Research Matters
researching issues of health and illness

Staying well with bipolar disorder

Training programs for consumers and mental health professionals

Sarah Russell and Margie Nunn

Evaluation Report
November 2009
www.researchmatters.net

Staying well with bipolar disorder: Training programs for consumers and mental health professionals

Dr Sarah Russell

❖ Research Matters
PO Box 1235
Fitzroy North
VIC 3070
Tel: 03 94890742
Email: researchmatters@comcen.com.au
www.researchmatters.net

Desktop publishing: MacNificent
Cover image designed by Wendy Ealey

Table of Contents


exercise
community
stay well plan
diet
medication
mindfulness
sleep
rest
laughter

Introduction

1

After our 'Staying Well with Bipolar Disorder' research[1] and the publication of "A lifelong journey: staying well with manic depression/bipolar disorder"[2], Research Matters developed a new research hypothesis. We hypothesised that a strength-based 'stay well approach' may help people with bipolar disorder to better manage their illness. To test our hypothesis, we worked with both 'consumers' of North West Mental Health Service and mental health professionals.

We recognised that our stay well model requires both people with bipolar disorder and mental health professionals to shift their approach to bipolar disorder. Our stay well model[3] requires:

- People with bipolar disorder to take responsibility for managing their illness/condition by designing their own 'stay well plan' in collaboration with others (e.g. health care professionals, family, friends, colleagues).
- Health care professionals to facilitate a person to develop their own 'stay well plan'.

Research Matters designed 'stay well' training curriculums for both consumers and mental health professionals. We designed:

1. A Stay Well Program for people with bipolar disorder.
2. A Stay Well Workshop for mental health professionals.

Both the Stay Well Program and Stay Well Workshop are underpinned by health promotion methodologies – they focus on wellness, not sickness. Teaching methods are based on adult learning principles that accommodate different learning styles.

Stay Well Program

A multidisciplinary team, including health promotion educators and people with bipolar disorder, designed an innovative curriculum (Table 1). The curriculum focuses on building participants' skills/knowledge which they then use to develop their own Stay Well Plan. The program is facilitated by Dr Russell and Margie Nunn.

Our research was approved by North West Mental Health Research and Ethics Committee before participants were recruited. Our recruitment methodology required mental health care professionals to recommend the program to clients. As a result, they were 'gatekeepers' of the Stay Well Program. Another problem with the methodology was bias – the sample may have been biased because all participants were 'consumers' of a mental health service[4].

Stay Well Program Evaluation

Participants evaluated each session of the Stay Well Program (Appendix 1). Participants of each session were asked to describe:

- the best things about the workshop (and why it was good)
- what was not good (and why not)
- what could be done better in the future

Most importantly, participants were also asked what new skills and knowledge they had learnt during the Stay Well Program. These skills are summarised in Table 2.

1 Russell S and Browne J (2005) Staying well with bipolar disorder Australian and New Zealand Journal of Psychiatry 39:187–193

2 Russell S 2005 A lifelong journey: staying well with manic depression/ bipolar disorder Michelle Anderson Publishing

3 Russell 2008 The role of stay well plans in the management of bipolar disorder" Australian and New Zealand Journal of Psychiatry 2008 42: 551-554

4 Russell S 2009 Staying well: you can have a mental illness and a life The Age 5th May

Table 1: Stay Well Program Curriculum Summary

Session	Title	Primary Aim	Activities
Week 1	Introduction to Stay Well Program	1. To identify participants' strengths and support networks	• Stay well show-bags with resources and novelty item • Photographs that represent feeling good • Introduce idea of a stay well plan • Home Talk - do at least one activity that keeps you well and identify at least one support
Week 2	Getting into it	1. Focus on insight 2. Discuss triggers and warning signs	• Describe an episode of illness and what you learnt from it. • SNAP – a card game to introduce concept of triggers • What triggers can you control, and what triggers can't you control? • Honda ad • Early warning signs BINGO
Week 3	Focus on interventions that work	1. To learn how to minimise triggers and manage early warning signs 2. To focus on interventions that work for each of us 3. Identify who we will ask for help, and how, if we start to become unwell 4. To begin to construct a draft of stay well plan - something concrete to take home and put into practice	• Differentiate (where possible) specific warning signs for each different trigger. • Prepare a "managing check list" on how to manage early warning signs • Start a stay well plan by thinking about ways to minimise your triggers and notice EARLY warning signs • Home Talk - ask an outsider for signs that they notice when you are becoming unwell
Week 4	Putting our stay well plan into action	1. Reviewing, refining, adapting and a REALISTIC stay well plan 2. To determine format of participants' stay well plans	• What needs to change in current daily life? • Ideas how to implement this change? Who else needs to be involved in this change? • Managing "the unexpected" • Not feeling like "being good" • Disclosure – to tell or not to tell
Week 5	Celebrating staying well	1. Discuss stay well plan with family, friends and health care professionals 2. Share understanding of stay well plan 3. Assist others to understand their role in stay well plan	• Talk about stay well plans with others • BINGO triggers and warning signs • Present stay well plans to family, friends and health care professionals

Table 2: New skills and knowledge learnt during Stay Well Program

Session 1	• To be reflective and aware of my condition • To learn from others experience of their condition • That I can manage bipolar disorder better • Fast-tracking the process of staying well - the difference between taking years to learn how to manage it myself or benefitting from others experiences/ideas and learning to manage it in 6 months
Session 2	• How to be more aware of my triggers • Huge amounts – a genuine understanding of triggers and warning signs (why had no-one told me this before?) • Feeling more confident in identifying aspects of my condition • How to handle my triggers better • Recognising the importance of managing my triggers • Aware of triggers and how they can ignite an episode of illness
Session 3	• The importance of being honest when I feel changes • How to go about things in a different way • I have read many publications but never really got the message about warning signs • Practical ways to intervene when feel warning signs • Importance of not leaving it too long when feel warning signs
Session 4	• To be diligent when experiencing triggers and warning signs • Prevention is always better than cure • Learning about myself and how I respond to this illness • That it may take time to get my stay well plan right • Not to be too hard on myself if I get sick • A stay well plan is better than going to hospital • Tolerance when I get it wrong
Session 5	• The importance of sharing my stay well plan with my family

The evaluation of the Stay Well Program included a focus group interview and a survey. The survey measured episodes of illness, hospitalisation, and time off work six months after completing the Stay Well Program (Table 3).

Table 3: Survey results at 6 months after Stay Well Program

Indicator	Results
Episodes of illness	All participants experienced an episode of illness
Hospitalisation	No participant required hospitalisation
Time off work	One participant took time off work

The focus group provided a context for these survey results. All participants indicated that they were watching their triggers and warning signs, and seeking medical assistance earlier and more often. When asked to describe their 'episodes of illness', participants described receiving treatment for an early warning sign rather than a 'full blown' episode of mania or depression. One participant described being unable to convince her case worker that she was hypomanic – the case manager told her that she was "not unwell enough to see a doctor". In short, data suggests that participants were treated more often, but when their symptoms were less severe.

One consequence of the Stay Well Program was participants being more assertive with health care professionals, with many seeking a second professional opinion. Three participants indicated that they had changed doctors and, as a result, changed their medication. They described feeling more "in control" in the management of their illness.

Participants said that the Stay Well Program had helped them to recognise the support their family could provide in helping them to manage their illness. Several participants had developed their stay well plan in collaboration with family members. One participant described forming a stay well committee as part of her stay well plan. By working with her 'stay well committee' she decided to take time off work, and later to change jobs.

Stay Well Workshop

50 mental health professionals have attended our Stay Well Workshops. We were initially invited to develop a training workshop for VICSERV. Dr Sarah Russell and Margie Nunn have also presented the workshop to other mental health professionals (e.g. Western Education and Training cluster in Warrnambool).

The Stay Well Workshop introduces mental health professionals to the stay well approach. During the workshop, mental health professionals were presented with ways to assist and support people with bipolar disorder to develop an individualised 'stay well plan'. The one day workshop was divided into 5 parts (Table 4).

Table 4: Stay Well Workshop Curriculum Summary

Part	Title	Primary Aim
1	What is bipolar disorder?	Brief background information
2	Staying well with bipolar disorder	To provide evidence from our research about how people with bipolar disorder stay well
3	Barriers to staying well	To discuss challenges that health professionals experience in assisting people with bipolar disorder to stay well
4	Stay well plans	To demonstrate how workers can assist people to develop and implement their 'Stay Well Plans'
5	Role Play	For facilitators to evaluate the effectiveness of the workshop

Stay Well Workshop Evaluation

The Stay Well Workshop was evaluated with an open ended questionnaire (Appendix 2). One question asked mental health professionals to describe what they learnt during the Stay Well Workshop (Table 5).

Table 5: New skills and knowledge learnt during Stay Well Workshop

Taught me how to ask different questions
I need to inquire more than advise
A stay well plan is a totally different concept to our usual care plans
Stay well plans are facilitated with client and not given to client
It was helpful to be reminded that the stay well plan is designed for the client and is not a plan to solely satisfy the clinician
Focus on the individual and their perspective
To involve others (carers, family) in developing a client's stay well plan
Involving client more in preventing episodes of their illness
Importance of giving client hope that they can manage illness
Understanding that we can give people tools to manage their illness effectively and live their life to their ultimate
To put it back on the client to make decisions about their own stay well plan
Helping both consumer and me to identify triggers, warning signs and strategies
To work with a client to focus on staying well part rather than how/ why they got here
Some strategies to use with clients and family members
A well planned strategy can help a client to stay well
Stay well plans are a new strategy that are empowering
Inclusion of maintenance in self management
If plan not working, review
Stay well plan will evolve over time
Workshop turned mental illness on its head by focusing on wellness not illness

Conclusion

The Stay Well Program and Stay Well Workshop both focus on wellness, not sickness. As such, they are distinct from, yet complement, other psychoeducation programs for consumers and training programs for mental health professionals.

Stay Well Program

The Stay Well Program is suitable for those people who have the capacity to take responsibility for their illness. It is not effective for those who conceptualise the Stay Well Program as another 'medical appointment'. Our stay well model requires that facilitators of the Stay Well Program do not tell participants how to stay well nor give participants a Fact Sheet with instructions about how to develop stay well plan. The Stay Well Program requires participants to work on their own stay well plan in collaboration with family, friends, colleagues and health care professionals.

Future Stay Well Program will benefit from a screening process to select participants of the Stay Well Program who are most likely to benefit from a stay well approach.

Stay Well Workshop

The Stay Well Workshop is suitable for mental health professionals who can assist a person to develop their own stay well plan. It is not suitable for those mental health professionals who want to give clients a stay well plan (e.g. 'Stay Well with Bipolar Disorder Fact Sheet'5[5]).

The stay well approach may be more effective if the concept is introduced to mental health professionals during their education. ❖

5 Black Dog Institute downloaded 18th October 2006

Appendices

A

Appendix I: Summary of Stay Well Program evaluation

Participants of the Stay Well Program were asked to rate each session out of 10. The overall mean score was 8.5. Individual mean scores of each session were:

Session	1	2	3	4	5
Mean score	8.3	8.6	8.8	7.6	8.5

In addition, the mean score from others (family, friends) who attended Session 5 was 8.5. The mean score of the 6 months follow up session was 8.9.

Participants of each session were also asked to describe: the best things about the Stay Well Program (and why it was good); what was not good (and why not); and what could be done better in the future. Participants were also asked what new skills and knowledge they learnt during the Stay Well Program. The following tables summarises their responses.

Table 1: Best things about Stay Well Program and why

Session	Best things about the Stay Well Program	Why so good
1	Being with a diverse range of people who are willing to share their experiences of bipolar	A friendly, relaxed and supportive environment
	Learning how to stay well	Information was good
	Clear introduction and outline of program	Everybody got involved and had input
	Show bags	Sense of humour
	Notion of focusing on wellness	* Idea that it is possible to nip the illness in the bud
	Being with others with bipolar in a supportive environment	* Presenters were positive
	New insights to bipolar disorder	Held in a relaxed atmosphere
		Good to discuss bipolar from a wellness perspective
2	Getting down to 'brass tacks'	Practical
	My own level of insight	Surprising that I could articulate my triggers
	Interactive	Comfortable with disclosure among group
	Pace was fast	Kept me engaged
	Depth of program	Thoroughly discussed
	Activities and props in show bags	Helped me to remember
	Card game 'snap'	Made the point about shared and individual triggers
	People sharing honestly	Good to talk with each other

3	Getting information about warning signs	No one had spoken with me about warning signs before
	Highlighting my supports	Hadn't recognised all my current supports
	Variety of activities	Helped me to learn
	Slower session –time spent on each activity	More enjoyable
	Sharing our ideas	Comfortable with group
	People sharing personal experiences of warning signs	Gave me more ideas about my own warning signs
	Feeling confident to share personal things	Relaxed atmosphere
	Personal stories	Feel less alone
4	Developing my stay well plan	Because it suit my life, it may work
	Laughed a lot	
	Everyone contributing ideas for a stay well plan	Benefitting from other's ideas
	Becoming like a family	
	Finding out more each session	Wish I had this information when I was younger
5	Meeting partners and families of other participants	Puts other participants in context
	Participant presentations	Variety
	Fun	
	My partner got information	

Table 2: Not good things about Stay Well Program and why

Session	What was not good about Stay Well Program	Why not good
1	Too much information	A lot to absorb
	Felt like a lecture	Not enough interaction
	Participants did not talk enough about their illness	Would have liked to share experiences of illness
	Covered too much	Tiring
2	Activity with scales	Too simplistic
	Getting everyone to talk	May not want to talk
3	Some activities rushed	New ideas need more time to absorb
4	No comments	
5	Reminded me of a school speech night	
	Found it difficult to mingle with participants' families	
	Felt like an exhibit for health professionals	

Table 3: How could the sessions be done better in the future?

Session 1	More disclosure from participants about their experience of illness
	More activities to encourage participation
Session 2	Less activities and more breaks
Session 3	Pace was slow to accommodate others in group, but those of us who get things done more quickly also need to be accommodated
Session 4	More guidance with stay well plan
Session 5	Not sure about having a session that includes families and friends

Table 4: New skills and knowledge learnt during Stay Well Program

Session 1	To be reflective and aware of my condition
	To learn from others experience of their condition
	That I can manage bipolar disorder better
	Fast-tracking the process of staying well - the difference between taking years to learn how to manage it myself or benefitting from others experiences/ideas and learning to manage it in 6 months
Session 2	How to be more aware of my triggers
	Huge amounts – a genuine understanding of triggers and warning signs (why had no-one told me this before?)
	Feeling more confident in identifying aspects of my condition
	How to handle my triggers better
	Recognising the importance of managing my triggers
	Aware of triggers and how they can ignite an episode of illness
Session 3	The importance of being honest when I feel changes
	How to go about things in a different way
	I have read many publications but never really got the message about warning signs
	Practical ways to intervene when feel warning signs
	Importance of not leaving it too long when feel warning signs
Session 4	To be diligent when experiencing triggers and warning signs
	Prevention is always better than cure
	Learning about myself and how I respond to this illness
	That it may take time to get my stay well plan right
	Not to be too hard on myself if I get sick
	A stay well plan is better than going to hospital
	Tolerance when I get it wrong

Appendix II: Summary of Stay Well Workshop evaluations

Participants were asked to rate the workshop out of 10. The mean score was 7.8 with a median of 8. Participants were asked to describe the best things about the workshop (and why it was good); what was not good (and why not); and what could be done better in the future.

Participants were also asked what new skills and knowledge they learnt during the workshop. The following tables summarise their responses. In hindsight, it would have been worthwhile to ask workshop participants "How will you implement these new skills and knowledge into your practice?"

Table 1: Best things about workshop and why

Best things about the workshop	Why so good
Presenters	• Energy and passion of presenters
	• Facilitators expertise
	• Two different styles complemented each other
	• Approachable
	• "Eye opening" to attend a session facilitated by consumer-professionals
	• Welcome change from clinical approach
	• Spoke honestly about personal experience
	• Able to articulate consumer perspective and how professionals can best help
Informative	• Relevant information in accessible way
	• Research evidence and personal experience
	• Good mix of verbal education, case studies, activities and interaction
	• Helped understanding of bipolar
	• A lot of information in short amount of time
Practical	Will be able to implement stay well plan in my workplace
Easy to participate in session.	• Relaxed atmosphere;
	• Everyone given the opportunity to participate
Interactive	Participants had different jobs and different perspectives
Reflective	• Wellness oriented
	• Challenged the way professionals think about clients
	• Idea that consumers can have a say in their recovery plans
Client focused	• Importance of involving client when developing plans
	• Reinforce that that professionals must listen to clients
	• Taking time to allow person to develop their own stay well plan will make plan more effective
Personal stories	Insight into what it may be like to receive treatment
Stay well plans	• Gave practical examples of stay well plans
	• Assisted with strategies
	• Reminder of having a plan for each client
	• Learning how to empower people to develop their own stay well plan
	• Early intervention and relapse prevention prior to crisis
Role play	• Good to put theory into practice
	• To rehearse questions/interventions to assist development of stay well plan
	• To increase confidence in helping facilitate a plan

Table 2: Not good things about workshop and why

What was not good about workshop	Why not good
Required more clinical information about bipolar disorder, treatment and types of medication	I am new to mental health
Too much time spent giving clinical information about bipolar disorder	Clinicians should already know this information
Role play not structured	Role play was too long
Presenters critiqued our professional jargon	"Non-compliance" is a useful term for professionals to use
One session was not enough	• Wellness model is new • Need more time think differently about management of clients with bipolar disorder

Table 3: How could the session be done better in the future?

Have clients, management and clinicians together in workshop
More sessions on wellness model and how to develop a stay well plan
Small groups to discuss role play
More role plays to see variety of stay well plans
Role play shorter
More time on challenges that mental health professionals face in treating people with bipolar disorder
Less time giving clinical information about bipolar

Table 4: New skills and knowledge learnt during workshop

Taught me how to ask different questions
I need to inquire more than advise
Stay well plans are facilitated with client and not given to client
It was helpful to be reminded that the stay well plan is designed for the client and is not a plan to solely satisfy the clinician
Focus on the individual and their perspective
To involve others (carers, family) in developing a client's stay well plan
Involving client more in preventing episodes of their illness
Importance of giving client hope that they can manage illness
Understanding that we can give people tools to manage their illness effectively and live their life to their ultimate
To put it back on the client to make decisions about their own stay well plan
Helping both consumer and me to identify triggers, warning signs and strategies
To work with a client to focus on staying well part rather than how/why they got here
Some strategies to use with clients and family members
A well planned strategy can help a client to stay well
Stay well plans are a new strategy that are empowering
Inclusion of maintenance in self management
If plan not working, review
Plan will evolve over time
Workshop turned mental illness on its head by focusing on wellness not illness

Staying well with bipolar disorder

Sarah J. Russell, Jan L. Browne

Objective: The research aimed to investigate how people diagnosed with bipolar mood disorder avoided episodes of illness and managed to stay well. The research also examined the role that personal, social and environmental factors played in helping people with bipolar mood disorder to stay well.
Method: This project used a combination of qualitative research methods. The design contained three (3) components: recruitment from general community, preliminary written questionnaire and semistructured interviews. To meet the criteria for inclusion, the participant must have stayed well for the past 2 years. The two main analytical categories were 'stay well concept' and 'strategies to stay well'. The main category 'strategies to stay well' contained a number of subcategories. These subcategories were acceptance of diagnosis, mindfulness, education, identify triggers, recognize warning signals, manage sleep and stress, make lifestyle changes, treatment, access support, and stay well plans.
Results: 100 people were eligible for inclusion in the study. The sample included 63 women and 37 men. The ages ranged from 18 to 83 years, with 86% over the age of 30. Duration of time since last episode of illness ranged from 2 years to >50 years. In the sample, 76% of participants were in paid employment. In addition, 36% of participants were parents. Participants actively managed bipolar disorder by developing a range of strategies to stay well. These strategies were based on participants' individual needs and social contexts. The strategies included acceptance of the diagnosis, education about bipolar disorder, identifying both triggers and warning signals, adequate amounts of sleep, managing stress, medication and support networks.
Conclusion: Staying well involved participants being mindful of their illness, which enabled them to develop an individual stay-well plan, including intervention strategies to prevent episodes of illness.
Key words: bipolar disorder, health promotion, mental health, qualitative research.

Australian and New Zealand Journal of Psychiatry 2005; 39:187–193

Bipolar mood disorder is an episodic illness. Although bipolar mood disorder is a common cause of disability [1], some people develop strategies to stay well and avoid relapses of mania and depression [2]. These strategies enable people with bipolar mood disorder to identify early symptoms of relapse and take action to prevent an episode of illness [3].

The aim of the current research was to focus on the collective expertise of one hundred people who lived well with bipolar mood disorder. The National Health and Medical Research Council (NHMRC) *Statement on Consumer and Community Participation in Health and Medical Research* referred to 'those most affected and intimately acquainted with the issues' as providing important insights into health research [4]. The expertise of people who stay well with bipolar mood disorder may also provide new insights for practice.

Sarah J. Russell, Principal Researcher (Correspondence)

Research Matters, PO Box 1235, North Fitzroy, 3068, Victoria, Australia. Email: researchmatters@comcen.com.au

Jan L. Browne, Senior Research Fellow

Deakin University, Faculty of Health and Behavioural Sciences, Melbourne, Victoria, Australia

Received 29 March 2004; revised 25 September 2004; accepted 14 October 2004.

Using standard qualitative methods, our research explored the diverse range of strategies that people with bipolar mood disorder used to stay well. The research was designed to answer specific questions about living with a mental illness that could not be accessed through quantitative analysis. Although qualitative research does not have the statistical power of quantitative research, nor the generalisability, qualitative research has its own value. In this instance, qualitative methods identified *how* people with bipolar mood disorder stayed well. The research also examined the role that personal, social and environmental factors played in helping people with bipolar mood disorder to stay well.

According to the World Health Organization, health is not merely the absence of disease or infirmity. Health is a state of complete physical, mental and social well-being [5]. This research explored the concept of 'health' and 'staying well' for people with bipolar mood disorder. In addition, participants identified a range of strategies used to prevent episodes of illness. Although the individual strategies for staying well differed among the participants, common themes were identified.

Like others who experience incurable chronic illnesses such as heart failure, diabetes mellitus, asthma and HIV [6–9], people with bipolar mood disorder developed strategies to manage the symptoms of their illness. The strategies identified were based on participants' individual needs and social contexts [10]. Some people used their own life experiences and circumstances to document their 'stay well plans'. Others used a verbal plan of action. These personal stay well plans were developed with others – partners, family, close friends, and health care professionals. The stay well plans were adapted and revised as required during the course of their illness in response to changing needs.

Background

A critical review of the literature indicates that mental health research often relies on a convenience sample. Recruitment by convenience sampling limits the sample to those informants who can be easily recruited through mental health organizations, rehabilitation programs and consumer groups. People recruited via convenience sampling often provide different stories to those recruited in the general community [11].

By failing to include people with bipolar mood disorder who are not involved with mental health groups, positive accounts of living with bipolar mood disorder remain largely absent from the research literature. Instead, most social research into the experience of living with bipolar mood disorder focuses on the high rates of suicide, substance abuse, criminal behaviour, unemployment and divorce. For example, a recent study found that people with bipolar mood disorder are '4 times more disabled than the general population' [12]. Another study found people with bipolar mood disorder experienced social isolation, the failure of support networks and the breakdown of relationships [13].

To redress the balance, several autobiographical accounts have been written from a more positive consumer perspective [2,14,15]. Although these published accounts acknowledged that episodes of illness were often traumatic and disruptive, they also demonstrated that it was possible for people with bipolar mood disorder to lead fulfilling lives, including successful professional lives [15].

Bipolar mood disorder affects each person differently [16]. There are a range of personal, social and environmental factors that affect the individual impact of bipolar mood disorder. Increasingly, researchers are pointing to the importance of individual differences in resilience and vulnerability as key determinants of the intensity and duration of episodes of illness. In a risk-protective model of resilience, a protective factor interacts with a risk factor to mitigate the occurrence of a negative outcome [17]. For example, high levels of sociopolitical control were found to limit the negative consequences of helplessness on mental health [17].

A number of studies have examined the role of specific personality variables in episodes of mental illness. Some studies suggest that personality variables such as high self esteem may play a role in moderating the effects of bipolar mood disorder [18]. In contrast, it has been shown that individuals with feelings of low self esteem, insecurity, lack of personal control, and alienation from others were more likely to experience higher levels of depression [19,20]. It has also been shown that social and environmental factors, such as social support, may also moderate the effects of bipolar mood disorder [21–23].

Determining the relative influence of individual predictors is important for the development of intervention strategies that are sensitive to individual differences [19]. However, it is also important to examine how these personality variables interact with life events such as stress [24]. A number of empirical studies show an interaction between stress and personality variables such as dysfunctional attitudes [25], depression prone personality [26], sense of humour [27], self esteem [28] self complexity [29] and perceived competence [30]. However, the relationship between life event and personality variable is dynamic. It has been shown that the impact of a particular stressor may decrease with time [31]. This may suggest that a life stress that initially triggers episodes of illness may enhance long-term resilience. It

also suggests that self understanding may play a role in developing individual resilience [32].

With bipolar mood disorder, stress can trigger both hypomania and depression, particularly stress that causes disruption to sleep [33,34]. Family stress is also a common trigger for people with bipolar mood disorder [33]. Other events that may contribute to increasing levels of stress include personal relationships, employment issues, and environmental factors. It is often difficult for people with bipolar mood disorder to avoid these day-to-day stresses. It is important therefore that people with bipolar mood disorder develop strategies to deal effectively with stressful events.

Research has shown that people with bipolar mood disorder can learn to both identify factors that may trigger episodes of illness and recognize early warning symptoms [3,35]. These early warning symptoms (prodromes) are idiosyncratic to both the patient and to the type of relapse (mania or depression). Once people learn to identify their early warning signs, they are often able to intervene early to prevent relapses of mania and depression. For example, research indicates that teaching people to recognize early warning signs of mania and seek early treatment significantly increased time to the next manic relapse and reduced the number of relapses [3].

Method

To explore the types of strategies that people used to manage bipolar mood disorder, the focus of the research was only on people diagnosed with bipolar mood disorder who stayed well. Although the sample was not representative of all people who experience bipolar mood disorder, the current research fills an important gap in mental health research. By focusing on people who had developed strategies to manage stress and stay well, the research focused on a group of people who are often absent from research into bipolar mood disorder.

To recruit people with bipolar mood disorder who stayed well, it was necessary to use innovative recruitment methods to actively recruit people from the general community rather than mental health organizations. In November 2003, a media release was circulated to major Australian newspapers and radio stations. As a result, articles appeared in several major newspapers and 'Staying Well with a Mental Illness' was broadcast on national radio. In addition, a flyer was disseminated via professional colleagues and published on the internet. The recruitment strategies invited people diagnosed with bipolar mood disorder who stayed well to share their story about: the changes people make in their lives to stay well; the early signs of things going wrong; and what they do to prevent an episode of illness.

Within one month of launching the 'Stay Well' study in the media, 163 enquiries were received. Over a quarter of the initial enquiries came from those with bipolar mood disorder, family and friends seeking some sort of assistance. These people were unaware of support and information services that currently existed. They were given the contact details of appropriate support organizations.

From the 163 enquiries, 100 people self selected for inclusion in the study. The sample included 63 women and 37 men. The ages ranged from 18 to 83, with 86% over the age of 30. Duration of time since last episode of illness ranged from 2 years to >50 years. In the sample, 76% of participants were in paid employment. In addition, 36% of participants were parents.

Data were either written by the participant or collected through a personal interview with the researcher. To facilitate a detailed examination of the data, transcripts were entered into a computer software package designed for qualitative research [36]. The computer package, NVivo, was used to store and manage the data. Using NVivo, the transcripts were coded according to main themes that were identified in the data. The main categories were primarily determined by the interview schedule, though some new subcategories were identified from the data. The two main analytical categories were 'stay well concept' and 'strategies to stay well'. The main category 'strategies to stay well' contained a number of subcategories. These subcategories were acceptance of diagnosis, mindfulness, education, identify triggers, recognize warning signals, manage sleep and stress, make lifestyle changes, treatment, access support, and stay well plans. Data were compared and contrasted within and across categories and subcategories.

Results

Consistent with other qualitative research articles, the results and discussion are presented together. The discussion is required to provide a context for the data.

Stay well concept

In this study, 'staying well' meant different things to each participant. For some, it meant being free of symptoms and behaving 'normally'. For others, it meant being able to make choices and take control of their illness. A 29-year-old university student described how managing her symptoms had given her a sense of control over her illness.

> One of the best things I can say about my illness now is that I am not scared of it anymore. I believe that I have the power to control it. I have learnt how to manage my symptoms.

By gaining greater control over the illness, many participants became less fearful of the illness. With time, experience and insight, they described learning to minimize the impact that the illness had on their lives. Although they were all aware that the illness could not be cured, participants felt able to prevent relapses of illness.

For many participants, staying well involved separating themselves from their illness. A 54-year-old general practitioner was mindful that the medical diagnosis described only the illness. It did not describe him as a person.

> I see the problem as the manic depression and not me. I separate the two and see the need for me to be in control of the manic depression, so that it doesn't influence my life too much.

Although several participants stated that the illness was not a character flaw, personality trait or sign of personal weakness, they were aware that the diagnosis of bipolar mood disorder was perceived

negatively within the community. They felt that community attitudes were largely influenced by the way the diagnosis was applied. When participants were described as 'manic depressive' or 'bipolar', the medical diagnosis became a label that defined the whole person, not just the illness. A 40-year-old lawyer rejected this labelling.

> At some point I must loosen the tag on my forehead that says 'bipolar' and just get on with it. Otherwise I become obsessed about my illness and then I become my illness.

Strategies to stay well

The data indicate a range of strategies that were used to stay well. The individual stay well strategies were based on participants' specific needs and social contexts.

Acceptance of diagnosis

The first step in learning to stay well was receiving the correct diagnosis, and then accepting it. Unfortunately, many participants initially received an incorrect diagnosis. For them, the misdiagnosis of manic depression, and the subsequent mistreatment with incorrect medication, had serious implications for their quality of life. The most common misdiagnoses were clinical depression, schizophrenia, anxiety disorders, borderline personality disorder, and attention deficit disorder. A 35-year-old social worker felt health care professionals needed to take more care when taking a history.

> Unfortunately, the initial diagnosis and treatment was for schizophrenia, which was a bit of a nightmare only because the medication was all wrong and the doctor was not open to changing it. I needed to change doctors to get the correct diagnosis. My new doctor took a proper history, not just the presenting symptoms. With the correct diagnosis and treatment, I took more control over my illness.

Those participants who received the wrong diagnoses found the diagnosis of bipolar mood disorder a relief. Once he was correctly diagnosed, a 47-year-old librarian educated himself about bipolar mood disorder.

> Once you know what it is, you can deal with it. I've had bipolar mood disorder all my life, but it was not until I knew what it was that I could deal with it.

For many other participants, the diagnosis of bipolar mood disorder came as a shock. Data indicate that there was often a period of denial in which the diagnosis was not accepted. A 72-year-old retired judge had remained in denial for 20 years. Although he did not accept the diagnosis, he accepted the need to take lithium.

> It is 20 years since I have seen a psychiatrist and other than being told by my local GP that I should continue taking lithium each day as a precaution, I have not sought nor, in my opinion needed, any medical treatment.

Mindfulness

The data indicate the importance of participants remaining 'mindful' that they have bipolar mood disorder. 'Mindfulness' involved participants being aware of themselves and how they were responding to their physical, mental, emotional, social and physical environment. By maintaining a degree of vigilance, participants were able to recognize when they needed to intervene with strategies to prevent episodes of illness. Mindfulness helped the following participant, a 52-year-old school teacher, to control the illness and minimize its impact on her life.

> I now understand the illness and its impact on my body. I move swiftly to intercept a mood swing.

According to the data, health care professionals often advised people with bipolar mood disorder to 'take their medication and forget about the illness'. Participants described this as 'bad advice'. Data indicates that people with bipolar mood disorder benefit from maintaining an awareness of the illness' presence. A 57-year-old parks and gardens superintendent believed his mindfulness assisted his wellness.

> I am able to assist in my wellness by being aware and observing what is happening to me. Sometimes I need to make changes to stay well.

Participants made many different changes to their lives in order to stay well. Data indicate that there was often a period of 'trial and error' in which participants learnt what strategies worked for them and what did not work.

Education

Data indicates the importance of people with bipolar mood disorder learning about the illness. Participants learnt about bipolar mood disorder through books, health care professionals, mental health organizations, seminars, support groups, internet and talking with people. Participants felt that the sooner they accepted their illness, and learnt about it, the better chance they had of managing it.

In addition to being educated about bipolar mood disorder, participants described the importance of learning about their own individual response to the illness. Participants described the value of life experience, including episodes of illness, as a learning process. A 39-year-old mother and factory worker accepted her limitations.

> Many people hope for instant recovery. It takes time to learn how to control it. We learn to monitor ourselves and accept what our bodies can do.

Participants described the importance of time and life experience in learning to recognize their individual trigger and warning signs.

Identify trigger factors

Insight into bipolar mood disorder involved participants knowing what factors trigger episodes of illness. Participants were able to identify specific things that triggered their episodes of bipolar mood disorder. According to the data, the most common triggers were stress and sleep deprivation. The relationship between stress and sleep was complex. In some cases stress caused disruption to sleep. In other cases, a lack of sleep caused a low resilience to stress.

Participants also identified a number of other factors that may trigger an episode of illness. These included fatigue, jet lag, hormonal fluctuations, change of seasons, all night partying and recreational drugs.

Recognize warning signs

Participants described health care professionals advising them to watch for expansiveness and undue enthusiasm, involvement in excessive numbers of projects, poor judgement and changes in sexual and financial behaviour. However participants felt that these were late signs of an impending episode of mania. Participants felt it was much better for them to recognize their early warning signs.

Participants described the importance of observing small changes in their physical, mental and emotional status. Participants were particularly mindful of small changes in sleep, mood, thoughts, and energy levels. They felt it was important to take small changes seriously. Several participants relied on close friends and family to help them to monitor their moods and behaviour.

When participants experienced *early* warning signals, they implemented interventions to ensure they avoided episodes of illness. According to the data, there were many different types of interventions. Responses to early warning signs included canceling work and social engagements, exercise, sleep, yoga and meditation. In some cases participants increased/changed medication and made an appointment with a health care professional. Participants had developed strategies that worked best for them.

Managing sleep and stress

Data indicates that managing stress and sleep were crucial to staying well. Most participants were vigilant about their sleeping patterns. They kept regular bedtimes and avoided intellectual stimulation at night. Participants described trying to avoid situations likely to disrupt their sleeping routine. However, disruptions were sometimes hard to avoid. When sleep was disrupted, participants did not hesitate to take medication to help them to sleep.

Participants developed various strategies to minimize the impact of stress. Many of these strategies were related to managing workplace stress. These included regular holidays, changing jobs, part-time work and regular counselling. Some participants increased their medication during periods of increased stress. A 42-year-old chief executive officer learnt to manage his work stress. As a result, he also managed his illness.

> Stress is a big trigger for me. To a large extent, managing my illness is about managing my stress.

Make lifestyle changes

Participants identified a number of lifestyle factors that helped them to stay well. They included eating healthy foods, exercising, drinking less alcohol/caffeine, sleeping well, spending time with loved ones, having quiet times, managing stress, and laughing. These lifestyle factors help all people to stay well, not only people with bipolar mood disorder. In addition to trying to maintain a healthy lifestyle, participants described making specific changes in their lives to stay well. Some lifestyle changes were small such as remembering to take medication and being mindful about sleep. Others made significant lifestyle changes such as adopting a quieter lifestyle in a rural community and changing to a less stressful job. A 30-year-old woman left a stressful job in the corporate sector to work part time in community health.

> I had to make huge changes in my life to stay well. Taking medication religiously would be the smallest of these changes. I now lead a different but full life.

Treatment

Several participants described being prescribed incorrect medications. Their lives improved once they were prescribed the correct medication. In this study, 85% of participants took prescribed medication to help them control bipolar mood disorder – 80% took a mood stabiliser every day; 2% took a low dose of lithium and increased the dose during stressful life events; 3% only took lithium when they felt warning signals.

Many participants used both prescribed medication and complementary therapies. The most commonly cited complementary treatments were cognitive behavioural therapy (CBT), nutritional supplements, naturopathy, psychotherapy, traditional Chinese medicine, massage, tai chi, meditation and yoga. Data indicate that health care professionals were often not supportive of people with bipolar mood disorder using complementary therapies. A 36-year-old academic was discouraged from exploring other options.

> I wanted to explore alternative therapies. However, my psychiatrist was not supportive. He was very dismissive of other options. He just believes in pumping me with drugs.

Fifteen participants in the current sample did not take any prescribed medication. This included three participants who had ceased taking lithium on the recommendation of their psychiatrist. The remaining 12 participants treated their bipolar mood disorder with complementary therapies instead of medication. One participant had stayed well for the past 5 years with only orthomolecular treatment while another had remained well for over 30 years by taking only brewers yeast. She felt that one teaspoon per day of brewers yeast had the same effect on her as lithium. Ten participants stayed well by using only psychological treatments such as cognitive behavioural therapy (CBT).

Access support

Participants relied on a range of support networks to stay well. This included partners, parents, children, brothers, sisters, friends, colleagues, pets, churches, community and mental health groups and health care professionals. With assistance from their support networks, participants described learning to set limits and boundaries, establish safety nets and set up harm minimization strategies. In particular, many participants enlisted the help of their personal support networks to help them to recognize early warning signs.

Participants in this sample joined local community groups such as writing groups, book clubs, music groups and sport clubs. They rarely joined mental health support groups. A 50-year-old accountant disapproved of mental health support groups.

> You mix with the same people as in hospital. You drink coffee, smoke and talk about the same things – hospital admission, drug reactions and Centrelink. These groups do not encourage you to get on with your life and get back to work.

Most participants received some sort of professional psychiatric support, though the quality of the professional psychiatric support

varied enormously. Many participants shopped around to find the type of professional support that best suited them. Many participants found the process of choosing their own psychiatrist affirming.

In addition to shopping around for the most suitable health care professionals, several participants preferred to work with a number of different mental health professionals (GPs, psychiatrists, case managers, psychologists, social workers and counsellors). A 26-year-old speech pathologist acknowledged that psychiatrists and psychologists had different expertise.

> My visits with the psychiatrist are quick and infrequent. I see him twice a year. He just prescribes medication and arranges blood tests. My psychologist is more instrumental in helping me to get well. We talk things through.

Several participants in this sample saw their psychiatrist only once or twice a year. Their appointments were for routine matters such as prescriptions and/or blood test requests. Participants were generally happy with this arrangement. The data indicated that taking control of bipolar mood disorder often involved knowing when to ask for help. It also required knowing who to ask for help.

Stay well plans

The main finding from this research was the importance of stay well plans in preventing episodes of illness. All participants described their own stay well plan. Participants developed, adapted and revised their stay well plans as their circumstances required. These plans identified their trigger factors. They also identified their early warning behavioural changes and outlined strategies for themselves and others to ensure that the participant stayed well.

In some cases, stay well plans were a verbal understanding with partners, family, friends and health care professionals. In other cases, stay well plans were an informal written document. Having a documented stay well plan enabled participants to clearly identify their own triggers and warning signs. It also helped partners, family and friends to feel comfortable with any intervention that may be required.

Conclusion

This research focused on people with bipolar mood disorder who stayed well. Although participants do not represent all people who experience bipolar mood disorder, this research fills an important gap in our understanding of bipolar mood disorder. The data demonstrated that people with bipolar mood disorder could manage their illness and stay well.

This research may provide important new insights for health care professionals. Currently, the professional perspective focuses on people with bipolar mood disorder when they are unwell. The professional focus is on 'patients', 'clients' and 'consumers', rather than 'people' with bipolar mood disorder who stay well. It is important that health care professionals realize that people with bipolar mood disorder can get well, especially when diagnosed early and treated appropriately.

Once correctly diagnosed, participants actively managed bipolar mood disorder. Although no universal solutions were identified, participants learnt what worked for them. For many participants, controlling bipolar mood disorder involved adequate amounts of sleep; insight into their triggers and warning signs; manageable levels of stress; suitable medication for them; and compassionate social and professional support networks.

The research identified the importance of stay well plans. These stay well plans involved participants remaining mindful of their illness. Degrees of 'mindfulness' depended on the circumstances. For example, when participants were feeling well, the illness was in the back of their minds. It did not play a large role in their lives, but they knew it was there. On the other hand, when participants encountered triggers and felt 'early warning signals', it was necessary to become more vigilant. In some instances, participants needed to intervene to prevent an episode of illness. Intervention may simply involve a few good sleeps and a long walk along the beach with a dog. Alternatively, intervention may involve making an appointment with a health care professional and altering medication. With experience, participants learnt what worked best to keep them well.

Acknowledgements

We thank those who participated in the study, as well as Margie Nunn, Clare Carberry, Philomena Horsley and the reviewer for their comments on earlier drafts. The research was funded by *beyondblue* Victorian Centre of Excellence in Depression and Related Disorders Grants Program.

References

1. Murray C, Lopez A. Global mortality, disability, and the contribution of risk factors: global burden of disease study. *Lancet* 1997; 349:1436–1442.
2. Kelly M. *Life on a roller-coaster: living well with depression and manic depression*. Sydney: Simon and Schuster, 2000.
3. Perry A, Tarrier N, Morriss R, McCarthy E, Limb K. Randomised controlled trials of efficacy of teaching patients with bipolar mood disorder to identify early symptoms of relapse and obtain treatment. *British Medical Journal* 1999; 318:149–153.
4. National Health and Medical Research Council. *Statement on consumer and community participation in health and medical research.* Canberra: Commonwealth of Australia, 2002.
5. World Health Organization. Preamble to the Constitution of The World Health Organization as adopted by the International Health Conference. New York: World Health Organization, 1946.
6. Horowitz C. A story of maladies, misconceptions and mishaps: effective management of heart failure. *Social Science and Medicine* 2004; 58:631–643.

7. Hill-Briggs F. Problem solving in diabetes self-management: a model of chronic illness self-management behaviour. *Annals of Behavioral Medicine* 2003; 25:182–193.
8. Gibson P. Written action plans for asthma: an evidence-based review of the key components. *Thorax* 2004; 59:94–99.
9. Gifford A. Chronic disease self-management and adherence to HIV Medications. *Journal of Acquired Immune Deficiency Syndromes* 2002; 31:S163–S166.
10. Warsi A. Self-management education programs in chronic disease: a systematic review and methodological critique of the literature. *Archives of Internal Medicine* 2004; 164:1641–1649.
11. Browne J, Russell S. Kerbside Recruiting: recruiting participants in public places. *Australian Qualitative Research Journal* 2003; 3:75–88.
12. Access Economics Report. *Bipolar mood disorder: an analysis of the burden of bipolar mood disorder and related suicide in Australia*. Melbourne: SANE Australia, 2003.
13. Highet N, McNair B. The Impact of Living with Bipolar mood disorder 2004, retrieved 25th March 2004. Available from URL: http://www.beyondblue.org.au.
14. Orum M. *Fairytales in reality: my victory over manic depression*. Sydney, Australia: Macmillan, 1996.
15. Jamison K. *An unquiet mind: a memoir of moods and madness*. New York: Alfred A. Knopf, 1995.
16. Goodwin F, Jamison K. *Manic-depressive Illness*. New York: Oxford University Press, 1990.
17. Zimmerman M, Ramirez-Valles J, Maton K. Resilience among urban African American male adolescents: a study of the protective effects of sociopolitical control on their mental health. *American Journal of Community Psychology* 1999; 27:733–751.
18. Dumont M, Provost M. Resilience in adolescents: protective role of social support, coping strategies, self-esteem, and social activities on experience of stress and depression. *Journal of Youth and Adolescence* 1999; 28:343–363.
19. Regehr C, Hill J, Glancy G. Individual predictors of traumatic reactions in firefighters. *Journal of Nervous and Mental Disease* 2000; 188:333–339.
20. Coleman P, Aubin A, Robinson M, Ivani-Chalian C. Predictors of depressive symptoms and low self-esteem in a follow-up study of elderly people over 10 years. *International Journal of Geriatric Psychiatry* 1993; 8:343–349.
21. Hammack P, Richards M, Luo Z, Edlynn E, Roy K. Social support factors as moderators of community violence exposure among inner-city African American young adolescents. *Journal of Clinical Child and Adolescent Psychology* 2004; 33:450–462.
22. Slack D, Vaux A. Undesirable life events and depression: the role of event appraisals and social support. *Journal of Social and Clinical Psychology* 1988; 7:290–296.
23. Delgard O, Bjork S, Tambs K. Social support, negative life events and mental health. *British Journal of Psychiatry* 1995; 166:29–34.
24. Shahar G, Gallagher E, Blatt S, Kuperminc G, Leadbeater B. An interactive-syneryetic approach to the assessment of personality vulnerability to depression: illustration using the adolescent version of the depressive experiences questionnaire. *Journal of Clinical Psychology* 2004; 60:605–625.
25. Olinger L, Kuiper N, Shaw B. Dysfunctional attitudes and stressful life events: an interactive model of depression. *Cognitive Therapy Research* 1987; 11:25–40.
26. Miranda J. Dysfunctional thinking is activated by stressful life event. *Cognitive Therapy Research* 1992; 16:473–483.
27. Nezu A, Blisset S. Sense of humour as a moderator of the relation between stressful event and psychological distress: a prospective analysis. *Journal of Personal Social Psychiatry* 1988; 54:520–525.
28. Hall L, Kotch J, Browne D, Rayens M. Self-esteem as a mediator of the effects of stressors and social resources on depressive symptoms in post partum mothers. *Nursing Research* 1996; 45:231–238.
29. Linville P. Self complexity as a cognitive buffer against stress-related illness and depression. *Journal of Personal Social Psychiatry* 1987; 52:663–676.
30. Tram J, Cole D. Self-perceived competence and the relation between life events and depressive symptoms in adolescence: mediator or moderator? *Journal of Abnormal Psychology* 2000; 109:753–760.
31. Tennant C. Life events, stress and depression: a review of recent findings. *Australian and New Zealand Journal of Psychiatry* 2002; 36:173–182.
32. Beardslee W. The role of self-understanding in resilient individuals: the development of a perspective. *American Journal of Orthopsychiatry* 1989; 59:266–278.
33. Rasmana R, Bebbington P. Social influence on bipolar affective disorders. *Social Psychiatry and Psychiatric Epidemiology* 1995; 30:152–160.
34. Malkoff-Schwartz S, Frank E, Anderson B *et al.* Stressful life events social rhythm disruption in the onset of manic and depressive bipolar episodes: a preliminary investigation. *Archives of General Psychiatry* 1998; 55:702–707.
35. Geddes J. Prodromal symptoms may be identified by people with bipolar mood disorder. *Evidence Based Mental Health* 2003; 6:105.
36. Richards L. *Using NVivo in qualitative research.* Melbourne: Qualitative Solutions and Research, 1999.

The best papers and reviewers of 2005

Peter R. Joyce

Australian and New Zealand Journal of Psychiatry 2006; 40:721

For 2005, we changed the method for selecting the best papers. Rather than inviting three or four eminent psychiatrists to select the best 10 papers, we undertook an initial selection based upon the two most frequently downloaded papers from each of the 10 issues in 2005 from Blackwell Publishing's Synergy site. From the 20 most frequently downloaded papers, Associate Editors and the Editor chose their top 10 (with instructions not to choose any of their own). Each Associate Editor was given the opportunity to rate their top 10 into three categories, which were assigned weightings. The top 10 papers thus selected are listed in alphabetical order in the references below [1–10].

As reviewing is such an important task in the selection of papers for a peer-reviewed journal, Associate Editors and the Editor were invited to nominate top reviewers for 2005, based upon willingness to review, speed of review and quality of reviews received. For 2005, the reviewers of the year were Associate Professors Anne Buist (Melbourne) and Annette Beautrais (Christchurch).

At this time of celebrating the best papers and reviewers of 2005, we are delighted that our 2005 impact factor has improved to 1.6 from 1.3. We hope this is a first step towards making this journal a highly ranked international journal with an impact factor of greater than four.

Many thanks to our editorial team, publishers, reviewers and authors.

References

1. Burns J, Dudley M, Hazell P, Patton G. Clinical management of deliberate self-harm in young people: the need for evidence-based approaches to reduce repetition. *Australian and New Zealand Journal of Psychiatry* 2005; 39:121–128.
2. Carter FA, Carter JD, Luty SE, Wilson DA, Frampton CM, Joyce PR. Screening and treatment for depression during pregnancy: a cautionary note. *Australian and New Zealand Journal of Psychiatry* 2005; 39:255–261.
3. Keuneman RJ, Pokos V, Weerasundera R, Castle DJ. Antipsychotic treatment in obsessive-compulsive disorder: a literature review. *Australian and New Zealand Journal of Psychiatry* 2005; 39:336–343.
4. RANZCP Clinical Practice Guidelines Team for the Treatment of Schizophrenia and Related Disorders. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of schizophrenia and related disorders. *Australian and New Zealand Journal of Psychiatry* 2005; 39:1–30.
5. Quinlivan JA, Condon J. Anxiety and depression in fathers in teenage pregnancy. *Australian and New Zealand Journal of Psychiatry* 2005; 39:915–920.
6. Rees A-M, Austin M-P, Parker G. Role of omega-3 fatty acids as a treatment for depression in the perinatal period. *Australian and New Zealand Journal of Psychiatry* 2005; 39:274–280.
7. Russell SJ, Browne JL. Staying well with bipolar disorder. *Australian and New Zealand Journal of Psychiatry* 2005; 39:187–193.
8. Sachdev PS, Malhi GS. Obsessive-compulsive behaviour: a disorder of decision-making. *Australian and New Zealand Journal of Psychiatry* 2005; 39:757–763.
9. Vaillant GE. Alcoholics anonymous: cult or cure? *Australian and New Zealand Journal of Psychiatry* 2005; 39:431–436.
10. Yung AR, Yuen HP, McGorry PD *et al.* Mapping the onset of psychosis: the Comprehensive Assessment of At-Risk Mental States. *Australian and New Zealand Journal of Psychiatry* 2005; 39:964–971.

Peter R. Joyce, Editor and Professor

Australian and New Zealand Journal of Psychiatry; Department of Psychological Medicine, Christchurch School of Medicine and Health Sciences, PO Box 4345, Christchurch, New Zealand. E-mail: peter.joyce@chmeds.ac.nz

Role of a 'stay well' approach in the management of bipolar disorder

Sarah J. Russell

Australian and New Zealand Journal of Psychiatry 2008; 42:551–554

The World Health Organization ranks bipolar disorder as the world's sixth most disabling condition [1]. There is a spectrum, however, in the way people experience the symptoms of bipolar disorder. Some people experience severe episodes of both mania and depression throughout their lives; others experience less severe symptoms less often. In addition, people respond differently to medical treatment. Despite these differences in the ways that bipolar disorder is experienced, research indicates that the illness trajectory of bipolar disorder may be influenced by a stay well plan.

Initial research focused on 100 people who lived well with bipolar disorder [2]. This research examined the role of social, environmental, cultural, personal, psychological and medical factors that promote and maintain wellness. The main finding from this research was the importance of a stay well plan in preventing episodes of illness [3]. The findings from this research led to two new research questions. First, can people with bipolar disorder be taught skills to assist them to develop a stay well plan? and second, can health-care professionals and carers be taught skills to assist people with bipolar disorder to develop their own stay well plan? To answer these questions, a multidisciplinary team, including people with bipolar disorder, developed curricula for two innovative programmes: a Stay Well Programme for people with bipolar disorder and a Stay Well Workshop for health-care professionals and support people (i.e. carers).

Sarah J. Russell, Principal Researcher

Research Matters, PO Box 1235, Fitzroy North, Vic. 3068, Australia. Email: sarahrussell@comcen.com.au

This editorial describes the theoretical principles and professional values that underpin the stay well approach. It also compares the stay well approach to other psychosocial interventions.

Concept of a stay well approach

'Stay well plan' is a term that refers to a specific approach to managing a chronic illness. The stay well approach focuses on wellness, not sickness. This approach has been applied to a range of conditions, both physical [4–7] and, more recently, psychiatric [1,2,8,9]. The theoretical principles that underpin the stay well approach are based on the Ottawa Charter for health promotion [10]. According to the Ottawa Charter, health promotion is the 'process of enabling people to increase control over, and to improve, their health'. The Ottawa Charter also advocates a 'strengths-based approach' [11]. Rather than focus on 'what is wrong', a strength-based approach identifies a person's positive abilities and resources. The stay well approach values the expertise of both health-care professionals and people with bipolar disorder. The National Health and Medical Research Council (NHMRC) *Statement on consumer and community participation in health and medical research* referred to 'those most affected and intimately acquainted with the issues' as providing important insights into health research [12]. People with bipolar disorder also provide insights into practice.

The stay well approach is distinct from, yet complements, other psychosocial education programmes. The stay well approach is unique because it incorporates physical, psychological, social, environmental, economic, and cultural factors (commonly referred to as the 'biopsychosocial' model) with a

'wellness' model. The stay well approach is also unique in the way that these two models are combined.

Combining medical and wellness models

Within the medical model, health-care professionals provide information and advice to patients. This advice is often based on evidence. But many people, including people with bipolar disorder, do not follow advice given to them by health-care professionals. This mismatch between what is prescribed in terms of medication or lifestyle changes and what patients actually do is commonly referred to as 'non-compliance'. The literature largely interprets non-compliance as a problem located in irrational patient beliefs that contradict scientific evidence, or in patients' lack of knowledge or understanding [13]. To improve compliance, health-care professionals design 'compliance-enhancing' interventions such as improved therapeutic communication and psychosocial education programmes. One of the stated aims of bipolar disorder psychoeducation programmes is to improve patient compliance, particularly compliance with medication [14].

Within a stay well approach, the concept of non-compliance is rejected [13]. Rather than label people who do not follow health-care professionals' advice as 'non-compliant', and basing interventions on assumptions of patient irrationality or recalcitrance, a stay well approach provides the basis for understanding the aspects of patients' lives that are contributing to their decisions. The stay well approach accepts people with bipolar disorder as experts in their own lives and their health choices.

The stay well approach brings together the expertise of health-care professionals with the expertise of a person with bipolar disorder. Within the stay well plan approach, health-care professionals provide expertise in medical, psychological and social treatments. This expertise involves health-care professionals ensuring a correct diagnosis, prescribing the right medication at the right dose, providing psychological treatments (e.g. cognitive behavioural therapy, counselling) and recommending social interventions (e.g. self-help groups, work, housing etc). In addition to professional expertise, a stay well approach positions people with bipolar disorder as experts about their own lives. A stay well approach recognizes the mediating effect of social, economic, environmental and cultural context.

Comparing Stay Well Programme with other structured programmes

Self-management is widely accepted for people with chronic physical illnesses, particularly illnesses such as heart failure, diabetes mellitus, asthma, HIV and arthritis. Self-management programmes are increasingly being used for people with bipolar disorder. There are now psychoeducational programmes promoting compliance to medication; promoting sleep and daily routine; monitoring moods; detection of early warning signs; and general coping strategies. There is evidence to show that these structured programmes have beneficial effects in preventing relapses [15]. For example, a randomized controlled trial (RCT) investigated the effectiveness of a new psychosocial education programme, the Collaborative Therapies Programme [16]. The RCT demonstrated significantly improved functioning (as measured on Global Assessment Functioning) and a positive trend in reducing relapses.

The Collaborative Therapies Programme is an example of a psychosocial education programme that is based on different principles to those used within a stay well approach. Within a stay well approach, people design their own interventions that are suitable to their social, economic and cultural contexts. The intervention is not prescribed. In contrast, the Collaborative Therapies Programme prescribes a specific intervention: the programme provides each participant with a 'collaborative therapy journal' to record stressors, early warning signs, coping strategies and goals [16]. Although 'journalling' is therapeutic for some people with bipolar disorder, others choose not to complete journals and mood charts. Research identified several reasons for people choosing not to journal: journalling made some people obsess about their illness, while others said that they did not have the time to journal. Some simply said that they were not good at writing – writing was not one of their strengths.

Like the Collaborative Therapies Programme, the Stay Well Programme teaches people to identify their triggers and warning signs. A range of educational activities, designed to accommodate different learning styles, assists participants of the Stay Well Programme to identify common triggers and warning signs. These activities also assist participants to become mindful of their specific triggers and their own early warning signs. During the Stay Well Programme, people with bipolar disorder learn how to maintain a lifestyle that is conducive to maintaining their mental wellness.

Developing a stay well plan

The stay well approach works with people's strengths to facilitate the development of a stay well plan. A stay well plan is not prescriptive– it is a guide. A stay well plan is developed by the person with bipolar, for the person with bipolar, often with the assistance of family, friends and health-care professionals. A stay well plan often needs to be updated and revised regularly as an individual's personal circumstances change. For example, when a person get married, divorced, has children, changes jobs, moves into a new neighbourhood, a stay well plan needs to respond to a person's new circumstances. Also, triggers and warning signs may change with time.

Since the term 'stay well plan' was first applied to bipolar disorder in the psychiatric literature [2], the terms 'stay well plans' and 'well-being plans' have been used to describe markedly different processes to the stay well approach [17–19]. In addition, a 'Staying well with bipolar disorder' fact sheet was published [18]. This fact sheet gave prescriptive instructions about how to formulate a stay well plan. Although fact sheets are educational tools that provide information to patients, prescriptive descriptions of a stay well plan are contrary to the theoretical principles of a stay well approach. The fact sheet described a stay well plan as a written document, despite the fact that there is no requirement that a stay well plan is a written document. Examples of stay well plans include fridge magnets, songs, poetry, paintings or any other creative expression. One participant in the Stay Well Programme formed a 'Stay Well Committee' as her stay well plan. This participant acknowledged the importance of 'outside insight' [9] in helping her to manage her illness. People on her Stay Well Committee were given permission to communicate any concerns about her mood. In addition, members of her Stay Well Committee were told explicitly what she wants them to do whenever they think things are not right for her. The participant described her Stay Well Committee as a 'huge thing' for her.

A stay well approach requires health-care professionals to shift their role from (i) an expert who gives advice to (ii) a professional who facilitates a person to develop their own stay well plan. This facilitation process is fundamental to the development of a stay well plan. It not only shifts power and authority towards patients, but accepts people with bipolar disorder as experts in their own lives and their health choices. But the Stay Well Workshop demonstrates some of the difficulties that health-care professionals may experience when they attempt to shift from an expert who provides prescriptive advice to the role of a facilitator. For example, the final session of each workshop includes a role play in which an experienced actor plays the role of 'Jorja'. During this exercise, Jorja works with the workshop participants to develop a stay well plan. Several workshop participants have suggested that Jorja develops a daily routine. One participant wrote a timetable for her. This timetable included Jorja keeping a daily journal and recording her moods on a chart. Jorja then asked the participant if she could use the pen to write her own timetable. In addition, Jorja told the health-care professional that, with two young children, she did not have time to keep a daily journal or record her moods on a chart. She told the participant that she would not be able to 'comply' with the prescribed timetable.

Conclusion

A stay well approach brings the expertise of health-care professionals together with the expertise of a person with bipolar disorder. Within a stay well plan approach, health-care professionals provide expertise in medical, psychological and social treatments while the people with bipolar disorder provide expertise about their own lives. Rather than prescribe specific interventions, a stay well approach requires health-care professionals to work with people to assist them to design specific interventions that are suitable to their social, economic and cultural contexts. A stay well approach requires health-care professionals to shift their role. Rather than adopt the role of an expert who gives advice (and expects people to follow that advice), health-care professionals are facilitators. They facilitate a person to develop their own stay well plan.

Acknowledgements

My thanks to Margie Nunn, Philomena Horsley, Jenny Walsh, Carol Harvey, Jan Browne, Ruth Vine, Kathleen Brasher, Judi Kiraly and Gill Wilson for helping to develop the curriculum for the Stay Well Program. My special thanks to Margie Nunn who co-facilitates the Stay Well Program and Stay Well Workshop with compassion, patience and humour.

References

1. Murray C, Lopez A. *The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020*. Cambridge, MA: Harvard University Press, 1996.
2. Russell S, Browne J. Staying well with bipolar disorder. *Aust N Z J Psychiatry* 2005; 39:187–193.
3. Russell S, Browne J, Stay well plans can benefit people with bipolar disorder. *Primary Mental Health Care Resource Centre Newsletter* 2005; 2:17–18.
4. Russell S. Who knows where they go? Quality of life after intensive care. *Aust Nurs J* 1996; 3(8):20–22.
5. Russell S. Reducing readmissions to ICU. *Heart Lung* 1999; 28:365–372.
6. Russell S. Life after life-support. *Aust Nurs J* 1999; l6(7): 16–19.
7. Russell S. Improving the continuity of care after discharge from an ICU. *Prof Nurse* 2000; 15:497–500.
8. Russell S. 'Staying well with bipolar disorder'. *New Paradigm* 2005; June: 15–29.
9. Russell S. *A lifelong journey: staying well with manic depression*. Melbourne: Michelle Anderson Publishing, 2005.
10. World Health Organization. Ottawa: Health Promotion, 1986; 1: i–iv.
11. Prilleltensky I. Promoting well-being: time for a paradigm shift in health and human services. *Scand J Public Health Suppl* 2005; 66:53–60.
12. NHMRC. *NHMRC Statement on consumer and community participation in health and medical research*. Canberra: Commonwealth of Australia, 2002.
13. Russell S, Daly J, Hughes E, op't Hoog C. Negotiating 'difficult patients': whose work is it? *J Adv Nurs* 2003; 43: 281–287.
14. Zaretsky A. Targeted psychosocial interventions for bipolar disorder. *Bipolar Disord* 2003; 5:80–87.
15. Lam D. What can we conclude from studies on psychotherapy in bipolar disorder? *Br J Psychiatry* 2006; 188:321–322.
16. Castle D, Berk M, Berk L, Lauder S, Chamberlain J, Gilbert M. Pilot of group intervention for bipolar disorder. *Int J Psychiatry Clin Pract* 2007; 11(4):1–6.
17. Parker G. Bipolar disorders. In: *AIS School Counsellors' Conference 2006 Leura*. Available online at http://www.aisnsw.edu.au/PD/LinkClick.aspx?link=Conferences%2fCounse\2006%2fGordon+Parker+-+Bipolar+Disorder.ppt&tabid=874&mid=1550#26.
18. Manicavasagar V. Developing a 'stay well' plan for managing bipolar disorder. In: *New Perspectives in Mental Health Conference 2007*. Bond University, Griffith University, Gold Coast Integrated Mental Health Service and Queensland Health.
19. Orum M The role of wellbeing plans in managing bipolar II. In Parker G, ed. *Bipolar II disorder: modelling, measuring and managing*. Cambridge: Cambridge University Press, 2008:177–194.

You can have a mental illness and a life

The Age, May 5, 2009

Dr Sarah Russell

Statistics don't tell the whole story about living with manic depression.

We hear so much about the depressing side of mental illness. Statistics focus on the high rates of suicide, homelessness, substance abuse, criminal behaviour, unemployment and divorce. Mental health professionals describe the burden of mental illness in terms of pain, suffering, disability and death.

According to the statistics, people with manic depression (also known as bipolar disorder) are four times more disabled than the general population. Research highlights social isolation, breakdown of relationships and failure of support networks. Statistics also show that one in five people with manic depression commit suicide, with the rest of us statistically destined to a life on disability pensions.

This bias towards reporting the dark side of manic depression is not surprising given that people who stay well are largely absent from mental health research. Researchers often use convenient samples — they recruit "mental health consumers" through mental health organisations, rehabilitation programs and consumer groups. As a result, this research ignores the many of us with manic depression who are happy, enjoy family life, friends, work and are engaged with our local communities.

Manic depression is often portrayed as a "nightmare" — and while this is true for some people, it is not my experience of the illness. What can be a nightmare is other people's response to the illness. Most people respond to physical illness with sympathy and compassion, often sending "get well soon" cards. Kind gestures and compassion rarely accompany episodes of mental illness.

To be with a person experiencing an episode of manic depression can be exhausting, even terrifying. During one episode of depression, I simply sat silently and stared. It was a catatonic, psychotic depression. I have no memory of this, but my friends and family certainly do.

But during an episode of mania I neither sat still nor quietly. The illness gave me the energy to clean the house, weed the garden and believe I could translate War and Peace and split the atom, all by 3am, leaving the rest of the day free to save the world. So much energy, so many new ideas. I ate, moved and talked with a sense of urgency and importance. My mind and mouth were in overdrive. My friends were left gasping in my wake.

Like others with a chronic illness, my challenge has been to control the symptoms so that they do not interfere with my life, particularly my friendships. I have learnt to manage this illness just as a person with diabetes must learn to manage her sugar levels. I have learnt how to stay well.

Not surprisingly, the things that keep me well are the same things that help all people to stay well. We all benefit from eating healthy foods, exercising, avoiding too much stress, sleeping well, and so on.

However, with manic depression, I also need to make specific changes to my life to stay well. With kindness, support and trust of close friends, including my mother, I have developed my own "stay well plan". This helps me to control my illness so that symptoms — depression, psychosis, mania, anxiety — do not interfere with my day-to-day life. I now accept that my mental illness is not a character flaw, personality trait or sign of personal weakness. It is an illness that can affect anyone, regardless of age, race, social class or sporting ability.

Although my stay-well plan includes medication, equally important are my work, friends, local community, laughter, dog walking, sunshine, tennis, dancing and sleep. I do not take these everyday things for granted — they have made an enormous difference to my ability to live well with manic depression.

My experience shows that people with manic depression do get well — and stay well. Statistics only tell one side of the story. If researchers look outside the mental health system, they will discover that there are many good news stories to tell. ❖

Dr Sarah Russell is the principal researcher of Research Matters. Her book A lifelong journey: staying well with manic depression/bipolar disorder (Michelle Anderson Publishing) is based on research funded by beyondblue.