Living With Bipolar Disorder: A Qualitative Analysis Conducted Five Years After Completing a Psychosocial Group Treatment Program

Catherine Cronin
BBNSc, PGDipPsych.

Swinburne University of Technology
Melbourne Australia
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Author Note

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Declaration

I declare that this report does not incorporate without acknowledgement any material previously submitted for a degree in any University or educational institution, and that to the best of my knowledge it does not contain any material previously published or written by another person except where due reference is made in the text.

I further declare that the ethical principles and procedures specified in the Faculty of Life and Social Sciences Human Research Ethics Committee document have been adhered to in the process of conducting this research.

Name: Catherine Cronin

Signed:
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Abstract

There is growing recognition of the importance of studying people’s subjective experiences of living with bipolar disorder (BD). Such research has the potential to improve understanding of how people with BD manage their illness and maintain wellbeing, with potential implication for psychosocial treatments. The aim of the current research was to explore the lived experiences of people \((N = 18)\) diagnosed with BD five years after completing a psychosocial group treatment program (known as the MAPS group\(^1\)). Semi-structured interviews explored participants’ experiences of living with and receiving treatment for BD. Several factors that may contribute to relapse were identified, along with the unique and personal approaches participants take to manage these stressors. Strategies that might be important for promoting wellbeing were also identified, and it was noted that acceptance could have an important role to play in helping people to maximise wellbeing and become more actively involved in the management of their illness. It is proposed that psychosocial treatment interventions may help people to develop acceptance, along with skills and strategies that promote symptom management, psychosocial functioning, and wellness. Drawing on the narratives of these ‘lived experience experts’, the discussion concludes with tentative suggestions about how clinicians might think about psychosocial factors associated with BD, including approaches to treatment and routine care. Several areas for future research are suggested.

\(^1\) The MAPS acronym stands for: monitoring mood and activities (M), assessing prodromes (A), preventing relapse (P), and setting smart goals (S).
Chapter 1: Thesis Overview

While pharmacotherapy is the first line of treatment for bipolar disorder (BD; Goodwin & Jamison, 2007; Kulkarni et al., 2012; Severus, Schaaff, & Möller, 2012), people with this illness experience subsyndromal symptoms and symptomatic relapse even in the context of diligent medication compliance (Gitlin & Frye, 2012; Gitlin, Swendsen, Heller, & Hammen, 1995). In light of the limitations of pharmacotherapy, researchers have turned their attention toward exploring psychosocial factors that may predict relapse (onset of a mood episode; MacFadden et al., 2009), improve treatment outcomes, and enhance quality of life (Ehlers, Frank, & Kupfer, 1988; Geddes & Miklowitz, 2013; Goodwin & Jamison, 2007; Johnson & Leahy, 2004; Murray & Michalak, 2012). This emerging area of inquiry has emphasised the importance of psychosocial interventions for BD, such as cognitive behavioural therapy (CBT), family focused therapy (FFT), interpersonal and social rhythm therapy (IPSRT), and the role these play in minimising relapse and improving functionality (Castle et al., 2010; Lauder, Berk, Castle, Dodd, & Berk, 2010).

Although randomised controlled trials (RCTs) have provided evidence for the efficacy of adjunctive psychosocial treatments in terms of symptom reduction (Castle et al., 2010; Colom et al., 2003; Miklowitz et al., 2003; Perry et al., 1999), these quantitative methods throw little light on vital aspects of a person’s experience of living with BD. The investigation of people’s lived experience provides insight into the factors that help
people to minimise episodes of illness and promote lasting wellbeing (Murray & Michalak, 2012). An emerging body of research has started to investigate people’s personal accounts of living with BD – namely, their experience of recovery, wellness, and overall quality of life (i.e., Mansell, Powell, Pedley, Thomas, & Jones, 2010; Michalak, Yatham, Kolesar, & Lam, 2006; Russell & Browne, 2005; Suto, Murray, Hale, & Amari, 2010; Veseth, Binder Borg, & Davidson, 2012). There is, however, a paucity of knowledge about people’s experience of psychosocial treatment – a key aspect of living with BD.

The current study draws upon the insights of a group of ‘lived experience experts’ who participated in a psychosocial treatment program for BD. A qualitative analysis of their experiences provided rich, detailed, and contextualised information about their experience of treatment and living with BD.

1.1. Thesis Structure and Content

The introduction section reviews the relevant literature and provides a conceptual framework for the current thesis. Chapter 2 introduces the clinical features of BD, including information about phenomenology, symptomatology, diagnostic nosology, prevalence and course. Chapter 3 provides a rationale for focusing on psychosocial factors as precipitants of relapse. Chapter 4 will provide an overview of what is known about the occupational and interpersonal impairment that is experienced by people with BD, and will review qualitative literature that has started to investigate how this illness affects functioning in different life roles. Chapter 5 establishes the efficacy of

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2 A descriptive review was undertaken in the current thesis. A future project could conduct a systematic review (see Liberati et al., 2009) which would help to: (1) obtain a clear indication of how stressors affect bipolar relapse and the person’s lived experience of the illness, (2) compare the efficacy of one type of psychological intervention or treatment modality to the other, and (3) provide clarity around the factors people identify as being important to recovery, and living a meaningful and contributing life.
psychosocial interventions and their importance in treating people with BD. Chapter 6 provides a rationale for moving beyond a focus on treatment efficacy, and explores people’s personal accounts of living with BD and their subjective experience of recovery, quality of life, wellness, and self-management. The introduction is concluded by presenting the study’s overarching aim and research questions, followed by an overview of the study’s methodology and theoretical approach (i.e., Interpretive Phenomenological Analysis; IPA), and a detailed description of how the study was undertaken.

The results section presents the themes that were drawn from participants’ narratives and relevant excerpts from the interview transcripts. Further discussion of these themes, as they relate to pre-existing literature, is provided in the discussion. The thesis is concluded with a discussion of implications, limitations, and directions for future research.

Chapter 2: Bipolar Disorder: Overview, Background, Description and Diagnosis

Attempts at description and classification of BD can be dated back to the Greek physicians of the classic period (490-323 B.C.; Albuquerque, 2013). It is believed that Hippocrates (460/337 B.C.) was the first to provide discrete descriptions of the mood states termed ‘mania’ and ‘melancholia’ (Angst & Marneros, 2000; Goodwin & Jamison, 2007). Several hundred years later, Emil Kraepelin (1899) made one of the most notable contributions to the field of psychiatry when he categorised existing disorders with similar symptomatology, and integrated symptoms of mania and melancholia into a single
disorder known as ‘manic-depressive insanity’ (Goodwin & Jamison, 2007; Yatham, & Kusumakar, 2013).

The careful observations of Kraepelin had an important influence on contemporary description and classification of BD. For instance, his observation that clinical presentations can be distinguished in terms of severity is now reflected in our current disorder subtypes (viz., bipolar I, bipolar II, & cyclothymic disorder). Furthermore, his proposition that BD is a chronic condition requiring ongoing management is a view that is consistent with current approaches. Importantly, and of particular relevance to the current thesis, he argued that psychosocial variables have a role to play in the course of BD (e.g., co-existing substance use, life stress etc.) through their influence on the likelihood of relapse (Goodwin & Jamison, 2007).

Kraepelin’s conceptualisation of BD over a hundred years ago was followed by divergent ideas regarding optimal treatment. The popularity of psychotherapy in the United States led to a focus on the importance of psychological and social circumstances in treatment outcomes. In contrast, the Europeans continued to adhere closely to a biomedical model and pharmacotherapy, in both research and clinical practice (Goodwin & Jamison, 2007). Although both pharmacological and psychosocial treatments are used in current clinical practice, pharmacotherapy is the first line treatment for BD and psychosocial treatments are less routinely available (see Bracken et al., 2012; Gilbert, Miller, Berk, Ho, & Castle, 2003; Jones, Deville, Mayers, & Lobban, 2011).

2.1. Bipolar Disorder: DSM-5

The Diagnostic and Statistical Manual of Mental Disorder (5th ed.; DSM-5; American Psychiatric Association, 2013) clusters BD into two major subtypes, namely: Bipolar I and Bipolar II (Table 1). For a diagnosis of Bipolar I Disorder it is necessary to
meet the “… criteria for a manic episode. The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes” (DSM-5, 2013, p. 123). Bipolar II is defined as “… a clinical course of recurring mood episodes consisting of one or more major depressive episode, and at least one hypomanic episode” (DSM-5, 2013, p. 135).

The symptomatic criteria for these conditions specify that mania can manifest in the form of euphoria/grandiosity or irritability, and increased activity or energy. Diagnostically, three of seven mood symptoms are required, with four to be satisfied if irritability is the major mood state. Criterion requirements are the same for hypomania, with an absence of severe impairment and lesser duration requirement of four days. Depression necessitates five or more mood symptoms to be satisfied during a 2-week period, with one of the symptoms as depressed mood or loss of interest or pleasure. Specifiers provide information about symptoms that are concurrent with the mood episode, and indicate if an episode is with anxious distress, mixed features, rapid cycling, melancholic features, atypical features, psychotic features, catatonia, peripartum onset, and/or has a seasonal pattern (DSM-5, 2013).

A range of other bipolar spectrum conditions are also recognised in DSM-5 (2013; see Table 1) – namely: mild, but frequent hypomania and depression (i.e., cyclothymic disorder); substance abuse/prescribed medication/medical conditions that are associated with manic phenomena (i.e., bipolar and related disorders due to another medical condition); “…a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a substance” (p. 123; i.e., substance/medication-induced bipolar and related disorders); “…bipolar-like phenomena that do not meet the criteria for bipolar I, bipolar II, or cyclothymic disorder” (p. 123; i.e., other specified bipolar or
related disorder), and when a clinician chooses not to specify the reason criteria were not met (i.e., unspecified bipolar and related disorder; *DSM-5*, 2013).
This copyrighted information has been omitted.
Differential diagnosis presents an ongoing challenge to clinicians, with reports that an accurate diagnosis of the bipolar disorders can take seven-to-ten years after the initial onset of symptoms (Johnson & Leahy, 2004; Lish, Dime-Meena, Whybrow, & Price, 1994). The high incidence of misdiagnosis between BD and unipolar depression is of particular clinical concern, due to the potential for antidepressants to cause iatrogenic symptoms of mania (Stensland, Schultz, & Frytak, 2010).

2.2. Epidemiology and Course of BD

BD is believed to be the fifth most disabling physical or psychiatric disorder (World Health Organisation, 2008). The condition affects approximately 2.6% of the population at some point in their lives, usually before the age of 30 (Kessler, Wai, Demler, & Walters, 2005). The mean age of onset has been estimated as early 20s (Azorin et al., 2013); however, recent literature indicates that symptomatic onset may occur in adolescence (Demeter et al., 2013; Duffy & Carlson, 2013).

Although significant heterogeneity is observed, BD is typically characterised by recurrent and severe mood episodes, with limited inter-episode recovery (Johnson & Leahy, 2004). Given this disorder course, it is not surprising that individuals with BD experience significant disability, morbidity, and mortality, with an individual who experiences disorder onset during their 20s proposed to lose approximately nine years from their life expectancy, twelve years of health, and fourteen years of efficiency (Anthony, 2005). Although mood stabilising medications have demonstrated efficacy in reducing the severity of BD symptoms, such benefits are limited, with research suggesting that even with adherence people with BD typically relapse within a five-year period (Gitlin & Frye, 2012; Johnson & Leahy, 2004; Keller, Lavori, Kane, & Gelenberg, 1992).
Comorbidities. Comorbidity between BD and other psychiatric conditions is the norm (Semra Karataş, Güler, & Hariri, 2013), with more than 50% of people with BD also warranting an alcohol or substance abuse diagnosis (Brown, Suppes, Adinoff, & Thomas, 2001); 60% will have an anxiety disorder (Goodwin & Hoven, 2002); and 30-50% will have a personality disorder (George, Miklowitz, Richards, Simoneau, & Taylor, 2003; Üçok, Karaveli, Kundakçi, & Yazici, 1998). Comorbidities are of particular clinical relevance as they are associated with longer recovery time, higher likelihood of relapse, poorer adherence to medication, and increased likelihood of suicidality (Johnson & Leahy, 2004).

Chapter 3: Psychosocial Factors and Bipolar Relapse

Although biological models of BD have been a central focus of research and treatment, studies conducted over the past decade have underscored the importance of unifying biological and psychosocial approaches to bipolar etiology (see Ehlers et al., 1988). For instance, while biological theories of BD propose that relapse is caused by changes in brain chemistry, psychosocial researchers have provided evidence to suggest that factors such as life events, the experience of chronic stressors, medication adherence, and limited access to social support are all important precipitants for bipolar relapse – perhaps acting as catalysts for neurochemical changes that trigger mood episodes (Alloy, Bender, Wagner, Abramson, & Urošević, 2009; de Dios et al., 2012; Johnson & Leahy, 2004).
The impact of biological and psychosocial factors on bipolar relapse can be united within a diathesis-stress framework. Based on the seminal psychosocial work of Lam, Jones, and Hayward (1999) and others (e.g., Jones, 2001), Figure 1 provides a useful framework for considering the impact of these factors.

In line with the model of Figure 1, it has been well established that people with BD relapse more frequently under stressful conditions (see Johnson & Roberts, 1995), even in the context of diligent medication compliance (Ellicott, Hammen, Gitlin, Brown, & Jamison, 1990; Gershon, Johnson, & Miller, 2013; Gitlin et al., 1995; Stefos, Bauwens, Staner, & Pardoen, 1996). The remainder of this chapter will review literature consistent with this model, outlining the impact of life events (e.g., Gershon et al., 2013; Gutiérrez-Rojas, Jurado, & Gurpegui, 2011), medication non-adherence (see Berk et al., 2010),

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3 Psychosocial factors are defined broadly for the present purposes as factors over which the individual potentially has control, including, for example, medication adherence.
substance use (e.g., Salloum & Thase, 2000), and rhythm disruption (e.g., Levenson, Nusslock, & Frank, 2013) on bipolar symptoms and relapse. Although the impact of these factors has been relatively well established, there is a clear need for further research that seeks to untangle how these stressors affect bipolar relapse and the person’s lived experience of the illness (Gershon et al., 2013). Indeed, there is a paucity of qualitative data that speaks to this issue. Such data will help facilitate a greater understanding of the ways in which psychosocial stressors impact on relapse, and how people’s management of these factors affects their wellbeing.

3.1. Life Events and Bipolar Relapse

The impact of life events on BD has been a focus of research for the past twenty years (Gershon et al., 2013; Havermans, Nicolson, Berkhof, & deVries, 2010; Johnson, 2005; Johnson & Roberts, 1995). This research has strongly suggested that life events (e.g., relationship/family disputes, bereavement, a change in work commitments, or the attainment of an important personal goal) have a significant impact on a person’s likelihood of relapse (Ellicott et al., 1990) and the duration of time spent unwell (Johnson et al., 2008).

To investigate the interaction between psychosocial stressors and bipolar relapse, Ellicott et al. (1990) monitored the occurrence of life events, symptomatic relapse, medication adherence and treatment compliance in individuals with BD over a two-year period (N = 61). It was found that life events were an important predictor of relapse, preceding mood episodes for 32 participants. Similarly, Hunt, Bruce-Jones, and Silverstone (1992) found that bipolar relapse was reliably precipitated by an increase in stressful life events when monitoring participants’ mood episodes over a two-year period (Hunt et al., 1992).
Research has also found that life events can affect the length of time that a person stays unwell. Johnson and Miller (1997) conducted monthly observations of 67 people with BD during a one-year period of hospitalisation, and found that people who experienced a negative life event had a threefold increase in the amount of time spent recovering from a mood episode.

**Work and relationships as triggers for relapse.** In terms of identifying specific life events that contribute to bipolar relapse, initial research has pointed to the role of work and relationships in particular. It has been found that when an individual with BD struggles to cope with work they will subsequently experience increased manic and/or depressive symptoms, higher rates of relapse (Gershon et al., 2013; Gitlin et al., 1995; Gutiérrez-Rojas et al., 2011), and increased rates of hospitalisation (Gutiérrez-Rojas et al., 2011). Conversely, it has been found that having the opportunity to return to work after a relapse is associated with a quicker recovery, and as such, may constitute a protective factor that minimises psychosocial disruption (Elinson, Houck, & Pincus, 2007).

In addition to work, it has been found that relationship conflicts (e.g., martial disputes or family conflicts) and stressful interpersonal dynamics are associated with higher rates of relapse, exacerbation of clinical symptoms, and an increased risk of hospitalisation (Bauwens, Tracy, Pardoen, Elst, & Mandlewicz, 1991; Lish et al., 1994; Sheets & Miller, 2010). In addition to inducing heightened stress levels in the vulnerable individual, these life events may also exert their influence on relapse by way of disrupting daily routines and hence, circadian functioning (see section 3.3.).

**Social support as a potential moderator of psychosocial stress.** Interestingly, it has been proposed that social support has a role to play in buffering psychosocial stressors and their effect on relapse – the ways in which this occurs, however, are poorly understood. Research has suggested that supportive and close relationships improve
treatment outcomes for people with BD and are important to their sense of wellness (Levkovitz, Fennig, Horesh, Barak, & Treves, 2000; Suto et al., 2010; Weinstock & Miller, 2010). Conversely, Cohen, Hammen, Henry, and Daley (2004) reported that when individuals with BD were observed over a twelve month period, those who had limited support during stressful life events had a higher rate of symptomatic relapse. Interestingly, this study noted that social support did not moderate the effect of stressful life events and was an independent factor from stress in its impact on outcome (Cohen et al., 2004). Nevertheless, the avenues through which social support impacts on treatment outcomes and wellbeing remain unclear. More studies are needed to assess the role of social support at times of stress, and to investigate the other factors that might also have a role. For instance, it has also been found that people who have limited social support are not only at greater risk of relapse but also have poorer medication adherence (Stefos et al., 1996). Although there is limited data to inform us about the specific benefits of social support for people with BD, it seems possible that it may in part exert its effect through the enhancement of medication compliance (Reinares et al., 2008). Other factors might also have a role, for instance, social support may enhance outcomes through improving self-esteem (e.g., Johnson, Meyer, Winett, & Small, 2001) or enhancing prodromal recognition (Reinares et al., 2008).

Specific symptomatic impact of life events. Evidence has suggested that the impact of life events can vary depending on the valence of the event the person has experienced (Alloy et al., 2005). That is, research suggests that negative life events (e.g., bereavement) are more likely to trigger depression (Urošević et al., 2010), and life events that provide opportunity for reward or disrupt an individual’s sleep or routine are more likely to trigger mania (reviewed in Alloy et al., 2005).
A prospective study by Johnson et al. (2008) provided evidence for the relationship between negative life events and depressive symptom onset. Participants \(N = 125\) with BD were interviewed regularly for twenty-seven months to record the occurrence of negative life events and emergence of symptomatology. Results suggested a relationship between the occurrence of negative life events and increased depressive symptoms (Johnson et al., 2008).

In addition, Johnson et al. (2000) provided prospective evidence to support a role for life events associated with goal attainment in the onset of mania. It was concluded that individuals with BD were more likely to experience manic symptoms after significant goal attainment. Similarly, Johnson et al. (2008) found that goal attainment life events predicted the onset of manic symptoms when participants were observed over a twenty-seven month period.

**Summary – life events and bipolar relapse.** The aforementioned research has suggested that life events, work stress, relationship conflict, and a paucity of social support may significantly increase an individual’s likelihood of relapse and amount of time spent unwell (Cohen et al. 2004; Havermans et al., 2010; Johnson & Miller, 1997). It also appears that different types of events (e.g., positive vs. negative) may have a specific symptomatic impact (i.e., triggering mania or depression; Alloy et al., 2005). Although several pertinent life events have been identified, there is further scope to understand and explore people’s lived experience of these factors – particularly the role of social support, and how this may contribute to relapse and wellness.

### 3.2. Medication Non-Adherence, Substance Use, and Relapse

It is widely acknowledged that non-adherence to medication is commonplace and has a detrimental effect on patient outcomes (e.g., Berk et al., 2010; Johnson &
McFarland, 1996; Maj, Pirozzi, Magliano, & Bartoli, 1998; Sajaatovic et al., 2007; Strober, Morrell, Lampert, & Burroughs, 1990). Despite the importance of medication to the management of BD and improved treatment outcomes (Clarkin, Carpenter, Hull, Wilner, & Glick, 1998), there is a paucity of research into factors that contribute to medication non-adherence behaviours. Berk et al. (2010) have suggested several factors that may be relevant, including: the experience of stigma, denial of illness, fear of side effects, and family’s attitudes towards medication; however, research in this area is in its infancy.

Research has investigated the implications of discontinuing medication. For instance, Strober et al. (1990) observed a sample of adolescents with BD (N = 37) for eighteen months after being stabilised with Lithium Carbonate. When compared to individuals who had continued their lithium therapy (n = 24), those who discontinued (n = 13) were three times more likely to relapse (Strober et al., 1990). Similarly, Maj et al. (1998) found that patients (N = 402) who were compliant with their treatment had less severe symptoms and less time in hospital over a five year period.

A more recent study by Biel, Peselow, Mulcare, Case, and Fieve (2007) explored people’s reasons for discontinuing medication and the clinical implications of doing so. Reasons for discontinuing medication included: (1) the burden of taking medication on a daily basis, (2) a belief that medication was no longer required, and (3) stigma associated with having ongoing treatment for a mental illness. When compared to participants who discontinued lithium (n = 54), those who continued (n = 159) had a reduced likelihood of relapse over an extended period (<1yr). The importance of medication adherence is further emphasised by research that has found an increased risk of suicide following cessation of treatment. Baldessarini, Tondo, and Viguera (1999) found that individuals who ceased their medication had a substantially increased risk of suicide. In terms of
effect sizes, Gonzalez-Pinto et al. (2006) found that people who had poor medication compliance were a 5.2 times more likely to complete a suicide.

**Factors contributing to poor adherence.** In one of the first studies of its kind, Gibson, Brand, Burt, Boden, and Benson (2013) explored the beliefs and attitudes of people with BD and schizophrenia towards medication. Three themes were identified, namely: (1) living well for self and others, (2) obstacles to adherence, and (3) therapeutic support. In general, participants indicated that their adherence was dependent on whether medications were believed to be effective, and the extent of side effects. Participants also felt that good communication with medical professionals assisted them to manage their medication, and that conversely, poorer communication made adherence less likely. More specifically, participants spoke about the impacts of forgetting and being unable to gain access to their health care professional in a timely manner, and how regular contact afforded them a sense of stability in their care. While this study provides valuable insights into elements of treatment that are important to people’s adherence, there is a need to expand upon this literature, and explore the unique experiences of people with BD. Further research may help us to understand how people with BD manage the challenges associated with pharmacotherapy.

**Substance abuse.** Although not identified explicitly in the generic model of relapse (Figure 1), it is well established that decisions to engage with substance use are associated with a poorer course of BD, including a higher risk of relapse, suicide, and decreased medication adherence (see Salloum & Thase, 2000). Research in this area has begun to identify people’s reasons for use, with the findings suggesting that escapism, stress management, and mood enhancement are relevant factors (Healey, Peters, Kinderman, McCracken, & Morriss, 2009; Ward, 2011). Despite this, we know little about how people negotiate their substance use for the purpose of facilitating wellness,
the challenges associated with cessation, and how it contributes to people’s relationship with their illness over the longer term.

**Summary – medication non-adherence and substance use.** The research reviewed above demonstrates the costs of discontinuing medication and abusing substances, which emphasises the need for further research into factors that influence these choices, and the ways in which they affect people’s lived experience of BD (Jónsdóttir et al., 2013). Research in this area has been primarily focused on investigating the relationship between non-adherence and poorer treatment outcomes, with less of a focus on the reasons for non-adherence. Given that an important part of ongoing treatment is to understand and address people’s reasons for non-adherence, there is a clear need to build upon and expand the very limited research in this area. Similarly, while the qualitative data has begun to help us understand the motivations behind substance use among those with BD, there is room to develop our understanding of how substance use affects bipolar relapse and people’s experience of wellbeing.

### 3.3. Disrupted Rhythms and Bipolar Relapse

When an individual with BD has disrupted social, sleep, hormonal, or work routines, they are vulnerable to an increased likelihood of relapse and a poorer course of illness in the longer term (Ehlers et al., 1988; Frank, 2005; Leibenluft, Albert, Rosenthal, & Wehr 1996; Levenson, Nusslock, & Frank, 2013).

**Disrupted social routines.** Even minor disruptions to a person’s daily routines (i.e., social rhythms) can trigger symptomatic relapse in individuals with BD (Ehlers et al., 1988; Levenson et al., 2013). For instance, daily activities, such as sleep time and meal time, act as social prompts that synchronise the human circadian rhythm (Mistlberger & Skene, 2005). For those with no vulnerability to BD, these disruptions
may result in only mild mood symptoms (e.g., small changes in energy or mood). However, for an individual with high vulnerability to BD, changes to these routines may be sufficient to dysregulate their circadian rhythms and prompt symptomatic relapse (Frank, 2005; Levenson, Nusslock, & Frank, 2013).

While clinicians have emphasised the importance of regular routines in maintaining the wellness of individuals with BD (e.g., CANMAT guidelines; Yatham et al., 2013), only a small number of studies have directly tested this hypothesis (reviewed in Shen et al., 2008). The available research suggests that marital conflict or the loss of a life partner have a powerful capacity to disrupt daily routines. For instance, it is accepted that an individual’s partner acts as a primary social zeitgeber, with couples typically having synchronised meal times, sleep times, and times of activity. Therefore, marital conflict or the loss of a partner can prompt significant disruption to an individual’s daily routine and can place individuals with BD at a high likelihood of relapse (Frank, 2005).

Environmental factors impacting social and circadian rhythms (e.g., transmeridian flights and shift work) can also precipitate relapse in people with BD. For instance, when individuals with BD fly east there is an increased likelihood of manic relapse, and when they fly west there is an increased likelihood of depression (Jauhar & Weller, 1982). Data from case studies also suggests that the commencement of shift work often coincides with the onset of an affective episode (Frank, 2005). As such, researchers such as Shen et al. (2008) have speculated that the self-regulation of routines during times of disruption may help prevent bipolar relapse.

**Disrupted sleep routines.** It is well established that there is an important relationship between sleep and relapse for people with BD (Bauer et al., 2006; Levenson et al., 2013). Research has revealed that changes to an individual’s sleep-wake cycle can prompt symptomatic relapse (Leibenluft, Albert, Rosenthal, & Wehr, 1996), and
importantly, that altering a person’s sleep can impact on the duration and severity of their symptoms (Barbini et al., 2005).

To examine the interaction between sleep disruption and bipolar relapse, Leibenluft et al. (1996) instructed 11 patients with rapid cycling BD to monitor their mood (i.e., state mania, hypomania and depression) and sleep (onset, duration, wake onset) over an eighteen month period. It was found that shorter duration of sleep was associated with heightened manic symptoms on the following day (Leibenluft et al., 1996). Similarly, a study conducted by Barbini, Bertelli, Colombo, and Smeraldi (1996) found that reduced sleep predicted increased mania on the following day. More recently, Bauer et al. (2005) found that sleep disruption also precipitated negative mood states in people with BD. After asking participants \(N = 59\) to monitor their mood, sleep time, and bed rest, it was found that decreased sleep and/or bed rest was associated with increased manic symptoms, and increased sleep and/or bed rest was associated with increased depressive symptoms on the following day.

**Sleep deprivation/extension.** Sleep deprivation studies have also found that reduced sleep has a role to play in triggering manic symptoms (Wehr, 1982; Wehr, Sack, & Rosenthal, 1987). Colombo, Benedetti, Barbini, Campori, and Smeraldi (1999) for example, examined sleep patterns amongst people who were experiencing bipolar depression \(N = 206\), and found that approximately 12% of participants switched into hypomania or mania after a night of sleep deprivation. Also, sleep extension research has suggested that an extended period of bed rest can facilitate remission from an episode of mania (Barbini et al., 2005; Wehr et al., 1998). For instance, Wehr et al. (1998) found that sleep patterns and mood symptoms tended to stabilise when rapid cycling patients were administered 14 hours of bed rest. Similarly, Barbini and colleagues (2005) found that ‘dark therapy’ (14 hours, over a period of three days) was associated with a
significant decrease in manic symptoms when compared to people receiving treatment as usual.

**Female hormonal rhythms.** Interestingly, it has been suggested that the biological rhythm disruption that occurs for woman during child birth and menses may explain the increased severity of symptoms reported by women with BD (Diflorio & Jones, 2010; Kesebir, Şair, Ünübol, & Yaylacı, 2013), and that childbirth (Doyle et al., 2012; Oates, 2006; Viguera, Cohen, Baldessarini, & Nonacs, 2002) and hormonal fluctuations (Russell & Browne, 2005) are important triggers of illness. Given the suggestion that the self-regulation of routines during times of disruption may help prevent bipolar relapse (Shen et al., 2008), it is also possible that regular routines may reduce a women’s likelihood of relapse during times of hormonal vulnerability.

**Summary – disrupted rhythms and bipolar relapse.** The research reviewed above outlines the important relationship between the disruption of routines and symptom onset for people with BD (Shen et al., 2008). However, there is room to further explore how these disruptions affect bipolar relapse, symptom management, and people’s experience of wellness. Qualitative research is well positioned to speak to these areas of interest.

### 3.4. Summary: Psychosocial Factors and Bipolar Relapse

Taken together, the literature suggests that in addition to biological causes of relapse, psychosocial factors such as life events, medication adherence, substance abuse, and disrupted routines, increase a person’s likelihood of relapse and the amount of time spent unwell (Frank, 2005; Haermans et al., 2010; Johnson & Miller, 1997; Levenson et al., 2013; Salloum & Thase, 2000). However, there is room to expand upon our understanding of how these factors affect relapse, and how other factors, such as social
support and self-management affect a person’s vulnerability to relapse and experience of wellbeing (Gershon et al., 2013). Qualitative research that gains deep and meaningful insights into these factors is well positioned to add to our understanding of how stressors impact on people’s illness, and how people manage these stressors to minimise relapse and maintain wellbeing.

Chapter 4: Occupational and Relationship Impairment

While it is important to consider the impact of psychosocial stressors on bipolar relapse, it is also important to consider how this illness affects people’s general level of functioning and overall quality of life. Considering people’s broader experience of impairment acknowledges the journey that people face after diagnosis and highlights the reductionism inherent in conceptualising a person’s illness in terms of discrete episodes of time spent ‘well’ vs. ‘unwell’ (see recovery model of mental illness; A new mental health act, 2012). That is, the effects of mental illness are far reaching and resonate throughout different areas of people’s lives long after an episode has resolved (Murray & Michalak, 2012). This chapter will provide an overview of what is known about the occupational and interpersonal impairment experienced by people with BD, as well as reviewing qualitative literature that has started to investigate how this illness affects functioning in different life roles.
4.1. Occupational Impairment

The majority of people with BD experience severe impairments in occupational functioning as a result of their illness (Altshuler et al., 2006; Calabrese, Hirschfeld, Frye, & Reed, 2004; Dickerson et al., 2004; Marwaha, Durrani, & Singh, 2013; ten Have, Vollebergh, Bijl, & Nolen, 2002; Waghorn, Chant, & Jaeger, 2007). Most individuals with a formal diagnosis of BD do not work fulltime, and of those who do maintain fulltime work, a high rate of absenteeism is reported (Kessler et al., 2006), and a high proportion are employed in a capacity below their qualifications (Johnson & Leahy, 2004; Marwaha et al., 2013).

When comparing the occupational functioning of people with no diagnosis vs. an affective disorder diagnosis, it has been found that the latter tend to have lower work status and income, and are less likely to report advancement in their roles or improved income over time, even after clinical symptoms have remitted (Cohen et al., 2004). Furthermore, people with BD who are unemployed tend to have lower levels of social functioning, which in turn, is associated with greater cognitive impairment and increased depressive symptoms (Depp et al., 2010).

The experience of work for people with BD. While the quantitative research reviewed above has provided insight into the severe impairment people with BD experience in their occupational functioning (Altshuler et al., 2006), it provides limited insight into people’s more personal experiences of work, and how these challenges are managed to promote wellness. There is a body of literature investigating the work experiences of people with physical disabilities (reviewed in Gewurtz & Kirsh, 2009) and schizophrenia (reviewed in Krupa, 2004); however, only limited attention has been given to the subjective experience of work for people with BD (Borg, Veseth, Binder, & Topor, 2013; Michalak, Yatham, Maxwell, Hale, & Lam, 2007; Tse & Yeats, 2002). Literature
in this area has spoken to some of the challenges that people with BD face (e.g., Borg et al., 2013; Michalak et al., 2007), and the importance of having a supportive social network and practical support from employers (e.g., having access to sick leave; Tse & Yeats, 2002).

A study conducted by Michalak et al. (2007) explored the challenges that people with BD face in the workforce, conducting 52 interviews with people who have BD ($n = 35$), as well as their healthcare professionals ($n = 12$), and carers ($n = 5$). Participants’ narratives centred around the impact of symptoms on their vocational functioning. Several participants noted their struggle with the unpredictability of symptoms, with some choosing to seek a less stressful role, or leave the workforce altogether. Although some participants noted that the latter decision was associated with a sense of regret, the broader implications of leaving the workforce were not thoroughly explored. Also, while coping narratives centred on the need to change work commitments and seek support from others (e.g., co-workers and/or a treatment team), the ways in which these supports assist people with their employment was not of central interest to this study.

Along similar lines to Michalak et al. (2007), Borg et al. (2013) investigated the experience of work for people with BD ($N = 13$), and found that employment, including volunteering, was an essential part of maintaining wellness. Participants noted that employment afforded them a sense of identity, mastery, and structure. The importance of balancing work with other lifestyle factors was also emphasised (e.g., social commitments, sleep, exercise, etc.), along with the benefits of external support (e.g., friends, family, partners, managers, colleagues, and treatment team).

Notably, in the aforementioned studies, support from others was emphasised as a factor that might enhance vocational functioning. Indeed, it been suggested that both successful engagement with the workforce and career advancement for people with BD
could be contingent on: (1) the strength of an individual’s support networks, (2) the goodness-of-fit between the individual and the workplace, and (3) the accessibility of leave (Fazzino, 2011; Tse & Yeats, 2002). Regarding this notion of goodness-of-fit and individual preferences, Borg et al.’s (2013) participants were more varied than Michalak et al.’s (2007) in how they chose to manage work. For instance, while both samples noted the benefits of attending work, Borg et al.’s participants also emphasised the importance of balancing work with leisure.

When taken together, these studies (Borg et al., 2013; Fazzino, 2011; Michalak et al., 2007; Tse & Yeats, 2002) offer insights into the impact of bipolar symptoms on work, the strategies people use to manage these symptoms, and the importance of support in helping people with BD to maintain functioning. There is, however, room to shed further light on this topic, especially with regard to understanding: (1) how work itself impacts on symptomatology, (2) the positive and negative effects of ceasing work, (3) the factors that impact on career advancement, and (4) the strategies that people develop to cope with work, including the role of social and practical support.

4.2. Relationship Dysfunction

Interpersonal difficulties are very common for people with BD (Rowe & Morris, 2012). The irritability that is associated with mania and depression has been proposed to explain the higher proportion of disputes and marital discord that is experienced by this population. Additionally, temperamental features such as a tendency towards entitlement and grandiosity are thought to be central to the persistent interpersonal difficulties that are experienced by these individuals (Bauwens et al., 1991; Frank, 2005). The remainder of this section will review research that has investigated the interpersonal difficulties that are experienced by people with BD.
**Social dysfunction.** People with BD are known to experience considerable social impairment, typically having a limited number of established friendships and social contacts, and lower levels of satisfaction with these relationships (Depp et al., 2010; Gitlin et al., 1995). It has been found that people with BD have fewer social contacts than healthy controls (Bauwens et al., 1991), and impaired family and social functioning (Gitlin et al., 1995). More recently, Depp et al. (2010) assessed the social functioning of 164 people with BD and found that virtually all participants (92%) reported impairment in their social functioning. Individuals with BD also appear to have lower quality relationships on average, with participants consistently reporting that their close relationships provide them with less than adequate support (Johnson & Leahy, 2004).

**Marital dysfunction.** It is known that individuals with BD have pronounced difficulties in their marital relationships (Dore & Romans, 2001), with couples experiencing a higher amount of marital discord (Radke-Yarrow, 1998), lower relationship satisfaction, higher relationship failure (Coryell, 1993), and substantially higher rates of separation and divorce (e.g., Kessler, Walters, & Forthofer, 1998). Levckovitz et al. (2000) found that couples with one partner with BD consistently reported lower levels of marital satisfaction, both during episodes of illness and importantly, even after clinical symptoms had remitted. The literature also suggests that relationships are typically characterised by restricted social and leisure activities due to fear of stigma and financial difficulty (Dore & Romans, 2001).

Interviews conducted with couples where one partner has a BD diagnosis have provided a greater level of insight into the interpersonal difficulties that are experienced within these relationships. Partners of individuals with BD typically express difficulty being around their spouse during episodes of illness due to distress associated with their partner’s mood, and having serious concerns for their own safety (Radke-Yarrow, 1998).
Interestingly, it has been found that both members of these couples report having inadequate amounts of practical and emotional support (Levkovitz et al., 2000). Strikingly, 62% of partners have indicated that they would not have pursued their current relationship had they known what it would be like to be in a relationship with someone who has BD (Dore & Romans, 2001). In this regard, there is a need for further research into factors that may help bolster these relationships, and contribute to their long-term success.

4.3. Summary: Occupational and Interpersonal Impairment Associated with BD

The available research indicates that people with BD typically experience significant interpersonal and occupational dysfunction (Rowe & Morris, 2012). Although this has been established in terms of quantitative data, several researchers have called for further research into the subjective experience of work (Borg et al., 2013; Michalak et al., 2007) and relationships (Dore & Romans, 2001) for people with BD. There is significant room to develop our understanding of the poorer work and relationship dynamics that are associated with BD, and how people living with BD optimally manage these challenges. These were primary motivations for conducting the current research.

Chapter 5: Psychosocial Interventions for Bipolar Disorder

Growing recognition of the interaction between psychosocial factors and BD has prompted an increased focus on the potential benefits of adjunctive psychosocial treatment (Johnson & Leahy, 2004; Nathan & Gorman, 2002). There is increased
recognition that adjunctive psychosocial treatment for BD provides benefits in addition to those gained from medication alone (e.g., address medication non-adherence, social and occupational functioning etc.; see Lauder et al., 2010). Meta analyses have suggested that the inclusion of adjunctive psychosocial treatments can reduce relapse rates by up to 40% (see Scott, Colom, & Vieta, 2007), and can delay and/or prevent the onset of illness (see Lam, Burbeck, Wright, & Pilling, 2009). This chapter provides an overview of psychosocial treatment interventions for BD and their efficacy. A specific focus will be given to a group psychosocial treatment program that was completed by the participants of the current study (i.e., the MAPS group; see section 7.4. for information on the current sample), including a detailed overview of the group program and the outcomes of an RCT that investigated its efficacy (Castle et al., 2010).

5.1. Psychosocial Interventions for BD

Psychosocial interventions are aimed at assisting a person’s recovery by targeting different areas of vulnerability and bolstering their strengths and coping resources. Recognised interventions include: providing information about BD and cultivating a better understanding of the illness (i.e., psychoeducation; Colom, 2013; Colom et al., 2003), teaching cognitive and behavioural management skills (CBT; e.g., Lam, Hayward, Watkins, Wright, & Sham, 2005), assisting people to stabilise their routines and manage interpersonal difficulties (IPSRT; e.g., Frank et al., 2005), and assisting families to manage stress, enhance communication, and solve problems together (FFT; e.g., Miklowitz, 2012; Miklowitz, George, Richards, Simoneau, & Suddath, 2003; Rea et al., 2003; Miklowitz et al., 2013). The treatments have common content, namely: psychoeducation, stabilising social rhythms (primarily a focus of IPSRT), teaching identification and early intervention in response to prodromes, managing interpersonal
stress (important elements of both FFT and IPSRT), regulating activity and monitoring mood, evaluating unproductive thoughts and beliefs (primarily a focus of CBT), increasing acceptance of illness, enhancing medication adherence, facilitating engagement with social, family and occupational roles, and addressing difficulties with substance use (Geddes & Miklowitz, 2013; Murray, 2012).

**BD, psychotherapy and stage of change.** The concepts of acceptance and self-efficacy are central to psychotherapy for BD, and engagement is thought to be largely dependent on a person’s more general readiness to change. Even when a person willingly enters treatment, they may not be ready to accept they have an illness or their active role in managing it (Lam et al., 1999). This relates to the concept known as *stage of change* (i.e., SOC), which proposes that a person moves back and forth through a series of ‘stages’ regarding behavioural change. A person’s readiness to change can move between: precontemplation (not ready to change), contemplation (considering change), preparation (ready to change), action (people have made changes), maintenance (sustained action towards change), and termination (the person has changed; Prochaska, Wright, & Velicer, 2008). It may be that successful engagement with psychotherapy for BD is largely dependent on people being at least contemplative regarding their role in managing their illness.

**Psychoeducation.** Providing people with education about BD, including pharmacological treatment and side effects, can reduce rates of relapse and increased adherence to medication (Colom, 2013; Colom et al., 2009a; Colom et al., 2009b; Perry, Tarrier, Morriss, McCarthy, & Limb 1999). For instance, when comparing individuals receiving medication management as usual vs. medication management plus 7-12 sessions of psychoeducation, Perry et al. (1999) found that the latter group had a significant delay in the onset of mania and demonstrated better functioning in social and
occupation roles. The intervention aimed to teach individuals with BD to recognise the early warning signs of illness, and the importance of seeking medical intervention during this time.

Colom and colleagues (2003) conducted one of the largest studies in this area, investigating the efficacy of group therapy on 120 outpatients with BD, comparing small groups who received medication and non-structured meetings with those who received medication and 21 sessions of psychotherapy. Although the intervention was labelled ‘psychoeducation’, the content was drawn from a variety of therapeutic approaches, with treatment aimed at improving awareness of BD, improving medication adherence, teaching patients how to detect prodromal stages of illness (i.e., early symptoms of an episode; Lam & Wong, 2005), and improving lifestyle regularity. When compared to the control group, participants who received adjunctive psychotherapy had delayed recurrence of mania, hypomania, depression and mixed episodes, shorter periods of relapse, and a reduced number of hospitalisations (Colom et al., 2003). Furthermore, improved medication adherence was reported at two year follow-up, and treatment gains were maintained at five years (Colom et al., 2009a; Colom et al., 2009b).

**Family and marital therapy.** It has also been suggested that providing families with skills to manage stress, negotiate conflict, enhance communication, and solve problems, can improve medication adherence (Clarkin et al., 1998) and overall treatment outcomes (Miklowitz, 2008). In line with this, Clarkin et al. (1998) found that participants \(N = 33\) who received eleven months of marital intervention had better adherence to medication and better overall functioning compared to participants who received pharmacotherapy alone.

Miklowitz and colleagues (Miklowitz et al., 2000; Rea et al., 2003) have also conducted several controlled trials with FFT, investigating the benefits of teaching
emotion regulation and conflict resolution skills. In their first study (Miklowitz et al., 2000) 101 participants were assigned to receive either 21 sessions of FFT and pharmacotherapy, or two sessions of family crisis management and pharmacotherapy. When participants were followed-up after two years, those who received family therapy had longer periods of remission, and lower rates of relapse.

These findings were further supported by a subsequent study by Rea et al. (2003), who investigated the efficacy of FFT for BD. Participants ($N = 53$) either received FFT and pharmacotherapy, or individual therapy and pharmacotherapy. Both types of therapy were administered over 21 sessions for a period of nine months. The interventions were similar, providing psychoeducation, training in communication and problem solving, with the primary difference being the presence of family in the FFT group. No differences were found between groups when participants were followed up after one year; however, after two years, participants whose families had received treatment had significantly lower rates of relapse and rehospitalisation.

**IPSRT.** The primary foci of IPSRT are to: explore people's feelings about having BD, assist their coming to terms with the illness, address interpersonal difficulties and deficits, and stabilise daily routines. The therapeutic process typically begins by providing the patient with information to help them understand the importance of routines (e.g., daily functioning and sleep). Homework, which encourages the individual to track their routines and mood, is used to foster engagement with this concept, as it provides people with evidence for the relationship between routine and mood. Therapy is then focussed on modifying the factors that continue to cause disruption to a person’s routine (Frank, 2005).

IPSRT is based on the assumption that events triggering an increase or decrease in either sleep or social stimulation (concerts, social interactions, etc.) are likely to be
catalysts for mood dysregulation. Skills training in sleep hygiene are therefore essential in assisting individuals with BD to maintain regularity in their sleep/wake routine. Such training involves teaching people about the importance of having a regular wake time, avoiding caffeine and other stimulants, engaging in exercise early in the day, and to reserve bed for sleep and sexual activity (Frank, 2005).

Therapeutic intervention with IPSRT also aims to increase acceptance of BD by resolving grief for the lost ‘healthy self’. This process of acceptance usually requires therapist and patient to work together in developing realistic expectations with respect to the limitations imposed by the individual’s condition. For example, a woman with BD who is just about to become a mother may experience a sense of grief for her ‘healthy self’. While her ‘old self’ may have been well equipped to wake several times a night to care for her newborn, the reality is that her ‘new self’ is at risk of relapse due to sleep disruption. It is therefore necessary for therapist and patient to work toward the development of realistic expectations for this situation and process any difficult feelings associated with this adjustment. Of primary importance is that the patient acknowledges that relapse in this situation would create the most undesired outcomes (Frank, 2005).

This style of therapy also focuses on developing realistic expectations for relationships, and to accept the inequalities and injustices that are sometimes unavoidable when someone has a major mental illness. It can also be helpful for people to acknowledge the consequences of interpersonal disputes to help facilitate behaviour change (Frank, 2005).

**Efficacy of IPSRT.** Empirical support for the efficacy of IPSRT in the treatment of BD is sparse, with only one controlled research study (Frank et al., 2005; Frank et al., 1999). Although limited, early research has been encouraging, and has suggested that intervention with IPSRT may be effective in extending periods of wellness.
In an investigation of the efficacy of IPSRT, Frank et al. (1999) recruited people ($N = 175$) with BD who were acutely unwell and randomised them to one-of-four treatment strategies: (1) short-term and then ongoing treatment with IPSRT, (2) short-term and then ongoing treatment with intensive clinical management (ICM$^4$), (3) short-term IPSRT with ongoing ICM, and (4) short-term ICM and ongoing IPSRT. At two-year follow-up there was no significant difference in the outcomes of the four groups; however, at an extended longitudinal follow-up (i.e., Frank et al., 2005) it was found that participants who received short-term IPSRT were significantly less likely to experience relapse, and reported greater stability in daily routines and sleep-wake cycles. Regarding the efficacy of acute intervention, the authors speculated that participants might have been more receptive to IPSRT during and immediately after an acute episode, rather than introducing these concepts after episode remission. The authors proposed that the greater consistency in routines that are encouraged by this therapy might have protected these people against relapse (Frank et al., 2005).

**Cognitive-behavioural therapy.** The primary goal of CBT is to address maladaptive thinking and behavioural patterns associated with symptoms of mania and/or depression. This is achieved by fostering behaviour change and teaching cognitive restructuring techniques (Lam et al., 2003). Clinical intervention with CBT typically begins by providing psychoeducation about BD and associated treatments, followed by focussed work around the development of cognitive and behavioural skills (e.g., activity schedules, thought monitoring, thought challenging etc.) and improving the person’s ability to recognise early warning signs of illness. Ongoing treatment supports the person’s continued use of these strategies and skill consolidation (Lam et al., 1999).

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$^4$ ICM: an approach that focuses on medication/medical management.
Helping individuals to recognise their prodromal stage of illness is particularly important for improving treatment outcomes (Miklowitz, 2008). It is thought that prodrome recognition can facilitate timely engagement with relapse prevention procedures (e.g., medication adjustment), which minimise the likelihood of a full-blown relapse (Lam et al., 1999; Lobban et al., 2010). To this end, CBT encourages people to engage in daily mood monitoring to promote early recognition of prodromal symptoms. As sleep disruption is thought to be one of the most readily identifiable changes (Harvey, Talbot, & Gershon, 2009), it is monitored alongside mood. People are encouraged to keep rating scales in locations that are viewed regularly (e.g., on the fridge), to increase the likelihood of self-monitoring becoming a part of the person’s daily routine. Recent technological advancements have also provided innovative methods for self-monitoring which are growing in popularity (e.g., mobile phone technology and sleep monitoring devices; Malik, Goodwin, & Holmes, 2012; Sylvia et al., 2013).

Efficacy of CBT. Research has presented mixed results with regard to the efficacy of CBT for BD. Although a number of studies have found the intervention to be efficacious (Cochran, 1984; Lam et al., 2005; Lam et al., 2003), one large scale RCT found no significant benefit in terms of relapse prevention (Scott et al., 2006). These findings will be explored in turn.

In an early study by Cochran (1984), newly admitted BD patients (N = 28) were randomised into two treatment groups: (1) lithium only, or (2) lithium plus CBT, comprising 1-hour individual sessions for 6 weeks. The intervention targeted cognitions and behaviours that are thought to interfere with medication adherence. It was found that participants who received adjunctive CBT had significantly better medication adherence and were less likely to be hospitalised. Although there were no significant differences in
the total number of relapses, the lower rates of hospitalisation in the CBT group suggest that the intervention was associated with relapses of lesser severity (Cochran, 1984).

The findings of Lam et al. (2003) and Lam et al. (2005) provided further support for the efficacy of CBT for people who have a substantial history of bipolar relapse. Participants ($N = 103$) were randomised into two groups: (1) pharmacotherapy, and (2) pharmacotherapy plus CBT, comprising 14 sessions over six months, with the option of 2 booster sessions. When participants were followed over three years, it was found that those who received CBT had significant reductions in the total number of episodes, hospital admissions, and overall episode severity. CBT was also associated with significant increases in social functioning, and coping ability with regard to manic prodromes (Lam et al., 2005; Lam et al., 2003).

In contrast to the aforementioned studies, Scott et al. (2006) found no significant difference between individuals with BD who received CBT compared to those who received their regular treatment (Scott et al., 2006). Patients ($N = 253$) were randomly allocated to receive treatment as usual, or treatment as usual plus 15-weeks of CBT. The CBT intervention program addressed a broad range of psychosocial factors, including: acceptance of illness and need for treatment, mood management, stress management, handling interpersonal problems, coping skills, thought challenging, medication adherence, and substance misuse. It was hypothesised that the observed null findings could be explained by the nature of the sample – that is, Scott et al. recruited participants who had a severe illness history and it was thought that perhaps these people were less amenable to psychological treatment. However, in an investigation of this hypothesis, Lam et al. (2009) found no evidence to suggest that number of previous episodes moderates the efficacy of adjunctive treatment interventions for BD. Rather, Lam et al. proposed that the null findings of Scott et al. might be better explained by the fact that the
sample comprised participants who were currently unwell. It was proposed that this might have impacted on the results by way of directing the interventions toward immediate symptom reduction, rather than a longer-term focus on acquiring skills that would buffer against future relapses. In addition of this, and unlike most other studies in this area, Scott et al. did not require participants to be on mood stabilisers, which is an important feature of routine bipolar management (Lam et al., 2009).

5.2. The MAPS Group Treatment Program

Of the various psychosocial treatments that have been investigated, the present literature review will pay most attention to the MAPS group, because the sample for the current study was drawn from people who had previously participated in this treatment program (see section 7.4. for information on the current sample). Some participants completed the MAPS program as part of an RCT (discussed below) and some completed the group subsequently, after accepting an invitation once the RCT was complete.

Emphasising overlap between content areas in recognised treatments, the MAPS group utilised treatment strategies from a variety of therapeutic approaches, including psychoeducation, IPSRT, CBT, dialectical behaviour therapy (e.g., mindful attention), and motivational interviewing (e.g., participants were asked to weigh up/assess the value of using helpful strategies and set goals around these strategies). The focus of the program was to assist people to develop strategies and skills that would assist them to better manage their illness. Specifically, participants were taught to monitor their mood and activities (M), acquire strategies for relapse prevention (A), become familiar with their episode prodromes (P), and engage in smart goal setting (S) (Castle et al., 2010). The specific interventions that were administered during the MAPS group are summarised in Table 2. Each session lasted approximately 90 minutes in duration.
Table 2

Content of the MAPS Treatment Group

This copyrighted table has been omitted.

Table 2. The content presented above is from “MAPS: a guide to managing Bipolar Disorder, Information Book (p. 5), by L. Berk and S. Lauder, 2009a, the Mental Health Research Institute: Frameworks for Health. Copyright (2009) by Frameworks for Health. Adapted with permissions.

In addition to the content itself, it was thought that the manner of the facilitators was an important element of treatment. As such, guidelines for engendering a positive therapeutic process were disseminated among the facilitators, who were encouraged to
develop therapeutic relationships that provided empathy, genuineness, and acceptance. Facilitators were also encouraged to take a stance of ‘not knowing’, and tailor treatment to match each individual’s unique circumstance (Berk & Lauder, 2009b). Additionally, attending treatment with other people who have BD may have impacted on people’s experience of the MAPS group, due to the known benefits people gain from the supportive and social aspects of group treatment (Kelsey, 2004; May, Strauss, Coyle, & Hayward, 2014).

**RCT of the MAPS group.** An RCT investigated the efficacy of the MAPS group treatment program for BD. A total of 84 participants with BD were recruited from a variety of community facilities. To assist the generalisability of findings, criteria for inclusion in the study were broad, with few exclusions. The inclusion criteria were: a DSM-IV-TR diagnosis of BD (either BDI, BDII, or BDNOS), age between 18-65 years, English speakers, under the care of a medical practitioner, and not currently experiencing an acute episode of illness. Exclusion criteria were a developmental disability, or a significant amount of cognitive impairment. Although 84 participants were recruited, the withdrawal of 12 participants meant that only 72 participants completed the study, which comprised treatment as usual (control group; $n = 40$), or treatment as usual plus psychosocial group treatment for BD (treatment group; $n = 32$).

It was found that participants in the treatment group had significantly lower rates of relapse over a nine-month period (Castle et al., 2010). While the treatment group experienced an average of 4 episodes of depression and no episodes of mania, the control group experienced an average of 15 episodes of depression, and 6 episodes of mania. Interestingly, the treatment group experienced an average of 9 episodes of hypomania and the control group only experienced an average of 5, as well as having more visits to mental health clinics. The authors hypothesised that increased occurrence of hypomania
and more regular visits to healthcare professions was likely a by-product of engaging with early intervention and preventative health activities to prevent full-blown mania (Castle, Berk, Lauder, Berk, & Murray, 2009; Castle et al., 2010).

5.3. Summary: Psychosocial Interventions for BD

Although this literature is still developing, there is an emerging body of data that speaks to the efficacy of adjunctive psychosocial interventions for BD (Castle et al., 2010; Colom et al., 2003; Miklowitz et al., 2003; Perry et al., 1999). The one study that has offered null findings in this area (Scott et al., 2006) has been noted to have methodological issues which may have affected the results (see Lam et al., 2009). Considering the outcomes of the MAPS group treatment program was of central interest to the current study, due to the current samples participation in this program. Castle et al.’s (2010) results indicated that participants in the psychosocial treatment group had significantly lower rates of relapse than participants in the control group, as well as spending significantly less time unwell, and having fewer hospital admissions. When take together, Castle et al.’s and Colom et al.’s (2009b; reviewed above) findings provide further support for the efficacy of administering adjunctive psychosocial group treatment to people with BD (Castle et al., 2010). It has been proposed that group therapy can provide benefits beyond those obtained from individual treatment (see Palmer, Williams & Adams, 1995; Yalom, 1995), due to encouraging social functioning and the protective benefits that can be gained from social support. However there are currently no controlled trials to suggest the efficacy of one type of treatment modality (i.e., individual therapy, group therapy, or the newer web-based treatments; Smith et al., 2011) over the other (Castle et al., 2009; Hunsley, Elliott, & Therrien, 2014). This will be an important focus of future research.
Chapter 6: Qualitative Insights Into The Lived Experience of Bipolar Disorder

A number of researchers have argued that we can develop a deeper understanding of the strategies people use to minimise episodes of illness and promote wellbeing by analysing qualitative data on the experience of living with BD (Murray & Michalak, 2012; Russell & Browne, 2005). A small body of qualitative research has begun to investigate people’s personal accounts of living with BD. This research provides insight into the impact of BD on people’s quality of life (Michalak et al., 2006), experience of recovery (Mansell et al, 2010; Veseth et al., 2012), and how wellness is maintained (Russell & Browne, 2005; Suto et al., 2010). An important focus of the current project is to shed light upon and expand this literature. The concepts in this literature often overlap, having direct relevance to the psychosocial literature on BD in terms of relapse, functional impairment, and treatment (Chapters 3, 4, and 5). As such, the chapter will conclude with a summary of the overlapping findings into the lived experience of BD, and the areas that could be profitably explored in further detail.

6.1. Quality of Life and BD (Michalak et al., 2006)

In an investigation of how BD affects quality of life, Michalak et al. (2006) performed in-depth interviews with people who have BD ($n = 35$), caregivers ($n = 5$), and healthcare professionals ($n = 12$). The sample of participants with BD ranged from those who had been well for several years to those who were currently recovering from an episode of illness. Participants’ interviews were analysed thematically. Six themes were drawn from participants narratives about factors that affect quality of life, namely: (1) routine, (2) independence, (3) stigma and disclosure, (4) identity, (5) social support, and (6) spirituality. These are discussed in turn.
Routine, independence, and stigma. Participants had a range of beliefs about the importance of routine to their quality of life. For instance, although many people felt that routine was essential to their wellbeing (e.g., work, spiritual pursuits, childcare drop-offs etc.), others found it difficult to cope with the structure imposed by these activities. As such, there was a degree of individual differences with regard to the importance of routine. With regard to gaining independence, several people believed that having control of one’s finances and being less dependent on family had been particularly important in terms of achieving autonomy. However, a challenge noted by some was that family also helped with prodrome recognition, and this degree of involvement could make achieving autonomy difficult.

Stigma was also proposed to impact on people’s quality of life. The vast majority of participants noted that stigma had impacted on their participation in the workforce, and interactions with the healthcare system, in particular. Others reported that they had non-judgemental relationships with their treatment team and that they were well supported at work. This would suggest that stigma could play a mediating role between BD and people’s sense of social inclusion, as well as people’s engagement with the workforce and treatment.

Identity, social support, and spirituality. Participant’s sense of identity and self-worth were also found to be important to their quality of life, with several participants describing a sense of loss with regard to their pre-morbid identity. These people also felt that accepting BD had been an essential part of regaining their self-identity and building a new sense of self – people’s pathways to acceptance, however, were not thoroughly explored in this study. The impact of BD on relationships was noted; with participants expressing that BD could have positive and negative consequences. Of the former, participants noted that their illness had brought about a
strengthening of their support networks; however, others noted that manic episodes had been destructive to their close relationships. Although the management of relationships was not a focus of the study, some participants noted that they had to discard relationships that had a negative impact on their symptoms. People felt that making these changes to their social network had helped them to reduce symptoms and improve quality of life. Lastly, participants also spoke about the role of spirituality, and the issues that they faced when religiosity became a feature of mania – especially with regard to how this affected their standing in religious communities. Others noted that they enjoyed the spiritual aspect of their episodes, and that it helped with depression in particular.

6.2. People’s Experience of Recovery in BD

Understanding people’s adjustment to illness after onset is key to understanding the lived experience of BD. As noted in the “A national Framework for Recovery-oriented Mental Health” (2013), there is no single definition or description of recovery; however, it involves being able to create and live a meaningful and contributing life with or without the presence of mental health issues. To date, only two studies have investigated the phenomenology of recovery in BD (Mansell et al., 2010; Veseth et al., 2012), with one looking at people who identify as having struggled with their illness (Veseth et al., 2012), and the other looking at people who were symptom free for at least two years (Mansell et al., 2010). Both studies collected data through use of in-depth interviews and used similar methods of interpretation.5

The narratives of Veseth et al.’s (2012) participants fell into four themes, including: (1) handling ambivalence about letting go of manic states, (2) finding something to hang on to when the world is ‘spinning around’, (3) becoming aware of

5 Veseth et al. used a hermeneutical-phenomenological approach, and Mansell et al. used an interpretative phenomenological approach.
signals from self and others, and (4) finding ways of caring for oneself. The narratives of Mansell et al.’s participants fell into two categories, namely: (1) challenges to recovery – monitoring against mania, medication, prior illness versus current wellness, and sense of identity following diagnosis, and (2) approaches that were helpful to recovery – understanding, lifestyle fundamentals, social support and companionship, and social change. The remainder of this section will review these findings as they relate to two general categories, namely: factors that promote recovery, and factors that present challenges to recovery.

Before these findings are reviewed, an area of research that theoretically relates to the concept of recovery (i.e., the capacity to live a satisfying life despite illness) will be briefly discussed. There is a growing literature exploring the positive aspects of people’s bipolar experiences (reviewed in Lobban, Taylor, Murray, & Jones, 2012), which suggests that many people value aspects of living with BD and would not necessarily get rid of this illness if they were given the choice (Lobban et al., 2012). Specifically, it has been found that people with BD can experience heightened levels of achievement (Jones, Dodd, & Gruber, 2014), creativity (Jones et al., 2014; Murray & Johnson, 2010), sensitivity, alertness, productivity, social outgoingness, and sexual enjoyment (Jamison, Gerner, Hammen, & Padesky, 1980). Although this is not a direct focus of the current thesis, these findings bring attention to an important aspect of the bipolar experience and are therefore worth noting.

Factors that promote recovery. Participants from Veseth et al.’s (2012) study believed that engaging in simple tasks of daily living (e.g., gardening, hobbies, work, etc.) is important to recovery because they bring a grounding influence to their lives. In contrast to Michalak et al.’s (2006) findings, participants were unanimous in their belief in the importance of others in recognising early warning signs of relapse. An attitude of
self-care was also noted to help participants cope with the challenges of BD. Participants in Mansell et al.’s (2010) study noted that accepting the BD diagnosis had given them an increased sense of agency over their illness. Lifestyle factors such as consistent sleep, a healthy diet, and reduced work commitments were also thought to be important to living well with BD. In line with Veseth et al.’s findings, participants in the study of Mansell et al. reported that being open with others and socialising regularly assisted their recovery in the longer term.

Factors that present challenges to recovery. Participants across both studies in this area spoke about the challenges that are associated with elevated mood states – namely, that they are associated with increased productivity and heightened energy levels, while also having the potential to cause significant long-term damage to the person’s life (Mansell et al., 2010; Veseth et al., 2012). While participants could acknowledge the issues that are associated with these episodes, they also spoke of their mourning for manic states and the relief they bring from depression. To this end, participants in Mansell et al. (2010) noted how difficult it is to curtail the urge to engage in activities that might prompt a hypomanic mood state, such as productive tasks or pleasurable activities. Although identified as a challenge, people’s strategies for managing this were not explored in depth. These participants also noted that although medication had been essential to keeping them well, for many, the side effects had outweighed the perceived benefits, bringing about a desire to cease use. Lastly, participants also spoke about the role of stigma, and how concerns about being defined by one’s illness had presented a barrier to acceptance. These narratives were similar to those identified in Michalak et al.’s (2010) findings.
6.3. Lived Experience Expertise in BD – Wellness and Self-Management

A third approach to studying the lived experience of BD has been to learn more about people who cope well with their illness. Two qualitative studies have investigated how people with BD who are ‘high functioning’ manage their condition (Russell & Browne, 2005; Suto et al., 2010).

Russell and Browne (2005) investigated wellness in an Australian sample of high function people with BD (N = 100), including 63 males and 37 females. To be included in the study, participants must have maintained wellness for a minimum of two years. Data was collected from written submissions or interview transcripts. Many of the themes corresponded with pre-identified areas of interest (i.e., psychosocial factors that are implicated in BD), with new themes emerging during analysis. The researchers identified the following themes in participants’ narratives about staying well: (1) acceptance of diagnosis, (2) education, (3) mindfulness, (4) treatment, (5) identify triggers, (6) recognize warning signals, (7) manage sleep and stress, (8) make lifestyle changes, (9) access support, and (10) stay well plans.

Using a similar design and methodology, Suto et al. (2010) investigated the self-management strategies used by a Canadian sample of high functioning people with BD (N = 32), including 20 females and 12 males. Quantitative measures were used to assess participants’ current symptoms, psychiatric history, functioning, and quality of life. Participants could choose to be involved in an individual interview or focus group, where open questions explored the strategies people used to regain and maintain wellness. Thematic analysis was used to draw out the preliminary themes, which were further developed in meetings with the research team. Suto et al. identified six themes in participants’ narratives about wellness, including: (1) sleep, rest, exercise and diet; (2) ongoing monitoring of symptoms; (3) enacting a plan to prevent or reduce the severity of
relapse; (4) reflective and meditative practices; (5) understanding BD and educating others; and (6) connecting with others to gain social support. As both of the aforementioned studies employed similar research methods and drew similar themes, they will be reviewed together here.

**Acceptance of diagnosis and getting the correct treatment.** Participants in the Russell and Browne (2005) study discussed the importance of receiving and accepting their BD diagnosis. Many participants reported that they had initially been misdiagnosed, and that incorrect treatment had affected their quality of life. For instance, several participants noted a substantial improvement in their quality of life after being prescribed the correct medication and adhering to this treatment. People also spoke about the benefits associated with adjunctive treatments, such as psychotherapy and nutritional supplements; however, the ways in which these treatments affected wellness were not thoroughly explored. Even after gaining a correct diagnosis, people recalled the difficulty they had accepting their BD diagnosis. However, once participants had received and accepted a BD diagnosis, they experienced an increased sense of agency over their condition, which again points to the significance of acceptance of illness in BD management.

**Understanding BD and educating others.** Participants in Russell and Browne’s (2005) study spoke about the importance of learning about their illness, drawing upon resources such as books, mental health organisations, health care professionals, seminars, support groups, and other people with BD. People found that learning about BD had assisted them to accept their illness and as a result, better manage their condition. People also spoke about a process of experiential learning, where they had developed some mastery over their illness through lived experience of episodes and how this had helped them to identify their triggers and early warning signs of relapse.
Participants from Suto et al. (2010) also spoke about the importance of learning about their condition. Although these participants reported accessing information through similar avenues (e.g., reading books, newsletters, the internet, groups, and by talking with healthcare professionals), they also spoke more specifically about the benefit of having other people in their network who were knowledgeable about BD. This was thought to not only develop self-knowledge by learning from others, but also, to help people feel understood and accepted.

**Lifestyle factors.** Participants in both Russell and Browne’s (2005) and Suto et al.’s (2010) study spoke about the broader lifestyle factors that had assisted them to maintain wellness. Among these factors were eating a well-balanced diet, getting regular exercise, limiting alcohol and caffeine, maintaining regular sleep, spending time with friends and family, and managing stress. Participants in Suto et al.’s (2010) study emphasised the importance of taking time to rest, and how this helped facilitate the meeting of social commitments and work responsibilities. Key points of difference included the fact that Suto et al.’s (2010) participants emphasised the importance of diet and exercise to wellbeing, and place less emphasis on their management of work stress than the participants in Russell and Browne (2005).

Participants in Russell and Browne’s (2005) went into detail about the ways in which they managed both stress and sleep, noting the importance of having a consistent bedtime, avoiding stimulating activities before bed, and avoiding social engagements that disrupt sleep. Sleep medication was also mentioned as a way to promote sleep regularity. In terms of stress management, some of these participants found it helpful to adopt a slower-paced lifestyle by changing to a less stressful job or moving to a rural community. These people also described the benefit of increasing medication during times of stress, and the utility of taking regular holidays and working only part-time.
Reflective, meditative and mindfulness practices. Both Suto et al.’s (2005) and Russell and Browne’s (2005) participants discussed the wellness benefits that were associated with engaging in some form of meditative or reflective practice. While many of Suto et al.’s participants engaged in traditional meditation activities such as tai chi, yoga, and meditation, others preferred activities such as journaling, reading, prayer, calming music, and painting. Interestingly, some participants felt that these activities had helped them to stay well by way of assisting them to monitor their condition. Similarly, many of Russell and Browne’s participants reported a benefit from being mindful about their daily thoughts and feelings. Specifically, these participants described the utility of being aware of how they responded to daily stressors, and how self-observation had assisted them to recognise early symptoms of illness and subsequently, early intervention for relapse prevention. Narratives related to this theme were largely consistent across the two studies.

Identification of triggers, ongoing monitoring of symptoms, and recognition of early warning signs of illness. Coinciding with the concepts that are emphasised in psychosocial interventions for BD (see Chapter 5), both Russell and Browne’s (2005) and Suto et al.’s (2010) participants noted that identification of relapse triggers and prodromal symptoms had allowed them to better manage their condition. Participants identified many of the factors that have been identified in the literature on bipolar relapse, as discussed in Chapter 3. For example, a bidirectional relationship between sleep and stress was noted by Russell and Browne’s participants, with stress having the potential to disrupt sleep, and the absence of sleep causing a lowered resistance to stress. These participants also identified other triggers for illness, including: fatigue, hormonal fluctuations, change in season, jet lag, all night partying and recreational drug use. Interestingly, several participants in Russell and Browne’s study noted that potential ‘red
flags’ for relapse, such as poor judgement and changes in financial behaviour, were ineffective because they appeared late in the process of illness onset. That is, subtle changes in behaviour such as minor sleep disturbance or small changes in thinking were thought to be more useful markers of a prodrome.

Participants in Suto et al. (2010) went into greater detail about the importance of making as-needed changes to their medication to manage their sleep when they were vulnerable to relapse. For some participants, the process of medication adjustment was assisted by their psychiatrist; however, many people had learnt to implement this wellness strategy on their own and made minor alterations to their medication of their own accord. The role of spouses and partners in mood monitoring and early intervention was a prominent narrative in Suto et al.’s (2010) sample, emphasising the importance of receiving help from others to monitor behavioural warning signs.

**Having a plan for staying well.** Both Suto et al. (2010) and Russell and Browne’s (2005) participants spoke about their plans for maintaining wellness. Participants from Suto et al.’s study spoke about their relapse prevention plans, which typically involved gaining assistance from other people, and ranged from informal arrangements with friends and family, to more structured and detailed documents that acted as a guide for decision-making and intervention during this time. People also spoke about the strategies they used to prevent relapse, including: cancelling work and/or social engagements, meditation, sleep, yoga and exercise, adjustment of medication, contacting trusted friends/family, adjusting medication, and collaboration with a health care professional.

These findings were consistent with those of Russell and Browne (2005), where participants emphasised the importance of having a ‘stay well’ plan which incorporated important triggers, early warning signs of illness, wellness strategies, and early
Participants felt that having a structured plan for staying well had been an essential component in assisting them to maintain wellness and prevent relapse. In line with the findings of Suto et al. (2010), participants reported having varying degrees of formality in their plan, with some having a verbal agreement with their family and treatment professionals, and others having a formal written document.

Participants in Russell and Browne’s (2005) sample spoke more generally about their strategies for staying well, and their ‘stay well’ concept. For instance, most participants described staying well in terms of being in control and engaging in effective relapse prevention practices. Other felt that a state of wellness had been more to do with their identity, and the need to separate from their illness label.

**Social support and connecting with others.** Participants from both Russell and Browne’s (2005) study and Suto et al.’s (2010) study emphasised the role of psychosocial support to their maintenance of wellness. Russell and Browne’s participants identified the various support networks they draw upon, including family, friends, mental health and local community groups, health care professionals, churches, and colleagues. More specifically, participants described how supports had helped them to monitor their illness and make safety plans. Participants emphasised the importance of support gained from health professionals, and the need to find a psychiatrist that best suited them. Several participants felt that it was useful to have a number of health professionals in their team, including GPs, case managers, psychiatrists, psychologists, counsellors, and social workers. Participants explained that this was due to the diversity that these people provided in approaches to care.

Participants in Suto et al. (2010) made similar mention of the importance of social support, but also focused on the more subtle benefits gained from connecting with others.
The narratives of Suto et al.’s participants seemed to be more favourable towards mental health support groups, with people reporting that they helped them to develop relationships with treatment professionals. In line with Russell and Browne’s (2005) participants, people described the utility of having positive relationships with treatment professionals, and how these relationships had assisted them in staying well.

6.4. Summary: Qualitative Insights into the Lived Experience of Bipolar Disorder, and Areas for Further Exploration

There is significant overlap in the themes identified in the aforementioned qualitative studies (i.e., Mansell et al, 2010; Michalak et al., 2006; Russell & Browne, 2005; Suto et al., 2010; Veseth et al., 2012). When taken together, these findings provide insights into the factors that people identify as being important to recovery, and living a meaningful and contributing life. This includes strategies that promote wellness, challenges to recovery, and factors that contribute to quality of life. Table 3 provides a summary of the themes discussed in the preceding text and draws attention to overlapping themes.
## Table 3

*Overlapping Themes in the Qualitative Literature on Living with BD*

<table>
<thead>
<tr>
<th>Emerging Theme</th>
<th>Quality of life (Michalak et al., 2006)</th>
<th>Recovery (Mansell et al., 2010)</th>
<th>Wellness and self-management (Russell &amp; Browne, 2005; Suto et al., 2010)</th>
<th>Recovery (Veseth et al., 2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The role of social support</strong></td>
<td>Social support</td>
<td>Social support and companionship; Social change</td>
<td>Connecting with others; Access support</td>
<td>Ongoing monitoring; Identify trigger factors; Recognising warning signs</td>
</tr>
<tr>
<td><strong>The need to monitor symptoms</strong></td>
<td>Independence</td>
<td>Independence</td>
<td>Ongoing monitoring; Identify trigger factors; Recognising warning signs</td>
<td>Becoming aware of signals from self and others</td>
</tr>
<tr>
<td><strong>Ambivalence about manic states</strong></td>
<td>--</td>
<td>Prior illness versus current wellness; Avoidance of mania</td>
<td>--</td>
<td>Handling ambivalence about letting go of manic states</td>
</tr>
<tr>
<td><strong>The role of psycho-education</strong></td>
<td>--</td>
<td>Understanding</td>
<td>Understanding BD and educating others; Education</td>
<td>--</td>
</tr>
<tr>
<td><strong>The role of stigma and acceptance of illness</strong></td>
<td>Identity; Stigma and disclosure</td>
<td>A sense of identity following diagnosis</td>
<td>Acceptance of diagnosis</td>
<td>--</td>
</tr>
<tr>
<td><strong>Lifestyle changes that contribute to wellness</strong></td>
<td>--</td>
<td>Lifestyle-fundamentals</td>
<td>Making lifestyle changes; Sleep, rest exercise and diet; Managing sleep and stress</td>
<td>Finding something to hang on to when the world is spinning around</td>
</tr>
<tr>
<td><strong>Medication adherence and adjunctive treatments</strong></td>
<td>--</td>
<td>Taking medication</td>
<td>Treatment</td>
<td>--</td>
</tr>
<tr>
<td><strong>Reflective and meditative practices</strong></td>
<td>--</td>
<td>--</td>
<td>Reflective and meditative practices; Mindfulness</td>
<td>Finding ways of caring for oneself</td>
</tr>
<tr>
<td><strong>Proactive planning for staying well</strong></td>
<td>--</td>
<td>--</td>
<td>Enacting a plan; Stay well plans</td>
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</tr>
<tr>
<td><strong>The relationship between routine and quality of life</strong></td>
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<tr>
<td><strong>The relationship between spirituality and quality of life</strong></td>
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</tbody>
</table>
An analysis of this literature also points to several areas of inquiry that could be profitably explored in further detail. These will be reviewed in turn.

**Acceptance.** The notion of acceptance is a theme that threads through the findings in this literature. Some people have noted that accepting their BD diagnosis helped them to regain their self-identity (Michalak et al., 2006), whereas others thought that it helped them gain control over their condition (Mansell et al., 2010; Russell & Browne, 2005). While learning about one’s diagnosis may facilitate acceptance (Russell & Browne, 2005), people have also voiced concerns about stigma and being defined by their diagnosis (Mansell et al., 2010), which may present a barrier to acceptance. Although this literature provides insights into the potential importance of acceptance in aiding the wellbeing of people with BD, there is clearly room to better understand the factors that contribute to acceptance, and the specific role that acceptance plays in increasing people’s agency over their condition.

**Routines and rhythms.** Another theme that arose from this literature was the notion of routine and interpersonal rhythms, and how these may contribute to bipolar relapse. Many people spoke of the benefits associated with having behavioural routines (Michalak et al., 2006) and regulating sleep (Russell & Browne, 2005; Suto et al., 2010). However, others have noted that the need for structure and routine can be burdensome and restrictive (Michalak et al., 2006). There is a need to better understand how routines work for people, and to delineate ways in which routine may be optimised to facilitate wellness.

**Participation in the workforce.** Studies in this area have also pointed to the benefits associated with moving to a less stressful job to facilitate wellness (Michalak et al., 2007; Russell & Browne, 2005); however, aside from workload reduction and having access to sick leave (Tse & Yeats, 2002), the ways in which people with BD manage
work is not well understood. For instance, it would also be interesting to explore how people sustain work, and in addition to stigma, what factors might impede people’s advancement in the workforce.

**Self-care and tasks of daily living.** Two concepts that arose in only one study (Veseth et al., 2012) were those of self-care, and the importance of everyday activities such as gardening and household chores. Indeed, the notion of self-care is something that has not been heavily emphasised in the literature to date, and there is a need to better understand the ways in which people with BD can maximise their sense of wellness through simple behavioural activities.

**People’s experience of treatment.** Importantly, the studies reviewed above have not directly explored people’s experience of psychosocial treatment. Given the need to move beyond a symptom-focussed illness model and toward understanding people’s lived experience of illness, it seems essential to undertake an in-depth exploration of people’s thoughts, feelings, and experiences of treatment for BD. Although Russell and Browne’s (2005) participants noted that adjunctive treatments had been important to their wellbeing, there was minimal elaboration on this point, leaving room to further explore the role of adjunctive treatments and their importance to wellbeing. Specifically, it is important to investigate the role that treatment plays in helping people to learn about their condition, and the role of this knowledge in maintaining wellbeing. It is also important for research to explore how treatment affects people’s ability to self-manage their condition, and what strategies they use to do so.

**Addressing sampling restrictions.** It is important to note that sampling restrictions present a significant limitation to the existing body of literature – that is, with the exception of two studies (Michalak et al., 2006; Veseth et al., 2012), the majority of this research utilises high-functioning cohorts. A comprehensive understanding of what
helps people with BD to promote wellbeing and minimise episodes of illness clearly requires us to consider the experiences of people who have greater difficulty managing their illness. Indeed, it is possible that sampling issues may explain some of the contradictory findings in the literature. For instance, while Michalak et al.’s (2006) participants reported that their independence was affected by having others monitor their symptoms, studies with higher functioning participants have suggested that this an essential strategy for maintaining wellness. Similarly, people’s mixed views about the pros and cons of routine may reflect poorer acceptance of illness and hence, lower levels of functioning. These differences could also reflect general challenges to wellness for people with BD. There is a need to explore how strategies for wellness derived from the ‘high functioning’ literature manifest amongst individuals with a broader range of functioning.

Chapter 7: Aim, Research Questions, and Methodology

7.1. Rationale for Current Project

The current research explores the experience of BD with a group of people who have a broad range of functioning. Additionally, given the limited attention that has been given to people’s experience of treatment in the literature, an in-depth exploration of people’s lived experience of treatment will be undertaken. The participants of the present study took part in the MAPS group treatment program five years prior to the current study. Exploration of people’s experiences five years after the MAPS group provides a meaningful timeframe for exploring people’s personal accounts of this treatment
program, and has the potential to provide valuable insights into what people learnt, what people found beneficial from their experience of group treatment, and how/if these learning’s have been integrated into their management of BD (see section 9.5. for limitations of this approach). Five years has also been used as a meaningful timeframe for showing long-term maintained efficacy in quantitative studies (e.g., Colom et al., 2009b), which was part of the reasoning for using this approach here. Such research will provide broader insight into people’s personal accounts of treatment and assist in moving towards a more person-centred approach to patient care – which considers lived expertise when developing approaches to treatment and routine care.

**Aims.** The aim of the current project was to understand the lived experience of BD five years after completing a group psychosocial treatment program. A qualitative research design was used to gain rich, detailed, and contextualised information about participants’ experiences of living with BD. There were four specific research questions, namely:

- **RQ1:** Which environmental stressors contribute to bipolar relapse?
- **RQ2:** How does BD impact on psychosocial functioning?
- **RQ3:** What is important to people’s experience of wellness?
- **RQ4:** What was people’s experience of the MAPS treatment group, and its impact on their experience of living with and managing BD?

### 7.2. Epistemological Statement

My interest in severe psychiatric presentations was sparked while working in a psychiatric inpatient unit. It came to my attention that people with greater psychosocial impairment were regularly readmitted. This led me to question whether there was greater
scope for adjunctive psychosocial interventions that might improve medication adherence and improve quality of life. An opportunity arose during my postgraduate studies to explore this question empirically with the research team responsible for the MAPS group at St. Vincent’s Hospital in Melbourne, Australia.

During the course of my postgraduate studies I have reviewed the literature on this topic, spoken with people about their experience of living with BD, and gained a greater understanding of the lived experience of wellness, illness, and the MAPS program. Prior to conducting the interviews I expected that I would be interviewing people who were living with the detrimental effects of BD. Although this was partly true, what I didn’t expect was the capacity for many of these people to live satisfying and meaningful lives despite their illness (e.g., many worked and/studied, had long-term relationships, had published books etc.). Perhaps most surprising was the expertise that several participants displayed in their knowledge and management of BD. Engaging with these people has afforded me a far richer understanding of BD, and in particular, how resilient people become when living with this condition.

7.3. Interpretive Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009; Smith & Osborn, 2003) was selected as the theoretical framework for the current study, as it captures data arising directly from participants’ lived experience. IPA’s focus on the individuals experience makes it the most suitable approach for the current study (see section 7.1.), as oppose to other qualitative approaches which focus on the social context of people’s experiences (i.e., narrative analysis; Seale, 2012) or that are more concerned with understanding social processes (i.e., grounded theory; see Brocki & Wearden, 2006). As noted by Smith and Osborn (2003), IPA facilitates a deeper understanding of the
meaning that particular experiences and events hold for the individual – including their process of personal reflection during events or experiences they perceive as personally significant. This approach to research is phenomenological, in that it is concerned with a person’s perception of experiences or events rather than objective statements of truth (Smith et al., 2009; Smith & Osborn, 2003).

IPA’s commitment to understanding how people make sense of their major life experiences is intellectually connected to a process of interpretation known as hermeneutics, which was founded by Martin Heidegger in the mid-1920s. Hermeneutic interpretation posits that a person’s account of their experiences and life events is a product of their attempt to make sense of the world. Thus, IPA researchers acknowledge that data collection may be limited by what participants are willing, or capable of communicating about their experience (Rice & Ezzy, 1999; Smith et al., 2009). The process of interpretation is further complicated by the researcher’s second order interpretation of the participants’ account. For instance, to be able to gain access to a participant’s experience, the researcher must interpret the participant’s account through their own conceptions and constructs (Smith & Osborn, 2003). Therefore, the dynamic process of sense-making between participant and researcher requires a two stage interpretation process - a ‘double hermeneutic’, where “... the researcher is trying to make sense of the participant trying to make sense of what is happening to them” (Smith et al., 2009, p. 3). Utilisation of an IPA approach was deemed most appropriate for gaining a personal and contextualised account of people’s experiences of living with BD, and their experience of a psychosocial group treatment program.

**Ideography as a counterpoint to the nomothetic approach.** IPA’s commitment to depth over breadth of analysis exemplifies an ideographic approach to social science (Smith et al., 2009). IPA is dedicated to detailed case-by-case investigation in order to
gain a deeper understanding of how each participant makes sense of their experience. Thus, like other qualitative methodologies, it contrasts with nomothetic modes of enquiry, which are primarily concerned with making general claims that are relevant to a larger population. Conclusions drawn from research about groups and populations is a defining strength of psychological science, however it has been argued that an absence of individually relevant data is a limitation (Smith & Osborn, 2003). The ideographic approach provides such data – that is, information that is detailed and focussed on the experiences of the individual. For these reasons, the current research adopted a qualitative methodology, thereby facilitating the exploration of people’s experiences of living with BD, and helping to shed new light on existing research (Pringle, Drummond, McLafferty, & Hendry, 2011; Smith et al., 2009; Smith & Osborn, 2003).

**IPA and data collection.** Data for IPA analysis is typically collected via semi-structured interview, and this approach was used here. This method allows a flexible approach to data collection and facilitates depth of investigation. The research process is dynamic, in that the researcher is guided by theoretical ideas and research questions; however, the participant also contributes to the content and direction of the interview. This process is consistent with the phenomenological approach, where the individual’s lived experience is of primary interest. It is essential that the interviewer has the capacity to align with each participant and makes every effort to value and nurture their contributions (Conrad, 1987; Rice & Ezzy, 1999). IPA’s emphasis on obtaining a rich understanding of each individual case means that studies are usually conducted using a sample size of between five and ten participants (Smith & Osborn, 2003). Given that 40 people completed the initial MAPS program (Castle et al., 2010), it was anticipated that there would be sufficient participation for IPA analysis.
7.4. Participants

People were eligible for inclusion in the study if they had a diagnosis of BD and had attended the MAPS treatment program. Of the 18 individuals (Females $n = 13$; Male $n = 5$) who consented to participate in the current study, some had completed the MAPS program as part of an RCT ($n = 11$), and some completed the group subsequently, after accepting an invitation once the RCT was complete ($n = 7$). Bipolar diagnoses were confirmed during recruitment for the RCT – at this time, six people were deemed to have a diagnosis of BDI, eight had a diagnosis BDII, and four were diagnosed with BDNOS (established through use of the Mini-International Neuropsychiatric Interview 5.0). These diagnoses were not reconfirmed as part of the current study. Participants were aged between 35 and 71 years ($M = 51.4$, $SD = 10.72$). Participants were to be excluded if they were experiencing an episode of illness just prior to the interview; however, they were not required to be completely asymptomatic. Recruitment of a small homogenous sample is also consistent with an IPA approach (see section 7.3.; Smith et al., 2009).

7.5. Measures

Participants completed two sets of questionnaires prior to participation in the semi-structured interview. Measures of quality of life and mental state (i.e., current levels of depression and anxiety) assisted characterisation of the sample (Appendix A and section 8.2.). Pre-interview screening assessed symptoms of mania and depression prior to the interview (see Appendix B and section 8.1.).

World health organisation quality of life scale-brief (WHOQOL-Brief; The WHOQOL Group, 1998). The WHOQOL-Brief, a 26-item self-report inventory originally adapted from the WHOQOL-100 (WHOQOL Group, 1994) was used to assess

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6 No participants were excluded on these grounds.
subjective quality of life in the context of participants’ culture and value system. The revised WHOQOL-Brief contains two questions that enquire generally about quality of life, and 24 questions which are classified into four major domains, including: Physical (e.g., “to what extent do you feel physical pain prevents you from doing what you need to do”), Psychological (e.g., “how often do you have negative feelings such as blue mood, despair, anxiety and depression?”), Social Relationships (e.g., “how satisfied are you with the support you get from your friends?”), and Environment (e.g., “how satisfied are you with transport?”). Items are rated on a 5-point Likert scale, ranging from 1 (very poor, very dissatisfied, not at all, never) to 5 (very good, very satisfied, an extreme amount, extremely, completely, always). After reverse coding three negatively worded items, raw domain scores can be calculated by summing constituent items. The WHOQOL-Brief has been reported to have adequate internal consistency (α = .62 to .82), and has demonstrated discriminant and construct validity (The WHOQOL Group, 1998) comparable to the full version (Singh, Mattoo, Sharan, & Basu, 2005).

**Depression anxiety stress scale (DASS; Lovibond & Lovibond, 1995).** The DASS is a 21-item self-report inventory that measures the intensity of three negative affective states during the prior week, namely: Depression (e.g., “I couldn’t seem to experience any positive feeling at all”), Anxiety (e.g., “I was aware of dryness of my mouth”), and Stress (e.g., “I found it hard to wind down”). Items are scored on a 4-point Likert scale, ranging from 0 (did not apply to me at all) to 4 (applied to me very much most of the time). Scores are obtained by summing items for each subscale. When summed, scores are multiplied by 2 to correspond with the 42-item version of the DASS. Subscale scores range between 0 and 42, with a higher score indicating a greater level of distress (Lovibond & Lovibond, 1995). Henry and Crawford (2005) reported excellent internal reliability for the subscales (α = .82 to .90). When compared with other measures
of depression and anxiety, the DASS-21 has demonstrated good convergent and

discriminant validity (Henry & Crawford, 2005).

Montgomery and Åsberg depression rating scale (MADRS; Montgomery &
Åsberg, 1979). The MADRS is a 10-item self-report questionnaire that was used as a
pre-screening measure of depressive symptoms 24-48 hours prior to the interview. The
scale measures a range of mood symptoms (e.g., Apparent Sadness, Reported Sadness,
Inner Tension, Reduced Sleep, etc.). Each item is scored on a 6-point Likert scale,
ranging from 0 (absence of or minimal symptoms) to 6 (presence of severe symptoms).
Each Likert scale consists of four descriptive anchors separated by midpoint ratings
allowing the researcher to decide whether the participants response lies on defined scale
anchors (0, 2, 4, 6) or between them (1, 3, 5) (Iannuzzo, Jaeger, Goldberg, Kafantaris, &
Sublette, 2006). For specific information on Likert scales content, see Appendix B.
Scores from each of the 10 items are added to obtain an overall representation of
depressive symptoms with total scores ranging between 0 and 60. Total scores of
between 0-8 are considered to be within the normal range (Vieta, 2009), scores of 13.3
and 18.5 are thought to reflect mild and moderate depression respectively (Müller,
Himmerich, Kienzle, & Szegedi, 2003), and scores of at least 35 indicate severe
depression (Müller, Szegedi, Wetzel, & Benkert, 2000). To facilitate maximum inclusion
of participants with a broad range of functioning, a cut-off of 13.3 was deemed
appropriate for inclusion in the current study. Bunevicius et al. (2012) report that the
MADRS has a high degree of internal consistency (α = .82), and that it has demonstrated
good convergent validity with other depression rating scales.

Young mania rating scale (YMRS; Young, Biggs, Ziegler, & Meyer, 1978).
The YMRS is an 11-item clinician-administered scale that was used as a pre-screening
measure of manic symptoms 24-48 hours prior to the interview. The scale measures a
range of mood symptoms (e.g., Elevated Mood, Increased Motor Activity/Energy, Sexual Interest, etc.). All items are scored on a 5-point Likert scale, ranging from 0 (representing the absence of or minimal symptoms), to 4 (which represents the presence of severe symptoms). For clinical purposes, a cut-off score of < 12 is thought to represent remission of symptoms (Young et al., 1978). This score was used as an exclusion cut-off for the current study. Young et al. (1978) reported adequate inter-rater reliability between individual ($r = .66$ to $r = -.92$) and total scale scores ($r = .93$), as well as sufficient evidence for convergent validity with clinician administered rating scales for mania (see Beigel & Murphy, 1971 and Petterson, Fyrö, & Ssedvall, 1973).

7.6. Procedure

Ethical approval for the current study was obtained through St. Vincent’s Hospital Human Research Ethics Committee-A in February 2011. Approval for the interview venues was granted by Swinburne University’s Human Research Ethics Committee (March 2011) and Barwon Health’s Research and Ethics Advisory Committee (April 2011; see Appendix C).

Recruitment. Due to ethical restrictions around ‘cold calling’ of participants, all individuals were initially contacted by a member of the original Castle et al. (2010) research team. A brief summary of the current study was provided and people were asked if they would like to participate. People expressing interest in the study were then contacted by a member of the current research team, at which time they were informed that they would be mailed a consent form and questionnaires (see Appendix A). At this time, potential participants were also scheduled to attend an over-the-phone ($n = 6$), or in-person interview ($n = 12$). Participants were interviewed over the phone if they were unable to attend an in-person interview, and were provided with prepaid envelopes to
return questionnaires. Participants who attended their interview in-person returned questionnaires when they arrived at their interview. Importantly, participants were informed that interviews were being conducted for research purposes only, and would not interfere with routine care. Participants were also informed that their involvement in the study was on a voluntary basis and that they were free to withdraw at any time.

Interviews were conducted at Barwon Health, a regional community health service, and Swinburne University Psychology Clinic, which provides psychology services to the local community. Phone interviews were conducted at the participant’s convenience. Pre-interview screening was undertaken 24-48 hours before each interview, to ensure that participants were not experiencing an episode of illness (see sections 7.5. and 8.1.).

**Interview structure and process.** Confidentiality and risk procedures were explained prior to interview commencement. The semi-structured interviews went for approximately one hour, and were designed to be open and flexible to encourage a free flowing dialogue (Smith et al., 2009), while also addressing the study’s aim and research questions. First, the *Life Chart Method - Retrospective* (i.e., LCM-R; Denicoff et al., 1997, see Appendix D) was used to facilitate recall and depth of exploration of bipolar symptoms since the MAPS group (Benjamin, Flynn, Hallett, Ellis, & Booth, 2008). A theme list was then used to further explore people’s lived experience of BD and the MAPS group. Theme lists provide the interviewer with a general range of topics to be discussed as opposed to having a specific list of questions. This is thought to enhance rapport and facilitate a more focused understanding of the meaning contained within the participant’s words (Rice & Ezzy, 1999; Smith & Osborn, 2003). In addition to this, theme lists are helpful for redirecting excessively tangential narratives.
In keeping with the recommendations of Smith et al. (2009) the pre-determined interview structure was used as a guide rather than a rule, and although these different investigative tools were focused toward specific areas of theoretical interest (i.e., LCM-R towards participant experience of symptoms, and theme list towards people’s experience of wellness and the MAPS group) there was broad variation in how these prompts were used. This inductive approach to interviewing allowed the interviewer to engage freely in dialogue and explore themes as they emerged. The study’s aim and research questions (which were identified in the literature as being important to pursue) were used to guide the content of the interview theme list, which is presented in Table 4.
### Table 4

*Interview Theme List*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Prompts</th>
</tr>
</thead>
</table>
| Psychosocial functioning and bipolar relapse   | • The LCM-R can be used to gain insight into which environment stressors might contribute to bipolar relapse.  
• How does BD impact on your functioning? |
| Experience of Wellness (including enquiry about self-management strategies) | • The phrase “functioning well” is sometimes used to describe wellness. Can you describe what that phrase means to you, if anything?  
• Can you describe what’s going on in your life when you are feeling well and functioning well?  
• What suggestions would you have for staying well, that you would give to someone who has recently been diagnosed with bipolar disorder?  
• How do friends, family and co-workers affect your ability to stay well?  
• What strategies have you found most helpful in managing bipolar disorder? |
| Experience of the MAPS group                   | • What was it like for you to be a member of the MAPS group?  
• Did you get any benefit from being in a group with other people in a similar situation?  
• Overall, how useful was the MAPS intervention?  
• What do you remember about what you learnt in the MAPS program?  
• Of these things you remember, can you tell me the most useful things you learnt?  
• Let’s try and find some examples of how you might have used these things that you learnt over the years following the MAPS intervention.  
• Did the MAPS group impact on your life in any way? A Change in perspective; a shift in the way they see things; or a feeling of being understood… Did anything like this happen to you? |

At the completion of the interview, participants were asked if they had questions or additional thoughts to contribute. Ethically, it was important to consider that the discussion of previous relapses could trigger unpleasant thoughts and feelings. When this occurred, the interviewer provided supportive counselling and participants were
instructed to contact their current treatment provider if they experienced distress after completion of the interview. Participants were free to contact the research team if they had any additional questions about the study, and were offered a one-week follow-up call to debrief about the interview. Reimbursement in the form of a $50 voucher was provided to each participant at the completion of the interview.

**Thematic analysis.** The interpretative process requires the researcher to form a deeper level of appreciation for each participant’s psychological world and to develop an understanding of the meaning contained in the participant’s words. To achieve this depth of understanding, the researcher needs to form an interpretive relationship with each participant’s transcript (Smith et al., 2009; Smith & Osborn, 2003).

**Analysis procedure.** The process of interpretation requires engagement with the text using a step-by-step procedure. The first step involves preliminary interpretation of the transcript, which is achieved by careful reading (and re-reading) of the document and noting all preliminary thoughts. The second step in the process of analysis requires more in-depth reading (and re-reading) of the transcript to obtain an increased understanding of the individual’s narrative and emerging themes. An interpretive process is then undertaken, where themes are listed in chronological order and then grouped together based on thematic similarity (Smith et al., 2009; Smith & Osborn, 2003).

This process of thematic analysis is congruent with IPA’s ideographic philosophy, in that, the researcher starts with very specific examples obtained from one individual case, and then explores the differences and similarities between each progressive case. It is only after a detailed analysis of individual cases that the process of analysis can move toward a more general categorisation of information (see Smith et al., 2009). The final step in the analytic process involves the transformation of themes into a narrative account. This presents the researcher’s analytic interpretations together with verbatim segments
from interview transcripts. This method of data presentation demonstrates the reasoning of the researcher and allows for further interpretation by the reader. This is believed to enhance the validity of the results (Pringle et al., 2011; Smith et al., 2009; Smith & Osborn, 2003).

**Transcription and data storage.** Interviews were audiotaped and transcribed by the researcher. The following transcription rules were developed to assist uniformity of transcription: (1) interviews were transcribed verbatim, with the exception of the following – an ellipsis using three full stops: “[...]” indicated the presence of expressive interjections such as ‘um’ being left out, (2) all the researcher’s interjecting words (e.g., yeah), and encouragements (for example: ‘uh huh’) were excluded; therefore only questions asked and comments made were included, (3) any identifiable information has been replaced with pseudonyms. Throughout the current thesis, participants’ comments are often edited and replaced with the ellipsis symbol “[...]” to enhance readability. Following completion of the data analysis process, all data was converted into re-identifiable format and stored electronically on the password protected main drive at Swinburne University.

**Chapter 8: Results**

**8.1. Pre-Interview Screening**

The MADRS and the YMRS were used as pre-interview screening measures of symptomatology. This data is presented in Table 5.
Table 5

Descriptive Statistics for the MADRS and YMRS

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (SD)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montgomery and Åsberg Depression Rating Scale</td>
<td>4.56 (3.33)</td>
<td>0 – 10</td>
</tr>
<tr>
<td>Young Mania Rating Scale</td>
<td>3.06 (3.54)</td>
<td>0 – 10</td>
</tr>
</tbody>
</table>

*Note. N = 18. Range refers to observed range.*

In accordance with established cut-off criteria (see section 7.5.), no participants needed to be excluded at pre-screening. The mean scores on the YMRS and the MADRS were broadly comparable to those observed in previous studies (see Perich, Manicavasagar, Mitchell, Ball, & Hadzi-Pavlovic, 2013).

8.2. Data Analysis Procedure

The two-step data analysis procedure comprised: (1) analysing descriptive statistics to characterise the sample in terms of quality of life and negative affects (depression, anxiety, and stress), and (2) conducting a thematic analysis of the interview transcripts. These findings are presented in turn.

**Characterising the sample - quality of life (WHOQOL-Brief) and negative affect (DASS).** The WHOQOL-Brief and DASS were used to assess the current sample’s overall level of functioning at the time of data collection. This data is presented in Table 6.
### Table 6

*Descriptive Statistics for DASS and WHOQOL-Brief*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (SD)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depression Anxiety Stress Scale</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>6.2 (6.21)</td>
<td>0 – 36</td>
</tr>
<tr>
<td>Anxiety</td>
<td>7.2 (6.37)</td>
<td>0 – 26</td>
</tr>
<tr>
<td>Stress</td>
<td>11 (7.65)</td>
<td>0 – 22</td>
</tr>
<tr>
<td><strong>World Health Organisation QoL Scale - Brief</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical QoL</td>
<td>23.6 (5.16)</td>
<td>16 – 34</td>
</tr>
<tr>
<td>Psychological QoL</td>
<td>20.8 (3.25)</td>
<td>13 – 26</td>
</tr>
<tr>
<td>Social QOL</td>
<td>10.6 (2.83)</td>
<td>5 – 15</td>
</tr>
<tr>
<td>Environment QoL</td>
<td>30.6 (3.94)</td>
<td>22 – 38</td>
</tr>
<tr>
<td>Total perception of QoL</td>
<td>4.2 (0.65)</td>
<td>3 – 5</td>
</tr>
<tr>
<td>Overall perception of health</td>
<td>3.2 (1.11)</td>
<td>2 – 5</td>
</tr>
</tbody>
</table>

*Note. N = 18. Range refers to observed range.*

The descriptive statistics for the DASS and WHOQOL-Brief were comparable to those observed in studies that have randomly sampled people with BD (e.g., Perich et al., 2013; Singh et al., 2005). That is, in comparison to normative data for this population, the current participants had a broad range of quality of life and negative affects. As such, the sample was characterised as being largely representative of a normal sample for BD.

### 8.3. Thematic Analysis: Participants’ Experience of Living with BD

The aim of the current project was to understand the lived experience of BD five years after completing a group psychosocial treatment program. Overall, participants
were well engaged during the interviews and were enthusiastic to share their experiences of living with BD. Many participants thanked the interviewer for the opportunity to talk about their lived experience in an empathic environment, which may suggest a therapeutic benefit of the interview itself. The four research questions will be considered in turn, and will explicate the themes that were drawn from the interview transcripts. There is some unavoidable overlap in the content that is presented across the different research questions.

**RQ1: Which psychosocial stressors contribute to bipolar relapse?** The following themes were drawn from participants’ narratives about environmental stressors that exacerbated symptoms and contributed to relapse: (1) *Life events*, (2) *Hormonal rhythms*, (3) *Physical illness*, and (4) *Substance use*.

**Life events.** Several participants (*n* = 5, 28%) noted the impact of life events on their symptoms. Nicole, a 49-year-old woman, discussed the impact of losing a close friend and being bullied at work on her mood: “Yes, anxiety was high, [it was an] irritable depression” (Nicole, 49). Robert also identified the multiple stressors that had coincided with his last episode of mania:

> I’ve got a 9-year-old son. [I] had a huge blow-up with his mum, and […] that ended up being a 14-month legal fight to get my access sorted […]. Again that was [a time where I was manic]. Another thing is our relationship […] - for all intents and purposes [was] abysmal. (Robert, 36)
Relationship stress. Nicole felt that relationship stress prompted symptoms of illness. She described her experience of depression following her husband’s decision to attend a golf trip when she had an injury:

I broke my leg […] during the group […]. I had to go in a wheelchair, and my husband […] went on a golf trip. [He] left me with my two children […]. I wasn’t very happy. I felt lonely. I felt very sad and he left me […]. I didn’t feel very loved. I think I was a bit depressed. (Nicole, 49)

Starting and ending relationships had a significant affect on Marie (58) and James’ symptoms of illness. Marie, for example, experienced hypomania when meeting her new partner: “[I was] a little higher, especially meeting [my new partner], because that was totally unexpected” (Marie, 58). James had also found relationships to be a trigger for illness: “[becoming manic] was also concomitant with me breaking up with my girlfriend […]. That’s the biggest issue usually, is my relationship fracturing. Because [when my relationships end it] strike[s] this unusual mania and I find it too much to bare” (James, 59). James also described manic symptoms when commencing a new romantic relationship: “I tried Internet dating and I started communicating with a woman in Poland […]. She decided to visit, so that was fun, and I did have the first of a mild euphoric rise” (James, 59).

Work stress. Several participants (n = 4, 22%) described stress at work as an important trigger for mood disturbance. Amy (38), James (59), and Samantha (51) discussed the impact of work on their symptoms. As described by Amy:

I realised that I was having a lot going on at that time. I find if I have too much going on, it sort of can trigger things [symptoms of illness]. I was working [in] a really stressful
job, and there were a few things that I changed and [since making these changes] things seem to have gotten easier. (Amy, 38)

A 53 year-old woman, Emma, changed professions because she believed her work as a tutor was making her unwell; however, she found that this only exacerbated her symptoms:

I was always so sick and couldn’t do [my job]. I tried, [and then] I went to pharmacy, because I thought: “I’ll try another career and see if I can stay well”, [but it was] worse! [It made me] very anxious, very anxious, and [...] of course pharmacy is a very perfect profession. They say in the course, in the organisation, you can’t make mistakes. Which is true, but I was also put in a place that I shouldn’t have been put into as a beginning pharmacist, [because] it was far too busy. I did one whole day by myself [and] I was just so stressed out [...]. It is very stressful, because you’re dealing with drugs and you can’t make mistakes. (Emma, 53)

**Hormonal rhythms.** A relationship between hormonal rhythms and BD relapse was evident in three participant’s narratives (17%). Two of these participants recalled episodes of illness that corresponded with the birth of a child. Nicole, for example, spoke about the initial misdiagnosis of her illness as uni-polar depression: “[After giving birth] they thought I was just post-natal, but she [my psychiatrist] diagnosed my BD [shortly thereafter]” (Nicole, 49). Amy also recalled that she “had post-natal depression as well, so I was sort of a bit messed up [at that time]” (Amy, 38).

In addition to childbirth, one participant, Lauren, identified that her episodes corresponded with the onset of menses: “All of these episodes have occurred with my
period, every single one of them [...]. They’ve either come exactly on my period [or] I’ve got my period like the day after my episode, or the day before” (Lauren, 45).

**Physical illness.** Two participants (11%) discussed the impact of physical health concerns on their BD. Marie, for example, experienced an episode of mania in response to severe tooth pain:

> The [tooth] pain pushed me in to mania. I was taking so many painkillers as well for the tooth. When I got back [from my holiday] they took the tooth out, thank god [...]. Yes, that was a situation that really stood out. (Marie, 58)

For another woman, Samantha, depression was triggered by cessation of medication that she was taking for a physical illness. In her words: “[…] I’d stopped [my medication this year]. [This caused] major withdrawal symptoms […]. That caused real problems [with my mood]. I ended up suicidal within about a day” (Samantha, 51).

**Substance use.** Several participants ($n = 3, 17\%$) talked about the impact of substance use on BD. James described his realisation that cannabis use was both a sign of becoming unwell, and a factor in the onset of his episodes:

> Okay two things and I must bring them up now [...]. When I’m more elevated, when I’m beginning to rise […] I would have [a] toke, or you know taste whatever is going around in marijuana […]. I think I have to admit [it] now, that on this occasion […] the reason for the rise was because [of cannabis use]. Here is the other thing, [my partner] used to smoke [cannabis, and] I didn’t really like her smoking […]. Then when I’d take some elevated state, I’d say “oh let’s try what you’re smoking” - you know just out of interest […]. I think that would trigger elevated states [for me]. There’s more than one instance [I can] remember […]. I believe it has been concomitant with other pressures or other
excitements to push me to this state here [pointing to a manic episode in the LCM-R graph]. (James, 59)

Alcohol use was also identified as a trigger for illness. Robert (36) and Paul (68), for example, reflected on the impact of alcohol on their illness, and on their lives more generally. Robert recalled that being intoxicated at a recent work function had triggered symptoms of mania:

After I got the job we had our national conference at the end of the year. Well, obviously the first one of those I got […] really hammered […]. I think sometimes some of my behaviour becomes a bit manic […] and pretty out of control because of alcohol […]. My behaviour definitely gets a lot more excitable then what it would be normally, almost sometimes just a bit ridiculous. (Robert, 36)

Furthermore, Robert recalled the shame and guilt that he experienced after this event, and how this had left him vulnerable to experiencing subsequent episodes of illness:

So I nearly lost my job after having all of this great experience. So I obviously had a period […] where I really had to [monitor my mood]. Because I’d kind of started to do well and then just let myself down a bit […]. I always had that tendency to really kind of beat myself up pretty hard in that respect. (Robert, 36)

Paul also recalled using alcohol to suppress his negative feelings, and how ceasing alcohol had prompted an episode of illness: “I used to use alcohol to medicate myself and
when I became sober I fell in a heap. I went through depression, manic phases […] That’s when I sought help - professional help” (Paul, 68).

**RQ2: How does BD impact on psychosocial functioning?** Two themes were drawn from participant’s narratives about their functioning in key life roles, namely: (1) *The negative impact of BD episodes on employment*, and (2) *The negative impact of BD symptoms on relationships*.

**The negative impact of BD episodes on employment.** Some participants (*n* = 3, 17%) discussed the impact of bipolar episodes on their immediate employment and career advancement more generally. James explained how he lost his job due to mania:

> I had a very big wobbly [when I was elevated]. I was […] quiet drawn away to remind me of my behaviour - my obligations [to my employer]. I didn’t have my contract renewed. In other words […], I wasn’t sacked, I was quietly seen off on sick leave […]. My contract expired at the end of the year. So at the end of that period [I was] feeling very dismal. (James, 59)

Unlike James, who suspected that his illness stopped his contract from being renewed, Alison (65) elected to stay home after her first episode of illness. She explained this further: “[…] after I had the breakdown […] I stayed home with my daughter and I didn’t go back to the office. I did some community work - some church things […], but I decided I wouldn’t go back to work” (Alison, 65).

Robert shared his views about the more subtle impact of BD on his working life. While he felt as though his employer had been supportive in providing him with sick leave, he suspected that time away from the workplace had an indirect effect on his career by way of limiting progression into more senior roles.
I think in hindsight there’s periods of time off [that have impacted on my work]. I think [my condition] probably has [impacted on my career] to a degree […]. It shouldn’t, but I think it probably would harm some of my progression within work, unfortunately.

(Robert, 36)

**The negative impact of BD symptoms on relationships.** Several participants \( n = 4, 22\% \) reported that their illness had presented significant challenges to their partners, and consequently, the health of their relationships. James, for example, recalled how his partner became frightened of him while he was manic:

She was scared. She said “What’s wrong with you, why are you doing these silly things?” I was playing up to the Queensland [government]. I remember this incident - I was making a mockery of the Queensland law about smoking […]. (James, 59)

While the impact of specific symptoms was important to some participants, others stated that the course of the illness was the biggest challenge. For example, Lauren relayed the impact of her ongoing illness on her husband. In her view, BD had caused him prolonged stress. In her words: “... it really wears him out” (Lauren, 45). She described a sense of concern about this, and that he felt as though he was without support:

He […] is the primary support […]. I mean [my doctor] is supportive, but Robert is actually there on a day-to-day basis helping me. He actually said to me not long ago, “You’ve seen the end of my nerves” […]. It like really depresses me […], it really upsets me to hear that […]. He’s witnessed four or five suicides [attempts]. He’s been there constantly […], as a safety net and [to] try and stop me getting too high [manic]. He lives with this person who is totally volatile, and it’s taken its toll on his nerves […]. He used
to always say to me when I was very sick, he used to say: “who cares for the carer?”. He had no support at all. (Lauren, 45)

While several participants spoke about the impact of BD on their partners, one participant was more concerned about the effect of her illness on the family unit. Heather, a 50-year-old woman, began to cry when she reflected on her family’s experience:

In my worst years they tended to be there for me. Although [my episodes] sent them into crisis themselves and they weren’t coping very well [...]. I think that after the amount of years I was in such a bad way. I think I wore them out [...] I think it just seems to me that they’ve given up on me and walked away, actually. (Heather, 50)

management, 18. Using cognitive strategies, 19. Developing assertive communication, 20. Reducing alcohol use), and lifestyle factors (21. Maintaining a healthy lifestyle, 22. Using mindfulness strategies, and 23. Valuing self-care and compassion). The MAPS group treatment program also featured in participants’ narratives about wellness, which is distinct from people’s more specific experiences of participating in the MAPS group that are discussed in RQ4. The 23 themes will be considered in turn.

**Being correctly diagnosed.** Many participants \((n = 7, 39\%)\) stated that getting an accurate diagnosis was the beginning of their journey toward effective self-management and maintaining wellness. Misdiagnosis was an experience shared by several participants. Tom, a 40 year-old man, reflected on his experience of misdiagnosis and being treated with incorrect medication:

[...] before that I was diagnosed with depression [...]. I went to the psychiatrist and I was being treated for depression [...]. It was funny - I came along to a session and we were talking about some things, and just before I was about to leave the psychiatrist said to [my wife], “Oh has he had any up days as well?” and I said, “oh yeah”, and then it just went from there [...]. We had to do a whole back track of up and down and things like that [...]. I reckon we got back to when I was about 15, 16, 20, and I could still vaguely recognise things then [...]. So it’s possible that the treatment for depression [...] triggered off a bit of rapid cycling. (Tom, 40)

Both Alison and Nicole described their experience of being misdiagnosed following childbirth. Nicole indicated that they initially “thought I was just post-natal, but she [my psychiatrist] diagnosed my BD [shortly thereafter]” (Nicole, 49). Alison spoke about the exacerbation of her illness as a result of being prescribed incorrect medication following the birth of her child:
[...]

my GP said that whatever the episode was when [my child] was born, he thought it was over with and I was okay, because he’d never seen me sick. He said: “I don’t think you need this medication and you can’t have it anyway [because it has been discontinued], but I’ll give you a script for something else in case you get sick”. [So, I took it and] I got very sick and psychotic, and didn’t realise what was happening to me, and ended up in hospital. (Alison, 65)

Similarly, Lauren noted that her psychiatrist initial thought she had a psychosomatic illness, and recalled that it had taken some time and effort to get a correct diagnosis:

[My first doctor] said this is totally psychosomatic […]. I phoned up my [community psychiatrist] one day in desperation, and I said […] I’ve had this since I was 14, I want to get over it. I just want to move on with my life, and so he recommended [my new psychiatrist] who put me on lithium, and he said you’ve got a mood disorder. (Lauren, 45)

Conversely, several participants emphasised the benefits of appropriate diagnosis and treatment. For example, Lauren went on to describe the reduction in duration and severity of her symptoms after being correctly medicated: “[My new psychiatrist] put me on lithium […]. He said you’ve got a mood disorder, and immediately, the episodes lessened in their severity. The mania wasn’t as high […]” (Lauren, 45).

**Acceptance of the diagnosis.** Some participants (n = 6, 33%) described that coming to terms with their diagnosis was an important step toward wellness, as it prompted the self-management of their condition. For Ann, acceptance of BD had
involved an acknowledgment that her ‘normal’ may not be the same as everyone else’s idea of normal. In her words:

Well my normal state is being depressed, that is what was described to me by my psychiatrist in 2007. That my idea of normal is everyone else’s idea of borderline depressed and my idea of a good day is everyone else’s idea of normal [day]. […] I am quite happy that those are the constraints I live within. (Ann, 42)

For James, acceptance had been intimately linked with his willingness to adhere to medication. Specifically, he described how denial had caused poor medication compliance:

I kidded myself about taking my own medication, and I probably got worse […]. That’s quite the issue with my experience. I learn now at my age that it’s quite common for bipolar sufferers to kid themselves and not believe they need their medication […]. I did it not so much to kid myself, but more to avoid again that there’s something wrong with me, [a] sort of denial. (James, 59)

Other participants described that accepting the chronicity of their condition facilitated an ongoing commitment to self-management. Participants described a realisation that they needed to take their medication and see their psychiatrist regularly, regardless of whether they were feeling well or unwell. In Robert’s words: “[…] one of those things I tried [was to] see [my psychiatrist] when I was well, as well as unwell” (Robert, 36).

Finding ‘the right’ psychiatrist. A number of people (n = 4, 22%) discussed the importance of finding a psychiatrist who was ‘right’ for them, and how essential this had
been to their wellness. Lauren describes her experience of finding a doctor who she believed to be competent:

I mean I’ve seen a few doctors and some I wouldn’t ever see again because I don’t think they’re up to much good. Or, not that they’re not up to much good […] but I don’t think they’re competent, and […] so [I would suggest that people] try and find a good doctor […]. I would recommend [my psychiatrist] but he’s just so busy - he never takes on new patients [because he is in such high demand]. (Lauren, 45)

Similarly, Amy recalled that although she was initially reluctant, she now feels that her current doctor has been essential to her wellness: “[…] I had the thought […] “this isn’t going to work - been there done this”. But I realised that this was a totally different person [to my previous psychiatrists] and from the moment I met him, I felt, “yep this feels right”” (Amy, 38). She further noted that her psychiatrist hadn’t made her feel stigmatised, which was important to her:

So I think that’s really important. Having the support and having someone to talk to who’s not judging you and who’s just listening, is what turned it around for me. So the one thing that I thought wasn’t going to work [seeing a psychiatrist], is the one thing that did […]. (Amy, 38)

For Alison and Amy, it was important to have a psychiatrist who was available when they needed support. This afforded them a sense of security, which assisted them in maintaining wellness. As noted by Amy:
When I’ve been [unwell] I have text[ed] my doctor and he’s always got back to me, and usually [he will] see me. And I think, even knowing that would happen [gave me a sense of safety]. I knew I could talk to him and it would work itself out somehow. So, he would put it all in perspective for me. (Amy, 38)

Amy went on to speak further about having a psychiatrist who makes himself available to her in times of need:

He was fantastic like that. I mean I know that he’s a professor and he’s quite well to do, but he would always make himself available. I could always give him a text message.

Even he said he felt he could trust me [...] he knew I wouldn’t take advantage of the situation. So he would often say, give me a text or give me a call, and I’ll always get back to you [...] He would always get back, and that meant a lot. (Amy, 38)

_Having enough professional support based on individual preference._ Many participants (n = 10, 56%) described gaining benefit from having multiple professionals involved in their treatment; however, people had clear preferences about the professionals who were involved in their care. People mentioned caseworkers, mental health nurses, general practitioners, psychiatrists, and psychologists. One woman described the benefit she experienced from having both a GP and a psychiatrist: “Yep, so if I can’t see my psychiatrist, then I can go to the GP and get scripts […]. Because sometimes […] it doesn’t work with the psychiatrist, and sometimes it’s night sessions and you can get there” (Amy, 38).

Amy also gained benefit from seeing a psychologist: “I’ve seen a psychologist as well, and I had so many free sessions that I was entitled to […]. That was a referral from my GP. I think it was 6 sessions or something, but that was amazing” (Amy, 38).
Although James was initially sceptical, he too reported benefit from seeing a psychologist:

I used to call it “bitter outcomes in mental health” […]. I had a social worker friend who told me about it and I learnt that it was not easy to join. You had to discover a doctor by some means, [to] give you a referral to a psychologist […]. I did 6 sessions [and] I think I might have got a repeat […]. I [have recommended this service] to a number of friends now. (James, 59)

Conversely, two participants (11%) had a preference for fewer professionals in their treatment team. For example, Marie reported that she had not needed to see her psychiatrist, as her GP manages her medication: “Nah, haven’t seen him, my psychiatrist, since ‘99. Which I think is really good” (Marie, 58). Lauren reported that she was managed well by her psychiatrist exclusively: “Well I’m seeing [my psychiatrist] and we have discussions on various topics […]. He manages the whole lot [and also provides psychotherapy]” (Lauren, 45).

**Having intimate relationships.** In addition to having professional supports, participants \( n = 4, 22\% \) spoke more generally about the benefit of having intimate relationships. Robert and others (Marie, and David) described how having relationships promoted a sense of hopefulness:

In 2006, I met Jane, who’s [now] my wife. That made me feel like maybe I was going to get [my life] back, and maybe I could go back and work and have a normal life […]. By this stage, I’m working, and I met Jane and a relationship was forming and it seemed like it was going to be really good […]. Things were looking a bit brighter I suppose.

(Robert, 36)
Conversely, Nicole, spoke about the absence of a long-term intimate relationship, and how this had impacted on her wellbeing. She explained that she has experienced a persistent feeling of loneliness due to the absence of a life partner: “The only thing that I really struggle with, is the fact that I’m really lonely because I don’t have a partner [...]” (Nicole, 49).

**Accessing couples counselling.** In line with the previous theme, participants spoke about the importance of maintaining intimate relationships with professional support. For example, two participants (11%) spoke about the benefits of engaging in couples counselling. Generally, these people (Amy and Tom) reported that engaging with couples’ therapy increased their capacity to empathise and communicate effectively with their partner:

> It was good, because [my husband] came [to counselling] as well […]. So it was his take on how he felt about things […]. It was really good to step back and look from another person’s perspective […]. He was learning something, and we went together. It was invaluable in that sense because that brought us closer, because [until then] I didn’t know what he was thinking, [and] he didn’t say a lot. (Amy, 38)

**Having social support.** While having intimate relationships helped people to feel more hopeful and fulfilled, the majority of participants (n = 11, 61%) spoke more generally about the importance of having support from family members, partners, and friends. Some participants (Lauren, Marie, David, and Robert) reported relying on their husband or wife for support. As David (31) explains: “[...] Pat counsels me a lot, we talk about things. We’re constantly talking about how we feel […]. We share a really good quality life together […]. I think, you know, Pat [has] helped me a lot” (David, 31).
Marie explained that although she doesn’t get much consideration from her family, she feels that her partner has been very understanding and supportive:

Oh and Jack of course, because he’s got his own mental illness, so there’s no judgement [toward me or my behaviour]. As far as my mum and dad go, I wish they would give me a little more leeway, consideration. Cause I do a lot and I do [a lot of] good things that probably no one else in the family could do, but they don’t [consider my illness in the same way]. Jack gives me that consideration. (Marie, 58)

Others (n = 8, 44%) spoke of the importance of having supportive friends and family. Amy, for example, described the benefit of being able to contact friends when she fears that she is becoming unwell:

I will always ring a friend, or I will always make contact with somebody, so somebody knows where I am at […]. They will usually be a friend or family […]. They will make the next step, to check that things are okay – and usually they are [however] I think it’s good to say “look I’m not so great, so don’t stress, but I thought it was good just to touch base”. (Amy, 38)

The role of other people in mood monitoring and relapse prevention.

Participants (n = 10, 56%) also spoke more specifically about the role that partners, friends, and treating professionals play in the maintenance of wellness. Participants (n = 4, 22%) spent time discussing the difficulty they experienced trying to identify symptoms of illness without the assistance of others: “I still had trouble for years working out the difference between mania and depression […]. This went on for years, and I said: “no, I can’t tell” […]. I had to rely on my doctor” (Emma, 53). Lauren also noted that she
struggles to identify her prodromal symptoms: “It’s really hard to know if it’s just me being the up person that I am, or whether it’s me starting to lose it” (Lauren, 45).

In line with this, participants spoke about the benefits of being surrounded by people who are able to notice prodromal symptoms and prompt a discussion about proactive intervention for relapse prevention. This encompassed: (1) discussing symptoms with the person, and (2) developing plans to prevent relapse. Paul described his wife’s role in bringing his attention to early warning signs of illness:

Well, early warning signs are [usually noticed by me] but […] I don’t always see them. My wife is a marvellous measuring stick. In the most compassionate way she alerts me […] to where I’m at, or where she feels I’m at, which is very accurate. (Paul, 68)

These participants generally reported that when someone notices their symptoms, it prompted the enactment of their relapse prevention plan. James recalled a situation where he realised that he needed to contact his psychiatrist after his partner had voiced concerns about his mood:

[My symptoms were pronounced] enough for Kym to look at me in a crestfallen way and say, “What’s wrong with you? Why are you like this?” And then it was enough for me to click, and think […] “I think I’m having a rise - I should call my psychiatrist”. (James, 59)

In some circumstances, family members enacted early intervention on behalf of the individual with BD. Paul described how his wife had, on occasion, contacted his psychiatrist when she was concerned about his mental state: “My wife rang him, we have a signed contract […] where my wife can have me hospitalised without my consent, but in
this case I rang him [my psychiatrist] also, and unbeknown to me, my wife [had already called]” (Paul, 68).

In addition to contacting the person’s psychiatrist, Alison spoke about harm minimisation strategies that she had developed with her husband to prevent reckless behaviour. This typically involved discussing ideas with him to determine if they were sensible. Alison recalled her initial resistance to advice, and the gradual process of accepting the benefits that could be gained from her husband’s input.

Well, originally when I came to live with [my husband] Travis, I resented him […]. I resented him spoiling my fun […]. I was a bit outrageous […]. It was a humbling experience to realise [that I should]: “hey check it out with Travis”. He’s pretty sensible - if [my behaviour] doesn’t ring right with [him], then [I] don’t bother. (Alison, 65)

Alison went on to talk about financial safety contracts that been developed between her and her husband: “Travis used to [help me control my spending]. [We had an agreement that] if I’m spending over $50 or $100, I’ll ring [him], and he’d say “okay” (Alison, 65).

Alison explained that after years of checking with her husband, she had made inroads with regard to internalising this skill. In her words, when weighing up certain decisions, she “wouldn’t even [need to] run it by Travis, because I thought [that he] is not going to approve […], so I wouldn’t do it” (Alison, 65).

*Participate in the workforce and being adequately supported.* In addition to gaining support from their social and treatment network, people also spoke about the important ways they managed work to maintain wellbeing. Several participants needed to negotiate workloads to maintain wellness. Some people (Gabriel, Alison, and Nicole; 17%) found that reducing work, or indeed, ceasing it all together, afforded them more
control over their moods. For Gabriel (51), working part-time and maintaining a moderate workload helped control her moods. As she described it: “I try not to do to much at work [...]. [I] try to take it easy” (Gabriel, 51). For others, work had become unviable after the onset of illness: “After I had [my first episode] I stayed home with my daughter and I didn’t go back [to] teaching [...]. I decided I wouldn’t go back to work” (Alison, 65). Similarly, Alison reflected that work stress had affected her wellbeing, which prompted a change in her behaviour:

Now I’ve come to realise that I was pushing myself and stressing myself, and I don’t want to do that anymore. I just want to write when I feel like writing and send haiku to a couple of magazines, and do what’s enjoyable and pleasurable [...]. Not be in such a working mode anymore. (Alison, 65)

One participant, Nicole, noted that her working environment became too stressful to manage, which prompted her to leave her position. This, in turn, allowed her to appreciate the extent to which her mental state was compromised by work and the importance of spending time with her children:

I was being bullied by my [boss]. He wouldn’t let me do my job [...]. I left with no job to go to [...]. I kind of felt relief [...]. It made me slow down a lot, and it made me take time to enjoy my kids, and just enjoy the small things in life. Because in the past, with my drinking and with my BD, I’ve always been one of those people who’s go go go, and now I’m smelling the roses. I’m just taking pleasure in really simple things [...]. My expenditure has gone right down, but I’m happy. I have two boys and I see so much of them. (Nicole, 49)
While several participants indicated that they had gained wellness by changing their workloads, others (David, Emma, and Robert; 17%) spoke about the benefits of attending work. Robert noted that work had been protective due to its capacity to stabilise his daily schedule and sleep routine:

Well I think [work is] crucial for that sort of routine in my life [...]. I think if I don’t work, and I’m having a particularly more of a depressed time, I might sleep all day - sleep halfway through the night [...]. My routine just goes out the window. (Robert, 36)

For Emma, it was not the routine of work that was of benefit – rather, it was the distraction that it provided: “[...] and once again, you’re not thinking about yourself [when you are being productive at work]. You’re thinking about other things, it’s always the focus off you” (Emma, 53).

Robert and Emma also felt that gradually returning to work after an episode of illness had assisted them to regain their wellness. For Robert, returning to work increased his sense of agency about his life:

I suppose it felt good to make a decision that my life was going to be like my life had been in Melbourne for ten years previous to [my episode]. I felt really good that I was going back to do one day of work, and then two days, and then it slowly just built up from there. (Robert, 36)

Emma described the benefit of being around people and the things that were important to her in the workplace: “The first couple of weeks were anxious […], but now it’s great! Okay, it’s not a lot of money, but I’m back out there with people and kids and everything I’ve loved - and outdoors too” (Emma, 53).
Aside from the more general psychological impact on returning to work, Robert and David reported that ‘pushing through’ symptoms at work had been an important for maintaining wellness. David, for example, described how he managed his symptoms at work:

I work three days a week and I struggle at work, but I do a bit of self-talk or go for a walk and go back to my desk and continue working. Yeah I struggle with it, even today I’ve had ‘cloudy head’, but I just keep pushing myself and telling myself that everything’s going to be okay, and I’ll get through it. When I have cloudy head, the fog, it lasts for about an hour and I get really depressed and [then] I come up again and move on.

(David, 31)

Similarly, Robert reported that it was helpful to attend and persevere at work whenever possible:

One of the things my brother said to me is: “you can’t stop”. He put the idea in my head. “No matter what happens in your life, you can’t stop every time something bad happens”. You need to keep going because I guess [work] forces you to do that […]. Whether work distracts you, or whatever, it just seems to be very good for me. (Robert, 36)

In addition to the benefits of being employed, these participants also noted the importance of being supported to work. Participants noted that work related support had been important in facilitating their re-engagement with work – Emma, for example, found that support from a job network agency helped her to sustain her current employment and maintain her wellness:
[My job agency] have done a wonderful job […]. They still support you for 26 weeks after you work, making sure you’re not taking your work home, and [checking in on] how are you coping, and [asking if you] have [had] any bad days. (Emma 53)

Also, as previously mentioned, Robert received sick leave from his boss when he needed it: “They’ve always been really supportive, it [my bipolar] hasn’t been an issue […]” (Robert, 36).

**Managing sleep routines and maintaining regular routines during times of vulnerability.** Many participants also spoke about the importance of getting adequate and consistent sleep ($n = 10, 56\%$). As noted by Ann: “I just now know these are things that I have to do, [and one of those is that] I can’t lose sleep” (Ann, 42). Indeed, the notion of maintaining a consistent sleep-wake cycle featured heavily in participants’ wellness narratives. For three people (17\%), medication was the most effective way to achieve a good quality of sleep. Lauren, for example, explained that she has not experienced any difficulty with her sleep since commencing an anti-psychotic medication:

Until I started Seroquel I didn’t realise how significant my sleep disturbances were. That to me has been an absolute miracle drug for my health […]. For years, I’ve taken sleeping tablets to no effect. I’ve laid awake for hours at night just worrying that I’m not getting enough sleep, and therefore [I think that] I’m going to get sick […]. [Now] I know [that if] I take my Seroquel, I’m going to get a good night’s sleep and everything will be ‘hunky dory’. (Lauren, 45)

Three other participants (17\%) reported a benefit from employing sleep hygiene practices. One participant, Hannah, spoke about “aiming for 10 o’clock” each night, and
listening to her preferred music as a part of her pre-bed evening ritual (Hannah, 72).

Alison placed more of an emphasis on maintaining consistency in her sleep routine and gaining adequate sleep: “Oh I’d say go to bed at the same time and get up at the same time as much as you can, get plenty of sleep” (Alison, 65). In addition to routines, participants also mentioned specific behavioural strategies. James, for example, reported that using relaxation strategies before bed had helped with the maintenance of wellness:

[My previous psychologist] created an individual sleep and relaxation tape for me [...]. I used it in those crisis times, and it was effective [...]. I [have] ‘poo-poo’d’ these things a little in the past […]. Oh it’s always been an issue for me - and quite honestly, Kathy [the research interviewer] it’s a precursor when I miss a night and then another night [toward] an elevated mood. Which can go from a form of higher thoughts and ideas, to ‘full-blown’ mania. (James, 59)

In addition to the noted importance of maintaining consistent sleep routines for promoting wellbeing. Laura reported the importance of maintaining consistent routines during times of hormonal vulnerability. She recalled an instance of this, when she worried that a late night out while she was premenstrual would be too destabilising to her already vulnerable mood state:

I was premenstrual [a time where I’m known to be hypomanic]. We were committed to go to a little 2-year-old birthday [party], and we had booked a gig to see a band that we love […]. It was coming up to my period, and I just went: “nah I can’t do it, I’m not going to go to that gig”. (Lauren, 45)
Enhancing self-knowledge through psychoeducation. In addition to maintaining routines, many participants (n = 8, 44%) identified that learning about their condition helped them to develop wellness. This was true whether the source of information was books, journals, professionals, or other people with lived experience of BD (discussed further in RQ4). An example of this was provided by Ann, who discussed the usefulness of having access to books and journals whilst participating in the MAPS treatment program: “I was lucky at the time because I was at university and I was able to have papers sent to me. I could read whatever I wanted to read [about BD]” (Ann, 42).

Similarly, Tom also described his endeavours to learn about BD when he was first diagnosed: “[...] the knowledge of it did [help]. As soon as I was diagnosed I did a whole lot of research. I got stuff out of the library and looked up a whole bunch of all sorts of things” (Tom, 40).

A few participants (n = 2, 11%) felt that without access to information, people with BD are unable to effectively engage in their treatment. Participants suggested that an absence of knowledge about BD resulted in an external locus-of-control, and hence, a passive attitude toward managing their illness. Ann spoke about the importance of being an active participant in treatment, and being able to critically evaluate treatment options:

If you don’t know [...] there are three legs on the stool [reference to self-management as an important component of treatment] then you don’t know to ask those questions. So if you’re told that the guy who’s charging a fortune [...] is giving the best drugs, then you accept it [...]. If you don’t know that there’s controversy about the drugs, or that there are other drugs out there, or that 30% of patients are treatment resistant, then you don’t know to ask the questions [...]. If you don’t know to ask the questions, then things never change, and they can’t change [...]. I do believe that the patients don’t have access to
enough information […]. It could assist more just by simply [prompting them to] ask simple questions, feeling more in control. (Ann, 42)

**Enhancing insight into core schemas.** In addition to developing knowledge about BD, participants also spoke about the importance of understanding the origins of their personality and associated vulnerabilities. Laura and Ann (11%) suggested that personality-oriented psychotherapy had cultivated a deeper level of self-understanding. Laura explained: “[…] Your tendencies […] - you know things that you’ve taken on over your life that might not be too healthy. So that kind of thing. So you need to address those, your internal mechanisms […]” (Lauren, 45). Amy noted that therapy had helped her to develop a greater understanding of her developmental origins: “I have a great insight into how my mind works - and how screwed up my family is […]” (Ann, 42).

**Lived experience as a facilitator of wellness.** More broadly, several participants ($n = 5, 28\%$) commented on an increased capacity for wellness due the years spent living with BD. It was evident that the type of knowledge developed from living with BD was different for different people. For Sally (67), the years of living with her condition had helped her to develop insight into herself and others:

I really think it’s just years of experience [that assist wellness]. I mean I’ve been like this for thirty odd years […]. I think basically it’s having that insight into myself and how I react, and the insight into my family and how they react to me. (Sally, 67)

For a few others ($n = 2, 11\%$), the years of living with and receiving treatment for BD had taught them to pay closer attention to their mood symptoms. Tom, for example, described his increased capacity to identify prodromal symptoms using a list of prodromal symptoms that are ranked in terms of their severity:
If I notice behaviour number eight, and that’s the first thing I notice, then I’ve gone through the first seven behaviours and didn’t even notice [my symptoms]. Or if I notice behaviour number two, then I’ve just gone up a bit and missed the first one. I don’t think I had it as rationally thought out as that [before the MAPS group]. (Tom, 40)

Interestingly, a few participants \( n = 2, 11\% \) felt that wellness had come about due to their resiliency. Emma explains: “[...] everything I’ve always done, I’ve always worked hard at practicing, and that’s why I’m here [why I’m well]. I know that” (Emma, 53). Two participants (11%) described that they had come to understand that their episodes were temporary, and as such, could be managed. This self-knowledge, gained through experience, helped to reduce the distress they experienced during periods of illness. This is evident in Robert’s narrative:

井 back here [points to 2005, the year he did the MAPS] it felt as though it was going to be forever, and this was all my life was going to be […]. Then once I started with getting a bit of momentum [I realised that things would get better]. You know, I knew there were going to be periods […] where my mood was noticeably low or maybe even higher, [but] I just knew eventually, the fog was going to clear […]. If I just tried to stay on top of it […], just doing what you can do. Looking at each of the things that were an issue for me, taking things one-step at a time. (Robert, 36)

**Self-monitoring and early intervention.** Many participants \( n = 8, 44\% \) emphasised that learning how to recognise triggers, monitor their mood, and participate in early intervention had been essential to their ongoing management of BD. For instance, six participants (33%) reported that learning about the impact of stressors on mood had helped them to better understand and respond to mood variation. As noted by Tom: “[…]
stress, lack of sleep and stress are all triggers for me [...] So avoiding stress, I learned about it with the MAPS” (Tom, 40). Similarly, Lauren noted that she “[learned to] monitor and to find out the triggers - [I became] aware of the menstrual trigger because of MAPS [...]. I think MAPS brought it all together and made me realise the significance of them, and how I can actually do something about it” (Lauren, 45). Nicole expanded on the utility of this self-knowledge:

I remember using the [MAPS] group’s book for your stressors and your triggers. So that was really good. I found the big thick book that they gave you very helpful, because we’d written things down and I used to go to refer to it, and think “now why am I feeling like this, why am I feeling low or depressed?” I got a stressor ‘these’ and it’s triggered by ‘this’. So I found that enormously helpful. (Nicole, 49)

Lauren also commented on the knowledge that she had gained about triggers for illness and how this had affected her approach to BD management:

I do want to say that I think overall the MAPS course has helped me considerably [...]. Just in the way that I tackle, and the approach that I take [...]. The daily monitoring [...] because you think you know how you feel and you think you know what the triggers are, but until you actually write it down day-to-day, you don’t actually really. (Lauren, 45)

In addition to the benefit people gained from learning about triggers, numerous people (28%) reported that becoming more familiar with their prodromal symptoms and learning how to engage in early intervention was one of the most helpful aspects of the group. As Tom recounted, the most helpful feature of the group was:
[...] recognising [my prodromal] symptoms and being able to act on them [...] Knowing what to do when you get those, and then there might be a more extreme step when the symptoms step up again. So recognising those and knowing what to do if you’re getting those symptoms. (Tom, 40)

Similarly, Ann spoke about the power of being better able to identify her symptoms: “Well nothing has actually changed, I’m just in a better position to identify it now [...]. Actually, that was something that the MAPS program really helped with… [that is,] identifying when you’re getting manic and what to do about it” (Ann, 42).

Participants also spoke about the different ways that they can detect their prodromal symptoms - information which is emphasised during the MAPS program (see Table 2). Heather, for example, explained: “Yeah, […] the visualisation [of my moods was helpful], and the levels of where most people go to and where [I] go to. Just being able to visualise that [content from the MAPS group] helps me to see where I’m at” (Heather, 50). Tom noted that he could detect his prodrome more readily through his behaviour (as opposed to feelings or cognitions):

I found it [the MAPS group] useful [to personalise my] symptoms in terms of […] ‘on your way up’ or ‘on your way down’, and [the associated] thoughts and behaviours. Mainly, I think it was behaviours [that helped] me […] ‘cause it was something I could observe […] - different behaviours you go through on the way up or down [...]. And knowing that if you’re observing behaviour number five, that you’re near the top, and you’ve missed number four and something’s a little bit askew. (Tom, 40)

In addition to the importance of recognising prodromes, many people (n = 6, 33%) felt that modifying their medication had been essential for preventing or reducing the
severity of relapse. One participant, Lauren, explained that making minor adjustments to medication had helped to reduce the severity of mania. As she described it: “[When I am] prone to a bit of mania - instead of taking 150 [my normal dose], I’ll take 200 or 250gs [a little more]. That way I know I’m just going to take the edge off […]” (Lauren, 45). Similarly, James recalled that his psychiatrist’s advice to adjust medication had reduced the severity of mania, and noted the benefit gained from his ongoing use of this strategy:

I took his [my psychiatrist’s] advice […]. I remember it very well, and I’ve almost followed it without needing to call again: double the dosage of lithium […], [and] take a double dosage of the Seroquel […]. I recovered from that within 24 hours. (James, 59)

While some participants engaged in ongoing self-management, Gabriel continued to consult with her treatment team and make adjustments accordingly: “If I’m […] feeling a bit light and the colours are bright [experiencing prodromal symptoms], they’ll [my treatment team] say take another Seroquel of a night and see if that helps, and usually it does” (Gabriel, 51).

**Adhering to medication.** Several participants (n = 4, 22%) also expressed positive beliefs about medication and emphasised the importance of compliance, more generally. As noted by Tom: “I’m pretty diligent […]. I know the importance of taking [my medication]” (Tom, 40). For some, taking medication was a serious commitment of the utmost importance: “[I] never forget. [I would] have to be dying to forget [to take my medication]” (Sally, 67). Participants went on to elaborate about the need to incorporate medication into their lives. Tom, for example, explained that he had “learnt to […] get into a [medication] routine” (Tom, 40). Others spoke more broadly about medication, in terms of following general medical advice. Hannah, for example,
attributed her wellness to the fact that she is committed to “taking my medication - doing what I am told [by my treating team]” (Hannah, 72).

When discussing medication, two participants (11%) offered advice to others based on their positive experiences. For Marie, this advice was quite clear: “the first thing [is] to take your medication […]. I think it’s the cornerstone of my wellness” (Marie, 58). James encouraged people to think of medication in terms of a cost/benefit analysis, where the scales weigh in favour of compliance: “[I would suggest that you] be ready to accept medication - it won’t hurt you […]. In other words, if you don’t need it, it doesn’t matter, if you do need it, it will work” (James, 59).

**Keeping a diary.** In relation to mood monitoring, a few participants ($n = 3, 17%$) found it useful to keep a record of their thoughts, feelings, and mood states. Heather, for example, noted that after all these years, she continues to be: “[…] going along the same way, still watching it” (Heather, 50). Nicole went on to note that her diary allowed her to reflect on how she had reacted to stressors: “[…] sometimes I look back [at my diary] and think, ‘Oh my god, look at how low you are!’ Why were you so low about that little thing? […]” (Nicole, 49).

While several participants used a diary to monitor their moods, others used them “for the structure” (Nicole, 49). As noted by Emma:

I’m just faster at doing things, and more on the ball [as a result of] writing things in my diary […]. So now I can get so many things done, so [I’m not] worrying about it, and [I can] still have an hour or two to myself. (Emma, 53)

Aside from mood monitoring, stress management, and reflective practices, people also spoke about their use of diaries as a communication tool. Specifically, participants noted that diaries helped enhance communication with their psychiatrists, and could give
a new psychiatrist a picture of mood variation over time. As noted by Heather: “[I thought that] it might be a good idea if I start [a mood diary]. Then when I do get my new doctor, I can say: “this is what’s been happening…” (Heather, 50). Emma’s psychiatrist reinforced her diary use, and the pair collaborated on her use of a diary as a self-management tool: “[My psychiatrist] says: “don’t put too much in the diary”. So I have a smaller diary so I can’t do that. Things like that [have helped me], and I’ve kept that habit up [...]” (Emma, 53).

**Behavioural modification for mood management.** When people spoke about managing their mood, there was a clear theme about the importance of making behavioural changes to prevent relapse or regulate mood states ($n = 6$, 33%). The use of behavioural interventions to manage a depressive state is well encapsulated in Ann’s narrative:

Yes, I have a great insight into how my mind works and into how screwed up my family was, but it had nothing to do with the ‘on the ground’ stuff. How your feeling at three o’clock on a Sunday afternoon […], why you can’t get out of bed - the strategies that you’ve got to put into place to be able to get out of bed […]. (Ann, 42)

People felt that behavioural intervention had helped with both mania and depression. Samantha noted the importance of reducing stimulation when she starts to feel manic. She explained that: “[...] living alone is one way of managing the stress [associated with mania]. So for example, if I need to quieten down the environment so that I’m not getting over stimulated, I can do that” (Samantha, 51).

Other participants were aware of their tendency to withdraw when they first started to feel depressed, and placed emphasis on the importance of reaching out when they felt this way. Emma offered the following advice:
Don’t sit at home if you’re depressed - reach out. It’s like when I stop talking to people and I close right down. I tell myself: “you’ve got to go out today, walk that dog” […]. It’s like a real big decision, and every person you pass you practice saying the word “hello” […]. Even if they don’t respond it doesn’t matter - you’ve just got to practice opening your mouth. (Emma, 53)

Similarly, Ann reported that she had gained benefit from engaging with simple daily behaviours during depressive periods of illness:

Well, being made to write a list of things [to do] when you were depressed, that really stands out [as a benefit of the MAPS group]. So […] you know, the things that you know that you’re able to do, like have a shower […]. Okay, if you write down things that you know you have to do every day, you have to go for a walk every day, it doesn’t matter whether its five minutes or round the block. Or things like getting up. When you’re depressed you get up, you have a shower you put on some clothes, you put on some lipstick. If getting dressed is all you can do then you just get dressed. You had a list [and] you did something on the list […]. Just the fact that you know it’s there, and you know you’ve got strategies in place is really good. (Ann, 42)

People went on to specify which approach-oriented behaviours were helpful for maintaining wellness. These fell into three general categories, namely: activities that brought about pleasure, a sense of mastery, or distraction.

*Pleasurable activities.* Several participants (*n* = 4, 22%) gained benefit from engaging in activities that they enjoy. A number of different activities were noted. Amy thought that it was important to take time for herself:
When I don’t have my children […] I give myself some time. Whether it’s talking to a friend, whether it’s having a bath, weather it’s going shopping - something that’s my time. So I feel more well rounded when I have the kids, cause I’ve had my time […]. So I feel like my needs are getting met too. (Amy, 38)

David felt that listening to music had helped him to stay well: “Yeah, I listen to music. I have music on all the time” (David, 31). Marie noted that being close to nature brought her pleasure: “I did some bird watching yesterday […]. They’re just so beautiful” (Marie, 58).

While these people reported an immediate benefit from intentionally engaging in pleasurable activities, Emma felt that persistence and perseverance was needed to gain a longer term benefit: “Yeah and nothing [I did] gave me satisfaction […]. I learnt later, in one of the other courses - no it’s not going to give you [immediate] satisfaction, but [to gain benefit] you’ve got to do it [anyway]” (Emma, 53).

Mastery tasks. A number of participants (n = 5, 28%) spoke about the benefit they had gained from activities that provided a sense of achievement. For instance, Hannah described feeling grounded and reassured by a book keeping task: “I’ve been doing archives and finding that solid […]. I think it helps to prove that I’m stable […]” (Hannah, 72).

Sally had gained benefit from the act of cleaning her home. Her narrative emphasised the importance of pacing and providing reward for these behaviours:

I’ll start off doing one room […]. I never expect anymore from myself than one room at a time […]. When I’ve done one room I feel extremely happy, and I think: “okay I’ll have a cup of tea and I’ll go on to the second room” […]. If I can […] do two rooms at a
time - that for me is a really good day [...] . I’m just trying to think how I do that [...]. I suppose I’m a bit like the dog - I reward myself. (Sally, 67)

Similarly, Hannah explained that breaking things into manageable goals had been helpful. She explains in her own words:

[…] dividing things up is important, rather than [doing everything at once]” (Hannah, 72). She went on to explain an instance of this further: “I’ll give you an example. I do the washing on a set day, and I try to have all the ironing before the day comes around again. (Hannah, 72)

*Activities that provide distraction.* Some participants (n = 2, 11%) noted the importance of directing their attention away from stressors and toward activities that absorb their attention. Emma, for example, describes how these sorts of activities assist in bringing her focus away from her difficult thoughts and feelings: “[...] and once again you’re not thinking about yourself [when your concentrating at work]. Your thinking about other things, its always the focus off you” (Emma, 53; this narrative also suggests a specific benefit of work, see RQ3).

*Using cognitive strategies.* Additionally, a number of participants (n = 5, 28%) spoke about the benefit they had gained from being aware of and changing unproductive thinking. Marie, for example, described her awareness of thinking in terms of rigid “should” statements:

If you’re having a bad day for instance. I mean, everyone has good days and bad days. If you have a bad day, [I might tend to think] “Well you ‘should’ have done…” […] . We
are not allowed to say should! [Instead saying] we ‘could’ do that, we ‘could’ do that.

Yeah just sort of things like that. (Marie, 58)

Similarly, two participants (Amy and David, 11%) reported that using helpful self-talk was beneficial during times of stress. David, for example, mentioned this in the context of his functioning at work:

[When I am at work] I do a bit of self-talk, or go for a walk, and go back to my desk and continue working. Even today I’ve had cloudy head, but I just keep […] telling myself that everything’s going to be okay, and I’ll get through it […]. (David, 31)

Interestingly, two participants (Nicole and Sally, 11%) found resources provided during the MAPS group useful for ongoing development of thought challenging techniques. For instance, Nicole explained how she used these manuals as a resource when challenging her thoughts about a stressor at work:

The book that they gave us was fantastic […]. Something would happen at work and a boss would, you know, sometimes give a look at you, and you think: “oh she’s looking at me because I’ve done something wrong”. And then you look into it [using the book] and think: “well, could she have just been having a bad day…”. […] So I often used to go to that book afterwards [for this]. (Nicole, 49)

Similarly, Sally found that doing homework during the MAPS group helped consolidate and develop her understanding of CBT techniques:
I’d say the MAPS group did help me… I had some training in CBT before I went along to the MAPS, but MAPS reinforced everything with me. And ‘cause I was doing it in a group, we were able to discuss things and do exercises and homework, and that all reinforced everything for me. It has been very valuable. (Sally, 67)

**Developing assertive communication.** Ann spoke at length about the importance of developing assertive communication skills. This had helped her to manage interpersonal difficulties and communicate when she was unable to fulfil a request that had been made of her: “I say “no” a lot […], “no I can’t be there”, “no I can’t do that”” (Ann, 42). Ann went on to explain that the motivation to develop assertiveness skills stemmed from her unwillingness to compromise when it came to her wellness:

[For example, I have said that] I’m not going to such and such’s house for Christmas […]. I’m not having such a person in my house, because it upsets me and I can’t afford to get upset […]. This is my reason, and it’s going to stay like that. It might be awkward for other people, but it’s the way I live my life […]. I’m no longer interested [in] the risk of offending people, I’m much more interested in keeping myself well. Because, yes there’s a premium, but yes it’s worth it […]. These are skills that I’ve learnt, and yes I’ve learnt them the hard way, but I’m not letting them go now. (Ann, 42)

**Reducing alcohol use.** Aside from monitoring and relapse prevention practices, many participants ($n = 6, 33\%$) also discussed the management of alcohol and its effect on wellness. Most participants had been advised by treatment professionals to avoid alcohol; however, many reported that alcohol still featured in their lives, albeit to a lesser extent. Some participants had attempted to cease alcohol consumption - both Emma and Marie discussed their failed attempt to stop drinking, but further noted that they had
managed to substantially reduce their alcohol intake. For instance, Emma reported that although her use is now more restrained, she knows that she shouldn’t be drinking:

In the very early days, I used alcohol, but not since 2006 [the year she did the MAPS group]. I’ve started drinking a bit more now because I’m well, but I shouldn’t be, I’ve been thinking more about that again […]. I went through a period when I didn’t drink at all. (Emma, 53)

Ann and Samantha described their decision to stop drinking. Ann’s decision to stop drinking had been in the interest of managing her BD:

It’s not like my life has changed because I can’t go out to parties until four in the morning, that’s just, that wasn’t me anyway. I stopped drinking alcohol a long time ago […]. It’s just become part of life, but the point is that it never would have become part of life, if it wasn’t for the MAPS program. I simply would not have known that there was stuff that I could do to change things. (Ann, 42)

Samantha’s related more to her concern about the contraindication with medication: “[I’ll] put it this way, I don’t think I could drink more than a glass, or I’d be out on the floor” (Samantha, 51).

Others (Paul and Nicole) had ceased drinking since attending Alcoholics Anonymous (i.e., AA). Paul explained that he is now a recovering alcoholic, and that the strategies he learned in AA have also helped with respect to managing his condition: “I’m a recovered alcoholic, and I use techniques I learned as a practicing member of alcoholics anonymous on a daily basis […]. Right down to “just manage the next task” and worry about whatever comes after that” (Paul, 68). Nicole explained that it had taken
time to gain control over her drinking, but noted that when she did, she was able to completely cease her use. She explains in her own words:

I was the only person in the [MAPS] group that drank. The other 5 participants had bad problems with alcohol and they didn’t drink. One guy went to AA and never drank again, and I thought god that guys mad. How on earth can you do that, to me it was just not possible […]. [Now, since attending AA] I’ve gotten rid of alcoholism. (Nicole, 49)

**Maintaining a healthy lifestyle.** Many participants ($n = 8, 44\%$) noted that paying attention to nutrition, exercise, sleep, and taking time to rest, were important components of living well with BD. Ann (42) discussed the lifestyle changes she made to maintain wellness:

I can’t go out and eat lots of sugar […]. I can’t lose sleep. I’m okay [because] I’m an introvert, [so] I don’t care anyway […]. It’s not like my life has changed, because I can’t go out and party until four in the morning […]. That wasn’t me anyway. I stopped drinking alcohol a long time ago [so these changes are now] just part of life. (Ann, 42)

According to Robert, the MAPS group helped him to realise the importance of maintaining a consistent routine and healthy lifestyle. He describes his vigilant attitude towards these lifestyle factors:

For me it always really struck a chord: that if I tried to stay vigilant, if I tried not to drink too much, if I try and keep a routine […], not get too tired, eat right [then I will stay well]. You know that’s what the [MAPS group] was kind of suggesting really. (Robert, 36)
Another women, Lauren, found it important to reduce her intake of sugary foods in the evening:

No lollies in the evening. I found that a lot of sugar late at night [would make things worse]. I’m prone to getting those liquorice packs, devouring the whole things at like 10 o’clock at night, and finding that would make me quite nervous and agitated with that sugar hit. So, that’s become a thing of the past now as well. Yeah, so just little things like that […] add up. (Lauren, 45)

Lauren and Marie believed that eating well and growing their own produce had contributed to their ongoing health and wellbeing: “I eat very well, so I eat really really well. I grow our own food, I grow our own veggies and fruit and stuff. So we eat really well” (Lauren, 45).

Another commonly identified lifestyle factor was exercise. Three participants (17%) emphasised the importance of engaging in regular exercise for wellness. Lauren, for example, discussed her diligent commitment to exercise: “[…] exercise daily including three-to-four gym sessions a week. I’ve now quit the gym actually, but I’m running and I’m walking the dogs” (Lauren, 45). Ann felt that in addition to diet and exercise, maintaining a low body weight is an important component of wellness:

I know that I have to go for a walk. I know that I have to eat properly - I mean I know that I have to keep my weight down. This is one of my hunches in life that there’s a causative relationship between […] weight and depression. I’m still waiting for somebody to do some research on that, but I’m pretty sure it’s there. So I know to keep my weight down. I know that I can’t have too much sugar. (Ann, 42)
Two participants (11%) felt that engaging in regular waking rest contributed to their capacity to maintain wellness. For Alison, this simply involved taking some time each day to “unwind”. For Hannah (76), this involved taking time to relax in her favourite armchair: “I often have a rest, so for me that’s […] important. […] I use a recliner […]. I often drop off. So in a way, it’s a waste of time, but it does revive me” (Hannah, 76).

**Using mindfulness strategies.** Several participants (n = 8, 44%) spoke about mindfulness practices, and how getting in touch with their personal values had helped to live a more fulfilling life. Emma found it useful to cultivate an observant stance towards her thoughts and bodily sensations. She recalled the moment when she first understood the busyness of her internal dialogue and the subsequent effect on her wellbeing:

[I did] 10-weeks of mindfulness meditation, and that’s when I realised how ill I was. […] I saw what was actually going on up in my head [...]. With a movie screen going back and chatting away, and I thought: “oh my God!” […]. That’s when I knew this stuff was good for me. (Emma, 53)

She went on to describe how mindfulness skills had helped her to cope with suicidal thoughts during depressive episodes:

What’s actually worked for me is knowing what my body’s feeling - knowing what anxiety feels like, knowing when my head takes off in thoughts, watching what thoughts are coming up. The one thing I did learn is that when you have suicidal thoughts - it’s only a thought; you do not need to take action. (Emma, 53)
The importance of the ability to be in the here-and-now experience of life was emphasised by Emma, who spoke about connecting to nature: “So I also know that that’s helped me […]. So you know […] going for a walk and looking at the flowers” (Emma, 53). For Marie, engaging with mindfulness exercises on a regular basis is something she has incorporated into her life and relationship:

Now we’re [Jack and I] doing those brain exercises […]. They take an hour, over an hour to do everyday […]. I find it’s like mindfulness, like when you’re doing the exercise you’re not thinking or anything else, nothing goes in [and] nothing goes out. You’re just doing it. (Marie, 58)

Some participants (Heather and Alison) spoke about the importance of connecting to their values after being diagnosed, and having a clear sense of what sort of person they wanted to be despite their illness. Alison offered the following advice:

Ask yourself what sort of lifestyle you want to have. Be self-reflective and […] say […] “what do I want from my life?”,”what sort of person do I want to be?” […]. One of the things that I wanted to do […] when the bipolar really became evident in my life was to live responsibly […]. I mean, you’ve got the bipolar and you get high or you get grumpy or whatever, but to me that’s not an excuse for being rude. People deserve courtesy and kindness […]. I don’t think you can cause a row in the pub, or spend heaps and heaps of money that’s not yours, or put the family in debt, or […] claim that you just felt like it and you couldn’t help it […]. I think we all, in any society, have a responsibility to live responsible towards ourselves and towards others […]. That’s just one of my beliefs […] I don’t want to be somebody that causes mayhem and chaos wherever I go. (Alison, 65)
For Heather, finding a life purpose, and connecting to her value of beneficence, was a turning point in her experience of living with BD.

I couldn’t see a day where I would be able to leave the house, so how are you going to make plans [...]. At the time I looked at my caseworker and I said “Sarah, you know what, I really want to be like you when I grow up”, and that was the moment I realised the job I wanted. I wanted to help people the way that she was helping me [...] and all of a sudden we’ve got a life plan. (Heather, 50)

**Valuing self-care and compassion.** The importance of valuing self-care and having an attitude of kindness to oneself, was also spoken about by several participants (n = 6, 33%). Two participants (11%) explained how they had learned to relax their self-expectations over the years of living with BD. Nicole, for example, spoke about learning “to be less hard on [myself]” (Nicole, 49). In her words: “I looked back at what I was like in 2004 and I was very hard on myself […]. I slowed down a lot and I [am] being less hard on myself [now]” (Nicole, 49).

Two participants (11%) practiced self-care by limiting activities that they found taxing. Alison, for example, reported that she once spent of lot of time working and volunteering, which took an emotional toll. She recalled making a decision to limit these activities so that she and her husband could have more time for enjoyment:

When I came to live with Travis [my former husband] he wasn’t doing any volunteer work […]. He said he wasn’t going to, and he said “Retire for God sakes!” […] “You’ve done enough, you’ve done twenty years of it”, and he said: “lets enjoy life”. So we did […]. There’s a lot in the papers about volunteering - how it gives you this and gives you that, and I thought, yeah, but it takes up a lot of your time too. (Alison, 65)
Self-compassion was also mentioned ($n = 2, 11\%$). David described the nurturing attitude he takes towards himself, and how this has helped him to sustain wellness: “ [...] over the last four or five years I’ve learnt to love myself. Which I never did before, and I think that gets me through” (David, 31).

**RQ4: What was people’s experience of the MAPS treatment group, and its impact on their experience of living with and managing BD?** There were 5 themes in participant’s narratives about the experience of the MAPS group, namely: (1) *Positive experiences during the group*, (2) *The effect of active symptoms on engagement and group cohesion*, (3) *Increased agency since participating in the group*, (4) *Needing time to consolidate and integrate skills into daily life*, and (5) *Suggestions for group improvement*. These will be explored in turn.

**Positive experiences during the group.** In general, participants spoke in glowing terms about the MAPS group. As noted by Ann, “the MAPS group gave me the skills to change my life completely” (Ann, 42). Heather similarly noted that the MAPS program was “[...] one of the best recovery tools I’ve had” (Heather, 50). Participants spoke in detail about the many benefits of the group experience, namely: socialising with others who had BD, learning more about the illness, and forming rewarding therapeutic relationships with the group administrators.

**The benefit of meeting others with BD.** Most participants ($n = 11, 61\%$) found it rewarding to spend time with others who shared their diagnosis. For Robert, the group experience afforded him a sense of ‘not being alone’ in his struggles. He described the feeling of affiliation that he experienced when listening to the stories of other members: “[The benefit of the group was] probably […] sharing; it was just hearing stuff that I’d know I was going through […] and then just that feeling of not being alone” (Robert, 36). Similarly, for James and Heather, meeting other people with BD had helped them to feel
more ‘normal’. In Heather’s words: “I enjoyed mixing with the people. I enjoyed being in a group where I was understood and a part of the group [...]. It normalised me” (Heather, 50). James emphasised that meeting other people with BD had helped to reduce shame and embarrassment about previous episodes:

Well I suppose it gave me a sense of confidence [and made me realise that] I need not be as humiliated as I often felt. Because particularly in my case, because I’m a coach and had been a coach, it seemed very difficult for me to return to normalcy, when I’d done rather stupid things. Which is often some of the dreary parts of depression and recovery, you know getting over the humiliation. (James, 59)

While many participants talked about the normalising effect that the group had, Robert also commented on the perspective that he had gained from meeting others who were more severely impacted by their condition:

I think I remember thinking: “maybe I haven’t got it as bad as some of these other people”. Like, there was some […] people with children [who had things particularly difficult]. I mean, I had a child, but he wasn’t living with me […]. I remember […] some people […] looked like maybe their illness was affecting their appearance […]. I think that maybe it was helpful for thinking: “well other people are worse off”. (Robert, 36)

**Developing a greater understanding of BD.** Many participants ($n = 9, 50\%$) reported that information provided during the group had helped them to develop a better understanding of their condition, and appreciate the importance of this self-knowledge. Robert, for example, described how the MAPS program helped him to appreciate the importance of understanding his illness: “I really felt [that I had to learn about the
condition after I was diagnosed] in 2005, and MAPS was a part of it.” (Robert, 36).
Heather explained how she gained “clarity, and self-understanding” (Heather, 50) from
the group. Ann gained this knowledge by listening to the experiences of others. For her,
the stories of others were a rich source of information that could inform her self-
understanding:

I probably did get the feeling that I was interested in people for my own reasons […] It
was a bit like a fact-finding mission for me […]. When you were listening to people’s
stories, I wasn’t prying, but I was paying attention, because I wanted to find out
information for myself. (Ann, 42)

*Positive relationships with administrators of the MAPS group.* Many participants
\((n = 6, 33\%)\) made positive comments about the people who administered the group, and
how they had left a lasting impression on them as health professionals. In Ann’s (42)
words: “I have [group facilitator] to thank for what my life is like now […]”, and further
noted that in her view “the group was run really well” (Ann, 42). Similarly Marie
explained that “the coordinators and [other group facilitators] were terrific. They were
just great” (Marie, 58). Alison felt that her relationship with the facilitators had made her
more engaged with the group, and felt that they had played a role in her positive response
to the interventions:

I really believe [what] Carl Rogers said: “If you have unconditional positive regard for
somebody, that will help them to change and grow more than anything else”, and he said
“the relationship with the psychiatrist or the psychologist […] is the greatest factor in
whether they’ll do well and recover and keep going”. […] I feel that very strongly - I was
highly motivated to go every week, because they were taking an interest in me and my
difficulties, at that point in my life […] I was really grateful for the help. (Alison, 65)

**The effect of active symptoms on engagement and group cohesion.** In contrast
to the benefits people gained from the group, three participants (17%) reported their
difficulty engaging with the MAPS group because they had symptoms during some of the
sessions. For instance, Heather recalled that her low mood made it difficult to attend the
group:

> It was very […] hard for me to drag myself out of bed and just get here, even though I
only live about five minutes down the road by car. It was very difficult to keep attending.
[I experienced] depression... just, you know, a general sadness […]. (Heather, 50)

Heather went on to describe that her low mood made it difficult to engage with
some of the interventions that were focussed on positive goal setting: “They were saying
it’s great to have some goals, make some goals and have something to look forward to,
but absolutely nothing appealed to me, because I was so miserable” (Heather, 50).

Similarly, Emma found it hard to connect with the content relating to goal setting:
“I couldn’t benefit from it […]. I couldn’t relate to the things they were saying, as in life-
things to do […]. I couldn’t do them, I couldn’t think of them” (Emma, 53). Emma
reflected on her difficulty gaining knowledge from the MAPS group due to her mood:

> [I couldn’t take things on until] I wasn’t in the ‘right place’ - [I was so] ill that I couldn’t
take it on board […]. I learnt that if I wasn’t in the right place, I couldn’t take on board
what was offered. (Emma, 53)
She went on to describe the emotional impact of struggling with these interventions: “I don’t think I was well enough to cope with that course. So I always felt guilty, frustrated, because I couldn’t find the answers for the work” (Emma, 53).

While some people had difficulty attending and/or completing tasks during the group because of their low mood, others believed that their level of functioning was different to the rest of the group, and as such, felt that they didn’t quite ‘belong’. Elizabeth, a 54 year-old woman, described feeling less competent than others who she thought to be functioning at a higher level than her: “[Other] people in the group appeared to be operating on all cylinders, you know - really, really well, from what I could see. I started to think that they were doctors. Yeah it was really odd” (Elizabeth, 54). Similarly, Amy recalled that being in a group with people who were unwell made her feel as though she didn’t ‘fit’ in the group:

In my mind, I was like: “I shouldn’t be here, I’m fine”. And I was with a lot of people who really weren’t well, and it was obvious that they weren’t well. So it really kind of felt like I didn’t fit with that either. [I thought] I’m “kind of” meant to be here [...]. It was a bit difficult for me. (Amy, 38)

**Increased agency since participating in the group.** Many participants believed that the group had improved their agency over BD in some way (n = 7, 39%). Some participants spoke about their enhanced sense of control since participating in the MAPS group. In Ann’s words:

Well it was a cognitive shift, and it basically happened on the very first session [of the MAPS group]. When the presenter drew a picture on the board of a stool, three legs: one is medication, one is talking therapy, and one is what you do for yourself […]. Nobody at
that point had ever suggested that there was something I could do for myself […]. That was [the] moment [I realised there was something I could do]. Because up until that point I’d been told that my problems were essentially to do with brain chemistry. (Ann, 42)

James described a similar instance where he realised that addressing psychosocial factors could also contribute to his wellbeing:

I gained a lot of self-awareness from the MAPS program […]. One of the things I particularly learnt [was to consider my emotional health]. I put it to my psychiatrist […]. I suggested that his attitude had always been that it is only medicine that can maintain my wellness. I suggested to him that […] we don’t really talk about my emotional health […]. This was the first time I considered my emotional health. (James, 59)

Emma provided further insight, by explaining the relief she felt upon finding out there was something she could do to manage her condition: “I was so thrilled to have something [strategies to manage my condition], because I was so alone not knowing what I could do to help myself and [it is so] difficult trying to help yourself” (Emma 53). Similarly, Heather has used self-management strategies: “[…] ever since the MAPS group […]” (Heather, 50). Ann went on to explain in more detail how the self-management skills she learnt during the group had assisted her to maintain wellness since ceasing medication:

I did start to question whether the medication I was on was suitable […]. I thought that there was reasonable evidence that the medication was actually part of the problem. So I thought if I went off the medication and tried the specific strategies that were given to us in the MAPS program […] maybe I could make it work, and it did work! (Ann, 42)
Needing time to consolidate and integrate skills into daily life. While many participants spoke about the benefits of group and improved self-management, three participants (Emma, Heather, and Tom, 17%) spoke about the time it had taken to benefit from the group, and the need to refresh the material on occasion. As noted by Emma, the information provided in the group only became useful to her sometime after completing it:

I think they talked about what you can put into your life to help, and I knew I needed to do that. But I found it very hard to do it [at that time]. But learning that stays with you, so that when you’re ready or able to, you do it. (Emma, 53)

She went on to reflect that the person must be ready to engage in self-management before the interventions can be of maximum benefit. In her words: “It takes much longer than you think, because getting off your butt takes a lot longer than you think” (Emma, 53). Similarly, Tom found that it took him time to implement the strategies he learnt during the MAPS group. He also alluded to a ‘trial-and-error’ process that needed to occur before he could develop an understanding of his limitations:

[...] stress, lack of sleep and stress are all triggers for me [...]. So avoiding stress, I learned about it with the MAPS, but then I think I took a little while to actually implement it. But once I did, and I’m still implementing it now, sort of determining what level of stress I can handle without disintegrating […]. So yeah that was important. (Tom, 40)

In relation to the need to integrate and consolidate content from the MAPS group after completion, Heather commented on the usefulness of the materials for further study
and revision: “I know that having that handbook is great, and [I] like to review it every now and again. Even if it’s just a section of it” (Heather, 50).

Similarly, Emma described using the MAPS resources after the completion of the group: “Yeah I thought [the resources were] very good, because I had actually gone back and read it sometime later. Because I knew it had things in there to question for yourself” (Emma, 53).

**Suggestions for group improvement.** When reflecting on their experience of the group, several participants (n = 6, 33%) offered some ideas about how the group could be improved. Specifically, people commented on content that could be added to the group, and the tone and complexity of the material. With respect to the former, people commented on the need for a better orientation to the group, and a greater emphasis on developing lines of communication with psychiatrists.

**Group orientation.** Alison felt that a better orientation would improve future iterations of the MAPS groups. According to her, an orientation would help people to get the most out of the group:

Or you could have an orientation day for it [...]. Or you could have a phone thing. Or you could have a list of information of the things you need to do to get [...] benefits out of this course [...]. Also stress the benefit to them of doing the course [...]. Because I believe if you’re doing research, or you’re studying something, or you’re learning something, then you know, you have to go every week to get the benefit and give the benefit. So I did that. (Alison, 65)

Alison went on to suggest that there could be a greater emphasis on practical matters, such as travel options, constraints, and barriers to accessing the group:
I’d suggest that you talk about making it easy for people who have to get there on public transport […]. Some buses in Geelong only run once an hour […]. Access is hard for people who don’t have a car, and people who may not be completely well. (Alison, 65)

Emphasise the importance of effective communication with treating professionals.
Ann felt that the group members would benefit from having guidance around how to communicate with treatment professionals. She felt that communication skills training would assist people to participate more collaboratively in their treatment:

I think MAPS could have a list that you ask your doctor. “How am I tracking?”, “How am I going?”, “Do I need somebody to come in and sit with me like a patient advocate?”. “Do I need somebody to come in and sit with me and discuss these things?”. (Ann, 42)

Tone and complexity of the interventions. Several participants (n = 3, 17%) commented on the depth, language, and complexity of information that was presented during the group. Opinions on this matter were mixed, however. While some participants (n = 2, 11%) felt that the group had too much information and was too ‘academic’ in tone, others felt that the tone was appropriate. Of the former view, James believed that simplifying the content and reducing the volume of information could improve the group:

Look I have to be honest about the MAPS. [It] was interesting, but perhaps […] it was too much to absorb in the short time that was provided. […] Some of it was rather lost [on me], because it took quite some intellectual absorption, and therefore thinking, and deliberating to really make a lot of that sort of course. I mean, if you can appreciate some people have difficulty just rating anything between one to seven […] - I think the pressure
to think ones way through that material was too exacting for [...] some [people] over the 
time-frame. (James, 59)

On the other hand, Ann reported that the depth and complexity of the content was 
not only appropriate, but that it motivated her to supplement her learning with additional 
reading:

It was very well presented - it was very clear, there wasn’t too much stuff, and there 
wasn’t too much information. It was just about the right level. It wasn’t condescending, 
and it was just right. I mean I was lucky because I was at uni at the time, and I could get 
my hands on research, get my hands on books, and that was good. So that was a good 
backup for me, because I need that sort of intellectual part to it as well. (Ann, 42)

Chapter 9: Discussion

The central aim of the current project was to understand the lived experience of 
BD by conducting qualitative interviews with a group of participants who had completed 
a group psychosocial treatment program for BD five years earlier. The findings have 
provided rich, detailed, and contextualised insights into people’s experiences of living 
with and receiving treatment for BD. These insights help us to develop a greater 
understanding of factors that might be important to the wellbeing of people with BD. 
Specifically, the current findings have shed new light on: (1) how people with BD 
uniquely manage psychosocial stressors to reduce their impact on relapse, (2) how these 
people promote wellbeing, and (3) the benefits and challenges that were experienced by
people with BD during their participation in the MAPS group treatment program. This chapter will be structured these key areas of insight.\(^8\) A summary of the current findings as they relate to the aims and research questions of the current study will now be provided.

The results indicate that life events, hormonal rhythms, physical illness, and substance use were important to people’s experience of bipolar relapse (RQ1). The findings also indicate that BD has a substantial psychosocial impact by way of affecting people’s experience of employment and relationships (RQ2). A broad range of factors were found to be important to people’s ongoing sense of wellbeing, including: gaining an accurate diagnosis and optimum treatment, social support, routines, self-knowledge, self-management, and broader lifestyle factors (RQ3). The MAPS group was found to be associated with a range of perceived benefits, including: socialising with others who had BD, learning more about the illness, and forming therapeutic relationships with the group administrators. The group experience was difficult for people who were experiencing active symptoms, and suggestions were made for group improvement (RQ4). The remainder of this chapter will discuss the current findings as they relate to previous research, and will conclude with an overview of implications, suggestions for future research, and limitations of the current project.

9.1. Developing our Understanding of Psychosocial Triggers for BD Relapse and their Management

While it has been well established that psychosocial stressors can trigger bipolar relapse (Jones, 2001; Lam et al., 1999), less is known about the ways in which these stressors affect relapse, or how they tend to be managed by people living with BD. The

\(^8\) Throughout the discussion, research questions will be cited in parentheses.
current findings shed new light on this issue, as well as how work and relationships may contribute to relapse, and how these stressors are managed. Participants’ narratives also suggest that physical illness may be a stressor of interest for future research. These findings will be explored in turn.

**Life events, relapse, and the valence of stressors.** The findings in relation to the impact of life events on relapse were in keeping with previous research, in that a range of life events (e.g., loss, work/relationship disputes, physical injury etc.), as well as limited social support, were found to contribute to participants’ experience of bipolar relapse. While the majority of participants noted that negative life events such as the loss of a friend, or being bullied at work prompted depressive episodes, one participant (viz., James) recalled that ending relationships – a negative stressor in his view, prompted mania (RQ1). It is interesting that this finding is somewhat inconsistent with Urošević et al.’s (2010) hypothesis that negative life events increase the risk of depressive relapse, whereas positive life events are associated with mania. This current qualitative data raises the hypothesis that negative life events may prompt an episode of mania. This is not implausible in the context of the model of relapse presented above (Figure 1), which points to the role of sleep disturbance in relapse, which may be triggered in the context of either positive or negative life events (see Chapter 3). However, the limitations of a retrospective self-report design must also be considered with regard to untangling the impact of mood-related life events (see 9.5 below). Notwithstanding these issues, the current findings shed new light on the unique impact that life events can have on people’s symptoms of BD, and suggest a need to further investigate whether opposingly valanced life events trigger specific mood polarity (discussed further in section 9.4.). Participants also spoke more specifically about their management of work and relationship stress, and how this affected their likelihood of bipolar relapse.
**Coping with work.** In line with previous findings, work stress was associated with people’s likelihood of bipolar relapse (RQ1; e.g., Gutiérrez-Rojas et al., 2011). In line with Borg et al.’s (2013) findings, it was found that strategies for managing work were idiosyncratic. For instance, reducing or ceasing work was the strategy of choice for some (e.g., Gabriel, Alison, and Nicole), whereas others found it useful to ‘push though’ symptoms and continue to attend (e.g., David, Emma and Robert). The former finding contrasts somewhat with the findings of Michalak et al. (2007), who found that people with BD who decided to cease work were regretful of this. The fact that the current sample had completed a psychosocial treatment group (unlike Michalak et al.’s sample) could go some way to explaining this finding. That is, it is possible that the provision of psychosocial treatment helps people to appreciate the extent to which work can impact on BD, which may in turn facilitate a degree of acceptance, and an acknowledgment that reducing/ceasing work can be seen as a step toward wellness and as a way to manage the illness. People with BD who may be less informed about the psychosocial management of illness may be more inclined to view the withdrawal from the workforce as loss or failure, rather than a management strategy. Participants who benefit from reducing/ceasing work noted that they were better able to manage their mood, experienced less stress, and benefitted from spending more time with loved ones. Participants also spoke about the importance of adopting an attitude of self-care and kindness towards oneself (RQ3), which might also tend to encourage an acceptance of health-oriented withdrawal from difficult challenges.

Participants who found it helpful to attend work reported similar benefits to those noted in previous literature (e.g., routine, feelings of mastery, distraction, etc.; Borg et al., 2013). In terms of coping strategies for managing stress in the workplace, one participant noted that cognitive strategies in particular had been of use, which has not arisen
previously in the literature. Others noted that it was important to have support from the workplace in terms of managing workloads (RQ3). The sources of support that have been previously identified, such as friends, family, colleagues, managers (Borg et al., 2013; Michalak et al., 2007), and government agencies (Tse & Yeats, 2002) were also mentioned by the participants as useful avenues for gaining work related support. Although previous research has made some early suggestions about the specific benefits of support (e.g., being supported to take sick leave when needed; Tse & Yeats, 2002), the current findings shed light on other elements of support (RQ3). For example, participants also spoke of the utility of being supported to resolve workplace conflicts, and being discouraged from taking work home.

Stalled career progression. The current study adds to previous findings relating to the lack of career progression that can be associated with BD (e.g., Cohen et al., 2004). The limited literature in this area has pointed to the role of workplace stigma (Michalak et al., 2007), and the importance of social support (Fazzino, 2011), and practical support (Tse & Yeats, 2002); however, the current findings suggest that increased leave requirements, and hence, less time spent in the workplace, may have a negative affect on career advancement. While Robert felt that requests for sick leave were always accommodated by his employer (RQ3), he also suspected that taking time away from work might have negatively impacted on his career advancement (RQ2). That is, it seems that although Robert’s employer was sensitive to the challenges of living with a mental illness, the adequacy of his workplace performance continued to be assessed. It would appear that there might be a two-fold challenge in terms of career progression for people with BD, including workplace stigma (Michalak et al., 2007), and the associated necessity to take sick leave while unwell (e.g., Robert). Given the benefits many people with BD experience from attending work (e.g., David, Emma and Robert; and Borg et al., 2013)
and the suggestion that taking time away from work may negatively impact on career progression (Robert), future research should investigate the strategies that people use to stay in the workforce (e.g., cognitive strategies), as this may help to address issues associated with career progression and general psychosocial functioning.

**Relationships, relapse, and coping strategies.** Participants’ narratives about impact of relationship conflicts and stressful interpersonal dynamics on bipolar relapse (RQ1) largely mirror the findings of previous quantitative studies, which have found that these stressors can trigger relapse (e.g., Sheets & Miller, 2010). The current findings elaborate on this literature by expanding our understanding of how people with BD might reduce the impact of relationship stress on their illness. For instance, while Michalak et al.’s (2006) participants found it beneficial to discard relationships that were thought to worsen their symptoms, one of the current participants, Ann, noted that communicating her needs assertively helped to reduce the impact of stress in her social network, and had been important to her wellbeing (RQ3). This underscores the need to learn to manage relationships in addition to discarding those that may be beyond repair (see 9.4 below).

In addition to improving social networks, people also spoke about the impact of BD on family systems (Heather, RQ2), and the benefits of psychotherapy in helping them to repair the negative impact of BD on marital relationships (RQ3). Similar to Radke-Yarrow’s (1998) findings, the current findings suggest that BD presents significant challenges to partners, which at times, may involve feeling unsafe and/or inadequately supported (RQ2). In light of these difficulties, couples counselling was thought to improve communication and foster a mutual understanding within partnerships, which helped repair some of the damage caused by BD (RQ3).

**Summary.** The current findings reinforce previous research that suggests an important impact for life event, specifically those that involve work and relationships on
These findings have also provided valuable insight into how people with BD uniquely manage these factors to reduce their impact on relapse and to promote wellbeing. For instance, it seems that while some individuals benefited from reducing or ceasing work, others gained benefit from pushing through symptoms to attend work. The potential benefit of using cognitive strategies to manage symptoms at work and receiving practical support to work was also noted. The current findings suggest that communicating assertively may be important for reducing the impact of social relationships on relapse, and that psychotherapy might assist to minimise the impact of BD on marital relationships. It may be helpful to further investigate the benefits people with BD gain from using these strategies to manage work and their relationships.

Managing the challenges of medication. Previous research has provided valuable insight into elements of treatment that impact on people’s adherence to medication (e.g., Gibson et al., 2013), with the current findings adding to this literature. Participants emphasised that acceptance of diagnosis prompted a willingness to adhere to medication (RQ3). Although acceptance of diagnosis has been mentioned in previous studies (i.e., Russell & Browne, 2005), little has been made of the role that this plays in attitudes toward medication. It may be that participating in the MAPS treatment group, where the role of medication was a central focus, helped participants to appreciate the importance of medication in the maintenance of wellness (RQ3), as well as developing strategies to address the challenges of adherence. For instance, while participants in Gibson et al.’s (2013) study cited difficulties with the accessibility of health care professionals and forgetting medication, the current findings suggest that these issues could be addressed by having multiple professionals involved in a treatment team (Amy, RQ3) and developing medication routines (Tom, RQ3). For example, Amy found it
particularly useful to be able to receive a medication script from her GP if her psychiatrist
was not available. These findings suggest that having multiple professionals to contact
and having medication routines may assist people with BD to maintain adherence.
Psychosocial treatments might have an important role in helping people with BD to
accept the importance of taking medication and in developing strategies for overcoming
barriers to adherence.

**Substance use and stage of change.** Participants’ narratives about the impact of
substance use on relapse (RQ1) were consistent with previous quantitative findings into
the relationship between substance use and poorer BD course (e.g., Salloum & Thase,
2000). Participants specifically mentioned the impact of cannabis and alcohol on their
illness, and that reducing substance use was important to maintaining wellness. While
previous qualitative research has provided insight into the reasons people with BD use
substances (i.e., Healey et al., 2009; Ward, 2011), the current findings provide insight into
people’s efforts to cease substance use. One participant (Nicole) explained that it had
taken time to accept the importance of ceasing alcohol use. Many participants noted that
they were aware of the importance of avoiding alcohol (including Nicole who eventually
came to this realisation), with some people ceasing use entirely (e.g., Ann and Samantha),
while others had difficulty maintaining abstinence (Emma and Marie, RQ3). The current
findings suggest that substance use is an ongoing struggle for many people with BD, with
many people in the current sample being at least contemplative with regard to changing
their substance use patterns – perhaps due to their engagement with psychosocial
treatment, which emphasises the consequences of use.

**Hormonal rhythms, routines, and the importance of sleep hygiene.**
Participants’ narratives about the impact of hormonal variations on bipolar relapse (RQ1)
align with previous studies suggesting the role of hormonal factors in triggering
symptoms of illness (i.e., Diflorio & Jones, 2010; Doyle et al., 2012; Oates, 2006; Russell & Browne, 2005; Viguera et al., 2002). Specifically, participants discussed the impact of childbirth (Nicole and Amy) and menses (Laura) on symptoms of illness.

Participants’ narratives about the benefits that are gained from maintaining consistency in daily and sleep routines (RQ3) were consistent with quantitative findings into social rhythm disruption and a poorer course of illness in the longer term (Ehlers et al., 1988; Frank, 2005; Leibenluft, Albert, Rosenthal, & Wehr 1996; Levenson, Nusslock, & Frank, 2013). While previous research has focused on the relationship between the disruption of routines and symptom onset for people with BD (Shen et al., 2008), the current findings provide insight into people’s use of routine to manage symptoms and maintain wellbeing. Specifically these findings provide additional insight into the benefits that people with BD might gain from maintaining consistency in daily and sleep routines. In line with Borg et al.’s (2013) data, the current findings suggest that having a stable work routine is important to wellbeing (e.g., Robert, RQ3), along with maintaining adequate and consistent sleep (RQ3; Russell & Browne, 2005; Suto et al., 2010). In congruence with the majority of the previous qualitative literature (i.e., Borg et al., 2013; Russell & Browne 2005; Suto et al., 2010), the current findings emphasised the benefits of having a regular routine.

These findings are consistent with Shen et al.’s (2008) theory about the importance of self-regulating routines during times of vulnerability. For instance, while previous research has spoken mostly about the benefits people gain from using medication to manage sleep (Russell & Browne, 2005; Suto et al., 2010), the current findings suggest that sleep hygiene strategies may also be useful for achieving consistent sleep. This is consistent with recent findings (e.g., Kaplan & Harvey, 2013) that suggest an important role for regular sleep/wake times in improving the sleep of people with BD.
One participant, Laura, also provided additional insight into the importance of self-regulating routines during times of hormonal vulnerability, in particular (RQ3). These findings contrast with Michalak et al.’s (2006), where participants had mixed views regarding the role of routine (see section 6.4.). It may be that the current sample’s participation in the MAPS group facilitated acceptance of the importance of maintaining a consistent routine, when people who have not had psychosocial treatment may less readily accept this.

Taken together, the current findings shed light on the benefits people with BD might gain from having consistent routines. It is possible that accepting the importance of maintaining regular routines may be important to wellbeing and be facilitated by psychosocial treatment. The importance of maintaining routines during times of vulnerability, and the benefits that can be gained from using sleep hygiene strategies to manage sleep, were also noted. Although the MAPS group provided education on sleep hygiene, it might be worth investigating if treatment outcomes are improved by making this a more central focus of group treatment and by expanding this content to include other elements of sleep hygiene (e.g., cognitive strategies to address night-time worry/rumination). Lauren, for example, may have benefited from having cognitive and behavioural skills to manage nightly worry (see RQ3 p. 93), which may have provided a viable adjunct to sleep medications such as Seroquel.

**An emerging psychosocial stressor of importance – the impact of physical health on relapse.** Participants described the impact of physical health concerns on bipolar relapse, which is noteworthy because it is not emphasised in the existing literature (RQ1). Specifically, people reported the potential for physical pain and adjustments to pain medication to prompt bipolar relapse. The impact of physical health on bipolar
relapse has not been emphasised in previous literature and is therefore important to explore in future research.

**Summary of 9.1 – psychosocial triggers for BD relapse and their management.** The current findings have pointed to the significance of psychosocial factors implicated in BD relapse, having shed new light on the role of life events, hormonal rhythms, substance use, and physical illness (Gershon et al., 2013; Russell & Browne, 2005; Salloum & Thase, 2000). The current findings have also provided specific insights into the strategies that people use to reduce the impact of psychosocial stressors, and the ways in which coping strategies for psychosocial stressors need to be individualised – in many cases, participants adopted different approaches to managing psychosocial stressors depending on what worked best for them. When taken together, the current findings suggest that acceptance of the BD diagnosis may be an important first step towards self-management, and that the MAPS treatment group may have played a role in helping people to accept the importance of self-managing BD. The notion of acceptance of the BD diagnosis is a latent theme in existing literature (e.g., Mansell et al., 2010; Michalak et al., 2006; Russell & Browne, 2005; see section 6.4. for a review), and it is therefore not surprising that it has emerged as an overarching theme in the current findings. The implications of these findings will be discussed further in section 9.4.

**9.2. Maximising Wellness in BD**

In addition to strategies that reduce the impact of psychosocial stressors on bipolar relapse, participants also spoke about the ways in which they actively promote wellness. While some of these strategies featured in the MAPS group, participants also identified aspects of wellness that were unique and personal to them. Exploration of these wellness
strategies expands upon the lived experience literature and sheds light on how these strategies are used (Borg et al., 2013; Michalak et al., 2006; Michalak et al., 2007; Russell & Browne, 2005; Suto et al., 2010). The findings also hint at strategies that might be useful additions to future psychosocial treatment programs for BD.

**Being correctly diagnosed.** In line with Russell and Browne’s (2005) findings, the current participants emphasised the importance of obtaining an accurate diagnosis in the initial stages of treatment. Participants discussed how receiving an incorrect diagnosis had most commonly lead to incorrect management (e.g., being taken off medication) and the serious implications of this, such as relapse and exacerbation of symptoms. The importance of gaining a correct diagnosis was underscored by one participant in particular, who reported an almost immediate reduction in symptoms following her BD diagnosis and the subsequent treatment regime (i.e., Lauren, RQ3). The current findings also add to our understanding of how misdiagnosis is experienced by people who become unwell in the context of hormonal dysregulation (see above). Misdiagnosis in the context of pregnancy and/or menses was noted (Nicole and Lauren, RQ3), with participants speaking about the challenges they faced when these symptoms were thought to be due to a unipolar mood disorder or a psychosomatic illness. While it is known that cross-sectional differential diagnosis is a challenge for clinicians in terms of differentiating between unipolar/bipolar/psychotic illness (DSM-5, 2013), these findings help develop our understanding of how misdiagnosis is experienced by people with BD.

**Social support.** The importance of supportive relationships was a strong theme in the current findings, with participants noting that friends, family, and partners were important to their sense of wellness (RQ3). In addition to adding support to previous findings (Borg et al., 2013; Michalak et al., 2006; Michalak et al., 2007; Russell & Browne, 2005; Suto et al., 2010), the current data also sheds new light on how social
support may work for people. That is, while existing literature has typically emphasised the general benefits that people with BD gain from support, the current findings hint at the specific elements of support that might be particularly helpful. For example, participants spoke about the utility of having an open dialogue with their partner (e.g., David and Marie), and to have people whom they can contact when they are feeling unwell. They also spoke about the more general sense of hopefulness they gain from having long-term intimate relationships, and the loneliness that may be experienced in the absence of partnership (Nicole, RQ3).

In addition to the emotional benefits of social support, and similar to previous findings (Russell & Browne, 2005; Suto et al., 2010), the current results also suggest that social support might help people with BD to manage their illness, and that accepting this support may be important to wellness. Reinares et al. (2008) hypothesised that social support helps via enhancing medication adherence, and in line with the current findings suggested that social support may work through detection of early prodromes. Participants spoke at length about the important role their supports had played in helping them to monitor symptoms, and specifically noted the important role that partners and friends played in identifying symptoms of illness during a prodromal period (RQ3). These qualitative findings may therefore have something important to add to early theorising in the quantitative literature about the benefits of social support and medication adherence (Reinares et al., 2008). That is, it may be that symptom monitoring has an indirect role in enhancing medication adherence, with the former possibly facilitating the latter.

While the majority of past research has suggested that people with BD gain benefit from having their hypomanic behaviour monitored by supports (e.g., Russell & Browne, 2005; Suto et al., 2010), a number of participants in Michalak et al.’s (2006)
study felt that this process had in fact impeded their independence. The reflections of one participant here (Alison) may go some way to understanding the issue of perceived independence vs. autonomy. Alison noted that although she had initially resisted being monitored by her husband because it engendered a sense of being limited in her behaviour, she eventually came to accept this help and appreciate how it helped maintain her wellbeing. Alison also found that after many years of checking with her husband as to the riskiness of her behaviour, she learned to internalise this skill and as such, was now largely responsible for her own decisions (e.g., spending). Alison’s dialogue suggests that being open to gaining help from others may involve a process of acceptance, which in turn, helps the person move toward self-sufficiency. Hence, of relevance to people with BD is the idea that acceptance of help may in turn, promote self-sufficiency after coping skills are acquired. It may be that participating in the MAPS group helped people to appreciate the ways in which social support can be of benefit. It seems that accepting the need to gain help from others might be important to the wellbeing of people with BD, and that participation in psychosocial treatment may have an important role in helping people to reach this state of acceptance.

The current findings provide valuable insight into the ways in which support might help people with BD. It has been suggested that people with BD might gain benefits from having intimate relationships with open communication, where there is an ongoing dialogue about potentially risky behaviour helping the person with BD to move toward self-sufficiency. It also seems that accepting help from others might be important for wellbeing and a potential benefit of psychosocial treatment.

Support from health professionals. In addition to the support people gained from social networks, participants also spoke about the type of professional support that was important to them. Participants emphasised the need to find a psychiatrist who they
believed to be competent, non-judgmental, and empathic. In addition to these personality qualities, it was also thought that the psychiatrist needed to be readily available in times of crisis (RQ3). These findings further emphasise the value people with BD place on receiving non-judgemental treatment support (Michalak et al., 2006), and the benefits that people might gain from being able to contact their psychiatrist. That is, it seems that people with BD may be provided with a feeling of security from knowing they can contact their psychiatrist when needed, and may gain therapeutic benefits due to the empathy and support that is provided during this contact.

While many participants (56%) expressed their preference for having multiple practitioners in their treatment team, others preferred to have fewer people involved (11%). Hence, this appears to be a point of individual preference and it follows that it would be helpful to take this into consideration when developing a treatment approach. Therefore, although having access to multiple treatment supports may be a benefit to most people, this does not seem to be universally the case. Taken together, these findings suggest that people with BD could potentially gain therapeutic benefit from being able to readily contact their psychiatrist (whom they find to be empathic and non-judgemental), and that treatment support should be tailored to fit the unique preferences of each individual.

**Lifestyle and wellness.** Participants spoke about lifestyle factors that were important to wellness, such as getting regular exercise, taking time to rest, and having good nutritional intake. The lifestyle factors that were identified in the current study were largely consistent with those identified in the previous literature (Russell & Browne, 2005; Suto et al., 2010; RQ3). These findings appear to be largely robust and as such, are likely to be important to a person’s capacity to maintain a sense of wellbeing whilst living with BD. Interestingly, one participant, Robert (RQ3), noted that the MAPS group had
been important in helping him to realise the benefits that could be gained from maintaining a healthy lifestyle. Consequently, the importance of maintaining a healthy lifestyle may be an element of the MAPS group that helped people to promote wellness. Similar to the findings of Russell and Browne (2005), the current research also highlighted the benefits of transitioning to a quieter way of life (RQ3) and spending more time with loved ones. This was also thought to be a particular benefit of reducing/ceasing work (RQ3).

**The importance of enhancing self-knowledge.** The current findings further underscore the importance of enhancing self-knowledge for managing BD (Russell & Browne, 2005; Suto et al., 2010; RQ3), and the role of treatment in cultivating this. Participants in the current study noted that they learned about their condition through similar means to those identified in previous studies (e.g., from others, from books, from treatment professionals). One participant, Ann, also used academic journals to learn about BD. Individual psychotherapy was also thought to develop this self-understanding (RQ3), along with keeping a diary. While Suto et al.’s (2010) participants emphasised their use of diaries for personal reflective practices, participants in this sample used their diaries as a collaborative tool to enhance communication with treating professionals (RQ3). Participation in the MAPS program likely contributed to this, where structured diary use was emphasised for mood monitoring. It seems that documenting one’s experience, either in the form of a diary or a reflective journal, may be helpful to people living with BD.

Similar to previous findings (Russell & Browne, 2005; Suto et al., 2010) the current data suggested that people might gain expertise and an increased capacity for wellbeing through time spent living with this illness. In line with this concept of lived experience expertise, participants commented that living with BD helped them to develop
insight into self and others, self-efficacy with regard to managing prodromal symptoms, and an understanding that episodes resolve with time and treatment, which reduced distress experienced during episodes (RQ3).

Self-monitoring and early intervention is known to be important to the wellbeing of people with BD, and the current findings were largely supportive of these principles (Russell & Browne, 2005; Suto et al., 2010; RQ3). Participants commented specifically on the learning gained from the MAPS group, and how this assisted them to better understand their condition (e.g., Robert, RQ4). Participants noted that the MAPS group helped them to learn about triggers and the management of prodromal symptoms (Tom, RQ3), suggesting that this may be an important element of the MAPS group treatment program. Participants’ narratives about the successful detection of prodromal symptoms further expands on the qualitative literature by way of identifying how people detect their episodes (Russell & Browne, 2005; Suto et al., 2010). For instance, one participant (Tom) noted that he could more readily detect his prodromal symptoms through his behaviour (as opposed to feelings and cognitions), and another participant (Heather) noted that visualising what she had learnt about symptoms during the MAPS group helped her to identify prodromal symptoms. In line with previous findings, participants noted that making minor adjustments to their medication helped prevent and/or reduce the severity of relapse (Russell & Browne, 2005; Suto et al., 2010). While some participants reported that they self-managed these adjustments, others made these in collaboration with their treating team. The consistent use of this self-management strategy suggests that it may be important to the wellbeing of people with BD.

The current findings further underscore that psychosocial treatment has an important role to play in helping people with BD to gain agency over their illness through understanding themselves and self-managing their condition. The results of the current
study suggest that participants of the MAPS group felt that this was a clear benefit of the group, which in turn, facilitated their ongoing wellness.

**Mindfulness and values.** Participants’ narratives shed new light on the benefits that people with BD might gain from developing a capacity to defuse from distressing thoughts, to remain in the present moment, and from connecting with their personal values, such as self-care and spending time with loved ones (RQ3). These mindfulness skills were emphasised by several participants, with the findings being largely consistent with themes identified in previous research (Russell & Browne, 2005; Suto et al., 2010). For instance, participants described the utility of being mindful about thoughts and bodily sensations, and how this cultivated a sense of wellness (RQ3).

In terms of pursuing values, participants spoke about the importance of adopting an attitude of self-care and kindness towards oneself (RQ3). Similar to the findings of Veseth et al. (2012), participants spoke about the importance of reducing the demands of everyday life, and noted that relaxing their expectations had helped to promote wellness. The current finding suggest that mindfulness skills and connecting with personal values around self-care and kindness might have a role in helping people with BD to promote wellbeing.

**Cognitive and behavioural strategies.** Both cognitive and behavioural mood management strategies featured in participants’ narratives. It is notable that participants appeared to place more emphasis on the importance of the behaviour-mood interaction than participants in previous studies (Mansell et al., 2010; Russell & Browne, 2005; Suto et al., 2010; Veseth et al., 2012). Participants were quite specific in their accounts of engaging in activities that bring pleasure and those that provide distraction or mastery. Participants also discussed the ways in which they schedule in these tasks and break them down into manageable goals. One participant noted that repeated engagement in
pleasurable activities was usually needed to gain a longer-term benefit (RQ3). This high degree of insight into the principles of positive behaviour change and reinforcement is suggestive of a benefit derived from the MAPS group, which emphasised these behavioural concepts.

While cognitive strategies were not a prominent theme in previous qualitative studies (e.g., Russell & Browne, 2005; Suto et al., 2010) the current study suggests that people with BD who have been taught these skills may find them useful. Participants reported that (1) being aware of, and (2) challenging unproductive thinking helped with mood management – participants gave specific examples of challenging rigid “should” statements and engaging in helpful self-talk during times of stress (RQ3). Again, participation in the MAPS group treatment program, which provided cognitive interventions, may explain the use of this self-management strategy. Furthermore, the fact that participants recalled instances where these skills had been helpful suggests that cognitive interventions were a useful component of the group.

Summary of 9.2 – Maximising Wellness in BD. The current study contributes several insights into the factors that might contribute to wellbeing in BD, and the impact that treatment may have on optimising wellness. Several factors were perceived as being particularly important to wellbeing, including: gaining an accurate diagnosis and optimum treatment, social support, routines, self-knowledge, self-management, and broader lifestyle factors. The current findings also hint at elements of the MAPS group that might have been particularly useful in terms of promoting wellbeing. This, in turn, could suggest interventions that might valuably contribute to psychosocial treatment programs for BD. For instance, participant’s ongoing use of wellness strategies that featured in the MAPS group (e.g., social support, making positive lifestyle changes, learning about BD, mood monitoring, cognitive and behavioural strategies) provides
initial support for the hypothesis that these are mechanisms by which psychosocial treatment achieves its therapeutic effect. Although mindfulness strategies were not a feature of the MAPS treatment group, the current findings suggest that mindfulness-based approaches, which emphasise: thought defusion, acceptance, and value-committed action, might have a role in helping people with BD to promote wellbeing. It may therefore be worth investigating if psychosocial treatments for BD are improved by including mindfulness strategies and the exploration of values – an area of treatment that has only begun to be investigated in BD (e.g., Perich et al., 2013; Reinares, Sánchez-Moreno, & Fountoulakis, 2014). The implications of these findings are discussed further in section 9.4.

9.3. People’s Experience of Psychosocial Group Treatment for BD

The current findings provide insight into people’s experience of the MAPS program, and have implications for group psychosocial treatment more generally. The following section provides an overview of people’s experience of the group, including perceived benefits of participation and challenges that arose during the treatment, and the longer-term benefits that were gained from the group. Suggestions for group refinement, as made by the participants, will conclude the section.

Perceived benefits of the MAPS group. Overall, participants spoke very positively about their participation in the MAPS program (RQ4). Narratives about the benefits of the group were broadly consistent with the notion that people find the social aspect of group treatment to be rewarding (May et al., 2014; Palmer et al., 1995). For instance, participants found that hearing the struggles experienced by others with BD was normalising and that it fostered a sense of connectedness between group members. Similar benefits of group psychosocial treatment have been reported in follow-up studies.
Participants explained that hearing the stories of others had helped them to feel less alone, more ‘normal’, and in turn, less shameful about behaviours that were associated with a sense of regret. This is consistent with the idea that shame associated with mental illness can be healed in a supportive social setting, which helps people to see themselves and their behaviour in a new light (Kelsey, 2004). Some participants also described a ‘downward social comparison’ effect (Robert, RQ4; Major, Testa, & Blysma, 1991), whereby interacting with others who were more unwell provided a sense of perspective as to how debilitating the illness can be, and in turn, a sense of appreciation for those who were at a higher level of functioning.

In addition to the emotional benefits associated with socialising with others who have BD was the knowledge that participants gained from the group. This appeared to come from two sources, namely: from studying the group material itself, and by listening to other participants’ stories (Ann). This suggests that in addition to the potential benefits associated with the group material, people may have also learnt about their condition from other ‘lived experience experts’. For example, Ann spoke about the self-understanding and knowledge she had gained from listening to the stories of others (RQ4).

Two participants (Alison and Marie) also commented on the benefits gained from having positive relationships with the administrators of the MAPS group. This included enhancing motivation levels and feeling supported to engage in the treatment (Alison, RQ4). This is consistent with a body of research into mediators of psychotherapy treatment efficacy, which have consistently pointed to the quality of therapeutic engagement as the key variable (Bedicks, Henry, & Atkins, 2005; Roberts & Bailey, 2011). Indeed, several participants had positive recollections of the group administrators,
suggesting that the facilitator pre-training, which emphasised therapeutic engagement strategies, fostered positive engagement with the group members. Taken together, these findings help to develop our understanding of the more specific benefits that people with BD might gain from psychosocial group treatment.

**Perceived challenges of the MAPS group.** In contrast to the aforementioned benefits of the group, several participants commented on their difficulty gaining a sense of belonging to the group, and how their level of functioning affected this. For example, Heather and Emma found it difficult to engage with the MAPS group due to active symptoms of illness; whereas Elizabeth found it challenging to be functioning at a higher level than the other group members (RQ4). That is, it appears that participants’ mental state at the time of the group could affect their sense of belonging – this may have implications for pre-screening and/or group orientation (see section 9.4.). Although the MAPS group excluded people who were experiencing a mood episode prior to the group, it seems that some participants became symptomatic during the group, which in turn, led to difficulty engaging with the content and a sense of distress, confusion, and frustration. These findings are consistent with the suggestion that the efficacy of psychosocial intervention for BD may be compromised when individuals become unwell (Lam et al., 1999). This also sheds new light on the distress that may be felt when people who are unwell are in a group setting, and why it has been difficult to establish treatment efficacy in samples that are currently unwell (e.g., Scott et al., 2006; see 5.2. above).

While a small number of participants found it difficult to be in a group with a broad range of functioning, the vast majority reported that they had benefitted from interacting with other people who had BD. Specifically, these findings suggest that people find it useful to listen to the stories of others who have this illness, and that having good rapport with the facilitators is important. When people with BD relapse during the
MAPS group they seemed to experience substantial difficulty engaging with, and thus benefiting from treatment.

**Ongoing impact of the MAPS group.** In addition to experiences of the group itself, participants also spoke about the ways in which the group had affected their ongoing experience of living with BD. The current findings provide insight into the importance of readiness-to-change, and how this may play a role in the longer-term benefits gained from the group. While most participants reported that the group had fostered an increased sense of agency and enhanced their capacity to manage their condition (RQ4), others found it difficult to implement the strategies presented during the group due to issues with motivation and their attitude toward self-management at the time (RQ4).

Several participants (Ann, Heather, and James) spoke about the role the MAPS group had played in prompting their active and ongoing management of BD (RQ4). These participants described a sense of relief and empowerment when learning that they had a role to play in effectively managing their stress and risk of relapse. Several participants indicated that they ceased alcohol following the MAPS group, with one participant (Ann) noting that this was a particular benefit for her. This participant went as far as to say that self-management skills had changed her life, and that for this, she was grateful to the facilitators of the MAPS group. Another participant (Heather) noted that the self-management strategies were the best recovery tool she had. In a general sense, these comments are in keeping with the underlying philosophy of the MAPS group, which emphasises the role of the individual in managing their condition. It appears that, for some people, this message was well received and associated with a sense of gratitude.

Participants also spoke about the difficulties they experienced in implementing the strategies presented during the MAPS group (RQ4; Emma, Heather, and Tom), with some
attributing this to issues with stage of change specifically (Emma and Nicole; Prochaska et al., 2008). While one participant didn’t see a need to change her substance use until long after the group had finished (Nicole, RQ3), others didn’t start to use the coping skills until much later (Emma, Heather, and Tom; RQ4). This could suggest that readiness to engage with treatment may have a role to play in gaining a greater immediate benefit from the MAPS group, but that in time, the content could be revisited and utilised when the participants wanted to take a more active role in managing their symptoms. Broadly speaking, the current findings relate theoretically to the concept of stage of change (see section 5.1.), and suggest that people may need to be ready to engage in self-management before the intervention can be of maximum immediate benefit. However, it appears that group intervention could ‘sow a seed’ in the minds of participants who were less ready to make immediate changes, and that in time, this material could be implemented when the person was ready.

**Suggestions for group improvement.** In addition to discussing their experiences of the MAPS group and its impact on wellbeing, participants also made some specific suggestions for refining the content of the group (RQ4). One participant (Alison) believed that an orientation might help to make participants aware of the importance of attending every session of the group, and that this might prompt a discussion about the challenges of travel. Although it is noted that the importance of making a commitment to attend all sessions was outlined in the first session of the MAPS group, Alison felt that this should be emphasised and presented prior to the group. Another participant (Ann) felt that the group could have placed more emphasis on teaching people how to effectively communicate with treatment professionals. It is interesting to note the congruency between this suggestion and the current study’s finding about the importance of having good communication with psychiatrists (RQ3), which has also been emphasised
in previous research (Gibson et al., 2013). Ann’s narrative may hint at a need to actively cultivate this skill in people living with BD (RQ4).

Participants had different views about the appropriateness of the tone and complexity of the MAPS content. For instance, while some people (James) reported that the group had been academically challenging with too much volume and complexity, others (Alison) found the content to be appropriately complex (RQ4). It would seem that participants had different needs in this regard, perhaps due to varying aptitudes for the complexity and quantity of information that was provided. This raises questions about the recruitment of participants for particular types of groups (e.g., structured and content based vs. unstructured and support-based), and it is an interesting consideration when moving forward with the development of psychosocial group treatments. More generally, the current findings have provided insight into participants’ suggestions for refinement five years after completing the MAPS program for BD.

Summary of 9.3 – people’s experience of group psychosocial treatment for BD. The current findings have shed new light on people’s experiences of group treatment, while hinting at potential benefits and challenges associated with the MAPS group. The MAPS group may also have had an important role in enhancing the self-efficacy of people with BD, however, participants’ narratives suggest that a pre-contemplative stage of change could present a barrier to benefiting from group treatment in the short term – there does, however, appear to be the possibility of a ‘lag time’ for the uptake of some interventions. Participants’ suggestions for group refinement help to develop our understanding of their experience of the MAPS group, which can help inform clinical practice and hint at things that might be worth investigating in future research. Taken together, these findings help to develop insight into the lived experience of group
treatment for people with BD – the implications of these suggestions are discussed further in section 9.4.

9.4. Implications of the Current Project

Although there are a range of evidence-based interventions that are available for BD, there is room to further consider people’s personal experiences of living with BD, and what helps people to manage their condition. This was a central motivation of the current research. The insights that have been gained from people’s accounts of living with this illness have provided a greater understanding about: (1) the phenomenology of BD, (2) how clinicians might help people to manage their illness, (3) elements of service provision that may be usefully revised, and (4) questions that may be profitably investigated in future research. The implications of the current project for understanding BD, clinical practice, and future research, are discussed in turn.

Implications for how we understand people with BD. The narratives of these ‘lived experience experts’ help to expand our understanding of BD. Indeed, their stories teach us about the experiences of living with this condition, and people’s experiences of group treatment. Although their narratives did reflect the substantial difficulty people with BD experience in their psychosocial functioning, similar to those reported in the findings of Rowe and Morris (2012), participants also spoke about the rewards associated with work and relationships. This reflects the more hopeful experiences people with BD can have in their psychosocial roles.

Similar to previous findings (Russell & Browne, 2005; Suto et al., 2010) it was suggested that people gained expertise in symptom management from time spent living with the illness. This offers a more hopeful framework for thinking about people’s ongoing experience of living with BD – that is, people can learn how to better manage
their condition over time. Related to this was the idea that accepting one’s diagnosis may be an important step toward self-management and wellness. Accepting the need to monitor routines, take medication, limit substance use, and receive help from others, may be milestones toward active BD self-management, and psychosocial treatments might have an important role to play in this. It may also be that as people become better at self-management, they might be able to become more independent with regard to monitoring behaviours that can be affected by the illness (e.g., potentially risky behaviour). These findings provide some hopeful narratives for people living with BD.

**Implications for clinical practice.** In addition to providing general insights into the phenomenology of living with BD, a number of tentative suggestions about self-management and wellness can be offered to clinicians. The present findings tell us about what clients value about their treatment, and suggest how clinicians might go about including self-management interventions in their routine care. Furthermore, these findings hint at refinements that might improve psychosocial group treatment programs. Although the present findings provide valuable insights from the ‘lived experience experts’, it should be acknowledged that these suggestions require further validation and as such, should be considered tentative at this stage.

**Helping people manage work and relationships.** Clinicians have a role to play in helping clients negotiate difficulties associated with work and relationships, and indeed, relationships with treatment professionals. Regarding the former, clients’ preferences about their level of participation in the workplace should be seen as a choice that is unique to each individual, and clinicians could benefit from exploring, understanding, and respecting the goodness-of-fit between a client’s work situation, supports, and illness. This acknowledges the importance of individual choice, and the utility of taking a collaborative approach when helping people make decisions about their lives (Berk, Berk,
& Castle, 2004; Jones & Lobban, 2013; Nemec & Cichocki, 2008). Encouraging sick leave when needed, and assisting with the management of work stress, may be valuable topics to build into routine reviews. Of the latter, cognitive interventions may be of particular use. Further to this, it may also be useful to assist clients to recruit the support of family, friends, employers, colleagues, and government agencies (Borg et al., 2013; Michalak et al., 2007; Tse & Yeats, 2002).

Clinicians may also be able to help clients with BD to develop communication skills to limit the impact of friendships on BD, as well as maximising relationship satisfaction (Miklowitz, 2012; Miklowitz et al., 2013; Miklowitz, George, Richards, Simoneau, & Suddath, 2003; Rea et al., 2003). Helping clients assertively communicate their needs (i.e., neither passively nor aggressively) may be of use (Rosenberger, 2011), and providing (or giving referrals to) couples counselling may help ameliorate the impact of BD on marital relationships (Clarkin et al., 1998). Clinicians may also have a role to play in encouraging assertive communication in their own relationships with clients. Encouraging open communication, perhaps by setting a collaborative agenda at the beginning of routine reviews, may facilitate this while also presenting an opportunity to provide feedback and encouragement.

**Enhancing people’s treatment.** A few general suggestions about treatment can be offered to clinicians. These include: (1) creating treatment teams with respect to individual preference, and (2) acknowledging stage of change and acceptance of illness. Regarding the former, clinicians should also consider the preferences of the individual when forming a treatment team. The present findings suggest people with BD may have unique needs for treatment support, with some people preferring more professionals in their treatment team, and others preferring less. These findings emphasise the importance of considering individual preferences when forming treatment teams. If fewer
professionals are preferred, it would seem particularly prudent for the primary clinician to be readily contactable in times of crisis. In some instances, it may be beneficial to provide clients with the option of having multiple professionals in their treatment team to promote medication adherence – those who opt for multiple doctors in their team will have more clinicians who can dispense scripts, inquire about adherence, and encourage side effect management. Furthermore, with regard to adherence, the current findings also suggest that helping clients with BD develop routines around medication may address the issue of forgetting (Berk et al., 2010; Depp & Lebowitz, 2007).

The present findings suggest that clients with BD may need to accept their diagnosis and be in a state of ‘readiness to change’ before they can engage in effective self-management of their illness. This relates theoretically to the concept of stage of change (see section 5.1.), and suggests that people may need to be ready to engage in self-management before treatment can be of benefit (Prochaska, Wright, & Velicer, 2008; see above). Clinicians may therefore need to help clients to develop acceptance and to grieve the loss of their ‘healthy self’, before teaching people strategies for managing their moods. If the former is absent from the clinician’s formulation, therapeutic efforts may be met with resistance and/or avoidance. Acceptance may take time – it is possible that several relapses may need to occur before the client appreciates the reality of their illness. Acceptance is hypothesised to be a prerequisite for helping clients to adhere to medication, maintain regular routines, limit substance use, accept help from others, and engage in stress management. In line with this, it was noted that participants who were not yet ready to change believed that they did not benefit from the group in the short term. However, some of these participants seemed to benefit from the group in the longer term, by way of reviewing the resources when they were ready to make changes. It may be beneficial for clinicians to provide clients who are ambivalent about treatment with
resources to take away, and hence, an opportunity to re-engage at a later date. Providing these options may help clients to eventually benefit from psychosocial treatments if they are not yet accepting of their diagnosis.

**Helping people to promote wellbeing and self-manage their condition.** The current findings provide clinicians with some insights into the approaches and strategies that might help clients with BD promote wellbeing and self-manage their condition. The current findings largely paralleled those in quantitative literature considering the importance of psychosocial factors on bipolar relapse (see Chapter 3), and qualitative research investigating people’s personal accounts of living with BD (see Chapter 6). As such, it is suggested that clinicians encourage clients to attend to the lifestyle factors that are thought to maximise wellness in BD. This includes maintaining a healthy lifestyle, developing consistent routines, practicing good sleep hygiene, having a support network, and minimising substance use (e.g., Russell & Browne, 2005; Shen et al., 2008; Suto et al., 2010; Ward, 2011; Weinstock & Miller, 2010). Reflective/meditative processes could also form a part of this discussion. Several participants touched on principles of mindfulness practice and as such, there may be some utility in discussing these concepts in the context of wellness. This could involve ideas such as: noticing thoughts and bodily sensations, ‘defusing’ from distressing thoughts, increasing awareness of the present moment, connecting with personal values, and taking an attitude of self-care and kindness towards oneself (Chadwick, Kaur, Swelam, Ross, & Ellett, 2011; Veseth et al., 2012).

Providing clients with the skills to self-manage their condition may also have a role to play in promoting ongoing wellbeing (Colom et al., 2003; Colom et al., 2009a; Colom et al., 2009b; Lam et al., 1999; Miklowitz, 2008). This may include detecting and managing prodromal symptoms (Lobban et al., 2010), using behavioural and cognitive strategies to manage moods, and adhering to/adjusting medication. Directing clients to
use these strategies might help them to be more actively involved in the management of their condition, cultivating a sense of control and self-efficacy. Helping clients to enhance their knowledge about the condition of BD and assisting them to gain insight into their personality and associated vulnerabilities may also be valuable for some clients (see Hawke, Provencher, & Parikh, 2013).

**Insights into group treatment.** In terms of refining group treatment, it might be worthwhile to consider adjustments to the recruitment process and content. Although the MAPS program excluded people who were acutely unwell, it seems that several participants became symptomatic during the group. People who were unwell during the group seemed to experience a substantial amount of distress and poorer engagement with the content. This may suggest a need for clinicians to regularly screen participants who are involved in psychosocial group treatment programs. It may be useful to have an ongoing dialogue about how to support people who experience symptoms during group treatment, which could involve group withdrawal, or shifting people to a more support-oriented group.

When designing a group such as the MAPS, clinicians might consider the need for a detailed orientation to the process of a skills-based group treatment program prior to their commitment to the group. There was some suggestion in the present findings that this could help participants understand the importance of consistent attendance for gaining maximum benefit (see Corey, Corey, & Corey, 2013). That is, participants may find it useful to know that such a group comprises sessions that cover different learning modules, and that sessions build on each other (as opposed to it being an open-ended support group). Clinicians may also need to more carefully consider people’s capacity for the complexity of group content. For instance, while some participants found the group too academically challenging, others found the content to be appropriately complex.
There may be utility in running ‘high functioning’ and ‘low functioning’ groups, and tailoring the content and group processes appropriately (see Yalom, 1983). During the process of orientation it may be beneficial to inform participants about the broad range of functioning they should expect to encounter during the group, and that this may be confronting for some people. An alternate method would be to develop a staged approach to treatment, which would classify people into subgroups based on illness severity and cognitive functioning (Reinares et al., 2013).

**Implications for future research.** Further qualitative and quantitative research is needed to validate the current findings and suggested implications. The current findings would be further validated by an investigation of the effectiveness of adjunctive BD psychosocial group treatments (Castle et al., 2010; Colom et al., 2003; Miklowitz et al., 2003; Perry et al., 1999; Scott et al., 2006), and the mechanisms of action that mediate quality of life and relapse rates (Miklowitz, 2008). The present findings have identified elements of the MAPS group that participants found beneficial for maintaining their wellbeing – a longer-term RCT could validate these findings (similar to Colom et al., 2009b), as well as testing whether the effectiveness of treatment is mediated by acceptance and/or increased self-efficacy regarding the management of BD. As a central tenet of IPSRT is to increase acceptance through assisting the patient to resolve grief for the lost ‘healthy self’ (Frank, 2005), it may be worth testing if treatment outcomes are improved by making this an initial focus of group treatment.

It would also be worth investigating whether there is benefit to be gained by adding the wellness strategies mentioned by participants, that were either: not in the MAPS group, or not a central focus of the group. This would involve testing whether treatments are improved by providing an increased focus on mindfulness strategies, assertiveness training, skills for communicating with treatment professionals, adjunctive...
couples therapy, and sleep hygiene. Additionally, although there is evidence to support the importance of FFT treatment and couples treatment for improving treatment outcomes (see section 5.1.; Miklowitz, 2012; Miklowitz et al., 2013; Miklowitz et al., 2003; Rea et al., 2003), the present findings pose the question as to whether these interventions should be a standard part of psychosocial treatments.

A between-groups longitudinal design would help to validate the role of social support and self-management strategies in helping people with BD to maintain work. This could be achieved by assigning BD participants who are employed into TAU vs. TAU plus practical support and self-management interventions, and assessing the groups on measures of work functioning, career progression, quality of life, and relapse rates. A similar design could be used to test the role of assertiveness training in assisting people with BD to manage the challenges of interpersonal relationships. On the question of factors that might impact on career progression for people with BD, it may be useful to interview employees and employers regarding the role of stigma and sick leave, and the extent to which it impacts on career advancement and perceptions in the workplace.

Prospective longitudinal research might also be useful for investigating other psychosocial factors that affect relapse. Of particular interest would be the impact of physical illness, which emerged as a theme in the current data. Within this framework it would also be useful to gain a greater understanding of how different types of life events affect symptoms of mania and depression. On the question of social support, it would be interesting to investigate whether social support moderates relapse (as in Johnson, Lundström, Åberg-Wistedt, & Mathé, 2003), and specifically to investigate the different mechanisms of action through which social supports function (e.g., by encouraging medication adherence and assisting people with BD to monitor their mood). Conducting in-depth interviews regarding the subjective benefits gained from social supports might
further enhance such a study, and would compliment existing research on the lived experiences of BD for family members/carers (reviewed in Rowe, 2012).

9.5. Limitations of the Current Study

The current study has several methodological limitations. Firstly, the qualitative design of the current study limits the strength of the conclusions that could be drawn from the current data regarding the efficacy of the MAPS program (Castle et al., 2010), and the mechanisms of action that mediate quality of life and relapse rates (Miklowitz, 2008). There may also be issues related to the accuracy of retrospective self-report. James, for example, recalled that mania was associated with the ending of his relationships. It is possible, for example, that mood disruption played a part in his relationship stress, which consequently contributes to relationship breakdowns. Retrospective accounts are also unable to speak definitively to the question of whether there are symptomatic differences associated with positively vs. negatively valenced stressors.

Although qualitative approaches necessitate small sample sizes (as this facilitates detailed transcript analysis and gaining a rich understanding of the meaning contained in each individual case), this data is not broadly generalisable. That is, it speaks more specifically to the unique experiences of individuals rather than general experiences associated with BD. This data is, however, well equipped to add richness to our understanding and clarify previous findings, which was in keeping the aims of the current project (Smith et al., 2009).

Sampling restrictions also present a limitation. Although recruitment of a homogeneous sample of participants who all took part in the MAPS group treatment program is consistent with the IPA approach, it could be argued that this provides a narrow range of insights into the experience of living with BD. Furthermore, many of the
people who participated in the MAPS group either could not be contacted, or did not wish to participate in the current study. It is possible that participants who were functioning well were more easily recruited for the current study. It is also possible that individuals who found the MAPS group beneficial were more inclined to participate in the current study. Thus, although the findings of the current study looked at a broader range of functioning than previous studies (e.g., Mansell et al., 2010; Russell & Browne, 2005; Suto et al., 2010), it would have been informative to recruit the full range of participants who completed the MAPS group.

Some of the more deductive elements of the methodology could also be considered a limitation of the current study. Although the LCM-R was useful in assisting people to recall past experiences (Benjamin et al., 2008), providing this structure to the interviews put a limit on open-ended narratives about the experiences of living with BD. The theme list that was used to focus the current interviews (see 7.6. above) could also be considered too specific and directive, which may have narrowed participants’ accounts of living with BD (DiCicco-Bloom & Crabtree, 2006; Smith & Osborn, 2003). It is possible that a less structured interview which used fewer prompts and more open questions may have given participants more time and space to communicate their experience of living with BD, allowing for additional detail to emerge.

Observer-expectancy bias may also have confounded the present findings. Although an IPA approach relies on the researchers own concepts and constructs to interpret what is observed (see Smith & Osborn, 2003) this also shapes the results. For instance, it is possible that the interviewer’s concept map may have limited spontaneous insights and kept the interview focused on pre-existing areas of theoretical interest. It is also possible that participants may have been less likely to make negative comments
about the MAPS group due to the researcher’s dual relationship with the team that designed and implemented the MAPS group.

9.6. Conclusion

The aim of the current study was to better our understanding of the lived experience of BD five years after completing a group psychosocial treatment program. The findings of this research provided rich, detailed, and contextualised insights into people’s experiences of living with and receiving treatment for BD, and adds to our ever-evolving understanding of factors that contribute to wellness and relapse. The current study makes several contributions to the literature based on the narratives of live experience experts. It seems that the negotiation of psychosocial stressors may be a unique and personal process – this involves a process of finding what works best for each person, and clinicians clearly have a significant role to play in helping their clients with this. It is proposed that physical illness may be an emergent triggers for bipolar relapse, and that cognitive and assertiveness skills might be important strategies for managing psychosocial stress. Acceptance of the diagnosis appears to have an important role to play in helping people to overcome the challenges of living with BD, and may assist people to become more actively involved in the management of their condition. Several factors were perceived as being particularly important to wellbeing, including: gaining an accurate diagnosis and optimum treatment, social support, routines, self-knowledge, self-management, and broader lifestyle factors. The narratives of ‘lived experience experts’ also provided insight into the experience of group psychosocial treatment for people with BD. It is proposed that psychosocial treatment interventions might play an important role in helping people to develop acceptance and manage their illness, and that people with BD gain benefits from listening to the stories of group members and from forming
rewarding relationships with group administrators. These findings have provided some insights into the factors that might help people with BD to minimise episodes of illness and promote lasting wellbeing, and several lines of inquiry for future research have been suggested. Systematic quantitative research that attempts to validate the current findings would address the need to better understand the experiences of mental health consumers, and would assist clinicians to take a more person-centred approach to the treatment.
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Appendix A: Questionnaire Pack

Participant Information and Consent Form (PICF)

Frameworks for Health at St Vincent’s Hospital Melbourne

St Vincent’s Hospital (Melbourne)
Participant Information and Consent Form
Version No.4 Dated 1 March 2011
PROTOCOL NO. (STV): HREC-A 085/10
NAME OF PARTICIPANT:

U.R. NO:

NAMES OF INVESTIGATORS: Associate Professor Gregory Murray (Swinburne University of Technology, Australia), Professor David Castle (St. Vincent’s Hospital, Melbourne), Professor Michael Berk (Barwon Health, Geelong), Catherine Cronin (Swinburne University of Technology, Australia), Carolynne Holdsworth (St. Vincent’s Hospital, Melbourne), Monica Gilbert (St. Vincent’s Hospital, Melbourne), Dr James Chamberlain (St. Vincent’s Hospital, Melbourne).

1. Introduction
You are being invited to take part in this research project, because we would like to investigate the progress you have made over the 5-6 year period since your participation in the initial trial of the “MAPS: A guide to managing bipolar disorder” program. The research project aims to assess the long-term treatment outcomes of the original Randomised Control Trial. It is hoped that this will assist to further develop understanding of what was useful for those individuals who receive treatment. This Participant Information and Consent Form provides you with more information about the current research project. It explains the procedures involved. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don’t understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or healthcare worker.

Participation in this research is voluntary. If you don’t wish to take part, you don’t have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:
- understand what you have read;
- consent to take part in the research project;
- consent to participate in the research processes that are described;
- consent to the use of your personal and health information as described

You will be given a copy of this Participant Information and Consent Form to keep.

2. What is the purpose of this research project?
The current study is a follow-up study of the original Randomised Control Trial conducted by the Collaborative Therapy Unit at the Mental Health Research Institute.
The aim of the current study is to further examine the long-term treatment benefits of the “MAPS” program, through investigation of treatment outcomes 5-6 years post-intervention.

Research has indicated the effectiveness of psychosocial intervention in improving long-term treatment outcomes for individuals with bipolar disorder. However, there has been limited research on the long-term effectiveness of such interventions and little is known about the specific mechanisms which underlie improved treatment outcomes.

All individuals (72 participants) who participated in the original study will be given the option of participating in the current research study.

Long-term treatment outcomes will be investigated: for individuals that received the intervention, those who did not receive the intervention, and those that received the intervention post-RCT.

The current project will involve the collaborative effort of researchers from both St. Vincent’s Hospital and Swinburne University. The research will form part of Catherine Cronin’s doctorate thesis.

3. What does participation in this research project involve?

Consent
Consent is being sought for this research project only. Therefore, information collected as part of the following research will be utilized for the purposes of the current project only.

If consent is provided for the following project your research files from the previous RCT will also be accessed, this will enable comparisons to be drawn between your functioning before the intervention and 5-6 years after the intervention.

Procedures

- You will be contacted via phone by a member of the previous MAPS research team to see if you would like to participate in the following 5-6 year follow-up study.
- If you agree to participate in the current study you will be contacted by Catherine Cronin (15 minute phone conversation) who will provide you with additional information regarding the project and further enquire as to whether you would like to participate (obtain verbal consent).
- If you consent to participate Catherine Cronin will organise for a set of questionnaires, together with this consent form, to be mailed to your postal address. Additionally, a time will be organised to conduct a one hour interview.
- The following questionnaires are to be completed (in approximately 1 hour): World Health Organisation Quality of Life Scale- Brief (WHOQOLS-Brief), Depression Anxiety Stress Scales (DASS), Medication Adherence Rating Scale (MARS), Locus of Control of Behaviour scale (LCB Scale), Australian Personality Inventory (API), Brief-COPE (COPE), and the Social Provisions Scale.
- Questionnaires are to be completed prior to the interview date, and together with written consent, will be returned to Catherine Cronin on the day of your interview.

Participant Interviews (1 hour duration)
• Interviews will be conducted by Catherine Cronin (student researcher) at various sites: Barwon Health; Swinburne Psychology Clinic; and Melbourne Clinic, depending on what is most convenient for you (a phone interview may be offered if an individual participant cannot attend the interview, due to living remotely or interstate).

• Before your interview, Catherine Cronin will ask questions to determine if you are currently experiencing symptoms. You will receive a phone call (20 minute duration) on the day before the interview. If it is determined that you are not experiencing a manic or depressive episode the interview will be confirmed. However, if it is determined that you are experiencing a mood episode the interview will be postponed and you will be advised to contact your regular health care provider.

• Interviews will be audio taped and transcribed, so they can be reviewed in depth.

• You will be asked questions, with the aim of investigating the following over the preceding 5-6 year period: level of social support experienced, utilisation of health care services, general functioning: specific investigation of the retrospective occurrence of relapse, and investigation of individual coping style as well as techniques utilised to stay well.

• Current functioning will also be measured, so that comparisons can be drawn with how you were before being involved in the trial.

• Individual differences and personality characteristics will also be investigated.

4. Reimbursement (if applicable)
You will not be paid for your participation in this research, but you will be reimbursed for your time in the form of a $50 Coles/Myer gift voucher.

5. What are the possible benefits?
We cannot guarantee or promise that you will receive any benefits from this research. However, possible benefits may include identification of strategies that you have utilised since the initial trial of the “MAPS: A guide to managing bipolar disorder” program, to maintain wellness.

6. What are the possible risks?
Possible discomforts include: discussing previous relapses may potentially trigger unpleasant memories. Debriefing will be provided if necessary. If you become upset or distressed as a result of your participation in the research, the researcher (Provisional Psychologist; Catherine Cronin) will conduct debriefing procedures with you, additionally you will be directed to contact your current service provider for additional medical treatment if necessary. In addition, you may prefer to suspend or end your participation in the research if distress occurs.

7. What if new information arises during this research project?
During the research project, new information about the risks and benefits of the project may become known to the researchers. If this occurs, you will be told about this new information and the researcher will discuss whether this new information impacts you.

8. Do I have to take part in this research project?
Participation in any research project is voluntary. If you do not wish to take part you don’t have to. If you decide to take part and later change your mind, you are free to
withdraw from the project at any stage. Your decision whether to take part or not to take part, or to take part and then withdraw will not affect your relationship with St. Vincent’s Hospital.

9. What if I withdraw from this research project?
If you decide to withdraw, please notify a member of the research team before you withdraw. If you decide to leave the project, the researchers would like to keep the personal information that has been collected. This is to help them make sure that the results of the research can be measured properly. If you do not want them to do this, you must tell them before you join the research project.

10. How will I be informed of the results of this research project?
Results of this project will be made available to you on request. Results will also be made available through publications.

11. What else do I need to know:
What will happen to information about me?
Any information obtained in connection with this research project that can identify you will remain confidential and will only be used for the purpose of this research project. It will only be disclosed with your permission, except as required by law.

In any publication and/or presentation, information will be provided in such a way that you cannot be identified. This is done through coding all participants’ information using numbers, and the presentation of group average data. All information concerning participants will be kept on an electronic spreadsheet and held on a password protected main drive at Swinburne University, or in a locked filing cabinet at the St Vincent’s Hospital (Melbourne). Only members of the research team will have access to information within participant files. Files will be stored for a period of 7 years after completion of the study, after which time all information will be disposed of either through shredding or file deletion.

How can I access my information?
In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to access the information collected and stored by the researchers about you. You also have the right to request that any information, with which you disagree, be corrected. Please contact one of the researchers named at the end of this document if you would like to access your information.

Is this research project approved?
The ethical aspects of this research project have been approved by the Human Research Ethics Committee-A (HREC-A) of St. Vincent’s Hospital (Melbourne) and Swinburne University. This project will be carried out according to National Statement on Ethical Conduct in Human Research (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

12. Consent
I have read, or have had read to me in a language that I understand, this document and I
understand the purpose, procedures and risks of this research project as described within it.

I have had an opportunity to ask question and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described.

I understand that I will be given a signed copy of this document to keep.

Participant’s name (printed) ……………………………………………………………

Signature Date

Name of witness to participant’s signature (printed) ……………………………

Signature Date

Declaration by researchers: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher’s name (printed) ……………………………………………………

Signature Date

* A senior member of the research team must provide the explanation and provision of information concerning the research project.
Note: All parties signing the consent section must date their own signature.

13. Who can I contact?

Who you may need to contact will depend on the nature of your query, therefore, please note the following:

For further information or appointments:
If you want any further information concerning this project or if you have any medical problems which may be related to your involvement in the project (for example, any side effects), you can contact:

Name: Associate Professor Gregory Murray
Role: Principal Researcher
Telephone: (03) 9214-8300
Email: gwm@swin.edu.au

Name: Catherine Cronin
Role: Student Researcher
Telephone: 0421 461 688
14. Complaints
If you have any complaints about any aspect of the study or the way in which it is being conducted you may contact the Patient Liaison Officer at St Vincent’s Hospital (Melbourne) on Telephone: (03) 9288 3108. You will need to tell the patient Liaison Officer the name of the person who is noted above as principal investigator.

15. Research Participant Rights
If you have any questions about rights as a research participant, then you may contact the Executive Officer Research at St Vincent’s Hospital (Melbourne) on Telephone: (03) 9288 3930.
The Depression Anxiety Stress Scales (Lovibond & Lovibond, 1995).

**Instructions:** Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

*The rating scale is as follows:*

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I found it hard to wind down</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>2</td>
<td>I was aware of dryness of my mouth</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>3</td>
<td>I couldn’t seem to experience any positive feeling at all</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>4</td>
<td>I experienced breathing difficulty (eg. excessively rapid breathing, breathlessness in the absence of physical exertion)</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>5</td>
<td>I found it difficult to work up the initiative to do things</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>6</td>
<td>I tended to over-react to situations</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>7</td>
<td>I experienced trembling (e.g. in the hands)</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>8</td>
<td>I felt that I was using a lot of nervous energy</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>9</td>
<td>I was worried about situations in which I might panic and make a fool of myself</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>10</td>
<td>I felt that I had nothing to look forward to</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>11</td>
<td>I found myself getting agitated</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>12</td>
<td>I found it difficult to relax</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>13</td>
<td>I felt down-hearted and blue</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>14</td>
<td>I was intolerant of anything that kept me from getting on with what I was doing</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>15</td>
<td>I felt I was close to panic</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>16</td>
<td>I was unable to become enthusiastic about anything</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>17</td>
<td>I felt I wasn’t worth much as a person</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>18</td>
<td>I felt that I was rather touchy</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>19</td>
<td>I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>20</td>
<td>I felt scared without any good reason</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>21</td>
<td>I felt that life was meaningless</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>22</td>
<td>I have thoughts / plans of killing myself</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>
World Health Organisation Quality of Life Scale - Brief (The WHOQOL Group, 1998).

**Instructions:**

This assessment asks how you feel about your quality of life, health and other areas of your life. Please answer all the questions. If unsure about which response to give to a question, please choose the one that applies most to you. This can often be your first response.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the last two weeks.

**Example:**

Do you get the kind of support from others that you need?

<table>
<thead>
<tr>
<th></th>
<th>Not at All</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Very</th>
<th>Completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>You would circle the number 4 if in the last two weeks you got a great deal of support from others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

but if you did not get any of the support from others that you needed in the last two weeks you would circle 1.

Please read each question and assess your feelings, for the last two weeks, and circle the number on the scale for each question that gives the best answer for you.

1. How would you rate your quality of life?

<table>
<thead>
<tr>
<th></th>
<th>Very Poor</th>
<th>Poor</th>
<th>Neither Poor nor Good</th>
<th>Good</th>
<th>Very Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How would you rate your quality of life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

2. How satisfied are you with your health?

<table>
<thead>
<tr>
<th></th>
<th>Very Dissatisfied</th>
<th>Fairly Dissatisfied</th>
<th>Neither Satisfied nor Dissatisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. How satisfied are you with your health?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
The following questions ask about how much you have experienced certain things in the last two weeks.

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at All</th>
<th>A Small Amount</th>
<th>A Moderate Amount</th>
<th>A Great Deal</th>
<th>An Extreme amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. To what extent do you feel that physical pain prevents you from doing what you need to do?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. How much do you need any medical treatment to function in your daily life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. How much do you enjoy life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. To what extent do you feel your life to be meaningful?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. How well are you able to concentrate?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. How safe do you feel in your daily life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. How healthy is your physical environment?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Do you have enough energy for everyday life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Are you able to accept your bodily appearance?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. Have you enough money to meet your needs?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. How available to you is the information you need in daily life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. To what extent do you have the opportunity for leisure activities?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. How well are you able to get around physically?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
The following questions ask you to say how good or satisfied you have felt about various aspects of your life over the last two weeks.

<table>
<thead>
<tr>
<th>Q</th>
<th>Very Dissatisfied</th>
<th>Fairly Dissatisfied</th>
<th>Neither Satisfied nor Dissatisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>17.</td>
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<td>18.</td>
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<td>19.</td>
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<td>20.</td>
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<td>21.</td>
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<td>23.</td>
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<td>24.</td>
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<td>25.</td>
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<td></td>
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<tr>
<td>26.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

26. How often do you have negative feelings such as blue mood, despair, anxiety and depression?
Appendix B: Pre-Interview Screening

1. **Apparent Sadness**: Representing despondency, gloom and despair (more than just ordinary transient low spirits), reflected in speech, facial expression, and posture.
   Rate by depth and inability to brighten up.

<table>
<thead>
<tr>
<th>Degree</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>No sadness</td>
<td>Looks dispirited but does brighten up without difficulty</td>
<td>Appears sad and unhappy most of the time</td>
<td>Looks miserable all of the time. Extremely despondent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Reported Sadness**: Representing reports of depressed mood, regardless of whether it is reflected in appearance or not. Includes low spirits, despondency or the feeling of being beyond help and without hope.
   Rate according to intensity, duration and the extent to which the mood is reported to be influenced by events.

<table>
<thead>
<tr>
<th>Occasional sadness in keeping with the circumstances</th>
<th>Occasional sadness in keeping with the circumstances</th>
<th>Pervasive feelings of sadness and gloominess. The mood is still influenced by external circumstances</th>
<th>Continuous or unvarying sadness, misery, or despondency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sad or low but brightens up without difficulty</td>
<td>Sad or low but brightens up without difficulty</td>
<td>Pervasive feelings of sadness and gloominess. The mood is still influenced by external circumstances</td>
<td>Continuous or unvarying sadness, misery, or despondency</td>
</tr>
</tbody>
</table>

3. **Inner Tension**: Representing feelings of ill-defined discomfort, edginess, inner turmoil, mental tension mounting to either panic, dread or anguish.
   Rate according to intensity, frequency, duration and the extent of reassurance called for.

<table>
<thead>
<tr>
<th>Occasional feelings of edginess and ill-defined discomfort</th>
<th>Continuous feelings of inner tension or intermittent panic, which the patient can master only with some difficulty</th>
<th>Unrelenting dread or anguish, overwhelming panic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occasional feelings of edginess and ill-defined discomfort</td>
<td>Continuous feelings of inner tension or intermittent panic, which the patient can master only with some difficulty</td>
<td>Unrelenting dread or anguish, overwhelming panic</td>
</tr>
</tbody>
</table>

4. **Reduced Sleep**: Representing the experience of reduced duration or depth of sleep compared to the subject’s own normal pattern when well.

<table>
<thead>
<tr>
<th>Sleep as usual</th>
<th>Slight difficulty dropping off to sleep or slightly reduced, light or fitful sleep</th>
<th>Sleep reduced or broken by at least two hours</th>
<th>Less than 2 or 3 hours sleep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep as usual</td>
<td>Slight difficulty dropping off to sleep or slightly reduced, light or fitful sleep</td>
<td>Sleep reduced or broken by at least two hours</td>
<td>Less than 2 or 3 hours sleep</td>
</tr>
</tbody>
</table>

5. **Reduced Appetite**: Representing the feeling of a loss of appetite compared with when well.
   Rate by loss of desire for food or the need to force oneself to eat.

<table>
<thead>
<tr>
<th>Normal or increased appetite</th>
<th>Slightly reduced appetite</th>
<th>No appetite. Food is tasteless</th>
<th>Needs persuasion to eat at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal or increased appetite</td>
<td>Slightly reduced appetite</td>
<td>No appetite. Food is tasteless</td>
<td>Needs persuasion to eat at all</td>
</tr>
</tbody>
</table>

6. **Concentration Difficulties**: Representing difficulties in collecting one’s thoughts, mounting to incapacitating lack of concentration.
   Rate according to intensity, frequency, and degree of incapacity produced.

<table>
<thead>
<tr>
<th>No difficulties in concentrating</th>
<th>Occasional difficulties in collecting one’s thoughts</th>
<th>Difficulties in concentrating and sustaining thought, which reduces ability to read or hold conversation</th>
<th>Unable to read or converse without great difficulty</th>
</tr>
</thead>
<tbody>
<tr>
<td>No difficulties in concentrating</td>
<td>Occasional difficulties in collecting one’s thoughts</td>
<td>Difficulties in concentrating and sustaining thought, which reduces ability to read or hold conversation</td>
<td>Unable to read or converse without great difficulty</td>
</tr>
<tr>
<td></td>
<td>Lassitude: Representing a difficulty getting started or slowness initiating and performing everyday activities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>----</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Hardly any difficulty in getting started. No sluggishness.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Difficulties in starting activities.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Difficulties in starting simple routine activities, which are carried out with effort.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Complete lassitude. Unable to do anything without help.</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Inability to Feel: Representing the subjective experience of reduced interest in the surroundings or activities that normally give pleasure. The ability to react with adequate emotion to circumstances or people is reduced.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Normal interest in the surroundings and in other people.</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>Reduced ability to enjoy usual interests.</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Loss of interest in surroundings. Loss of feelings for friends and acquaintances.</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>The experience of being emotionally paralysed. Inability to feel anger or grief and a complete or even painful failure to feel for close relatives and friends.</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Pessimistic Thought: Representing thoughts of guilt, inferiority, self-reproach, sinfulness, remorse and ruin.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No pessimistic thoughts.</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>Fluctuating idea of failure, self-reproach or self-deprecation.</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Persistent self-acusation, or definite but still rational idea of guilt or sin. Increasingly pessimistic about the future.</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Delusions of guilt, remorse, or unredememable sin. Self-acusations that are absurd and unshakeable.</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Suicidal Thoughts: Representing the feeling that life is not worth living, that a natural death would be welcome. suicidal thoughts, and preparations for suicide. Suicide attempts should not in themselves influence the rating.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Enjoys life or takes it as it comes.</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>Weary of life. Only fleeting suicidal thoughts.</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Probably better off dead. Suicidal thoughts are common, and suicide is considered as a possible solution, but without specific plans or intention.</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Explicit plans for suicide. When there is an opportunity, active preparations for suicide.</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>
The Young Mania Rating Scale (Young et al., 1978).

**Timeframe: current (last 48hrs)**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Elevated Mood</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mildly or possibly increased on questioning</td>
<td>Elevated, inappropriate to content; humorous</td>
<td>Euphoric; inappropriate laughter; singing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definite subjective elevation; optimistic; self-confident; cheerful; appropriate to content</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Increased Motor Activity-Energy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subjectively increased</td>
<td>Excessive energy; hyperactive at times; restlessness (can be calmed)</td>
<td>Motor excitement; continuous hyperactivity (cannot be calmed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Animated; gestures increased</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Sexual Interest</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal; not increased</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mildly or possibly increased</td>
<td>Spontaneous sexual content; elaborates on sexual matters; hypersexual by self-report</td>
<td>Overt sexual acts (toward patients, staff, or interviewer)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definite subjective increase on questioning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Sleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reports decrease in sleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleeping less than normal amount by up to one hour</td>
<td>Sleeping less than normal by more than one hour</td>
<td>Reports decreased need for sleep</td>
<td>Denies need for sleep</td>
<td></td>
</tr>
<tr>
<td>5. Irritability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subjectively increased</td>
<td>Irritable at times during interview; recent episodes of anger or annoyance on ward</td>
<td>Frequently irritable during interview; short, curt throughout</td>
<td>Hostile, uncooperative; interview impossible</td>
<td></td>
</tr>
<tr>
<td>6. Speech (Rate and Amount)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No increase</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feels talkative</td>
<td>Increased rate or amount at times, verbose at times</td>
<td>Push; consistently increased rate and amount; difficult to interrupt</td>
<td>Pressured; unbreakable; continuous speech</td>
<td></td>
</tr>
<tr>
<td>7. Language - Thought</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circumstantial; mild distractibility; quick thoughts</td>
<td>Distractible; loses goal of thought; changes topics frequently; racing thoughts</td>
<td>Flight of ideas; tangentiality; difficult to follow, rambling, echolalia</td>
<td>Incoherent; communication impossible</td>
<td></td>
</tr>
<tr>
<td>8. Content</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questionable plans, new interests</td>
<td>Special project(s); hyper-religious</td>
<td>Grandiose or paranoid ideas; ideas of reference</td>
<td>Delusions; hallucinations</td>
<td></td>
</tr>
<tr>
<td>Special project(s); hyper-religious</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Disruptive-Aggressive Behaviour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absent, cooperative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sarcastic; loud at times, guarded</td>
<td>Demanding; threats on ward; shouting; interview difficult</td>
<td>Threatens interviewer; interview impossible</td>
<td>Assaultive; destructive; interview impossible</td>
<td></td>
</tr>
<tr>
<td>10. Appearance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate dress and grooming</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimally unkempt</td>
<td>Poorly groomed; moderately dishevelled; overdressed</td>
<td>Dishevelled; partly dishevelled; garish make-up</td>
<td>Completely unkempt; dressed bizarrely</td>
<td></td>
</tr>
<tr>
<td>11. Insight</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present; admits illness; agrees with need for treatment</td>
<td>Possibly ill</td>
<td>Admits behaviour change, but denies illness</td>
<td>Admits possible change in behaviour, but denies illness</td>
<td>Denies any behaviour change</td>
</tr>
</tbody>
</table>
Appendix C: Ethics Approval

Swinburne University of Technology
Human Research Ethics Committee (SUHREC)
Certificate of Ethics Clearance

SUHREC Project 2010/288
Psychosocial intervention and its long-term effectiveness in the treatment of bipolar disorder

Chief Investigator/Supervisor: AProf Greg Murray
Co-Investigator(s): Prof D Castle (SVH) / Ms C Holdsworth (SVH) / Ms M Gilbert (SVI) / Dr J Chamberlain (SVH) / Prof M Berk (Barwon)

Duration Approved: 17/02/2011 To 01/09/2014

This is to certify that the above project has been given ethics clearance in accordance with the current National Statement on Ethical Conduct in Human Research. The standard conditions and any special conditions for on-going ethics clearance are here printed.

All human research activity undertaken under Swinburne auspices must conform to Swinburne and external regulatory standards, including the above-mentioned National Statement and with respect to secure data use, retention and disposal.

The named Swinburne Chief Investigator/Supervisor remains responsible for any personnel appointed to or associated with the project being made aware of ethics clearance conditions, including research and consent procedures or instruments approved. Any change in chief investigator/supervisor requires timely notification and SUHREC endorsement.

The above project has been approved as submitted to date for ethical review by or on behalf of SUHREC. Amendments to approved procedures or instruments ordinarily require prior ethical appraisal/ clearance. SUHREC must be notified immediately or as soon as possible thereafter of (a) any serious or unexpected adverse effects on participants and any redress measures; (b) proposed changes in protocols; and (c) unforeseen events which might affect continued ethical acceptability of the project.

At a minimum, an annual report on the progress of the project is required as well as at the conclusion (or abandonment) of the project.

Additional Note:
Project approved by and subject to monitoring by St Vincent’s Hospital, Melbourne HREC (SVH HREC-A Project 085/10)

Approval includes:
- P/CF version 4 dated 2 February 2011

The SUHREC project number and title should be cited in any communication.

Keith Wilkins
Secretary, SUHREC and Research Ethics Officer
18/03/2011
13 October 2010

A/Prof Gregory Murray
Faculty of Life and Social Sciences
Swinburne University of Technology
PO Box 218
HAWTHORN VIC 3121

Dear A/Prof Murray,

HREC-A Protocol No: 085/10
'Psychosocial intervention and its long-term effectiveness in the treatment of Bipolar disorder.'

A/Prof G Murray
Dr J Chamberlain

Prof D. Castle
Ms C Cronin

Prof M Berk
Ms M Gilbert

Ms C Holdsworth

The Professional Secretariat of Human Research Ethics Committee-A (HREC-A) has agreed that your latest correspondence dated 6 October to the conditions of approval dated 23 September 2010 has satisfied the conditions imposed and granted full approval for this project to be undertaken at the following site/s:

St. Vincent’s Hospital (Melbourne)

HREC-A is constituted and operates in accordance with the NHMRC National Statement on Ethical Conduct in Research Involving Humans 1999 (including supplementary note 7 dated November 1992).

HREC-A has a policy of granting approval for four years. This approval is valid for four years from the date of this letter. Approval may be renewed at the end of this period by application to the HREC-A.

Approval is subject to:

1. immediate notification to HREC-A and sponsor of any serious adverse effects on participants;
2. immediate notification of any unforeseen events that may affect the continuing ethical acceptability of the project;
3. notification and reasons for ceasing the project prior to its expected date of completion;
4. the completion of an annual report on progress of the project;
5. HREC-A approval of any proposed modification to the project; and
6. the submission of a final report and papers published on completion of project.

St Vincent's
Continuing the Mission of the Sisters of Charity

SJKH412
This approval is for Participant Information and Consent form version 2 dated 5 October 2010.

HREC approval also includes the following:

Questionnaire - Appendix A: Montgomery and Asberg Depression Rating Scale
Questionnaire - Appendix B: World Health Organisation Quality of Life Scale – Brief
Questionnaire - Appendix C: Young, Biggs, Ziegler & Meyer Mania Rating Scale
Questionnaire - Appendix D: Depression Anxiety Stress Scales
Questionnaire - Appendix E: Medication Adherence Rating Scale
Questionnaire - Appendix F: Diagnostic Interview for Psychosis - Service Utilisation
Questionnaire - Appendix G: Locus of Control of Behaviour Scale
Questionnaire - Appendix H: Australian Personality Inventory
Questionnaire - Appendix I: Brief-COPE
Questionnaire - Appendix J: Life Chart Method
Questionnaire - Appendix K: Social Provisions Scale

Yours sincerely,

Ms Anita Arndt
Senior Administrative Officer and HREC-A Secretary
Research Governance Unit
Direct Tel: 9288 3924

cc. Ms Catherine Cronin
ETHICS COMMITTEE APPROVAL STATEMENT

HREC Project Number 11/15

Site Barwon Health

Date Approved 24/04/2011

Principal Investigator Catherine Cronin

Title: Psychosocial Intervention and its Long-Term Effectiveness in the Treatment of Bipolar Disorder

Co-investigators A Prof Gregory Murray
Prof Michael Berk
Dr Tom Callaly

Student names

Thank you for submitting the above for our consideration. Your project is approved and you may commence.

Your obligations under this approval include notifying the Committee of any intent to deviate from the approved protocol and of the occurrence of any untoward events.

It is now your responsibility to undertake the following:

1. To inform any personnel who should be aware of this project

2. To ensure, if applicable, that accurate documentation of the consent process is recorded in the participant’s hospital history and that a photostated copy of the consent form is also placed in the hospital history.

3. To advise the Committee, in writing, of any changes you wish to make to the running of the project, including extending beyond the anticipated completion date.

30/06/2011 Project Number 11/15 Page 1 of 4

The Barwon Health Human Research Ethics Committee (HREC) operates in accordance with guidelines established by the National Health and Medical Research Council, National Statement on Ethical Conduct in Human Research (2007).
4. To advise the Committee, in writing, of any serious adverse events

5. To supply written annual reports on the anniversary of your approval advising of the progress of the project and a final report advising of completion

6. To ensure that, if applicable, the project is registered on a Clinical Trials Registry and that the number is made available to the Committee for out records

Please note: Research projects to be undertaken at private institutions are not covered by the Barwon Health Medical Malpractice Policy.

In the case of medical research, care should be taken to ensure that the investigator’s medical insurance policy is current and the institute in which the research is conducted is adequately insured.

It is the responsibility of the investigator to ensure adequate coverage in the event of litigation

Should you require any further information concerning the Committee’s approval of your research or have any concerns regarding the reporting requirements please contact the Office for Research, on 5226 7920.

Finally, in all future correspondence regarding your study please quote the HREC Project Number and full title of your research project.

On behalf of the Committee, best wishes for your project.

Yours sincerely,

SIMON FRENCH
CHAIR
Human Research Ethics Committee
<table>
<thead>
<tr>
<th>Date Approved</th>
<th>Item</th>
<th>Document Date</th>
</tr>
</thead>
</table>

The Barwon Health Human Research Ethics Committee (HREC) operates in accordance to guidelines established by the National Health and Medical Research Council, *National Statement on Ethical Conduct in Human Research* (2007).
## HUMAN RESEARCH ETHICS COMMITTEE MEMBERSHIP

The Barwon Health Human Research Ethics Committee operates in accordance to guidelines established by the National Health and Medical Research Council, National Statement on Ethical Conduct in Human Research (2007).

<table>
<thead>
<tr>
<th>Member</th>
<th>Highest Degree</th>
<th>Specialty</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Peter Ball</td>
<td>B.Sc. Biochem Ph.C. Pharmaceutical Chemist</td>
<td>Community (Layman)</td>
<td>No</td>
</tr>
<tr>
<td>Mr Lynsey Blakston</td>
<td>M.A.</td>
<td>Community (Minister of religion)</td>
<td>No</td>
</tr>
<tr>
<td>Ms Patricia Boom</td>
<td></td>
<td>Professional (SIOG)</td>
<td>No</td>
</tr>
<tr>
<td>A/Prof Thomas Callaly</td>
<td>FRANZCP, MRC Psych, MB, B Ch, B Sc, H Dip Ed, MBL</td>
<td>Professional (Mental health)</td>
<td>Yes</td>
</tr>
<tr>
<td>Dr Mary Lou Chatterton</td>
<td>Pharm.D.</td>
<td>Professional (RRC Chair / Pharmacy)</td>
<td>Yes</td>
</tr>
<tr>
<td>Dr Lucy Cuddihy</td>
<td>RN, DN, MBA</td>
<td>Executive Director: Nursing</td>
<td>Yes</td>
</tr>
<tr>
<td>Ms Bernice Davies</td>
<td>BAppSci (msg), Adv.DipMgt, Grad.Cert. Biotechnology</td>
<td>Secretariat</td>
<td>Yes</td>
</tr>
<tr>
<td>Mr David Dethridge</td>
<td>LLB</td>
<td>Community (Lawyer)</td>
<td>No</td>
</tr>
<tr>
<td>Dr Rod Fawcett</td>
<td>MSc, MBBS, BMedSc, FAFPHM, AFCHSE, MRACMA</td>
<td>Professional (Medical administration)</td>
<td>Yes</td>
</tr>
<tr>
<td>Mr Hans Fikkers</td>
<td>LLB</td>
<td>Community (Lawyer)</td>
<td>No</td>
</tr>
<tr>
<td>Mr Simon French</td>
<td></td>
<td>Chair (Lawyer)</td>
<td>No</td>
</tr>
<tr>
<td>Ms Michelle Heagney</td>
<td>BA.Sci (Chem) Masters (BusinessAdmin)</td>
<td>Community member (Laywoman)</td>
<td>No</td>
</tr>
<tr>
<td>Dr Cate Nagle</td>
<td></td>
<td>Researcher</td>
<td>No</td>
</tr>
<tr>
<td>Dr Neil Orford</td>
<td>MBBS, FANZCA, FI/JICM, PGDip Echo</td>
<td>Researcher</td>
<td>Yes</td>
</tr>
<tr>
<td>Dr Cameron Osborne</td>
<td>BBS, FANZCA</td>
<td>Professional (Medical/anaesthetics)</td>
<td>Yes</td>
</tr>
<tr>
<td>Dr Amutha Samual</td>
<td></td>
<td>Professional</td>
<td>Yes</td>
</tr>
<tr>
<td>Mr Greg Weeks</td>
<td>MPHARM MHA</td>
<td>Professional (Pharmacy)</td>
<td>Yes</td>
</tr>
<tr>
<td>Reverend Kevin Velverton</td>
<td>L.Th., Theol. Ma, D.Min</td>
<td>Community (Minister of religion)</td>
<td>No</td>
</tr>
</tbody>
</table>

The Barwon Health Human Research Ethics Committee (HREC) operates in accordance to guidelines established by the National Health and Medical Research Council, National Statement on Ethical Conduct in Human Research, (2007).
Appendix D: The Life Chart Method - Retrospective (Denicoff et al., 1997)

Sample NIMH-LCM™ 5-year retrospective completed life chart. Abbreviated example of 5-year retrospective patient LCM™ depicting past episodes at 3 levels of severity, dysphoric mania, cycling, medications, and illness response to treatment, comorbidities, and life events.