

Self-help, peer support and a multi-faceted approach are fundamental to learning to manage the complexity of bipolar disorder

Learning to cope together

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It is now commonly accepted that bipolar disorder is a complex mental illness¹ that is influenced by and impacts on all areas of an individual's life, often with devastating consequences. Hence, a multi-faceted intervention is needed¹ to help people in their recovery from it. Integrating various therapies for which evidence of effectiveness exists might surely create a more complete therapy² that would better 'encapsulate its complexity'³ and address more fully the multi-faceted needs.⁴

The NICE bipolar guidelines⁵ indicate some treatment effect for a variety of psychological therapies. Recommendations include a wide variety of strategies to enable people in their recovery. They include self-monitoring of triggers and warning signs; coping strategies; lifestyle advice; diet and exercise; support after significant life events, and increased social support, such as improved family support, participation in user groups, and befriending.

Illness management skills may be the cornerstone of moving on from a diagnosis of bipolar disorder and dealing with the illness, but recovering one's whole life is not about illness management alone. Baker⁶ found that, for members of the Mood Swings Network, only 25% of coping strategies used involved medication and services, whereas 75% involved essentially non-medical aspects. This points towards a holistic approach whereby (in order of importance) family and friends, support groups, positive thinking, exercise, sleep, education, mood monitoring, routine, work, hobbies, understanding the illness, talking, space, self-management, good food, socialising and faith are used.

In-Sight training

The components of the Insight training reported here were compiled from my own experiences of bipolar disorder, and from professionally delivered therapies that have found some success with the illness. A focus group

of five people with a diagnosis of bipolar disorder commented on the draft training manual, and their suggestions for improvement were incorporated.

The programme ran over 12 weekly sessions of three hours duration, and comprised both lifestyle advice and personal skills training:

- 'Looking back' – mood recognition and monitoring; stressors and warning signs; mood-thinking-behaviour
- 'Examining the present' – general and personal coping strategies; medication; lifestyle (sleep, exercise, diet etc)
- 'Developing skills' – communication; assertiveness; negative thoughts; positive thinking; relaxation etc
- 'Moving forward' – lifestyle choices; well-being action planning; goals for change; weekly activity diary; relapse agreement etc.

The training was first piloted with a group of eight participants (without a control group), who included one person with a diagnosis of schizophrenia and two people with a diagnosis of schizo-affective disorder. The training was then run again with five participants, and their outcomes after six months were compared with those of six people in a control group (who received normal care). All had primary bipolar disorder diagnoses. I delivered the pilot training on my own, but recruited a pilot group participant to co-facilitate the main group training.

The ages of the participants ranged from 24 years to 76 years. Length of time with the illness varied, although many had experienced bipolar disorder for over 20 years. All had a variety of secondary mental health difficulties, including general anxiety, panic, agoraphobia, claustrophobia, obsessive-compulsive disorder, substance abuse, sexual difficulties and developmental issues.

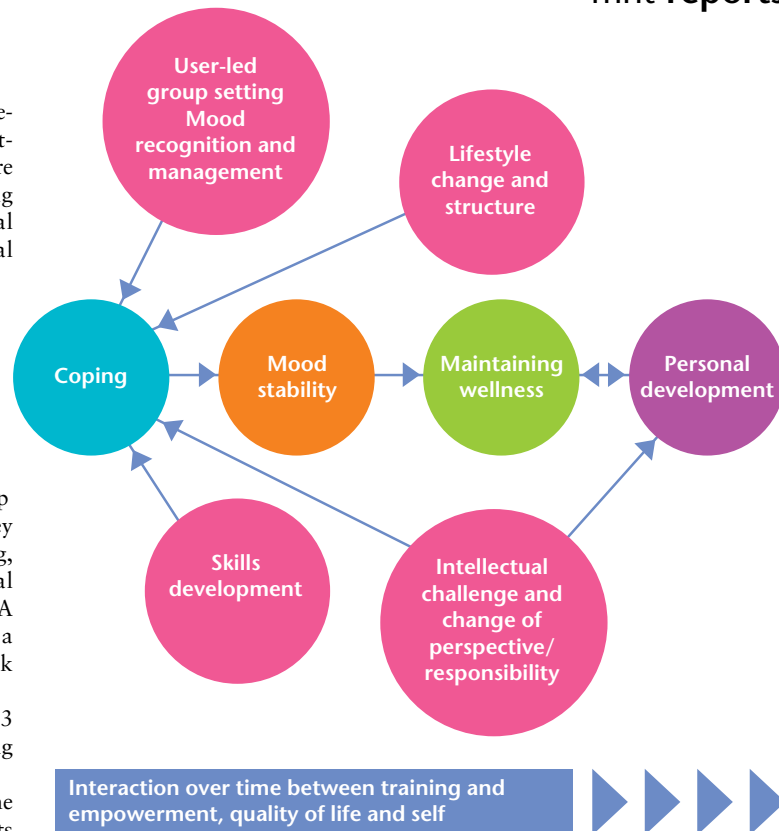
Self-report questionnaires were used to measure mood, empowerment, coping and quality of life. Semi-structured

interviews were also conducted with the participants pre-course, immediately post-course, and six months post-course. Clinicians with knowledge of the participants were also interviewed throughout the study, including consultant psychiatrists, day centre workers, social workers, community psychiatric nurses, a clinical psychologist, a befriending group organiser and a home support worker.

The quantitative self-report questionnaires provided a rough 'group snapshot' of general tendency in outcomes.⁷ Participants became more mood stable, improved their coping strategies, increased their sense of empowerment and improved their quality of life six months after the course had finished. The people in the control group generally fared less well over the same time period. They reported seasonal fluctuations in mood, worse coping, fluctuation in empowerment dependent on seasonal mood, and variable improvement in quality of life. A third of the people in the control group relapsed and a further third experienced deteriorating health with risk of relapse.⁷

Thematic analysis of the self-reports from the 13 participants produced rich qualitative data describing how the training had benefited participants.

The figure (right) illustrates the holistic nature of the training, demonstrating how the individual components on their own and in interaction with the others contribute towards overall improvement in coping and recovery.



User-led

That the training was user-led and situated within a self-help group format with socialisation and group sharing increased and deepened participants' knowledge of the illness and enabled them to establish a wider social network and friendships within the group. Self-expression and communication were also enhanced through this peer support. These benefits in turn were seen to enhance participants' general coping strategies:

'I think the group helped get things into perspective... people learn from other people's experiences, 'cos we all have highs, we all have lows. It was a common core of experience there... People can learn what other people do, and that's good.' (Participant 2, post-course)

'[He] felt very isolated before the group started... now he doesn't need to rely on me so much. He can discuss it with his friends and his new social network, instead of looking to me for answers.' (Day centre worker, post course)

Therapeutic alliance

This improved self-expression and communication helped to improve relationships between participants and their mental health professional team and improved the therapeutic alliance. Coping with a mood swing with the help of the group support enhanced participants' general coping strategies. Participants became more responsible for themselves, more independent and less reliant on their mental health professionals. They had more distance on the illness. All of these changes enhanced their general coping strategies:

'The conversations I have with him are more constructive and it is more about how I can help him rather than listening to him get things off his chest and not come up with any solutions or answers for himself... I wouldn't say he needs less input but it is a different kind of input, and it is two-way now, rather than one-way.' (Day centre worker, post course)

Lifestyles

Participants reported healthier lifestyle (healthier diet, weight loss, more exercise, better sleep patterns, healthier attitude towards food and alcohol, more knowledge about medication, more relaxation, healthier living situation and resolving money situations), improved structure to their life (better balance and routine, better schedules, more breaks and better planning around stressors) and personal goals that were often about a healthier lifestyle and structure to their life:

'And now I can probably deal with it more, by relaxing, or going out for a walk... not to go to bed, that was my failing. I just went to bed to shut everything out.' (Participant 13, post course)

'One of the goals I set myself was to improve my social circle and I have done this by starting up a social group... I now feel that if I want to go out and do something I have always got someone to call on to go with and need never be stuck in on my own bored.' (Participant 1, 10 months post course)

Relationships

The practice of assertiveness and anger management skills enabled participants to improve their relationships with others. Addressing past traumas in a positive light and challenging ingrained patterns of behaviour →

- resulted in a greater sense of responsibility for self and greater independence from mental health professionals:

‘I just thought, I don’t want to do this anymore. If people are going to say stuff to me, they should know how I feel about it... the emotional confidence now is there. It just fed into a new sense of “I am worth it”.’ (Participant 10, six months post-course)

Better boundaries

Challenging deeply seated beliefs and ingrained patterns of behaviour led participants to take a more considered approach to work and activities, and to feel less responsible for others, and less guilty about this:

‘I used to be self-critical that you’re down, so try to do something, but don’t do it particularly effectively, and then criticise yourself for that. That kind of cycle, whereas by letting go, I don’t worry too greatly about my level of accomplishment. I just get on with things and then actually find the enjoyment comes along with it... that keeps you in that stable area.’ (Participant 11, six months post-course)

One mental health professional summarised this change:

‘Better boundaries... he has been empowered to get what he wants – a job or social group... He now takes a step back and thinks before saying. He copes by taking time out.’ (Befriending organiser, 18 months post-course)

Mood management

Participants reported improved mood recognition and swifter mood management, helped by the self-help and user-led format of the training:

‘I now know what the first steps of my mood are now... I feel that I can actually stop my moods swinging and I’ve controlled this upswing within in a week, so I don’t lose contact with me friends. If I would have been in a job, I probably would have been able to get through it and still have the job at the end of it. So it’s given me a lot more hope for the future.’ (Participant 1, post course)

‘He has been much more responsive in trying to change it [medication]... And he has been much better at reading what is going on... he has got more of his own resilience.’ (Consultant, 18 months post course)

Mind-set

Through success in challenging ingrained patterns of behaviour, a different ‘mind set’ was achieved:

‘I didn’t know there was even any coping strategies. I just thought, you just get down and depressed and have got to pull yourself out of it, and then it happens again. It was like the best thing that had happened to me, coming to something where I could see that just by taking responsibility for actions, you can actually change your behaviour to help yourself.’ (Participant 12, post course)

‘Just having belief in yourself, and what you now know, and that you can cope. I think that dealing with things like suicide, suicidal thoughts, if that ever comes about again, I believe that I will have many more tools to handle it, and much more resilience.’ (Participant 10, six months post-course)

Hope for the future

Throughout the process, the improvement in general coping resulted in greater hope, and improved outlook for the future:

‘... [to] know that despite feeling depressed a lot of the time in the past I have still managed to achieve quite a lot. So if I can do that feeling dreadful, then there is hope that feeling a bit better will be more positive and therefore I’ll feel even better in myself.’ (Participant 12, post course)

Negotiating the health system

Maintaining wellness meant that, in order to continue to move forward, participants had to use their new skills of communication and assertiveness to renegotiate their care plans with their mental health team:

‘They tend to listen more to what I have got to say... Not just the day centre manager – my social worker, my consultant psychiatrist, they give me more leeway... they think I am actually doing the right thing most of the time.’ (Participant 1, 16 months post course)

Conclusion

Participants used a range of techniques from the training to attenuate and avoid a mood swing, thereby improving situations in their lives or coping successfully with fluctuations in their mood. This skill-building enabled participants to draw on these various components at different points in their illness cycle, while the range of techniques had a knock-on effect, each enhancing the effect of other techniques. The overall effect was a more rounded, stable resilience in recovery, and better equipped, skilled and knowledgeable individuals who are more able to deal with situations in their lives. ■

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