

Appendix 3 : DSM-IV criteria for Bipolar Disorder

Major Depressive Episode:

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

- (1) Depressed mood most of the day, nearly every day.
- (2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
- (3) Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day.
- (4) Insomnia or hypersomnia nearly every day.
- (5) Psychomotor agitation or retardation nearly every day
- (6) Fatigue or loss of energy nearly every day
- (7) Feelings of worthlessness or excessive or inappropriate guilt.
- (8) Diminished ability to think or concentrate or indecisiveness, nearly every day
- (9) Recurrent thought of death, recurrent suicidal ideation without a specific plan or a suicide attempt or a specific plan for committing suicide

The symptoms:

- do not meet the criteria for a Mixed episode.
- cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
- are not due to the direct physiological effects of a substance or a general medical condition.
- are not better accounted for by bereavement.

Manic Episode:

- (A) A distinct period of abnormally and persistently elevated, expansive or irritable mood, lasting at least one week
- (B) During the period of mood disturbance, three or more of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

- (1) inflated self-esteem or grandiosity
- (2) decreased need for sleep
- (3) more talkative than usual or pressure to keep talking
- (4) flight of ideas or subjective experience that thoughts are racing
- (5) distractibility
- (6) increased goal-directed activity or psychomotor agitation
- (7) excessive involvement in pleasurable activities having a high potential for painful consequences.

(C) The symptoms do not meet the criteria for a mixed episode.

(D) The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalisation to prevent harm to self or others, or there are psychotic features.

(E) The symptoms are not due to the direct physiological effects of a substance or a general medical condition.

Mixed Episode:

(A) The criteria are met both for a manic episode and for a major depressive episode (except for duration) nearly every day during at least one week.

(B) The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalisation to prevent harm to self or others, or there are psychotic features.

(C) The symptoms are not due to the direct physiological effects of a substance or a general medical condition.

Hypomanic Episode:

(A) A distinct period of persistently elevated, expansive or irritable mood, lasting throughout at least four days, that is clearly different from the usual non-depressed mood.

- (B) During the period of mood disturbance, three or more of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
- a. inflated self-esteem or grandiosity
 - b. decreased need for sleep
 - c. more talkative than usual or pressure to keep talking
 - d. flight of ideas or subjective experience that thoughts are racing
 - e. distractibility
 - f. increased goal-directed activity or psychomotor agitation
 - g. excessive involvement in pleasurable activities having a high potential for painful consequences.
- (C) The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.
- (D) The disturbance in mood and the change in functioning are observable by others.
- (E) The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalisation, and there are no psychotic features.
- (F) The symptoms are not due to the direct physiological effects of a substance or a general medical condition.

Appendix 4: Introductory letter to participants, Client Information Leaflet and Consent Form

Version 2: dated 2/7/03

July 2003

My name is Heather and I have worked as a volunteer at ... day centre for over three years. It may be news to you that I am also a mental health service client, who is diagnosed as having extreme mood swings (bipolar disorder). I am carrying out my PhD study on this illness and think that this might interest you and would like you to take part. For those of you who do not have a firm diagnosis of bipolar disorder, this would have to be confirmed prior to your participation.

This is a 'user-run' study and involves current and former mental health service clients every step of the way. Your involvement counts and your participation is important to me in my work. This is an opportunity for you to get involved, for your experience to benefit others and for you to benefit from the experience of others by participating in this study. I would like to assure you that, as an honorary member of staff of Herts. Partnership NHS Trust, all information will remain anonymous.

I am currently writing a training programme which aims to benefit people who have extreme mood swings like us. This programme includes things like recognizing mood (highs and lows) and learning how to cope better when this happens. It looks at general lifestyle and suggests ideas about improving it and techniques for how to do this. The idea is that people with mood swings are able to manage better, remain well for longer and enjoy life more. A worthwhile exercise, I hope you agree.

When I have finished writing this training programme, it will be run as a group at ... starting in September this year. About 8 people with similar mood swings will make up the group. It will involve a commitment of 3 hours per week for 10 weeks. Refreshments will be provided during the break half way through the session. There is no cost to you. Similar courses have

been run before and have proved very beneficial to those participating: they have felt more in control of their mood swings, more able to cope and have felt more positive about life in general.

I would like to add that your participation in this study might just make all the difference for people with extreme mood swings. If the training programme shows favourable effects of the therapy, it is my aim to share the findings with the local mental health provider trust to increase awareness of the training as a potential therapeutic option for people with mood swings.

Above all, it is hoped that participating in this study will be of benefit to you.

If you are interested in participating in this group training programme, please attend the meeting to be arranged at ... At this meeting you will be able to ask any question you may have about the research. If you would prefer to speak to me at any time, you may contact me on ...

Looking forward to seeing you then.

Heather Straughan

Version 2: dated 2/7/03

July 2003

**A STUDY TO LOOK AT A USER-LED LIFESTYLE DEVELOPMENT GROUP
TRAINING PROGRAMME FOR PEOPLE WITH BIPOLAR DISORDER
(Mood Swings)**

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask the researcher, Heather Straughan, if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

The purpose of this study is to see if taking part in a user-led lifestyle development group training is beneficial for people with bipolar disorder (mood swings). The study will start in August 2003 and finish in March 2004.

All clients attending ... day centre and outreach projects who have mood swings have been invited to take part in the study (about 20 people). Approximately 10 will be chosen to take part in the study.

It is up to you to decide or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time or a decision not to take part, will not affect the standard of care you receive.

You will be asked to take part in the training programme from September to December this year. You will be asked to complete questionnaires and give interviews before taking part in the group training (August this year), at the end of the training (December this year) and three months after the end of the training (March next year).

Your GP and consultant psychiatrist will be informed of your wish to take part in the study. You will be asked to allow the researcher, Heather Straughan, to have a look at your medical

notes and talk with your psychiatrist. This is to fill in background details and to see if participants taking part in the group training programme have found it beneficial for them.

The training programme lasts for 10 weeks, 3 hours each weekly session and will be held at ... day centre. It will be run by the researcher, Heather Straughan, who has a diagnosis of bipolar disorder (mood swings). The training or the interviews may take place on days you do not usually attend the centre, in which case you will be reimbursed your travel expenses to the centre.

Sometimes, so that we can see which way of treating clients is best, we need to make comparisons. People taking part in this study will be put into groups and then compared. The groups are selected by giving a number to everyone taking part in the study and choosing a number randomly i.e. by chance. Clients in each group then have a different treatment – they either take part in the training programme in September or remain on a waiting-list to take part in the training next year – and these groups are compared.

Taking part in this study does not stop you from doing any of the activities you usually do. However, it is advisable that people who have been prescribed medication for mood swings continue to take it.

The group training will cover things such as commonly recognisable changes in behaviour, thoughts and mood and participants will be assisted in recognizing their own mood, signs of illness and stressful situations. They will be guided to manage their mood swings by monitoring their activities and mood, adopting individual coping strategies for both highs and lows and by continuing their medication. Within a framework of balance and routine, participants will be aided to establish a balance in their activities and they will be guided to look at helpful and unhelpful lifestyle choices, for example in areas such as social, activities, accommodation, exercise and sleep and learn new techniques, for example, positive thinking, assertiveness and communication. Using a weekly activity diary and ensuring that their needs and interests are met, participants will be encouraged to establish new lifestyle choices and carry out a lifestyle change. During the training, week by week, participants will build their own personal lifestyle action plan. There will be group discussions so that everyone can share each other's experiences and homework to do between each weekly group, so that group members can practice what they have learnt as the group goes along.

This study is free of charge to you. You will not be paid for taking part. Tea and coffee will be provided at the break during each weekly session and a meal will be provided each week after the group has finished. Group members will receive a Certificate of Attendance at the end of the completed 10-week course. Those on the waiting-list for next year will receive a small thank-you gift for having taken part in the study.

This is the only user-led lifestyle development group training programme currently offered to people with bipolar disorder (mood swings) in Hertfordshire. However, other treatments may be available from the NHS in the local area which focus on specific areas related to mood difficulties.

Some people taking part in this study may find that some parts of the training programme might produce quite strong emotions. This may be related to learning from past experiences in order to create improved coping strategies and to the nature of the illness itself. If you agree to take part in the study and at any time you feel concerned about how the training programme affects you, please discuss your concerns with the researcher, Heather Straughan (telephone no: ...) or write to her at the above address.

If you are harmed by taking part in this research study, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. If at any time you have any cause for concern or any complaints about the way you have been treated or you have any queries related to the research, then feel free to contact ... (his secretary's telephone no is: ...) or write to him at:....

It is hoped that taking part in the training group will be of benefit to you. However, this cannot be guaranteed. The information we get from this study may help us to provide better care in the future for clients with bipolar disorder (mood swings). Clients who have taken part in similar training groups found that they were better able to cope with their mood swings and had a more positive outlook on life.

Sometimes during the course of a research study, new information becomes available about the treatment that is being studied. If this happens, the researcher, Heather Straughan, will

tell you about it and discuss with you whether you want to continue in the study. If you decide to withdraw, your care will continue in the usual way it did before you agreed to take part in the study. If you decide to continue in the study, you will be asked to sign an updated consent form. Also, on receiving new information, the researcher might consider it to be in your best interests to withdraw you from the study. She will discuss the reasons with you and arrange for your usual care to continue.

When the group training programme finishes in December this year, support will be available for you to continue putting into practice the new skills you have learnt. The researcher, staff at ... day centre and outreach projects and other key mental health personnel will be informed of the training so that they can best support your needs. After December, those taking part in the group will be given the opportunity to meet together on a regular basis so that they can continue to mutually support one another.

All information which is collected about you during the course of the study will be kept strictly confidential. Only the authorities making sure that the researcher, Heather Straughan, is doing this study correctly are allowed to look at this information. Any details thus disclosed will still remain private and confidential. Any information about you that leaves the hospital or surgery will have your name and address removed, so that you cannot be recognized from it.

The results of the research study will be published in the context of the researcher's PhD with the University of Hertfordshire, estimated to be at the end of 2006. However, the results of this study will be made known to all participants in Autumn 2004. Any details published will not identify individual participants.

Heather Straughan is funded for this study on "User Perspectives in Mental Health" from the University of Hertfordshire. No health professional taking part in this research is paid for their contribution.

This study has been reviewed and approved by the East and North Hertfordshire Local Research Ethics Committee.

Please talk over the details of this study with family or friends, your day centre worker or Heather Straughan so that you understand the above. Heather can be contacted on ... or at the day centre on Fridays if you have any questions about this study or the group.

You will be given a copy of this Information Sheet and a signed Consent Form to keep if you decide to take part.

Thank you for your continued interest and agreeing to take part in this study.

Centre No:

Study No:

Client Identification No. for this study:

CONSENT FORM

**A STUDY TO LOOK AT A USER-LED LIFESTYLE DEVELOPMENT GROUP
TRAINING PROGRAMME FOR PEOPLE WITH BIPOLAR DISORDER**

Name of Researcher: Heather Straughan

1. I confirm that I have read and understood the information sheet dated 2/7/03 (version 2) concerning the above study and have had the opportunity to ask questions.

(Please put your initials here)

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

(Please put your initials here)

3. I understand that sections of any of my medical notes may be looked at by the researcher or from regulatory authorities where it is relevant to my taking part in the research. I give my permission for these individuals to have access to my records.

(Please put your initials here)

4. I agree to take part in the above study.

(Please put your initials here)

Name of client:

Date:

Signature:

Researcher:

Date:

Signature:

1 for client, 1 for researcher, 1 to be kept with medical notes

Appendix 5: Aims of the “In-Sight” training

“In SIGHT”

Lifestyle Development Programme for people with Bipolar disorder

Your Thoughts – Your Actions – Your Mood

Taking responsibility for your own well-being

Looking back

- i) Behaviour-Thoughts-Mood Scale: -5 (low) to +5 (high) with 0 as balanced. Details of typical behaviour-thoughts-mood change. Space left for personal details to be added by participants regarding going low, high or what constitutes balanced.
- ii) General Life Stressors : tick off those you have experienced in the past.
- iii) Life Events Chart: Looking back over the highs or lows in your life, draw a life chart (from -5 to +5, with 0 as balanced) marking off your age and which events were significant to you. Any timings, seasonal/monthly vulnerabilities.
- iv) Personal Life Stressors (Triggers): When you look at the events which caused you to experience these highs or lows, list those which were most significant to you (2 columns: high & low).
- v) Mood Signature: Does your onset of illness take a usual pattern? Draw in the phases of how illness develops.
- vi) General warning signs: Reading through the list of possible warning signs of going high or low. Tick off those which you have you experienced?
- vii) Personal warning signs: When you look at the general warning signs, what personal warning signs did you experience (of a high/low)? Did some warning signs appear early or later as the high/low continued?

viii) The Character Game: Examining adopted 'personae' and past personal stressors to look at the meaning behind adoption of certain characters/appeal of certain traits and 'integrate' this period rather than 'seal it over'. Discussion of feelings associated with manic periods (guilt, shame) <NB Not incorporated into the final training, due to focus group comments>

Examining the Present

i) Current stressors and warning signs: what stressful situations are you in at the moment? Are there any warning signs that you are currently observing?

ii) Self monitoring (personal weekly event diary). Teaching awareness. (date, mood 0-10 using Mood Scale, sleep in hours, situation/event, emotion, thoughts, behaviour, outcome). Completed from one session to the next. Group discussion at start of each new session.

iii) Coping strategies: What things do you do to alleviate or stop you from going high/low? General coping strategies employed and the better coping strategies to employ (Wong & Lam, 1998)

iv) Medication adherence: What medication are you currently taking? How useful is this? What side-effects if any do you experience? Have you considered the effects of not taking your medication? Aim: to enhance knowledge about benefits of adherence and make a commitment to continuing adherence.

v) Balance & Routine: Taking a look at your lifestyle:

- the importance of good basic living skills
- the importance of a good relationship with your professional team
- the importance of your social circle/social support (educating others, e.g.family)
- the importance of sleep and relaxation
- the importance of good physical health
- the importance of a healthy diet & weight
- the importance of exercise
- the importance of comfortable accommodation
- the importance of managing your finances & legal aspects

- the importance of meaningful and enjoyable activities (voluntary, study, work, leisure)
- the comfort of spirituality
- the dangers involved in alcohol/illicit drugs
- the dangers involved in suicidal thoughts
- the dangers involved in high standards/expectations

Planning your future

i) Weekly Activity Diary: Monday – Sunday (morning, afternoon, eve). To be completed (social rhythm therapy)

ii) Life skills development:

- positive thinking
 - reality checks for highs
 - assertiveness
 - communication
 - relaxation and visualisation techniques
 - changing things & changing your attitude
- (goal planning - structured problem solving)

iii) Selecting a goal for change: When you look to the future, what do you wish to achieve or develop ? What aspects are you unhappy about and would like to change? (social, physical, cognitive, spiritual, financial, accommodation, activity/employment)?

iv) Planning the change: How would you go about achieving these things? (goal planning & problem solving approaches)

v) Well-being Action Plan: Looking back at what you may need to achieve balance, what would be the things you would do to prevent you from going low/high? What are the helpful lifestyle choices that would be beneficial for you? What should you avoid?

vi) Achieving the Balance: Weekly Activity Diary – using the diary, pencil in helpful choices. What would you like to see yourself doing in the coming months? How do you see your week looking now?

vi) Relapse Advanced Agreement: in the case of you becoming unwell again, how would you want to be treated?

vii) Making a start and following it through:

- continuing with a self-help group: ‘insight’ – weekly, ‘here & now’ problems emotionally supportive, open, informational
- researcher & centre staff: on hand if questions/problems arise.

Appendix 5: In-Sight training course contents

“IN-SIGHT”

Lifestyle Development Programme for people with bipolar disorder

Course Contents

Introduction & Welcome 1

Lifestyle components: Page Numbers

- Recovery: the ethos	2
- Linking Behaviour-Thoughts-Mood	4
- Sleep Part I	16
- Sleep Part II	60
- Sleep Part III	71
- Diet & weight	47
- Exercise	52
- Meaningful activities	73
- Good basic living skills	15
- Medication	22
- Medication adherence	28
- Social circle	31
- Family & communication	35
- Relationships	78
- Self-help group support	141
- Professional team	33
- Accommodation	90
- Finances/budgeting & legal	91
- Spirituality	104
- Alcohol & drugs	97
- Suicidal thoughts	100
- Balance & routine & time management	123
- Perfectionism	115
- The positive effects of the illness	139

Skills training: Page Numbers

- Relaxation – Part I: Deep breathing	9
- Relaxation – Part II: Body relaxation	20
- Relaxation – Part III: Visualisation (The beach)	116
- Counteracting negative thoughts	41
- Positive thinking & maintaining optimism	75
- Communication techniques	38
- Assertiveness	82
- Anger management	110
- Obsessional thoughts	102
- Anxiety & panic	108
- Coping strategies for highs	54
- Coping strategies for lows	62
- Changing things I: having a long think about a situation	93
- Changing things II: goal-planning	105
- Changing things III: problem-solving	120

Tools:

Page Numbers

- Mood scale (behaviour-thoughts-feelings)	3
- General life stressors	5
- Current personal life stressors	13
- Personal Life stressors (triggers)	10b
- Life events chart	7
- Personal mood signature	14
- Self-monitoring Behaviour-Thoughts-Mood diary	8
- Self-monitoring activity schedule (daily)	61
- Well-being activity diary (weekly)	19
- Doing a Well-Being Activity Diary	126
- General warning signs	11
- Personal warning signs	12
- Current personal warning signs	13
- Well-being action plan	129
- Advanced directive (leaflet)	end of course
- Checklist: Well-Being Action Plan	137
- Telephone Wheel: Group Support	141
- Body Mass Indicator	51b

Appendix 6: In-Sight introduction and 12 weekly sessions

Please note: This training manual is the Intellectual Property of the University of Hertfordshire.
The Copyright belongs to Heather Straughan

“IN-SIGHT”

Lifestyle Development Programme for People with Bipolar Disorder

Your Thoughts – Your Actions – Your Mood

Taking responsibility for your own well-being

September 2004

Dear Group Member,

I would like to welcome you to this course. It has been designed and written for people with bipolar disorder by a person who has experienced the illness herself.

As we work through the 12 weekly sessions together, you will be learning about how your moods, thoughts and actions are linked, how you can cope better with the highs and lows and how you can improve your lifestyle. You will also learn the skills to enable you to do this.

This course is your course, this group is your group: it is for your benefit. I am simply the facilitator. Like any new learning experience, what you will get out of it will reflect the time and effort that you put into it.

Like me, I hope that you believe that you are worth this effort, aiming towards a better life with and despite this illness.

I wish you all the very best during the next 12 weeks and beyond.

Heather Straughan
(PhD Researcher)

WEEK ONE:

GETTING TO KNOW YOURSELF: YOUR MOODS AND STRESSFUL SITUATIONS

- 1) Introduction and welcome to the course & ground rules
- 2) Recovery: the thinking behind the course
- 3) The Behaviour-Thoughts-Mood Scale
- 4) Linking behaviour, thoughts and mood
- 5) General Life Stressors – Loss and Change (quiz)
- 6) Your life events chart
- 7) Weekly Self-Monitoring Behaviour-Thoughts-Mood Diary
- 8) Relaxation exercise Part I

Homework:

- complete behaviour-thoughts-mood diary daily
- practice relaxation part I daily
- look over coursework for next week

WEEK TWO:

HOW YOUR MOOD AFFECTS YOU

REVIEW & QUESTIONS

- 1) Personal life stressors
- 2) General warning signs
- 3) Personal warning signs
- 4) Current stressors and warning signs
- 5) Your personal mood signature
- 6) The importance of Good Basic Living Skills
- 7) The importance of Sleep and Relaxation: Part I
- 8) Your Personal Well-Being Activity Diary
- 9) Relaxation exercise: Parts I and II

Homework:

- look over all coursework
- complete behaviour-thoughts-mood diary daily
- practice relaxation part I and II daily
- put your sleep quota into your Activity Diary

WEEK THREE:

The importance of your social circle and medication

REVIEW & QUESTIONS

- 1) The importance of medication
- 2) Medication adherence
- 3) The importance of your social circle and social support
- 4) The importance of your professional health care team
- 5) Relaxation Parts I & II (see Week 2)

Homework:

- complete behaviour-thoughts-mood diary daily
- practice relaxation part I & II daily
- look over previous coursework

WEEK FOUR:

Family influence, communication skills and counteracting negative thoughts

REVIEW & QUESTIONS

- 1) The importance of your family relationships
- 2) Improving your communication techniques
- 3) Counteracting negative automatic thoughts
- 4) Relaxation parts I & II (see Week 2)

Homework:

- complete Behaviour-Thoughts-Mood diary daily paying attention to any negative thoughts
- practice relaxation daily
- look over previous coursework

WEEK FIVE:

Physical well-being and coping with a high

REVIEW & QUESTIONS

- 1) The importance of diet and weight
- 2) The importance of regular physical exercise
- 3) Coping strategies – going high – the self-monitoring activity schedule
- 4) Relaxation Parts I & II (see Week 2)

Homework:

- complete behaviour-thoughts-mood diary daily paying attention to any negative thoughts/situations
- practice relaxation part I & II daily
- read over coursework

WEEK SIX:

Coping with a low and positive thinking

REVIEW & QUESTIONS: previous coursework

- 1) Coping strategies – going low
- 2) General coping strategies for going low
- 3) The importance of sleep and relaxation: Part 3
- 4) The importance of meaningful activities
- 5) Positive thinking and maintaining optimism
- 6) Relaxation: Parts I and II (see Week 2)

Homework:

- practice relaxation daily
- look over previous coursework, especially coping strategies (low)
- start maintaining a positive outlook and engaging in meaningful activities

WEEK SEVEN:

Relationships, assertiveness and making a change

REVIEW & QUESTIONS

- 1) The importance of your relationships
- 2) Assertiveness techniques
- 3) The importance of comfortable accommodation
- 4) The importance of finances and budgets
- 5) Changing Things I: Weighing up the pros and cons
- 6) Relaxation Parts I and II (see Week 2)

Homework:

- practice relaxation daily
- look over previous coursework
- look over costs/rewards for a relationship: is there anything you want to change?
- practice assertiveness in one situation
- look over Changing Things I: is there anything you want to change?

WEEK EIGHT:

Some dangers and working towards changing things

REVIEW & QUESTIONS

- 1) The dangers of alcohol & drugs
- 2) The dangers of suicidal thoughts
- 3) Obsessional thoughts
- 4) The comfort of spiritual support
- 5) Changing Things II: Goal-Planning
- 6) Relaxation Parts I and II

Homework:

- practice relaxation daily
- look over previous coursework, especially goal-planning
- practice new skills

WEEK NINE:

Anxiety, anger and total relaxation

REVIEW & QUESTIONS:

- 1) Working through anxiety and panic
- 2) Anger management
- 3) The dangers of perfectionism
- 4) Relaxation: Parts I, II and III

Homework

- Read the course work
- Practice relaxation Part III

WEEK TEN:

Taking positive action to improve your lifestyle

REVIEW & QUESTIONS

- 1) Changing Things III: Problem-solving
- 2) Balance and Routine
- 3) Doing a Well-Being Activity Diary
- 4) Reviewing the course - Improving your lifestyle
- 5) Relaxation Part III

Homework:

- Put your well-being diary into action and review your goals
- Practice relaxation (Part III)

WEEK ELEVEN:

Planning to stay well and planning in the event of a crisis

REVIEW & QUESTIONS

- 1) Your Well-Being Action Plan
- 2) Your Advanced Directive
- 3) Relaxation Part III

Homework:

- Complete the Action Plan and Advanced Directive
- Practice Relaxation and your new skills
- Review your chosen goals

WEEK TWELVE:

Course review and the importance of the group as support

REVIEW & QUESTIONS

- 1) COURSE REVIEW: Skills
Lifestyle components
Tools
Well-Being Action Plan
Well-Being Activity Diary
Your personal goal
Advanced Directive
- 2) Coping Checklist and Well-Being Checklist
- 3) The positive effects of the illness
- 4) The importance of on-going group support and the MDF
- 5) Group telephone wheel
- 6) Relaxation Part III

⇒ Next group meeting:

Homework:

- Review your Action Plan and Advanced Directive: give copies out
- Practice Relaxation and your new skills
- Review your chosen goals
- Re-read the course material at your leisure

Appendix 7: Aims of the training delivery & criteria for co-facilitators

For group facilitators: Training programme delivery

General approach

‘Counselling skills’ – non-judgemental, empathy, listening,

Teaching skills – able to put a point across whilst allowing for individual finer points

Having worked through certain issues before training delivery (e.g. hospitalisation, medication, self-esteem/efficacy, psychosis, etc)

Mood stable: able to recognize others’ moods and behaviour whilst being able to stand back from these.

Practical approach to learning/teaching

Specific to training programme (refer to programme contents)

For each part of the programme, the facilitator will successfully communicate the relevant information to the participants and guide them through the exercises so that they will build up their own personal self-management intervention.

Section A – Looking Back

Each participant will be able to use the mood scale to judge their own mood, recognize their own life stressors and personal warning signs from more general life stressors and warning signs presented. They will be able to draw from their own life events chart to establish their personal mood signature. Each participant will examine their personae adopted whilst high and in a group discuss the possible appeal of the features.

Section B – Examining the Present

Each participant will be able to recognize current stressors and warning signs and monitor their emotions/thoughts/behaviours in their personal event diary. Each participant will learn coping strategies to deal with highs or lows and rehearse implementation of these. Participants will be instructed on the benefits of medication adherence. Each participant will

examine their general lifestyle in the light of certain healthy lifestyle choices that promote wellness.

Section C – Planning your Future

Each participant will be able to complete their weekly activity diary. Participants will be instructed in life skills development and be able to practice these new skills. Each participant will select a goal for change in an area of their lives and undertake to make this change, with ongoing support. Each participant will complete a well-being action plan to aid in improving their lifestyle. Participants will be instructed on how to complete a relapse agreement and be assisted in completing this.

Following on from the training programme: a self-help group will be established from trainee participants to promote a supportive peer environment and to aid in implementing the changes mentioned above.

Staff at the day centres where the training programme is run will be instructed in the programme and be made aware of training outcomes. They will be available to offer support and encouragement to clients in their continuing to implement the above changes in their lifestyle.

Appendix 8: Themes for interviews with participants and mental health professionals

Major themes for individual interviews

Pre-Course - Main Study

(time frame: now - last year – then further back)

Describe your typical day –

Your background with regard to the illness -

MOOD: functioning – symptoms – medication– hospitalisations

COPING with the illness

EMPOWERMENT/CONTROL:

QUALITY OF LIFE – WELL-BEING:

attitude towards the illness - professional team

physical health

work/income/leisure or other activities

living situation/ safety

social support/family/friends network

self-esteem/self efficacy/ hopefulness

general thoughts (about yourself, the future, the world)- anger – suicidal thoughts

involvement in the community

on-going difficulties/stressful situations/recent setbacks

in the next year: any changes planned –things that might happen

Any other details you would like to add that have not been mentioned?

Any questions you would like to ask me about the course?

CLOSE

Major themes for individual interviews
Pre-Course - Main Study
For Professionals

Please describe your client (mood/thoughts/behaviour)

MOOD: functioning – symptoms – medication– hospitalisations

COPING with the illness

EMPOWERMENT/CONTROL:

QUALITY OF LIFE – WELL-BEING:

Secondary diagnoses/areas of concern

Family-social-work-leisure-partner-general lifestyle-physical health

Knowledge about/attitude towards the illness – other therapies

therapeutic alliance –medication adherence

does client want mood stability – or happy with highs/lows

self-esteem/well-being/hopefulness – anger - suicidal thoughts

learning new skills (motivation, attn. reading writing, planning)

on-going difficulties/stressful situations/recent setbacks

in the next year: any changes planned –things that might happen

in your opinion: how might your client benefit from such a course
what areas need most help with/client's goal for change.

Any other details you would like to add

Any questions you would like to ask

CLOSE

Appendix 9: Four sub-scales for Overall Quality of Life

Physical

DOMAINS PHYSICAL	Pre Course	Pre/Post Course	Pre/Post 6 mths
pilot (8 Ps)	13.14 (12.57 - 14)	12.86 (12.14 - 13.14)	13.71 (11.57 - 16.29)
pilot (5 BDs only)	12.57 (10.86 - 15.14)	12.57 (12.29 - 14.29)	14.29 (12.57 - 17.14)
main study (5 BDs)	12.56 (10.28 - 15.44)	16.56* (10.56 - 18)	9.32 (12 - 16.56)
controls (6 BDs)	13.72 (11.44 - 14.28)	14.84 (10.84 - 15.44)	16 (11.44 - 16.84)

(*) p < 0.10 Wilcoxon

(**) p < 0.05 Wilcoxon

(25% - 75%) Quartile range

Bipolar participants clinically improved their physical quality of life immediately after the course with the main study bipolars statistically significantly improving their physical quality of life post-course (p<0.10). At six months post course, bipolar participants indicate through their spread of scores that on a whole improvements are sustained, although the six months post course decrease median value for the main study group remains unaccounted for. The pilot participants clinically significantly showed worsening in physical quality of life post-course, at six months post-course variability of this group indicates that whilst some have a poorer quality of life others experience an improved quality of life.

Controls show clinically significant improvements post-course and at six months post-course; however, this is due to wider spread of scores indicating variability, so improvements were experienced by some participants whilst others have not experienced improvements.

Psychological

DOMAINS PSYCHOLOGICAL	Pre Course	Pre/Post Course	Pre/Post 6 mths
pilot (8 Ps)	12.50 (10.33 - 13.83)	13.17** (11.50 - 14.67)	13 (10.83 - 15.80)
pilot (5 BDs only)	12 (10 - 13.67)	13.33** (11.67 - 15)	13.33 (11.33 - 17.27)
main study (5 BDs)	9.32 (6.84 - 12.84)	12.32** (10.58 - 12)	13.32** (10.32 - 15)
controls (6 BDs)	12 (9.68 - 14)	12.68 (9 - 14.32)	14.68 (9.32 - 15.32)

(*) $p < 0.10$ Wilcoxon

(**) $p < 0.05$ Wilcoxon

(25% - 75%) Quartile range

Immediately after following the training, there is statistically significant improvement in psychological quality of life for all participants ($p < 0.05$).

Six months later these improvements for all participants are clinically significantly sustained or continue to improve, with statistical significance for the main study bipolars at six months post-course ($p < 0.05$).

Controls show clinically significant improvements in the median value post-course and six months post course; however variability in psychological quality of life scores indicates that whilst some have improved over this time frame, others have worsened.

Social

DOMAINS SOCIAL	Pre Course	Pre/Post Course	Pre/Post 6 mths
pilot (8 Ps)	14 (12.33 - 14.67)	14.67 (13.33 - 16)	12.67 (10.67 - 17)
pilot (5 BDs only)	13.33 (12 - 16)	14.67 (11.67 - 16.67)	16 (10.67 - 17.67)
main study (5 BDs)	10.68 (6.68 - 14.68)	13.32 (9.32 - 16)	12* (8 - 14.68)
controls (6 BDs)	12 (8 - 15.32)	12 (7.32 - 14)	13.32 (9 - 16)

(*) $p < 0.10$ Wilcoxon

(**) $p < 0.05$ Wilcoxon

(25% - 75%) Quartile range

Immediately after following the training course, all participants show a clinically significant improvement in their social quality of life in comparison with controls whose social quality of life deteriorates. At six months post-course bipolars showed clinically significant improvements in their social quality of life in comparison with pre-course scores with statistical significance for the main study group ($p < 0.10$); however spread of scores indicates variability so whilst some bipolars are clinically significantly improving others are worsening.

The pilot participants showed clinically significantly that whilst some participants had a worse social quality of life six months later in comparison with pre-course scores others experienced an improved social quality of life.

At six months post-course, controls indicated a clinically significant improvement in social quality of life in comparison with pre-course scores.

Environmental

DOMAINS	Pre Course	Pre/Post Course	Pre/Post 6 mths
ENVIRONMENTAL			
pilot (8 Ps)	15 (12.13 - 16.75)	15.5 (13.50 - 16.50)	14.5 (11.75 - 17.88)
pilot (5 BDs only)	15.50 (10.50 - 17.25)	16 (13.50 - 17.50)	16* (14.50 - 19)
main study (5 BDs)	15 (10.60 - 15.25)	15** (13.16 - 17.76)	14.52 (13.24 - 17)
controls (6 BDs)	13.72 (11 - 14.24)	14 (13.24 - 15.80)	14 (11.76 - 15)

(*) $p < 0.10$ Wilcoxon

(**) $p < 0.05$ Wilcoxon

(25% - 75%) Quartile range

Immediately after following the training, all participants clinically significantly improved their environmental quality of life with the main study group improving their environmental quality of life statistically significantly ($p < 0.05$).

At six months post-training, bipolar participants clinically significantly continued to further these improvements with statistical significance for the pilot bipolars ($p < 0.10$).

However, the pilot participants clinically significantly showed variability within their spread of scores indicating that whilst some improved on their pre-course scores at six months post-course, some deterioration was noted for others.

Controls show a clinically significant improvement in environmental quality of life post-course; however this returns to pre-course levels six months later.

Appendix 10: Vignette of Participant no. 1 (pilot participant who later trained as main study co-facilitator)

Participant no. 1 : Before the undertaking the training -

Background

P1 had suffered with depression since his teens – he is now in his mid-40's – with intermittent bouts of hypomania. He had a history of medication non-compliance with Lithium. When high he created companies and gave money away leaving him in debt; when low his parents used to take care of him, more recently his girlfriend of some 6 years. He lost both parents some 4 years ago to cancer within two weeks of each other. He had given up his job to nurse them both and shortly before their death had been operated on for bowel cancer, which his mother later died from. His parents had previously helped him with financial difficulties and had ensured he was not hospitalised for his illness. He had been forced to sell the family home and bought a mobile home nearby with his share. His brother also living in the family home at the time had bought a house some distance away. His sister lived a short distance away although he didn't see her often. He had a relationship with a woman with whom he had lived for a short while and who had taken care of him when he was chronically ill with depression but she kept him busy with repairs to her home and took his benefit money, contacting services if his mood changed and appeared to be quite controlling. He could become angry if interference by others either through his relationship or through mental health services was perceived although he was unable to express this anger at the time, withholding it for several months before exploding when another similar incident cropped up.

He was sociable and able to put people at their ease, but appeared to force himself in social situations. Apart from a befriending scheme, he had little social contact although he sought ways in which to rescue people. He had had some suicidal thoughts when depressed but had not acted on these. He generally pulled away from people when low and ceased to function. He feared becoming low as this would mean losing his job again. He realised he didn't cope very well with the illness. He was generally private about his feelings and emotions, apart from when hypomanic when he became argumentative. He admitted to being fearful of relapsing and these worries might precipitate a relapse like a snowball effect. He did not feel optimistic about the future and did not feel empowered to cope with the illness, as he

considered that everything would come crashing down again and he would have to start from square one again.

He had previously had group therapy for two years and followed two anxiety management courses. His community psychiatric nurse previously helped him to look at trigger factors and vulnerability issues and he relied heavily on his social worker for support. He felt very loyal towards his social worker who had helped him a lot in the past, especially with his appeal for benefits. He was equally loyal to the female befriending organizer to whom he felt he owed a debt of gratitude for her support in the past when he had been very depressed.

He did some voluntary work for a charity helping people with learning difficulties and had found this beneficial to his own health. He admitted to not being good at planning anything in the future.

Shortly before starting the In-Sight training, he had worked for a few months as a part-time carpenter but gave this job up during the course as his low mood, influenced by a reduction in his anti-depressant, and a period of overload at work made it impossible for him to continue. However, he attended all ten In-Sight group training sessions during this time. He had a low mood for several months before and throughout the training and then a high mood in the final weeks of the course. Although he had been told that he must keep taking the prescribed dose of Sertraline (an anti-depressant) by a Senior House Officer he consulted, as he was considered as having a 'normal' mood, he believed that the anti-depressant was responsible for his increasingly high mood and felt he must reduce this. He had been tracking his mood and noticed it was increasing with the fear that he would be up in the trees in cloud cuckoo land, running around buying gorillas, if he did not act. He was later instructed to reduce his anti-depressant by his consultant who was contacted in extremis and felt justified that he had coped well with the mood swing, resulting in him becoming transiently anti-psychiatry towards the end of the course. P1 thought that he had coped with a high mood for the first time in his life and felt more self-reliant, now capable of stopping himself from doing silly things, where previously his parents or his girlfriend had taken on this role.

Before the course, his consultant reported that p1 could get very low which covered psychosis and he was unable to continue working, everything stopped and his partner took over. He had a difficult relationship with this woman and it was hard to know if it was

helpful or not. When high, he tended to be hypomanic. He was private about his emotions and felt violated by the illness, not having accepted this illness model. He was not always making good judgements and could be difficult to deal with. He was an adolescent character, had some rebellious issues and could be flirtatious. He could be stroppy when high, but not nasty.

During the course

During the course, p1 brought his befriender who had drunk too much alcohol into the day centre and, rather than rescuing him, stood back and made him think for himself about his actions, making him see the errors of his ways. He bonded with other group members who were involved in other activities he started at the day centre and noticeably implemented certain coping strategies to reduce a high mood. He thus appeared more in control although still with a noticeably high mood.

After following the course

After the course, p1 felt he had managed a high mood swing for the first time in his life, made more difficult as he had to go against advice from trusted mental health professionals whom he had relied upon for some time but who advocated what he believed to be medication (Sertraline) at too great a dose. He had not lost his friends through this episode, rather he could build his circle of friends, as he had not allowed his mood to spiral out of control. Before the course, when in a stable mood he did not feel that he should make friends as he would just lose them again when he became unwell. He felt that he would worry less about fear of relapse now as he could cope with a swing and he could manage a mood swing in future and hold on to his friends and job if he had been working. He felt more optimistic and that there was hope for him for the future. He was attending the healthy eating group weekly and an exercise class. He was eating more healthily and was starting to lose weight. Although the end of the course coincided with many Christmas invitations for him, he did not plan any extra activities and intended to cut back on how much he did, giving himself breaks and time to relax.

He had accumulated debts of £30,000 during his last hypomanic mood some 18 months before undertaking the In-Sight course and during the course negotiated with the Consumer

Advice Bureau and creditors to pay this amount off at less than 40% of the total. Whilst managing his high mood at the end of the course, he was also able to attend to money matters despite fears from his mental health team that he might overspend again. A few months after the course finished, p1 cleared all debt of which he was very proud as financial security was important to him. He was now able to save money towards a new car.

P1 felt more able to put into action what he wanted to do and more able to achieve things whereas before he did not feel certain of these things working out. During the 18 months of the study, he continued to complete his daily diary noting his thoughts and mood. He started to make a weekly plan of activities after completing the course, which he considered a start towards better organisation. It had been the first time he had ever bought himself a diary.

He felt more able to say 'no' to not helping others, realising that it was their responsibility to sort themselves out, not his. He was able to recognize mistakes that others were making in their relationships by becoming too involved or too responsible towards others, especially if this meant risking financial security, which was important to him.

P1 kept recording his thoughts and mood in his diary, recognizing and combating his negative thoughts and chose to share this with his social worker so that he would be sure of completing it regularly and to give her an insight into how he was feeling.

A few months after completing the course, p1 became angry over what he perceived as interference from day centre workers and what day centre workers perceived as a high mood and their responsibility to inform his social worker. After the angry outburst, p1 was asked not to attend for a month. Deprived of the centre's activities, he still attended the associated befriending group and computer activities. He later sent correspondence threatening to sue the centre for negligence as his mood had worsened since not being allowed to attend. However, he did not return to the day centre after the month had expired as he had an ever growing social circle which he had formed into a supportive social group with others with mental health difficulties he had met since attending the course. This social group had started by p1 taking a few people back to his mobile home but then numbers made it impossible to continue meeting there and he arranged regular get-togethers outside for the group.

After following the In-Sight course, p1 split from his girlfriend of six years as he could no longer stand her interference and her restricting nature. He had always been asked by her to do a variety of tasks around her home and this had left him with little time for himself; he always had to dress and wear his hair how she had wanted him to. He had realized that the relationship was not doing him any good. With his growing social group he had been more able to do things with others, had felt more empowered and it had made him aware of what he had been putting up with from his girlfriend. P1's consultant psychiatrist was pleased that this 'entanglement' had come to an end. P1 seemed much happier in the people that he was now seeing.

Shortly after completing the course, p1 found work as a part-time driver for a charity and took many friends and members of his social group there to engage them in voluntary activities to help them with their own mental health difficulties. He was angry for some time about the day centre interference. This anger continued when he stopped attending the centre as a client and a promotion vacancy at his new place of work came up but he was denied this promotion as he felt that the day centre staff had contacted his employers advising them not to allow him to take on more responsibility.

A year after attending the course

P1 gave a presentation at a conference on Recovery a year after completing the course and attested to how the In-Sight training had helped him gain confidence and self-belief, make friends and manage his moods. He had lost 1.5 stone in weight at that time through a healthy diet, and lost over 3 stone when the study concluded. Weight loss was a second personal goal that p1 had chosen during the training; the first goal being to increase his social circle.

A year after starting the In-Sight course as a participant in the pilot group, p1 was trained to become a co-facilitator in the main study group. The training to be a co-facilitator enabled p1 to revisit the course and allowed him to explore areas of his life where he encountered difficulties, for example, assertiveness with friends and acute performance anxiety as a child. He admitted to not having disclosed as much about himself to his mental health professional team as he had done to the researcher and felt that he had benefited greatly by this coaching time and chance to be open about himself.

Facilitating the course a year after having followed it as a participant gave p1 an insight into his own IQ level, as the main study group was generally higher than the pilot. He found teaching this group a challenge and realized that the group of friends with mental health difficulties that he had were not of a similar high IQ level. He thought he should develop his friendships with those who were a little more on a par with him in future. He was able to recognize certain facets of his own personality and behaviour in the main study group participants. Whilst facilitating the In-Sight course, p1 ceased to take part in the befriending group as a client and became a volunteer befriender in this group, of which he was proud.

After the course, p1's consultant reported that p1 had accepted that he had bipolar disorder which had made a big difference. He was now better at seeing it as separate to himself and had a distance on it. He was now less argumentative as he had previously not wanted to see it as an illness. He was now more able to listen. These two issues meant that p1 now had to renegotiate the system which was not flexible with him and did not reflect the change that he had undergone: he was now more amenable to discussion whereas before he had been told what to do, for example, his social worker was not flexible concerning his adjustment of medication according to his moods. The consultant considered that p1 was coping extremely well and although his mood after the course was a bit low he was not ill. The consultant considered that the reason why he was not depressed might stem from his previous successful coping with a high mood and hence avoidance of the post-manic depression. After the course, he had started looking for work again. His consultant thought that p1 was now more appropriately empowered and had shifted his empowerment into better areas. With his new knowledge he could now say things better. His quality of life was considered as better as he had not been ill.

His consultant thought that the social group enabled p1 to work through some developmental issues and the group was supportive towards each other, especially one female friend in particular towards p1. p1 appeared more in control and it felt like he was getting rid of his build up of anger. Good and bad things had come from p1's greater empowerment. The consultant was concerned that p1 continued to take his medication. He had taken on board the importance of a lifestyle balance and although he had enjoyed the high mood he had managed during the course, he had stopped this from continuing and had not suffered the post-manic downswing to a greater extent so he was managing his moods.

18 months after starting the In-Sight training: study end

At the end of the study – some 18 months after starting the In-Sight course – p1 had gone through his old Care Plan Approach notes and established what he considered to be his optimum dose of the anti-depressant he took, according to how low his mood was. He was now managing this dose on his own. He realised that in the September of following the course (now a full year before) as a member of the pilot group and a year later in the September of delivering the course as a co-facilitator, he had had low moods but at the second episode he had managed to reduce his anti-depressant before his mood escalated upwards to a high. He attested to having been able to do this with his ability to track his moods more finely and manage his medication accordingly. He felt that he was listened to more now by his consultant. He was medication compliant with Lithium. He felt more in control of managing his illness through being given the leeway to manage his medication than he ever had done before.

Eighteen months after attending the In-Sight course, p1 wrote to his employers and had his social group officially adopted as a member of the charity for whom he had continued to work part-time. He had taken many of his new friends there for them to engage in voluntary work and felt more at ease as his employers had known about his mental health difficulties and were supportive of him. The social group had grown to about 30 + members 18 months after attending the In-Sight training, had formed their own committee and was engaged in social activities regularly to help their members. P1 was proud of this achievement for the group and himself having successfully attained his personal goal.

He considered that he was getting more enjoyment out of life than he ever had in the last 20 years when he could not even recognize this word. The word enjoyment had kept cropping up in his diary which he still used regularly. He said that starting a new job had made him feel happy not the high mood that had been attributed to him and felt he could distinguish between the two. He felt able to manage his moods, highs or lows and kept himself busy around his mobile home keeping it tidy, which he admitted was a change as he was not naturally a tidy person. He had received many Christmas invitations as the year before but was taking leave from his job to rest in between these so as not to overload.

He was more assertive with his more demanding and persistent friends and was able to be firm and say no to them, putting his needs first before theirs. At first this new skill was not easy to put into practice as he found it was a fine line between helping friends and ensuring that they were responsible for themselves; however, p1 was able to develop this over the 18 months he took part in the study realising that it was not good in the long term that they did not take responsibility for themselves as they would always come to him for help and the best thing was to enable them to help themselves. He also became aware that others could be manipulative, for example, by making him feel guilty about not helping and he did not tolerate this. However, p1's dilemma was that his nature was one of wanting to help others and this firmness did not come easily to him. Rather than answering the telephone, p1 now let the machine pick messages up, deciding whether to answer the calls or not. This had dissuaded more persistent social group members and his ex-girlfriend who had continued to bother him since he had split from her. He had found a new girlfriend from among his social group members and found this to be more helpful for him, although still experienced some interference from his ex-girlfriend with persistent calls.

P1 recognized his over self-reliance and independence in that he did not find it easy to ask others for help, either instrumental help like another pair of hands to do a job or emotional support as he did not readily disclose his feelings. He was able to recognize this overly self-reliance in another study participant and an over dependence in one of his friends, a pilot participant and realised that the balance was somewhere in between. He recognized that he might benefit more if he were to be more open about what he was feeling although this did not come easily to him. He was also aware that he could sometimes be overly confident and this might have led to occasions when he had been perceived as bolshy with mental health professionals.

P1 also developed his anger management during this period as there were occasions when he perceived others as interfering. He became able to express feelings of anger calmly without acting these out. He also noted that as his professional team had given him more leeway in the management of his illness, he had had little cause to become angry. He noted that his team and staff at the day centre were treating him differently from some 18 months before and that they considered that he was doing the right thing regarding illness management most of the time.

His social group provided him with the social support he had previously lacked and he knew that he would never be on his own. Belonging to other groups gave him greater empowerment and these had been supportive of him when he had had difficulties with the day centre. The social group's committee members had followed their own training on mental health issues provided by the day centre and had given talks at local practice governance meetings on their activities and become involved in various fund raising activities for their group.

He had reviewed taking another medication for his slight hypomanic moods but considered that increasing his dose of Lithium would be preferable to risking side effects of this other medication and felt confident that he was more informed about medication.

P1 continued his healthy eating throughout the 18 months, eating more fruit and vegetables, more pulses and no longer bought wheat foods to which he had an intolerance since his bowel surgery. Eating wheat had previously caused sleep problems; however, he admitted that attending parties, when wheat food was served, was not easy as he enjoyed these foods and he would probably continue to tuck in and regret it later. He reduced his caffeine intake quite a lot, another personal goal whilst co-facilitating the In-Sight course. He continued to maintain a balanced week – with work, study, exercise and social – and found this helpful. He admitted to still not enjoying spending too much time on his own but could stay in and spend an evening reading or listening to music. He found co-facilitating the In-Sight group helpful for lifting his mood and it had boosted his confidence and this had brought back the desire that he had had of teaching and all the coaching work he had done with the Scouts in the past. He considered teaching computers and felt that when he compared himself to others his standards of English and Maths were actually quite good. He knew that he had never accepted a more challenging job as he would be able to do this even if quite depressed but 18 months after completing the course felt confident to go for a more challenging job as he could now control his mood swings.

He felt he had more self-confidence, more self-esteem and felt more hopeful about the future and felt he had a much better quality of life. He felt healthier and others had said that he looked healthier. However, he was still fearful that a relapse into a low mood would occur but hoped that he would stay perfectly stable. Although he had not been a person to plan for the future he felt that perhaps he could start planning to do things, for example, doing more

exercise in the coming year. However, he was not a person to set goals and this remained although he felt more confident about realizing projects that he undertook. Eighteen months after completing the course, p1 had almost saved enough to buy a new car.

He had undertaken several projects in his mobile home – new carpets, new bathroom suite – and had cleared a lot of clutter from it creating more room. He continued to keep it tidy and regularly did his washing, washing up, etc. He had been approached by his employer for his view as to whether the manager at the day centre was suitable to become a trustee of the charity and considered this funny as a year before he had been banned from the centre. He was aware that he was treated differently by staff there. He was planning holiday breaks during the summer.

He was concerned about his financial security and the risk of losing tax credits should he not qualify for these by being well. He thought he was well enough to look for a better paid job and had started to scan the papers. He was concerned for his brother who was in financial hardship and he felt obligated to help him out by finding him paid work to do at the weekends. He continued his voluntary work and this helped him manage his own mood. He was organizing his schedule on his computer and was making sure he did something every day. His relationship was going well.

Eighteen months after starting the In-Sight course, p1's consultant said that he had not been ill during this time and he had become clearer in his focus in terms of his life. Although he became slightly anti-psychiatry after the course, he then became more pro-psychiatry and now had achieved a balance, a more sensible view, which allowed him to take or leave bits. He was now taking things forward in a careful but sensible fashion which had not happened before. His consultant was now seeing p1 every 6 months, much less than before, but this would vary according to his mood state. P1 was also seeing his social worker much less than before. His consultant thought that he had accepted he had an illness and had the ability to manage it without devaluing himself. He had managed his illness well and the Sertraline he had been taking had been stopped. His consultant could spot the difference of his coping and it was now a more straightforward exercise. He was now much more responsive in trying to change his medication: he was much better at reading what was going on and in adjusting his medication by himself. Although this leeway was not officially allowed, the consultant would not go into a panic if p1 had told her that he had changed his medication as he was

now more responsible in this way. He had got used to coping well and was now more stronger in his own understanding and had more depth. Change had happened but it was more a case of him being more comfortable, more self-resilient in that change.

As he has been mood stable he had not been stroppy or argumentative, so his relationship with his social worker had been good. He also appeared to like himself more and did not feel so put down consulting as he was more trusting and believed that he was worth it. He had been able to renegotiate the system more easily as he had been able to distance himself from others' behaviour in that he could see how they reacted badly to the system and how he too might have done if he had not been doing things differently as he was now. His empowerment had developed greatly in that he was now looking at others' empowerment besides his own and was able to differentiate himself from others' needs which was a big development for him. His comfort zone had increased with regard to a healthy lifestyle so he had less fear if he missed a day. His hygiene had improved and he had reached a certain personal style. His boundaries had improved regarding his personal relationships and certain previously unhealthy entanglements had ended which was good. Although he was still reticent to disclose his personal feelings this was generally the case when people became well, as they didn't need to talk so much about them. The social group enabled him to find his way within the group and he appeared happier in the people he now saw. He was more content than he was before which was a big change.

The consultant said that p1 was now more self-reliant and responsible but since he had been ill a lot in the past he had not had the same opportunities to develop in certain areas (e.g. his personal development) and so might be reliant on professionals or others rather than develop a more fuller self-reliance. There were patterns in his life when he saw people as interfering, which was independent of the illness although the consultant thought that he had moved on from the incident at the day centre when he considered others were interfering and now saw himself and his mental health professionals as being on the same side. There would be times when he needed more support when he was ill but the support he had been receiving from his social worker had been reviewed within the last few months with a view to being stopped completely. His social worker was now prompting him regarding maintaining a balance not to overload himself and between time on his own and socialisation whereas before decisions had been made for him in these areas. He had been well for some time and had the ability to move on in terms of relationships. He could return to more adult ways of being. The

consultant thought that he was well enough to make choices about how he spent his time. The consultant thought as p1 had spent some time being ill in the past, but had been well for some time now, he could chose to revamp things about his life and there were also usual developmental issues that he had to go through. In this respect the training may not bear fruit for several years. The consultant said that p1 had used his new found feet to walk somewhere in that he had later facilitated the In-Sight group and this had been helpful to him. He had made use of the group which had been helpful. All in all, he had done bloody brilliantly since following the In-Sight course.