Juggling on Sticks-The lived experience and treatment of Bipolar Disorder

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Abstract
This study used an Interpretative Phenomenological Analysis (IPA) to examine the lived experience of six people diagnosed with Bipolar Disorder and their experience with a community mental health model of treatment. The study was designed as an exploratory investigation into the life-world of participants and a preliminary examination of community mental health treatment of Bipolar Disorder. In-depth, semi-structured, interviews were used to explore participants lived experience of Bipolar Disorder and how they made sense of these experiences.

Two superordinate themes were developed. This paper describes the second superordinate theme in full. The second theme 'Inside the net: A struggle for balance' involved participants journey through the mental health system and their struggles for maintaining equilibrium. Participants expressed frustration with the agenda of the mental health team which represented a heavy emphasis on biological aspects of their illness. Maintaining stasis within the mental health system was a juggling act, where psychosocial stressors, fears of relapse, and medication side-effects all required competing attention and balance. DBT offered an opportunity to address problems in a more holistic manner.

Living with a diagnosis of BD was a delicate juggling act, where psychosocial stressors, medication side-effects and fears of relapse competed and stasis was often illusive. Community mental health treatment of Bipolar Disorder was experienced by many as paternalistic and over-reliant on biological aspects. DBT offered significant promise for managing BD more holistically. (249 words)

Introduction
Bipolar Disorder (BD) is a serious mental health problem involving periods of extreme changes in mood from periods of deep depression to periods of pronounced mental agitation involving chaotic, overactive behaviour known as mania. With a prevalence rate of 5% in the world's population [1], BD is the world's sixth leading cause of disability [2], and is the psychiatric diagnosis associated with the greatest percentage of suicide attempts [3,4].

Despite its prevalence and risk profile BD remains one of the most under-researched of the psychiatric disorders [5], with traditional research focusing largely on psycho-pharmacological therapy [6,7], and little emphasis on examining what it is like to live with this disorder. More recently, a strand of research has emerged focusing on first-hand accounts of people diagnosed with BD [2,8] in order to provide information on the lived-experience of the disorder and some context for well documented BD phenomena such as ambivalence towards diagnosis [9], and poor treatment adherence [10]. Qualitative studies of BD reveal a complex and sometimes contradictory picture. For any advantages associated with hypomania and mania, from increased creativity [11,12], amplification of inner states, and intense human connectedness [13], there was a significant price to pay. Many qualitative studies focused on the limitations imposed by the disorder in terms of loss of control [14], impaired quality of life [15], reduced work functioning (Michalak et al., 2007) and disruption in relationships and family life [17].

Given the high rates of non-adherence to psychotropic medication in the BD population it is somewhat surprising that few studies have investigated how people with BD access mental health services, and the nature of their relationships with mental health service providers. In the only IPA paper found focusing exclusively on treatment, group psychoeducation was shown to have positive effects on coping strategies of participants, and normalisation of their 'uniqueness'. Participants emphasised the benefits of a collaborative relationship with their mental health professional [18].

With ambivalence characterising the acceptance and management of a BD diagnosis it becomes increasingly important to look at the interface between BD sufferers and those providing them with treatment. Such investigations may yield useful information on what it is like to live with this disorder, what it is like to navigate through the mental health system and which factors in treatment promote recovery. This may lead to service improvements and greater understanding of the lived experience of people diagnosed with BD. No IPA studies were found examining the life-long lived experience of the disorder, particularly regarding treatment and maintenance within a named model of mental health care. This study was guided by the following two research questions: What is it like to experience and live with this disorder, particularly regarding treatment and maintenance within a named model of mental health care? This study was guided by the following two research questions: What is it like to experience and live with BD in Ireland? What is the nature of the interaction between individuals with a BD diagnosis and community mental health services?

Methods
A paradigm for qualitative research
The purpose of this study was to explore the lived experience of people with a diagnosis of Bipolar Disorder (BD). The investigation was exploratory in nature, and attempts to document the way in which this under-researched group of people make meaning in their lives, and how BD fits into this meaning-making. Qualitative methods have been used extensively in studies of mental health (Smith et al, 1996, 1997, 2002). Qualitative methods tend to focus on understanding experiences from the point of view of the people who live them [22], thus providing a good fit with the research questions at the heart of this study.
**Interpretative phenomenological analysis (IPA):** Interpretative Phenomenological Analysis (IPA) has epistemological origins in the traditions of phenomenology [23], and hermeneutics [24]. Phenomenology is concerned with an examination of how people experience their lives, as opposed to revealing a reality which is true for everyone (Smith et al., 2009). Hermeneutics is concerned with how people make sense of their experiences, often referred to as 'sense-making' [26]. Therefore, IPA is a qualitative research approach with a focus on examining how people make sense of their major life experiences: a focus on the lifeworld [27].

**Rationale for IPA:** IPA was judged to be the most relevant methodology for this research, matching the phenomenological enquiry of the research question and its exploratory nature. IPA is thought to be the most relevant mode of inquiry when the area under investigation is under-studied, and emotionally-charged, and an idiographic account is desired (Smith, 2004; Smith, Flowers & Larkin, 2009).

**Design**

This qualitative study utilised a qualitative semi-structured interview design, employing an interpretative phenomenological analysis (IPA) approach to explore the lived experiences of adults with BD in a rural setting in Southern Ireland.

**Recruitment strategy:** IPA proposes that qualitative studies use a homogenous sample, either similar by way of socioeconomic or demographic indices, or an otherwise closely defined group. This process maximises the chance of meaningful cross-comparison and of realistic generalisation [30]. The present study was interested in examining the experiences of adults who had a diagnosis of Bipolar Disorder and who had received treatment with a community mental health team. The researcher approached the clinical lead, a Consultant Psychiatrist, of the South Kerry Home Treatment Team (HTT) and described the nature of the research to him. A list of 33 former HTT service users with a BD diagnosis was generated by the HTT co-ordinator. This list contained demographic information, as well as information regarding diagnoses and treatment history. Six of the twelve (50%) mailed people agreed to participate.

All six chose to be interviewed in one of two day-centres close to their home. Prior to beginning recording the participants were assured of the anonymity of their responses, given an opportunity to ask any questions about the research and asked to sign a consent form.

**Inclusion criteria:** Participants were included in the study if they had a primary diagnosis of Bipolar Disorder, had received community mental health treatment, and were resident in South Kerry. Service users who whose primary diagnosis was anything other than BD were excluded from the study. The keyworker for each potential participant was consulted prior to study participation to assess service user’s current mental state. Service users who were experiencing active depressive, manic, or psychotic states were excluded from the study. No exclusion criteria were applied for age, gender, or co-morbid diagnoses.

**Participants:** Background information about the participants is provided in Table 1. Each participant was assigned a pseudonym, which is used throughout the paper. Five females and one male, ranging in age from 37 to 60 (M = 49), volunteered to participate. Five of the six participants had a primary diagnosis of BD and a co-morbid diagnosis of Emotionally Unstable Personality Disorder (EUPD, also known as Borderline Personality Disorder). The median age for receiving a BD diagnosis was 35, with a wide range (26-59).

**Ethical Issues:** This project was reviewed by the National University of Ireland, Galway Research Ethics committee in March 2016. The study also received approval from the Cork University Hospitals Ethics Committee in September 2016.

**Informed consent:** An Information Sheet and Consent Form were used in this study. The information sheet was sent to the potential participants before the study began. In the information sheet, and in a subsequent telephone call it was made clear that participation in the study was voluntary, that participants were free to discontinue at any stage, and that withdrawal from the research would in no way affect their future service delivery (Table 1).

**Data Collection**

**Semi-structured interviews:** Interviews took place at one of two Health Clinics adjacent to the participants’ home. The interviews were semi-structured, meaning the researcher had a framework interview schedule but allowed the interview to progress naturally to include novel information, and returning to the interview framework as needed. Interviews lasted for approximately one hour. The interviewee was treated as the “experiential expert” on BD (Smith et al., 2009) and the interview process was conceived as a means of sharing their story.

**Interview schedule:** A semi-structured interview schedule consisting of 13 questions with prompts was devised. The purpose of the interview schedule was to facilitate discussion of the participants lived experience of BD. It represented a ‘loose agenda’ (Smith et al., 2009) around which a conversation took place that allowed for the exploration of the lifeworld of the interviewee. This covered a wide variety of topics pertinent to the research questions. The questions included: What BD means to them? How has having BD affected their life? What are their views on Recovery? What does a Manic/Depressive episode feel like?

The interview schedule was reviewed by the second author and amended prior to interviews taking place.

**Data Analysis**

Data analysis entailed case by case analysis with reading and re-reading of interview transcripts case by case generating initial codes which were formed into potential themes which capture the essential qualities of the accounts [31]. Following this step, the list of themes was listed chronologically into an initial list of themes.

**Cross-case analysis:** The superordinate themes for each participant was placed in a list and further collated to form master themes, which represented themes shared across the participants. This stage required a return to the original transcripts to ensure their compatibility with the emerging master themes. Three superordinate or master themes were developed and ordered into a coherent narrative.

**Narrative account:** This narrative account took the form of an argument, with verbatim extracts [32]. This account reflected the participants meaning-making of their own worlds, as well as the researcher’s efforts at making sense of the participants meaning making.

**Quality**

**Credibility checking:** To ensure the quality of the research samples of the transcripts, codes, subordinate and superordinate themes were reviewed by the second author, who had an expertise in IPA. Any differences in interpretation was discussed and any changes which emerged from these discussions were incorporated in the analysis and results. Themes were tested for their coherence, credibility, and explanatory power.

** Reflexivity:** Since the researcher is an integral part of the exploration and interpretation of meaning in qualitative research, the researcher...
made a reflexive statement outlining possible biases or influences he or she may bring to the process. Reflexivity involved the researcher examining his own preconceptions about the research [33].

Findings

Two superordinate themes were developed during the process of analysis: 'Outside the Net: A Life in Extremes, and 'Inside the Net: A Struggle for Balance'. This paper will focus on the second superordinate theme. The themes represent a gradual coming to terms of lives lived in extremes, and encompass early destabilising experiences, through losses and crises, to late diagnosis, coping with medication and its side-effects, and a struggle to be heard in the system. Table 2 lists the superordinate and subordinate themes (Table 2).

The image of “inside the net” was introduced by Paul when he described his difficulties accessing the mental health system and his many years spent outside of that system.

Paul: "I was trying to get into the net... there's a lot of stigma still... and the doctors are keyed into depression and that's it”.

JOK: “But now you are in the net? And you are, for that reason you are safer?“.

Paul: "A lot safer”

'Inside the Net': A Struggle for Balance

All the participants in this study, except Denise, received a diagnosis of BD after the age of 35. This late diagnosis meant many chaotic years “outside the net” of the mental health system, with misdiagnoses and missed opportunities leading people to feel “lost” and “alone”. When finally landed “into the net” of formal diagnosis and mental health treatment, participants’ interaction with this system was not always optimal to their mental health needs. Participants expressed frustration with the mental health system. In many cases the clinics were overcrowded, with long waiting times. They finally meet a doctor who, pressed for time, asked brief, formulaic questions regarding risk, checked on medication adherence and finished interviews quickly.

Participants reported a tangible power imbalance in their interactions with mental health staff, and complained of a paternalistic attitude adopted by some staff. Participants experienced a system where medication adherence is a cornerstone, where medical staff are always optimal to their mental health needs. Participants expressed frustration with the mental health system. In many cases the clinics were overcrowded, with long waiting times. They finally meet a doctor who, pressed for time, asked brief, formulaic questions regarding risk, checked on medication adherence and finished interviews quickly.

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See and Not heard. Traumatic early life experiences in the families of the participants meant that most participants grew up without adequate family nurture and support. Participants felt “on the outside” and “lost”. Their voice in the family was lost in the grief or turmoil which shook the family and they adopted a coping mechanism of concealing negative emotion – to be seen and not heard. This passive role was mirrored in the interactions of many participants with mental health staff, and in particular with doctors.

Paul describes the quick response and strong relationship he had developed with the Community Mental Health Nurse. When it got to the doctor’s office, however, the main focus was on medication:

“...the nurse [Name], he is very good, I have a very good relationship with him now and I had with the nurse in [Health centre] when I was there as well.... I mean that side is good, but I think dealing with Psychiatrists, it’s all meds, and its add meds, and it ‘y’know this isn’t working I’ll add something else” (Paul 373-376).

Paul describes a narrowed focus of options explored by the Psychiatrist, to the extent that only the influence of psychotropic medication is deemed worthy of examination. In Paul’s view, ineffective medication was continued and added to and there existed little forum for debate or discussion on the issue.

Participants reported a power differential between themselves and the mental health staff. The power differential and paternalism sometimes observed between participant and doctor was referred to by Helen who reported she was threatened with involuntary admission if she did not stop drinking:

“...there was a psychiatrist here who took a very kind of a paternalistic attitude, and all this time I was probably drinking by the way, which I shouldn't have been doing with my meds but I was, and I talked to her about the drinking and she threaten to section me if I didn't stop drinking” (Helen, 419-422).

This stark threat reveals the extent of the power differential between doctor and patient as well as the chasm between them in terms of communication and cooperation. In an eerie shadow of the way in which mental health patients were treated in the past, Helen’s very freedom was threatened, and whatever the degree of posturing on the part of the doctor, we are left in no doubt where the power rested in that relationship.
In their interactions with their mental health team, and with their Psychiatrist in particular participants report being seen but not heard. Being seen every three months, for ten minutes, with the main focus on safety and medication, but not being heard when it came to discussing management of life stressors and traumas.

**Medication matters**: Participants struggled to define their experience in wider terms than biochemistry, as outlined in the last section. All participants were taking psychotropic medication at the time of interviews. Overall, an ambiguous relationship with medication was expressed by participants. Medication was seen as key to their ongoing stability but brought with it side-effects which could greatly diminish their functioning and quality of life.

Common among the participants was a complaint that the medication resulted in a dulling of the senses, a general lethargy or a tendency to gain weight. The overall impression given was that psychiatric medication was an inexact science and much trial and error was commonplace:

> "It's using a sledgehammer to crack a nut. I wish there was something I could find that didn't flatten me out so much... I mean there was the real zombification and it had other effects which I couldn't stand, it was, they gave me restless legs syndrome and I have trouble sleeping and they just made it worse" (Helen 401-406).

Helen felt 'flattened out', 'hammered' and 'zombified' by her prescribed medication. From her perspective, she was only half-alive when taking medication, and added to this she had other side-effects; restlessness and sleeplessness. Her sense of self is diminished to such an extent that she remains a mere husk of her former self.

Helen describes a very clumsy medical approach to maintain stable mood. The price to pay, for her, was often too high and she chose to discontinue her medication for prolonged periods. Discontinuing medication was an option taken by only two of the six participants. The remaining four, although suffering various side-effects continued taking their medication.

**'Juggling on sticks': search for stasis**: Life before diagnosis involved constant juggling, with many balls in the air but the person could not keep all the balls up, sometimes they dropped them all, sometimes they focus on just one to the exclusion of others. But when they dropped the balls they just picked them back up and tried again – their focus was just on keeping the balls in the air. As Maura put it "I didn't know any different. Life was just life."

This vivid metaphor of someone juggling on sticks came from Helen when she was discussing the complexity of trying to run a house, influenced by psychotropic medication, yet wanting to unleash some creativity by reducing her medication and begin to write the books she had stored in her mind:

> "Helen: but my concentration isn't there and I find it a bit overwhelming...And I'm also scared, I just doubt my ability to organise that information...

**John:** And if you've got 3 books that's a lot of concentration required...?

**Helen:** It's juggling on sticks. But I have done it before (Helen, 700-719).

For Helen, there was a desire for self-development through writing but an underlying fear that any stretch outwards may trigger a relapse of her symptoms. She had little time or space to integrate life stressors with underlying instability.

After diagnosis for most there is initial relief because there is a name for the extremes they had been experiencing. But there is a trade-off, now they need to juggle on sticks; medication and diagnosis. They know that the sticks should be giving them the tools to juggle better but now they have extra balls, doctor's appointments, prescriptions, etc. The medication slows them down, the diagnosis means they are aware they have a disorder and that they can relapse. They enter a cycle of reducing the number of balls, e.g. relationships, ambitions, and increase the amount of medication until balance is achieved. At that point, they are deemed stable and less of a priority to the mental health team. And the person lives in a state of stagnation, afraid to add more balls (e.g. write the book, have another child) afraid to fight for reduced medication and afraid of relapse. Life is balanced but downgraded.

The post-diagnosis realisation that the person has a remitting disorder and the corresponding fear of relapse can prevent the person with BD from living out a fulfilled life. They may sacrifice important challenges and opportunities in order to maintain stability. Denise regretted that fears about instability prevented her from having more than one child.

> "But I suppose it prevented me from having other kids. 'Cause I was on Lithium at the time, which was great, it really helped me. But when I wanted to get pregnant I had to come off my medication...But once I was off my medication my mood dipped again so I had to give it up. But that's ok I suppose we are not too badly off, you know, just accept it."

Denise expresses resignation, but her sense of regret is keen as she looks back on a family she was prevented from having by fears she would become unstable. It was a high price to pay for a balanced life.

**Growing awareness; Therapy and DBT**: Five of the six participants had a dual diagnosis of BD and Emotionally Unstable Personality Disorder (EUPD). Because of the EUPD diagnosis, all five participants were referred Dialectical Behavioural Therapy (DBT) groups, which took place as part of the Community Mental Health Team. Four had already participated in DBT or were participating at the time of interview. One participant was about to start her DBT group.

For Kathy, who recently became pregnant, DBT had equipped her with life skills that prepared her for the upcoming changes in her life. Instead of 'exploding' when confronted with a challenge she learned to remove herself, stop building and distract herself:

> Kathy: "... I need to plan things out. I can't leave myself wander aimlessly,. ahm,. so I have learnt a different skill where I just remove myself from the situation or I distract it or I stop it building and as to a level where I fit to explode... to say that, you know, 'hang on this doesn't suit me' realizing what does suit me" (Kathy, 331-338)

In this extract Kathy gives an example of the practical psychological skills she has learned in the DBT group. The skills have come at a good time, as Kathy faces a pregnancy on her own. Her use of the word 'explode', and the risk she implies if she 'wanders aimlessly' suggest an external locus of control, which would have been her starting point before therapy. Due to her life change in becoming pregnant, she needed to plan and not wander, helping to motivate her to be open to learning new skills. Her assertive plans to 'remove myself' and 'hang on this doesn't suit me' suggest that her locus of control has become more internalised, which she associates with skills gained in the group.

Paul felt the DBT group was the most successful part of his mental health treatment. He described learning the vocabulary of emotions, to allow himself to express how he felt and what he needed:

> "I can see what's happening, I can stand back...a lot of it is standing back and being aware. I mean before I was just bashing off walls I couldn't describe the emotions, and that in itself was really screwing me over, I think the overall thing of it too is just being aware" (Paul 600-610).

Paul describes a greater self-awareness as a result of participating in the DBT group. He found a voice to describe his emotions, and
described a process of pausing before action. The impression is that engagement in therapy has strengthened him psychologically.

**Discussion**

The aim of the overarching study was to gain an in-depth understanding of how six individuals experienced and lived with Bipolar Disorder and how they navigated through community mental health services. Semi-structured interviews took place exploring the participants’ journey with BD, examining early life experiences, initial symptoms, through to diagnosis, and treatment. The data underwent a rigorous analysis through Interpretative Phenomenological Analysis. Two superordinate themes were developed: 'Outside the Net': Living with Extremes, and 'Inside the Net': A Struggle for Balance. The second superordinate theme is described in this current paper.

In the findings of the study, a unique depiction of the constant struggle for balance is outlined, which lay at the core of the participants lived experience of BD. This struggle takes place on a journey of empowerment where participants take increasing control of their own lives. The experience of DBT, as a transdiagnostic tool to foster psychological autonomy, was transformative for many of the participants and has offered hope for those still struggling with BD.

This superordinate theme, along with its subordinate themes will be discussed in relation to previous research and theory.

**Seen and not heard:** When participants finally got ‘into the net’ of the mental health services they expressed some dismay that busy clinics made for little time spent with doctors, who seemed more interested in medication monitoring than on discussing strategies for managing symptoms. Some participants reported questioning medication decisions, and routinely received a paternalistic response. The relationship between the service user and the mental health system generally, and with the psychiatrist in particular will next be discussed in the context of power and autonomy.

Weber's conceptualisation of power is that it was a finite resource to be divided among parties, the so called constant sum conceptualisation. Thus, for one party to gain in power the other had to relinquish or diminish their existing power [34]. This view can be contrasted with the three faces of power described by Lukes (1974,2005). The first ‘face’ of power is that of open decision-making and may include Weberian power relations. The second and third faces involve more covert power. The second ‘face’, for example may involve how agendas for meetings are decided, so that certain options are not considered. In the Service User (SU)-Psychiatrist relationship the second face power relations may revolve around medication-management consultations. Although the SU is seen to have a role in selecting medication variant or dose, the option for non-medical treatment is never presented, and thus the agenda is in the hands of the Psychiatrist. The third ‘face’ involves the exercise of power through the manipulation of roles and identities so that certain groups can be persuaded to accept certain situations without conflict. S Masterson and S Owen [34] suggest that convincing society that symptoms of psychological distress represent biochemical imbalances, and constitute a ‘mental illness’, could represent a third face power display.

In the current study, participants who met with MH staff who took the time to address their concerns saw it as remarkable and empowering. This could be interpreted as a sharing of power in the Weberian sense, or in the first ‘face’ of the Lukes’ model. The agenda for consultation with mental health staff, however, always included medication management. However much the participant was seen to have an input into the medication regime, the option of treatment without medication was never included in the agenda. The third ‘face’ of Lukes model also remained static from the perspective of the participants in this study. The agreed discourse was that they suffered symptoms indicating a mental illness, a biochemical imbalance, which needed to be treated with psychotropic medication until the symptoms stabilised.

This dominant discourse of mental illness has been challenged recently [36,37] and an argument was made that was needed was a new paradigm for mental illness. Bentall (2005) outlined evidence to dispute the notions that distinct psychiatric categories such as ‘bipolar disorder’ or ‘schizophrenia’ exist, or that there is a clear line between normal functioning and madness. This new approach conceptualises symptoms as existing on a continuum from normal functioning to extreme depression or mania, with positives and negatives associated with both ends of the spectrum [37].

**Medication matters.** All the participants in this study had been prescribed psychotropic medication. This was an effort, from the perspective of the medical model, to achieve stability and control over mood disturbances. All the participants had ambivalent feelings towards their medication. Medication made Denise physically sick yet she stated she would be “lost” without it, and would never think about discontinuing. Other participants took a more relaxed view of medication. Helen discontinued taking medication for up to seven years at a time, but went back to taking it when she felt she was “going off the rails”. This ambivalent relationship with medication had been shown in past studies. JG Proudfoot, GB Parker, M Benoit, V Manicavasagar, M Smith and A Gayed [2], reported ambivalent feelings toward medication in a sample of 26 people with BD. Centrally, participants focused on unwanted side effects of the medication, including loss of creativity, blunting of emotion and weight gain. Medication was also linked to a loss of identity for some, as they felt it robbed them of a sense of normality. In the current study, all participants spoke about unpleasant side effects of the medication from “zombification”, to weight-gain, to loss of creativity and productivity.

However most of the participants reported adhering to their medication regime, indicating an acceptance of their diagnosis and an acceptance that medication was the way to manage their symptoms. Other studies revealed higher non-adherence to medication than the current study. For example, Sajatovic et al. (2005) found non-adherence to be as high as 55%. It may have been an artefact of sampling in this current study that those with higher adherence rates were more likely to volunteer for a study, or it may have been that the questioning on non-adherence patterns was not detailed enough to reveal the true level of medication non-adherence in this group.

**'Juggling on sticks': Search for stasis:** The participants who have come ‘into the net’ of psychiatric treatment following years of struggling and misdiagnosis outside the system are faced with competing forces which constantly threaten their equilibrium. The need to juggle with daily challenges, such as rent, childcare and employment, while at the same time being confronted with the realisation that the extremes they experienced were controllable, but that relapse was likely. This is further complicated by side-effects of prescribed medication often leading to a dulling of the senses. Helen summed up this balancing act as “juggling on sticks”. All the participants in this study describe a struggle with equilibrium; a struggle to find stasis. Although the concept of balance in BD is an active field of research in the biological sciences [38-40], it has received less attention in psychological studies.

The model most associated with balance and synchrony in BD is the Interpersonal And Social Rhythm Therapy (ISRT) model which combines interpersonal psychotherapy [41] with circadian rhythm models [42]. The ISRT model, strongly influenced by the instability model (Goodwin et al., 1990), proposes to regulate both circadian rhythms and sleep-wake cycles by targeting social factors that modulate...
these rhythms. They argue that social 'Zeitgebers', that is, personal relationships, social demands, or tasks that entrain biological rhythms, may serve as the link between biological and psychosocial processes that place an individual at risk for developing mood symptoms [43]. Zeitgebers are persons, social demands or tasks that set the biological clock.

This is the first qualitative IPA study which describes the delicate balance in BD between managing psychosocial stressors, medication complications and fear of relapse. Fear of relapse has been shown to be an important clinical feature in studies on schizophrenia and predicts poorer emotional recovery and increased risk of relapse [44]. Individuals who think they will be unable to prevent a relapse are more prone to depression and anxiety [45]. It is hypothesised that greater fear of relapse leads to hypersensitivity of low-level symptoms potentially accelerating the process of relapse [44].

Growing awareness: CBT and DBT. Four of the six participants in this study had accessed Dialectical Behavioural Therapy (DBT), following assessment with the Home Treatment Team, and a fifth was about to start a DBT group. One of the four, Maura, had accessed both DBT and Cognitive Behavioural Therapy (CBT). Dialectical Behaviour Therapy was originally designed for use in a Borderline Personality Disorder (BPD) population. It targets emotional dysfunction, suicidality and self-harm behaviours [46]. There is evidence that DBT may be successfully used transdiagnostically for treating depression and emotional dysregulation [47-49]. In a recent review of treatments for Bipolar Disorder DBT was shown to be effective in reducing depression, although the evidence came from a single pilot study conducted with adolescents [50].

DBT is included in the so-called 'third wave' of CBT-based psychological therapies, which target the process of thought rather than the content, to help people to become aware of their thoughts and accept them in a non-judgemental way. Variants of 'third wave' CBT include: acceptance and commitment therapy (ACT) [51], compassionate mind training (CMT) [52], and mindfulness-based cognitive therapy (MBCT) [53]. 'Third wave' CBT has been shown to be as effective as traditional CBT in a depressed sample [47,48].

In the current study five out of the six participants were referred to DBT, probably due to a co-morbid diagnosis of Borderline Personality Disorder. Three of the six participants stated that participation in the DBT group was the most effective part of their treatment. Given the early stage in the literature of applying DBT to a BD population it is worthwhile examining which parts of the DBT treatment were particularly effective for these individuals.

Paul valued the skill of standing back and becoming aware of what was happening. Kathy also valued a growing awareness of things that don’t suit her and a wherewithal to remove herself from situations that could build into ‘explosive’ confrontations. Helen valued learning about mindfulness, and felt particularly liberated when she learned that thoughts were just thoughts and could not control her. She described this as a life lesson that could have saved her immense trouble had she learned about it earlier.

These individually empowering, transdiagnostic skills learned in DBT may be useful for participants in preventing relapse. The growth in awareness, and ability to observe thoughts and situations differently may insulate themselves against ascent or decent behaviours as per Mansell’s (2007) Integrated Cognitive model. Ascent or decent behaviours are generated by extreme or catastrophic appraisals of personal meaning to situations or thoughts. It is likely that the meta-cognition skills of mindful awareness, tolerance, and distraction learned in the DBT group would mediate the development of ascent or decent behaviours and thus would make relapse less likely for this group of people. They would, in other words, learn to juggle more efficiently with increased task focus, and use tolerance skills to reduce the effects of relapse fears and medication side-effects. This is the first qualitative IPA study examining the mechanisms of change in DBT with a BD population. It has suggested that further research focus on meta-cognitive skills mediating between DBT participation and symptom expression.

Clinical Implications

Participants in this study described many years struggling with symptoms of BD outside the reach of psychiatric help, largely due to mis-diagnosis of their symptoms as unipolar depression or anxiety disorder. Although differentiating unipolar from bipolar disorder is widely held to be a difficult task, it should be a requirement for all clinicians to routinely screen unipolar depression patients with a valid mania screen [54], as earlier diagnosis has been repeatedly linked to better outcome.

One of the most consistent recommendation made by the participants in this study was for greater face to face time with mental health professionals. Community mental health treatment, generally, meant very little time with treating doctors, with much of that interaction focused on medication and suicidality. There arose a need for dedicated individual time for service users to discuss their mental health issues. A therapy gap was identified. Participants did well in group DBT and learned important and useful skills. Perhaps, given limited resources, a group approach to therapy could be developed allowing clients at least that time to therapeutically address long term and current issues.

One of the consistent themes in this study was that participants were unsure which mental health professional to contact when in psychological emergency, and tended not to use the mental health services in a crisis. It should be outlined to clients of a mental health service who to contact in a crisis. Drawing up an individualised relapse prevention plan would help to situate the client into the mental health network and provide a blueprint of how to stay well, and how to optimally use the mental health resources.

Given the success of DBT with the participants in this group, it is recommended that DBT should be offered to all BD service users, irrespective of co-morbidity. The metacognitive skills learned in this group would benefit any person with BD, as outlined by Mansell’s (2007) integrated model. There is further evidence from the current study that DBT offers potential use as a transdiagnostic therapy.

The biopsychosocial model is at the heart of the treatment models examined in this study. However, in practical terms, the biological component of this model assumed a higher prominence in interactions between service users and mental health staff. As there is currently no proof that mental distress constitutes a biological illness, more emphasis should be placed on symptom-specific or complaint-orientated approaches, [36] which are potentially less stigmatising for service users and target treatment immediately to where it is needed.

References

Juggling on Sticks: The lived experience and treatment of Bipolar Disorder


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