections.*

Ongoing monitoring added to the knowledge that participants obtained about the disorder through other means, such as psychoeducation (PE).

### **Reflective and Meditative Practices**

Participants reported using various reflective and meditative practices to help them maintain their wellness. These ranged from practices such as Tai Chi, yoga and meditation to the use of regular journaling, inspirational reading and praying. Rather than relying on any one practice, participants typically drew from several actions that were successful in the past. For example, one participant stated that her main strategies were to: keep a journal, meditate and listen to calming music. Journaling was a popular strategy with many participants; one individual described its benefits this way:

*When I feel bad, then I write everything down. My emotions, and what it's directed to, whether it be a person or frustration at work. I have to be able to get it out, because I haven't really got anybody*

*that I can actually talk to about this, and if I can write everything down, then I can get everything that I need to out, cause if I'm talking to somebody, then the facial expressions, their voice intonation, their interrupting, whatever it might be, then I can't get everything out. So, with being able to do that, then it's a sense of relief.*

Participants who engaged in Tai Chi and yoga cited the benefits of regular practice, which for some included their roles as teachers. For Zoe, the commitment to Tai Chi practice along with self-monitoring strategies led to a 'zone of stability' that allowed her to manage BD well despite experiencing symptoms. Another eastern-based practice involved Buddhist-inspired watchfulness that emphasized 'compassion and loving kindness', taking a slightly different route than cognitive behavioural therapy (CBT) to reframe negative thoughts.

In addition to these practices, creative activities such as painting encouraged some participants to focus, stay well and gain insight into their actions. Another wellness self-management strategy was educating themselves and people involved in their lives about BD.

### **Understanding BD and Educating Others**

Participants learned about BD through a variety of methods that included reading books and newsletters, finding information on the Internet, attending groups, charting their unique cycles and stressors, and talking to healthcare practitioners. Participants read books that described the disorder and also texts that combined factual information with narratives such as *An Unquiet Mind* by Kay Redfield Jamieson (Jamieson, 1995) and *A Brilliant Madness* by Patty Duke (Duke & Hochman, 1992). One participant described learning about BD, and the benefits of doing so, in this way:

*Reading lots of books, on the Internet, the mental health counsellor gave me some good resources. Eventually I ended up being the chairperson of the bipolar disorder group, so I'm just making sure everybody else had resources, and also other people would also feed back information to me.*

Some participants attended PE groups organized by the Mood Disorders Association of British Columbia or through local hospitals to obtain initial information or keep current with new developments. Most individuals described a process of

obtaining information that required considerable self-initiative. There were strong opinions about the benefits and drawbacks of groups as a means to learn more about BD; some people found that the groups became less structured over time and were somewhat depressing. Some participants preferred individual sessions and recounted having supportive doctors and other healthcare practitioners who provided information about BD.

Many participants found that different forms of therapy, whether it was skills-based CBT or insight-oriented psychotherapy, helped them learn how to reduce stress, monitor mood changes and generally gain knowledge about how to live well with BD. Zoe identified a pivotal therapy experience in this way:

*There's a regular bipolar group which I've been attending since 1998. So I'm just thrilled. They're very open. They encourage the interaction between your family doctor, your family, your employer and so on and so forth. And if you don't want to do that, that's fine too. If you need help doing that, they provide that help.*

Participants shared what they learned about BD with family members and friends who were supportive. Thus, a spouse/partner of a person with BD learned the warning signs of mania and depression and encouraged their loved one to use strategies that helped that person stay well. Spouses/partners helped the person with BD to identify activity pattern changes or alterations from their usual habits that could signal mood changes. Robyn explains:

*I think my husband is really important because he will notice a depressive episode coming on before I will and he can tell by my body language. He says I walk differently. I carry myself differently and there is a look in my forehead and my eyebrows. He picks it out before I do. . . . He makes me aware of it and [then] I will just become more diligent about exercise, eating right, more sleep, and trying to . . . I guess, reassess priorities.*

It is not surprising that participants chose to connect with and seek support from family and friends who became knowledgeable about BD.

### **Connecting with Others**

This self-management strategy involved maintaining social connections with friends, seeking out

professional support, and for some people, doing volunteer work. Participants who had developed non-judgmental friends described the importance of socializing and having fun, of finding a balance between solitary and social time. One person described meeting with a core group of friends for coffee, a routine that provided considerable support and stability as he recovered from a manic episode. Lydia explains the benefits of connecting with friends:

*Hanging out with friends is a big one, just have that down time. Just being yourself with people you're comfortable with, probably helps me keep well.*

Psychiatrists, nurses and general practitioners were among the healthcare professionals whose services participants sought out as a means of staying well. This connection occurred through mood disorders support groups and one-to-one sessions. The value of a quality relationship, built on respect and collaboration, was emphasized by most participants who possessed one, and was desired by those did not have this type of support. One participant who lives outside of metropolitan Vancouver illustrated the role her doctor plays in her life.

*I see my psychiatrist one or two times a year. And he's available by email or phone anytime I feel that it's needed. So I have that as a resource. . . . He also treats me with more respect, for my level of intellect and level of understanding and my decision about my health care, than probably any other psychiatrist I've had. So that means more than me than having someone local.*

Volunteering was a useful means of connecting with others that many participants initiated. They described getting involved in charity work as a way to put their own issues into perspective. Some participants discussed volunteering with organizations that provided services for people with mental health problems and how they could use their own experiences to help others in an earlier phase of recovery. Alternatively, participants volunteered in a variety of capacities with community groups that were unrelated to mental health. Lydia sums up the benefits of volunteer work.

*Well, I had periods where I was really depressed and, and very dark, and not involved in community, not involved with others. I was really kind of, you know, just in my own space in my own*

*world feeling very isolated, and very self-analyzing. So what I've noticed is that when I have a bit more outward kind of motivation and movement and being involved in the world in helping other people or even just giving things away or giving of my time, and energy, that's really helpful in terms of keeping balanced in my own life.*

Connecting with friends, family and doing volunteer work is not unique to people with BD; the difference is the impact that these social interactions had on maintaining wellness especially during times of stress.

### *Enacting a Plan*

Enacting a plan occurred when participants recognized an impending manic or depressive episode and usually involved others to assist them. The plan could be an informal understanding between family members or friends about how to support the person with BD when wellness was compromised. Or the plan could be a detailed document that was developed over time and used to guide decisions. One example of the latter is the Wellness Recovery Action Plan (WRAP), popularized by Copeland (2000) as a self-management tool for recovery. The WRAP involves identifying triggers and stressors that threaten wellness, making a list of trusted individuals to call on for support, describing activities and strategies to maintain wellness and detailing the kinds of circumstances that prompt initiating a crisis plan. Robyn describes using the WRAP to judge the seriousness of an impending depressive episode.

*If I have three days in a row where I've just kind of felt down and blue, then I pull out my wellness plan and I look and it usually will kind of help me out in that time. If that's not working and I actually end up into 'signs and symptoms,' and those are listed, the little red flags like, 'I don't care.' That's a huge one with me. If I've gotten to the point where I am saying 'I don't care,' then I've kind of lost that hope. And that's getting into the signs and symptoms; still able to manage it at home but into signs and symptoms. When I am talking about death and dying, those are the kind of symptoms that we're looking at getting into a hospital then.*

While this excerpt describes the exacerbation of illness, Robyn stated 'I have never had to use my



actual crisis plan because I do my maintenance and it seems like the more well I am, the easier it is to be well.' This analysis supports the development and use of self-management strategies that are suited to each person that can serve as the sort of 'maintenance' that will facilitate living well with BD.

## DISCUSSION

A number of themes arose in our novel qualitative investigation of management strategies employed by high functioning people with BD. Our aim in this final section is to optimize the clinical utility of these findings by integrating it with existing knowledge about what works in adjunctive psychosocial interventions for BD. There is growing evidence that psychosocial interventions improve outcomes in BD (Miklowitz, 2008), and we show below how our qualitative findings are consonant with, and offer an elaborated personal narrative of, the core elements in evidence-based treatments.

### *Sleep, Rest, Diet and Exercise*

Maintaining sleep, diet and exercise routines were cited as a lynchpin to maintaining wellness by many of the sample. Although the biological underpinnings of BD are not well understood, there is consensus that instability of circadian rhythms is a significant pathway in the development and course of the condition, and the link between sleep and BD is well-established (Murray & Harvey, 2010). Importantly, circadian rhythms and sleep are modifiable by non-pharmacological means; consequently, their management is a core element of a variety of psychosocial treatment interventions for BD (e.g., Miklowitz, Goodwin, Bauer, & Geddes, 2008) and a component of consensus treatment guidelines (e.g., Yatham et al., 2006).

Frank and others (Ehlers, Frank, & Kupfer, 1988; Frank, 2007; Healy & Waterhouse, 1995) have argued that rhythmic features of the social environment (such as the timing of sleep, eating and exercise) are significant components of human circadian entrainment, and disruption of these habits may challenge the circadian clock. Frank and colleagues have developed a psychosocial treatment intervention based on this understanding known as 'Interpersonal and Social Rhythm Therapy' (IPSRT; Frank, 2007), a combination of a largely behavioural therapies aimed at helping patients maintain stability in their social rhythms and tradi-

tional interpersonal psychotherapy IRSPT (Frank, 2007). IPSRT has proven effective in two treatment studies (Frank et al., 2005; Miklowitz et al., 2007b). A key element of IPSRT is measurement of social rhythm stability via a scale known as the Social Rhythm Metric (SRM). The latest version of this self-report diary instrument, the SRM-II-5 (Frank, 2005), assesses the regularity of the time at which the individual (1) gets out of bed, (2) has first contact with another person, (3) starts work, school or housework, (4) has dinner and (5) goes to bed. As well as assessing social cues such as these, the clinician and client with BD can explore other interactions, such as: What is the relationship between social rhythmicity and daily mood? What role do others play in the person's social rhythmicity? What barriers to regularizing social rhythms can be identified and resolved?

Poor sleep quality is a major barrier to social rhythm stability and a primary target of IPSRT (Frank, 2005). Sleep disturbances are also a significant detriment to QoL in BD and a major clinical focus in their own right (Michalak et al., 2007). Sleep should be routinely assessed in individuals diagnosed with BD. This assessment can be simplified to a two-step process. First, the clinician can assess for the most common presenting symptoms of sleep disorders (insomnia and excessive daytime sleepiness). Second, the clinician can ask about additional symptoms such as snoring, observed apnea and abnormal sleep behaviours. Overall sleep quality can be usefully measured on the valid and reliable Pittsburgh Sleep Quality Index (Buysse, Reynolds, Monk, Berman, & Kupfer, 1989).

Insomnia in individuals with serious mental illness is often addressed with medication, and many patients' timely use of small doses of benzodiazepines or sedating antipsychotics is an effective part of manic relapse prevention (Russell, 2005). However, there is evidence that the psychosocial techniques effective for sleep disturbance in non-psychiatric populations are also effective in individuals with comorbid psychiatric disorders, and these should be offered as a first-line treatment (Biancosino et al., 2006; Huang, & Manber, 2005; Smith & Perlis, 2006). These interventions are generically termed CBT for insomnia (CBT-I).

Key components of CBT-I are stimulus control, sleep restriction, relaxation training, cognitive approaches and sleep hygiene education (see Morin & Espie, 2003; Perlis, Smith, Jungquist, & Posner, 2005). The overarching aim of CBT-I is to develop good sleep habits, which both facilitates

normal sleep and minimizes insomnia and hypersomnia. Although the techniques have not been systematically tested in this population, we believe they hold promise for improving sleep in BD. When applied to BD, the ultimate goal of these techniques is to regularize social rhythms, decrease sleep-driven relapse and increase self-efficacy around sleep (for further discussion, see Murray, 2010; Murray & Harvey, 2010).

What additional light do our interviews throw on this intervention? First, participants highlighted the key subjective distinction between sleep as a symptom of disorder, and sleep management as a stay-well strategy. The notion of 'waking rest' as a fruitful strategy is a second finding from our interviews that is not yet recognized in CBT-I. Finally, our analysis of the interviews highlighted a subjective link between sleep and daily exercise routines, consistent with contemporary models of sleep and alertness as complementary processes across the 24-hour day (Dijk & Franken, 2005). The importance of working to identify the exercise that suits the individual in context was highlighted by participants. The observation that people had tried various forms until finding a strategy that worked is critical information for clinicians as they support their clients in identifying and implementing useful routines.

### *Ongoing Monitoring*

Participants described the importance of regularly monitoring their moods in an effort to stay well with BD. Indeed, published treatment guidelines suggest that daily mood monitoring should be incorporated into the routine clinical management of the disorder (Goodwin, 2003; Sachs, Printz, Kahn, Carpenter, & Docherty, 2000). Mood monitoring is also a key element of PE (Bauer & McBride, 1996; Bauer, McBride, Chase, Sachs, & Shea, 1998) and cognitive behavioural (Basco & Rush, 1996; Lam, Jones, Hayward, & Brill, 1999) treatment interventions for BD.

Mood monitoring could influence outcome for clients with BD through a variety of mechanisms. First, regular monitoring of mood could provide an 'early warning system' for imminent relapse, allowing intervention to stop progression into a full-blown mood episode. A number of studies have shown that relapse, especially into mania, is preceded by idiosyncratic but identifiable and consistent prodromal symptoms in the 2–4 weeks prior to full relapse (see e.g. Lam & Wong, 1997) and that these symptoms can be used to trigger early inter-

vention to minimize the disruption and expense of a full-blown episode (Perry, Tarrier, Moriss, McCarthy, & Limb, 1999). Second, mood monitoring could improve social rhythmicity and hence lessen the likelihood of relapse. Daily monitoring of hours of sleep and concomitant mood may help stabilize sleep patterns and help develop a clearer understanding of the relationship between sleep and mood. Third, mood monitoring could increase adherence with medication regimens, and hence decrease symptoms. Partial or non-adherence to medication treatment is reported in up to 50% of people with BD (Maj, Pirozzi, Magliano, & Bartoli, 1998), and non-adherence is closely associated with poor outcome (Suppes, Baldessarini, Faedda, & Tohen, 1991). Traditional mood charts require that the individual record their adherence with their psychiatric medications; feedback regarding adherence (in combination with the feedback provided via mood graphs) may enhance education, engagement and empowerment.

Several paper-based methods for monitoring mood in BD are now in use, including the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP BD) Blank Mood Chart (Sachs, 2003), the Life Chart Methodology, (Denicoff et al., 2000) and the Chronosheet (Bauer et al., 1991). Well-designed daily mood charts are also available from the Internet (e.g., Personal Calendar, 2006). Technological advances and increasing acceptance of newer technologies by the general public have also allowed the development of computer-based methods of daily mood monitoring, such as the ChronoRecord software package (e.g. Bauer et al., 2004). Chronorecord mimics traditional mood charts in that it uses a 100-point visual analogue scale to assess degree of mania and depression, upon which respondents are asked to enter a single rating that best describes their overall mood for that day. As well, the ChronoRecord collects data on sleep, menstruation, medication adherence and life events (see ChronoRecord Background, 2009).

Our interviews highlighted that monitoring demands a high level of self-expertise, and can be particularly challenging for individuals who are in the earlier phases of their disorder. Again, there were marked individual differences in what was deemed most useful to monitor (energy, activity, mood). Clinicians should note that monitoring was described as an activity that required considerable effort; it may therefore be advisable to have a discussion with patients to explain how the benefits outweigh the demands. An additional benefit observed by participants was the consequent

awareness of their own idiosyncratic version of BD, which complemented the general knowledge of BD acquired through PE.

### *Reflective and Meditative Practices*

Participants reported using a variety of reflective and meditative practices to help maintain wellness, including Tai Chi, yoga, meditation, journaling, inspirational reading, exploring their spirituality and praying. Kilbourne and colleagues (2007) have provided data on the use of complementary and alternative medicines in a sample of 435 individuals with BD within a large urban mental health facility in the USA, finding that over half of their participants used prayer, spiritual healing or meditation to help manage their condition. There is as yet very little data relating to the efficacy of practices such as a yoga and massage in the treatment of the condition (Andresescu et al., 2008). The related approach of mindfulness CBT has received initial support as an adjunctive intervention (Williams et al., 2008), and our qualitative data suggest that such approaches may have face validity for many people with BD.

### *Understanding BD and Educating Others*

Although education about BD was critical for many of the sample, educational routes came in a number of guises, including entirely self-directed education (through reading, the Internet, etc.), support and education through peer support groups and formal PE groups delivered via specialist mood disorders centres.

PE at its most basic level is the process of imparting information to the individual with the disorder. A range of manual-based, standardized PE interventions (designed either for individual or group delivery) have been developed, although they all tend to have similar treatment goals and use similar techniques (e.g., Bauer Life goals [Bauer & McBride, 1996]). Typical treatment goals include: preventing relapse and recurrence, reducing the number and severity of symptoms, decreasing suicide risk, enhancing medication adherence and improving psychosocial functioning and QoL. Frequently used techniques include: education about BD and its treatment (for both the client and their significant others), promoting early detection of symptoms, encouraging lifestyle regulation (e.g., regulation of sleep-wakes cycles and social routines), enhancing self-monitoring and improving stress management skills.

The most convincing evidence to date for the effectiveness of group PE for BD is provided by Colom and colleagues (2003) who randomized euthymic patients ( $N = 120$ ) who had been in remission for at least 6 months and were receiving standard pharmacological treatment to either 21 sessions of group PE or an equal number of unstructured group meetings. During the acute treatment phase of the study, significantly more patients in the control group (60%) fulfilled criteria for recurrence (of hypomania, mania, mixed state or depression) than did patients in the intervention group (38%). At the end of the 2-year follow-up phase, 92% of the control group had experienced a recurrence, compared to 67% of the psychoeducated group. Of course, delivering a 21-session, manualized PE intervention may not be pragmatic or feasible for many clinicians. The strength of the evidence for PE in BD, however, does point to the importance of providing education about this complex psychiatric condition where possible. Our experience warns that individual differences are important in response to PE: only some participants in the current study were highly supportive of the formalized group PE model. Others preferred not to attend group sessions, relying instead on written resources in hard copy or on the Internet. These resources are both prolific and of varied quality. People managing BD in rural or remote areas may not have access to PE groups and may need additional direction to identify good quality educational materials and resources.

### *Connecting with Others*

Deficits in social support are reliably associated with poor outcome in BD (e.g., Goldberg & Burdick, 2008; Mueller et al., 2006; Ritsner, Gibel, & Ratner, 2006). Indeed, whether researchers have studied rates of divorce, marital conflict, social isolation, core confidant relationships or satisfaction with social support in individuals diagnosed with BD, there is evidence that these individuals describe dissatisfaction and problems with their relationships. Alternatively, there is evidence that adequate social support is protective in BD (Johnson et al., 1999; Johnson et al., 2000) and can counteract psychological vulnerability (Murray et al., 2007). Connecting meaningfully with other people was important to many of this sample of high functioning individuals. Once again, however, there was no single model for meaningful social support, with participants citing the importance of family, friends, work

colleagues, support group members and health-care professionals.

There is a growing literature on the role of family-focused interventions in the treatment of BD (e.g., Miklowitz & Goldstein, 1997) and data is available from some key clinical trials. For example, in one trial of medication plus family-focused therapy (FFT, a 9-month, 21-session intervention consisting of PE, communication training and problem-solving skills training), participants in the FFT protocol showed longer healthy intervals prior to relapse than participants receiving medication and brief PE (Miklowitz, George, Richards, Simoneau, & Suddath, 2003). However, there is insufficient data on family-orientated treatments for BD to permit meta-analyses according to Cochrane criteria (Justo, Soares, & Calil, 2007).

Another potential point of social leverage exists in the relationship between the individual with BD and their treating clinician. The power of this relationship can be maximized by adopting a strongly collaborative stance (Berk, Berk, & Castle, 2004; Crosini & Wedding, 2005). Key elements of a collaborative therapeutic relationship are: (1) the clinician is warm, directive and concerned, a problem-solver applying a coping model, (2) the client is active in determining the specific targets of therapy, while the clinician is expert in proposing pathways to achieve these goals, (3) the client and clinician therefore work as a collaborative team, (4) the therapeutic emphasis is on measurable changes outside the therapy room and (5) the therapeutic goals are supported by learning principles (e.g., change as incremental). In practice, a collaborative therapeutic atmosphere can be generated by asking clients to give their opinions about treatment, and what they think might be effective on the basis of past experience. A collaborative treatment approach also means that sometimes the client's, rather than the clinician's, treatment choice is followed. As noted by Basco and Rush (1996), the potential for short-term difficulties this generates is likely to be outweighed by the long-term impacts on the working relationship. Our data strongly supports this therapeutic prescription—all participants either had or desired, a professional relationship in which their views were respected and in which they were treated as collaborators in BD management.

### *Enacting a Plan*

Participants talked about a variety of plans they had in place for when early warning signs of an impending episode were detected, ranging from an informal understanding with family members

or friends, through to more formal plans such as the WRAP (Copeland, 2000).

Research has shown that most people with BD can both recognize their prodromes and appreciate the utility of early warnings of relapse (Lam & Wong, 2005). Importantly, there is evidence that, although prodromes vary between individuals they may be relatively stable within-person. Across studies, the most common early warning signs of mania are decreased need for sleep, increased activities/energy, being more sociable, racing thoughts, having increased self-worth, senses being sharper and increased optimism. The most common early warning signs of depressive relapse are loss of interest in activities or people, not being able to put worries or anxieties aside, interrupted sleep and feeling sad or wanting to cry. Central goals of psychosocial interventions, then, are to help the individual develop expertise about their own early warning signs. The individual can then be encouraged to respond to early warning signs by activating a pre-arranged personal relapse prevention plan. The rationale behind relapse prevention plans is that the individual commits to following the specific behavioural steps of the plan (developed with the therapist when euthymic) at a time when their mood state might be a barrier to calm problem-solving. Key elements of a relapse prevention plan include names and contact details of the primary clinician and others in the person's support network. More elaborate plans can include specific behavioural steps for managing prodromes of depression and mania/hypomania (for more discussion, see Basco, 2006; Basco & Rush, 1996). A number of points about relapse prevention plans are worth noting. First, managing BD requires a team approach that includes, but is not limited to, the primary clinician. Specified social supports also play an important role in relapse prevention plans, and participants in our study highlighted that this is premised on thinking about how and to whom to reveal one's diagnosis. Second, much of the work in adjunctive psychosocial interventions for BD focuses on developing the client's expertise about their own version of the disorder—a relapse prevention plan is largely a structured document summarizing this expertise.

### SUMMARY

Our novel qualitative investigation of self-management strategies used by people who are coping well with BD generated two incremental advances. First, we were able to give voice to

the positive well-being strategies that are found effective by people who are diagnosed with BD, and indeed have a significant mental illness history. This is important data because it provides a hopeful narrative, critical for clinicians and their clients as they approach the challenge of managing BD. Second, by integrating qualitative data with existing quantitative knowledge about effective psychosocial treatment strategies we were able to provide a more contextualized set of cognitive behavioural guidelines for clinicians to apply in their therapeutic collaborations.

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