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DOCTORAL THESIS

UNDERSTANDING AND MEASURING RESILIENCE IN PATIENTS WITH BIPOLAR DISORDER: EXAMINING ITS ROLE AS A PREDICTOR OF RECOVERY, QUALITY OF LIFE AND PSYCHOSOCIAL FUNCTIONING

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“When we love, we always strive to become better than we are. When we strive to become better than we are, everything around us becomes better too.”— Paulo Coelho, The Alchemist

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Understanding and Measuring Resilience in Patients with Bipolar Disorder: Examining its Role as a Predictor of Recovery, Quality of Life and Psychosocial Functioning

Abstract

Background: Bipolar Disorder (BD) is a complex, severe, and recurrent mental illness, characterized by cyclical and extreme mood swings ranging from episodes of mania or hypomania to depression, interspersed with periods of euthymia. The worldwide aggregate lifetime prevalence rate is 2.4% for Bipolar Spectrum Disorders (BSD), including BD-I (0.6%), BD-II (0.4%), and subthreshold BD (1.4%). BD is often unrecognized and frequently runs with other mental disorder comorbidities, and therefore it is underdiagnosed or misdiagnosed until the right diagnosis is given after an average delay of eight years since the first affective episode. BD impacts negatively in psychosocial and work functioning and quality of life of people who suffer the disorder. The chronicity across the life span and the early onset of this severe mental illness is responsible for the sixth leading cause of disability-adjusted life years worldwide; therefore, BD results in a high socioeconomic and health burden. *Resilience* is understood as the dynamic process in which psychological, social, environmental, and biological factors interact to enable an individual at any stage of life to develop, maintain, or regain their mental health despite exposure to adversity. Research is rapidly growing in the field of psychological resilience. In the area of BD, even if some studies have demonstrated that people with BD can live a positive, fulfilling, and contributing life, the available scientific literature about resilience in BD is very scarce.

Aims: The present doctoral thesis aims (1) to review the literature on resilience and recovery in order to understand their meanings and roles in the mental health area (Study 1), (2) to understand the resilience experience and its qualities in BD from the

perspectives of BD patients and clinicians, so as to build a synthetic theoretical model of resilience in BD (Study 2), (3) to develop a psychometrically reliable and valid questionnaire of resilience specific to BD (Study 3), and (4) to analyze the cross-sectional and prospective associations between resilience and mental health adjustment indicators in BD (Study 4).

Methods: The design of this doctoral thesis is based on a mixed methodology that includes a theoretical review (Study 1), qualitative methodology (Study 2), and quantitative approach, involving the development and validation of a questionnaire (Study 3) and path analyses (Study 4).

For the Study 1, a total of 84 documents on resilience and recovery were reviewed, and differences, similitudes, and convergences between both constructs were analyzed. For Study 2, 15 patients in remission from BD and six clinicians who were experts in the treatment of BD took part in semi-structured interviews or in different focus groups. For Study 3, a new BD-specific resilience measure, *the Resilience Questionnaire for Bipolar Disorder* (RBD), was developed based on results from the previous qualitative study and on the literature review on resilience. A clinical sample of 125 patients diagnosed with BD, and a comparison sample of 107 people from the general population completed the RBD along with a self-reported battery of questionnaires at baseline [sociodemographic and clinical questions, the Resilience Scale (RS-25), the Brief Quality of Life in Bipolar Disorder (Brief-QoL.BD), the Internal States Scale (ISS), the Bipolar Recovery Questionnaire (BRQ)], and were followed up 6 months later, analyzing the psychometric properties of the RBD (reliability, construct validity, concurrent validity, known-groups validity, and responsiveness). Exploratory and confirmatory factorial analyses were undertaken, together with reliability and ANOVA analyses. The same BD patients from Study 3 took part in Study 4. In Study 4, participants (n = 125) who participated in Study

3 received follow-ups between 6-12 months. For Study 4, participants at follow-up completed the following measures: sociodemographic and clinical questions, the RBD, the Brief-QoL.BD, the ISS, the BRQ, and the Work and Social Adjustment Scale (WSAS). Cross-sectional and prospective analyses included bivariate correlations and path analyses to explore associations between resilience and mental health adjustment indicators of personal recovery, well-being, bipolar symptomatology, psychosocial functioning deficit, and quality of life.

Results: Results from the Study 1 indicate that while there is a substantial overlap between aspects of resilience and recovery in the context of mental health, differences between both constructs enable understanding of the roles of each one and the relationship between them. As a result, it is suggested that resilience plays a moderating role in the impact of stressors on the process of personal recovery. Results from the qualitative study provide the first understanding of the process and qualities of resilience as experienced in BD. As a result, we obtained a resilience model for BD including the following resilience topics in BD: antecedent conditions for resilience, turning point, self-awareness, self-management of BD, balanced self-style, positive personality qualities, and interpersonal support. Results from the Study 3 support the development of the new 23-item RBD, which includes five factors ('self-management of BD', 'turning point', 'self-care', 'self-confidence', and 'interpersonal support'), that show satisfactory psychometric results with respect to construct validity, reliability, concurrent validity, known groups validity, and responsiveness (at follow-up) in people diagnosed with BD. Patients who were classified within the recovered group scored higher in resilience than either patients classified within the not recovered group or the comparison sample from the general population. In the last study, path analyses indicate that the resilience domains self-management of BD, self-care, and self-confidence, and turning point explain cross-

sectionally the variance of the mental health-related outcome variables. Study 4 also shows that self-management of BD and turning point resilience domains prospectively explain the variance on personal recovery. The role of turning point is notable, since it is negatively associated with well-being, quality of life, and psychosocial functioning in the cross-sectional path analysis; turning point at baseline, however, is a predictor (positively associated) of personal recovery at follow-up.

Conclusions: Findings from the different studies of this doctoral thesis point to the relevance of resilience in people diagnosed of BD as a construct that contributes to explain the process of personal recovery in these patients. Different domains of resilience explain cross-sectionally and predict prospectively the variance on a number of mental health indicators. This doctoral thesis supports the importance of resilience in the recovery process of people diagnosed with BD, providing a model of resilience in BD that explains in detail the main resilience qualities. This doctoral thesis also includes the development of a psychometrically sound measure of resilience specific for BD patients, the RBD (23 items). Next, this doctoral thesis identifies the domains of resilience that have statistical significance in the variability on mental health outcomes, both cross-sectionally and longitudinally. In the final section of this doctoral thesis, I provide a general discussion and conclusions from the four studies. This section also comprises main limitations, future directions, and practical implications of this research.

Keywords: resilience, bipolar disorder, recovery, mental health, review, qualitative methodology, quantitative methodology, questionnaire development, psychometrics, path analysis, prospective design

Comprender y Medir la Resiliencia en Pacientes con Trastorno Bipolar: Valoración de la Resiliencia como Predictora de la Recuperación, Calidad de Vida y Funcionamiento Psicosocial

Resumen

Introducción: El Trastorno Bipolar (TB) es una enfermedad compleja, severa y recurrente, caracterizada por oscilaciones cíclicas y extremas del estado de ánimo, que fluctúan entre episodios de manía o hipomanía y depresión, alternados con períodos de eutimia. La tasa de prevalencia agregada durante la vida es de 2.4% para el espectro de trastornos bipolares, incluyendo TB-I (0.6%), TB-II (0.4%), y TB subumbrales (1.4%). El TB suele pasar desapercibido y frecuentemente se acompaña de comorbilidades con otros trastornos mentales, y por lo tanto el TB es subdiagnosticado o no se diagnostica correctamente hasta dar con el diagnóstico acertado tras un retraso medio de ocho años desde el primer episodio afectivo. El TB impacta negativamente en el funcionamiento psicosocial y laboral y sobre la calidad de vida de las personas que lo sufren. La cronicidad a lo largo de la vida y el comienzo temprano de esta enfermedad mental severa, explica por qué el TB ocupa el sexto lugar entre las causas de años de vida ajustados por discapacidad del mundo; De esta forma, el TB supone una alta carga socioeconómica y sanitaria. La *resiliencia* se entiende como el proceso dinámico en el que factores psicológicos, sociales, ambientales y biológicos interactúan para permitir que un individuo, en cualquier etapa de su vida, desarrolle, mantenga, o recobre su salud mental a pesar de la exposición a la adversidad. La investigación en el campo psicológico de la resiliencia es cada vez mayor. En el área del TB, a pesar de que algunos estudios han demostrado que las personas con TB pueden vivir una vida positiva, plena y contributiva, la literatura científica disponible sobre la resiliencia en el TB es muy escasa.

Resumen

Objetivos: La presente tesis doctoral tiene como objetivos (1) revisar la literatura en resiliencia y recuperación para entender sus significados y roles en el contexto de la salud mental (Estudio 1), (2) entender la experiencia y cualidades de la resiliencia en el TB desde las perspectivas de pacientes diagnosticados de TB y clínicos para construir un modelo teórico que sintetice la resiliencia en el TB (Estudio 2), (3) desarrollar un cuestionario de resiliencia específico para el TB que sea psicométricamente fiable y válido (Estudio 3), y (4) analizar las asociaciones transversales y prospectivas entre la resiliencia y los indicadores de salud mental en el TB (Estudio 4).

Métodos: El diseño de esta tesis doctoral se basa en una metodología mixta que incluye una revisión teórica (Estudio 1), metodología cualitativa (Estudio 2), metodología cuantitativa que incluyó el desarrollo y validación psicométrica de un cuestionario (Estudio 3) y un estudio prospectivo usando la técnica estadística de path análisis para conocer las relaciones entre las variables de estudio (Estudio 4).

Para el Estudio 1, se revisaron un total de 84 documentos en resiliencia y recuperación, y se analizaron las diferencias, similitudes, y convergencias entre ambos constructos. Para el Estudio 2, 15 pacientes en remisión del TB y seis clínicos expertos en el tratamiento del TB participaron en entrevistas individuales semi-estructuradas o en diferentes grupos focales. Para el Estudio 3, se creó una nueva medida de resiliencia específica para el TB, el *Cuestionario de Resiliencia para el Trastorno Bipolar* (RTB), en base a los resultados del estudio previo cualitativo y de la revisión teórica de la literatura en resiliencia. Una muestra clínica de 125 pacientes diagnosticados de TB, y una muestra de comparación de 107 personas de la población general completaron el RTB junto con una batería de medidas auto-reportadas en el tiempo base [preguntas sociodemográficas y clínicas, la Escala de Resiliencia (RS-25), la versión breve del Cuestionario de Calidad de Vida en el Trastorno Bipolar (Brief-QoL.BD), la Escala de

Estados Internos (ISS), el Cuestionario de Recuperación Bipolar (BRQ)], y se realizó un seguimiento 6 meses después, analizando las propiedades psicométricas del RTB (fiabilidad, validez de constructo, validez concurrente, validez de grupos conocidos, y sensibilidad al cambio). Se llevaron a cabo análisis factoriales exploratorios y confirmatorios, además de análisis de fiabilidad y análisis intergrupal (ANOVA). Los pacientes diagnosticados de TB que participaron en el Estudio 3 también participaron en el Estudio 4 (n = 125). En el Estudio 4 también se emplearon los datos de seguimiento de entre seis a doce meses con los pacientes que participaron en el tiempo base. Para el seguimiento, los participantes completaron las siguientes medidas: preguntas sociodemográficas y clínicas, el RTB, el Brief-QoL.BD, el ISS, el BRQ, y la Escala de Ajuste Laboral y Social (WSAS). Los análisis transversales y prospectivos incluyeron correlaciones bivariadas y path análisis con el fin de explorar las asociaciones entre la resiliencia y los indicadores de ajuste de salud mental de recuperación personal, bienestar, sintomatología bipolar, funcionamiento psicosocial, y calidad de vida.

Resultados: Los resultados del Estudio 1 indican que mientras que existe un solapamiento considerable entre los aspectos de resiliencia y recuperación en el contexto de la salud mental, las diferencias entre ambos constructos permiten entender los diferentes roles ejercidos por cada uno y la relación entre ellos. Como resultado, se defiende que la resiliencia juega un papel moderador en el impacto que los estresores tienen durante el proceso de recuperación personal. Los resultados del estudio cualitativo (Estudio 2) proporcionan un primer acercamiento al proceso y las cualidades de resiliencia experimentadas en el TB. Como resultado, obtuvimos un modelo de resiliencia para el TB que incluye los siguientes temas de resiliencia en el TB: condiciones antecedentes para la resiliencia, punto de inflexión, conciencia de uno mismo, autogestión del TB, estilo de vida equilibrado, cualidades positivas de la personalidad, y apoyo

interpersonal. Los resultados del Estudio 3 apoyan el desarrollo de la nueva medida de resiliencia específica para personas diagnosticadas con TB (el RTB), de 23 ítems y cinco factores ('autogestión del TB', 'punto de inflexión', 'autocuidado', 'confianza en sí mismo', y 'apoyo interpersonal'). El RTB muestra resultados psicométricos satisfactorios respecto a la validez de constructo, fiabilidad, validez concurrente, validez de grupos conocidos, y sensibilidad al cambio (en el tiempo de seguimiento) en personas diagnosticadas de TB. Los pacientes clasificados en el grupo de recuperados puntúan más alto en resiliencia que los pacientes clasificados en el grupo de no recuperados y que el grupo de comparación de la población general. En el último estudio, los path análisis indican que los dominios de resiliencia de autogestión del TB, autocuidado, confianza en sí mismo, y punto de inflexión explican la variación transversal en variables relacionadas con la salud mental. El Estudio 4 también muestra que los dominios de resiliencia de autogestión del TB y punto de inflexión explican prospectivamente la variación en recuperación personal. El rol del dominio de punto de inflexión es destacable, dado que se asocia negativamente con bienestar, calidad de vida, y funcionamiento psicosocial de manera transversal; sin embargo, el punto de inflexión en el tiempo base es un predictor (positivamente asociado) de recuperación personal en el tiempo de seguimiento.

Conclusiones: Los hallazgos resultantes de los diferentes estudios que componen esta tesis doctoral demuestran la relevancia de la resiliencia en personas diagnosticadas de TB, ya que se muestra como un constructo que contribuye a explicar el proceso de la recuperación en estos pacientes. Varios dominios de resiliencia explican transversalmente y predicen prospectivamente la variación en diferentes indicadores de salud mental. Esta tesis doctoral apoya la importancia de la resiliencia en el proceso de recuperación de personas diagnosticadas de TB, proporcionando un modelo de resiliencia en el TB que explica en detalle las cualidades de resiliencia principales. Esta tesis doctoral también

incluye el desarrollo de una medida de resiliencia específica para pacientes con TB que es psicométricamente robusta, el RTB (23 ítems). Además, esta tesis doctoral identifica los dominios de resiliencia que son estadísticamente significativos en la variación de resultados de salud mental, tanto transversal como longitudinalmente. En la sección final de esta tesis, se proporciona una discusión general y las conclusiones de los cuatro estudios. Esta sección también comprende las principales limitaciones, direcciones futuras, e implicaciones prácticas de este estudio.

Palabras clave: resiliencia, trastorno bipolar, recuperación, salud mental, revisión, metodología cualitativa, metodología cuantitativa, desarrollo cuestionario, psicométricas, path análisis, diseño prospectivo

1. Background

Bipolar Disorder

1.1. General Considerations

1.1.1. Definition

Bipolar Disorder (BD), previously recognized as 'manic-depressive psychosis' (Akiskal et al., 2000), is a complex, recurrent, and severe mental disorder, impacting negatively on the psychosocial and work functioning and quality of life of people diagnosed with this illness, especially because of its early onset and chronicity across the life span (Grupo de Trabajo de la Guía de Práctica Clínica sobre Trastorno Bipolar, 2012; Merikangas et al., 2011; National Institute for Health and Care Excellence [NICE], 2014; National Collaborating Centre for Mental Health [NCCMH], 2014).

BD is characterized by mood swings ranging from episodes of mania or hypomania to depression, interspersed with periods of euthymia or much improved symptomatology and functioning (Grupo de Trabajo de la Guía de Práctica Clínica sobre Trastorno Bipolar, 2012; NCCMH, 2014; NICE, 2014). Since the release of the *Diagnostic and Statistical Manual for Mental Disorders* (DSM) and the *International Classification of Diseases* (ICD) in the 1960s, BD started to be a concept subdivided into BD Type I (BD-I) and Type II (BD-II). In the 1990s, several authors (Akiskal & Pinto, 1999; Angst, 1998; Goodwin and Jamison, 1990; Grande, Berk, Birmaher, & Vieta, 2016) returned to the Kraepelinian idea of a bipolar spectrum concept including also milder or subthreshold clinical manifestations of BD forms not comprised within the *DSM-IV-TR* (American Psychiatric Association [APA], 2000) or within the *ICD-10* (World Health Organization [WHO], 1992).

1.1.2. Diagnostic criteria in adults

The major diagnostic classification systems for the diagnosis of mental disorders are the *DSM* (APA, 2013) and the *ICD* (WHO, 1992). These main systems of

classification present some heterogeneity in the criteria for BD diagnostic. Given that the *ICD-10* is generally used for clinical, but not for research aims (Grunze et al., 2009), and that most of the evidence-based guidelines are based on the *DSM-IV* diagnostic entities, *DSM-IV-TR* (APA, 2000) overall criteria for a diagnosis of BDs are presented below (see Tables 1-14). Detailed criteria for each BD episode specifier (severity/psychosis/remission specifiers; chronic; with catatonic, melancholic or atypical features, with postpartum onset, longitudinal course specifiers, with seasonal pattern, and with rapid cycling) can be consulted in the *DSM-IV-TR* (APA, 2000). As additional information, a brief explanation of the similarities and differences between different classification manuals, which is presented below, underlies the need to join and homogenize criteria of the main classifications (i.e., *DSM* and *ICD*) (de Dios, Goikolea, Colom, Moreno, & Vieta, 2014).

Table 1

Bipolar disorders (296.xx Bipolar I disorders, 296.89 Bipolar II disorder, 301.13 cyclothymia, and 296.80 Not Otherwise Specified) and mood episodes (hypomanic, manic, mixed and mayor depressive episodes) classification of the DSM-IV-TR

Bipolar disorders classification and table-index			ICD-9-CM codes	ICD-10 codes [a]
Bipolar disorders [a]	Bipolar I disorders		296.xx	(___.__)
	Bipolar I disorder, single manic episode	See Table 2	296.0x	(F30.x)
	Bipolar I disorder, most recent episode hypomanic	See Table 3	296.40	(F31.40)
	Bipolar I disorder, most recent episode manic	See Table 4	296.4x	(F31.4x)
	Bipolar I disorder, most recent episode mixed	See Table 5	296.6x	(F31.6)
	Bipolar I disorder, most recent episode depressed	See Table 6	296.5x	(F31.x)

	Bipolar I disorder, most recent episode unspecified	See Table 7	296.7	(F31.9)
	Bipolar II disorder	See Table 8	296.89	(F31.8)
	Cyclothymia disorder	See Table 9	301.13	(F34.0)
	Not otherwise specified	See Table 10	296.80	(F31.0)
Mood episodes [b]	Hypomanic episode	See Table 11	Not assigned	
	Manic episode	See Table 12	Not assigned	
	Major depressive episode	See Table 13	Not assigned	
	Mixed episode	See Table 14	Not assigned	

[a]Key difference between the *DSM-IV-TR* and the *ICD-10* is that the *DSM-IV-TR* requires at least one manic or mixed episode for the diagnosis of Bipolar I disorder, and at least one major depressive episode and one hypomanic episode but no manic nor mixed episode for the diagnosis of Bipolar II disorder, while the *ICD-10* requires at least two mood episodes (one of them being mania or hypomania) for the diagnosis of bipolar affective disorder. In addition, the *ICD-10* does not provide specific criteria for Bipolar II disorder as a separate diagnostic entity and it can be coded as "other bipolar disorders" (F.31.8).
[b]Mood episodes cannot be diagnosed as independent entities, but instead are used to help the bipolar disorder diagnosis.

Table 2

DSM IV-TR diagnostic criteria for 296.0x Bipolar I disorder, single manic episode

A.	Presence of only one manic episode and no past major depressive episodes. Note. Recurrence is defined as either a change in polarity from depression or an interval of at least 2 months without manic symptoms.
B.	The manic episode is not better accounted for by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.
Specify if	Mixed: if symptoms meet criteria for a mixed episode.
Specify	(for current or most recent episode): Severity/psychotic/remission specifiers With catatonic features With postpartum onset

Copied from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (APA, 2000).

Table 3

DSM IV-TR diagnostic criteria for 296.40 Bipolar I disorder, most recent episode hypomanic

A.	Currently (or most recently) in a hypomanic episode

B.	There has previously been at least one manic episode or mixed episode.
C.	The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D.	The mood episodes in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.
Specify	Longitudinal course specifiers (with and without inter-episode recovery) With seasonal pattern (applies only to the pattern of major depressive episodes) With rapid cycling

Copied from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (*APA, 2000).

Table 4

DSM IV-TR diagnostic criteria for 296.4x Bipolar I disorder, most recent episode manic

A.	Currently (or most recently) in a manic episode.
B.	There has previously been at least one major depressive episode, manic episode, or mixed episode.
C.	The mood episodes in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.
Specify	(for current or most recent episode): Severity/psychotic/remission specifiers With catatonic features With postpartum onset
Specify	Longitudinal course specifiers (with and without inter-episode recovery) With seasonal pattern (applies only to the pattern of major depressive episodes) With rapid cycling

Copied from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (APA, 2000).

Table 5

DSM IV diagnostic criteria for 296.6x Bipolar I disorder, most recent episode mixed

A.	Currently (or most recently) in a mixed episode.
B.	There has previously been at least one major depressive episode, manic episode, or mixed episode.

C.	The mood episodes in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.
Specify	(for current or most recent episode): Severity/psychotic/remission specifiers With catatonic features With postpartum onset
Specify	Longitudinal course specifiers (with and without inter-episode recovery) With seasonal pattern (applies only to the pattern of major depressive episodes) With rapid cycling

Copied from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (APA, 2000).

Table 6

DSM IV-TR diagnostic criteria for 296.5x Bipolar I disorder, most recent episode depressed

A.	Currently (or most recently) in a major depressive episode.
B.	There has previously been at least one manic episode or mixed episode.
C.	The mood episodes in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.
Specify	(for current or most recent episode): Severity/psychotic/remission specifiers Chronic With catatonic features With melancholic features With atypical features With postpartum onset
Specify	Longitudinal course specifiers (with and without inter-episode recovery) With seasonal pattern (applies only to the pattern of major depressive episodes) With rapid cycling

Copied from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (APA, 2000).

Table 7

DSM IV-TR diagnostic criteria for 296.7 Bipolar I disorder, most recent episode unspecified

A.	Criteria, except for duration, are currently (or most recently) met for a manic, a hypomanic, a mixed, or a major depressive episode.
B.	There has previously been at least one manic episode or mixed episode.
C.	The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D.	The mood symptoms in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.
E.	The mood symptoms in Criteria A and B are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).
Specify	Longitudinal course specifiers (with and without inter-episode recovery) With seasonal pattern (applies only to the pattern of major depressive episodes) With rapid cycling

Copied from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (*APA, 2000).

Table 8

DSM IV-TR diagnostic criteria for 296.89 Bipolar II disorder

A.	Presence (or history) of one or more major depressive episodes.
B.	Presence (or history) of at least one hypomanic episode.
C.	There has never been a manic episode or a mixed episode.
D.	The mood symptoms in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.
E.	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Specify	current or most recent episode: Hypomanic: if currently (or most recently) in a hypomanic episode Depressed: if currently (or most recently) in a major depressive episode
Specify	(for current or most recent major depressive episode only if it is the most recent type of mood episode): Severity/psychotic/remission specifiers. Note: Fifth-digit codes specified on p. 377 cannot be used here because the code for bipolar II disorder already uses the fifth digit. Chronic With catatonic features

	With melancholic features With atypical features With postpartum onset Longitudinal course specifiers (with and without inter-episode recovery)
Specify	With seasonal pattern (applies only to the pattern of major depressive episodes) With rapid cycling

Copied from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (APA, 2000).

Table 9

DSM IV-TR diagnostic criteria for 301.13 cyclothymic disorder

A.	For at least 2 years, the presence of numerous periods with hypomanic symptoms (see p. 338) and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode. Note: In children and adolescents, the duration must be at least 1 year.
B.	During the above 2-year period (1 year in children and adolescents), the person has not been without the symptoms in Criterion A for more than 2 months at a time.
C.	No major depressive episode, manic episode, or mixed episode has been present during the first 2 years of the disturbance. Note. After the initial 2 years (1 year in children and adolescents) of cyclothymic disorder, there may be superimposed manic or mixed episodes (in which case both bipolar I disorder and cyclothymic disorder may be diagnosed) or major depressive episodes (in which case both bipolar II disorder and cyclothymic disorder may be diagnosed).
D.	The symptoms in Criterion A are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.
E.	The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).
F.	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Copied from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (APA, 2000).

Table 10

DSM IV-TR diagnostic criteria for Not Otherwise Specified

This designation abbreviated NOS can be used when the mental disorder appears to fall within the larger category but does not meet the criteria of any specific disorder within that category.

Copied from *the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (APA, 2000).

Table 11

DSM IV-TR diagnostic criteria for hypomanic episode

A.	A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 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: (1) inflated self-esteem or grandiosity (2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep) (3) more talkative than usual or pressure to keep talking (4) flight of ideas or subjective experience that thoughts are racing (5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
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 hospitalization, and there are no psychotic features.
F.	The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).
Note.	Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar II Disorder.

Copied from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (APA, 2000).

Table 12

DSM IV-TR diagnostic criteria for manic episode

A.	A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).
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 (e.g., feels rested after only 3 hours of sleep) (3) more talkative than usual or pressure to keep talking (4) flight of ideas or subjective experience that thoughts are racing (5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
C.	The symptoms do not meet 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 hospitalization 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 (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).
Note.	Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, and light therapy) should not count toward a diagnosis of bipolar I disorder.
Criteria for Severity/psychotic/remission specifiers for current (or most recent) manic episode	
	Note: Coding in the fifth digit. Can be applied only if the manic episode criteria are currently met. In partial remission and in complete remission, they can be applied to a manic episode in bipolar I disorder only if it is the most recent type of mood episode. .x1--Mild: Minimum symptom criteria are met for a manic episode. .x1--Moderate: Extreme increase in activity or impairment in judgment. .x3--Severe without psychotic features: Almost continual supervision required to prevent physical harm to self or others. .x4--Severe with psychotic features: delusions or hallucinations. If possible, specify whether the psychotic features are mood-congruent or mood-incongruent:

Mood-congruent psychotic features: Delusions or hallucinations whose content is entirely consistent with the typical manic themes of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.
Mood-incongruent psychotic features: Delusions or hallucinations whose content does not involve typical manic themes. Included are such symptoms as persecutory delusions (not directly related to grandiose ideas or themes), thought insertion, thought broadcasting, and delusions of being controlled.

.x5--In partial remission: Symptoms of a manic episode are present but full criteria are not met, or there is a period without any significant symptoms of a manic episode lasting less than 2 months following the end of the manic episode.
.x6--In full remission: During the past 2 months no significant signs or symptoms of the disturbance were present.
.x0--Unspecified.

Copied and adapted from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (APA, 2000).

Table 13

DSM IV-TR diagnostic criteria for major depressive episode

A.	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. Note. Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations. (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood. (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others) (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains. (4) insomnia or hypersomnia nearly every day (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down) (6) fatigue or loss of energy nearly every day (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

	(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others) (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
B.	The symptoms do not meet criteria for a mixed episode.
C.	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D.	The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
E.	The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.
Criteria for severity/psychotic/remission specifiers for current (or most recent) major depressive episode	
	Note: Coding in the fifth digit. Can be applied only if the major depressive episode criteria are currently met. In partial remission and in complete remission, they can be applied to a major depressive episode in bipolar I or bipolar II disorders only if it is the most recent type of mood episode.
	.x1--Mild: Few, if any, symptoms in excess of those required to make the diagnosis, and the symptoms result in only minor impairment of occupational functioning or in the usual social activities or relationships with others. .x2--Moderate: Symptoms or functional impairment between "mild" and "severe". .x3--Severe without psychotic features: Several symptoms in excess of those required to make the diagnosis, and symptoms that markedly interfere with occupational functioning or the usual social activities or relationships with others. .x4--Severe with psychotic features: Delusions or hallucinations. If possible, specify whether the psychotic features are mood-congruent or mood-incongruent: Mood-congruent psychotic features: Delusions or hallucinations whose content is entirely consistent with the typical depressive themes of personal inadequacy, guilt, disease, death, nihilism or deserved punishment. Mood-incongruent psychotic features: Delusions or hallucinations whose content

	does not involve typical depressive themes. Included are such symptoms as persecutory delusions (not directly related to grandiose or depressive themes), thought insertion, thought broadcasting, and delusions of control.
	.x5--In partial remission: Symptoms of a depressive episode are present but full criteria are not met, or there is a period without any significant symptoms of a major depressive episode lasting less than 2 months following the end of the major depressive episode.
	.x6--In full remission: During the past 2 months, no significant signs or symptoms of the disturbance were present.
	.x0--Unspecified.

Copied and adapted from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (APA, 2000).

Table 14

DSM IV-TR diagnostic criteria for 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 a 1-week period.
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 hospitalization 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 (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).
Note.	Mixed-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar I disorder.
Criteria for severity/psychotic/remission specifiers for current (or most recent) mixed episode	
	Note: Coding in the fifth digit. Can be applied only if the mixed episode criteria are currently met. In partial remission and in complete remission, they can be applied to a mixed episode in bipolar I disorder only if it is the most recent type of mood episode.
	.x1--Mild: No more than minimum symptom criteria are met for both a manic episode and a major depressive episode.
	.x2-- Moderate: Symptoms or functional impairment between "mild" and "severe".
	.x3--Severe without psychotic features: Almost continual supervision required to prevent physical harm to self or others.

.x4--Severe with psychotic features: Delusions or hallucinations. If possible, specify whether the psychotic features are mood-congruent or mood-incongruent:

Mood-congruent psychotic features: Delusions or hallucinations whose content is entirely consistent with the typical manic or depressive themes.

Mood-incongruent psychotic features: Delusions or hallucinations whose content does not involve typical manic or depressive themes. Included are such symptoms as persecutory delusions (not directly related to grandiose or depressive themes), thought insertion, and delusions of being controlled.

.x5--In partial remission: Symptoms of a mixed episode are present but full criteria are not met, or there is a period without any significant symptoms of a mixed episode lasting less than 2 months following the end of the mixed episode.

.x6--In full remission: During the past 2 months, no significant signs or symptoms of the disturbance were present.

.x0--Unspecified.

Copied and adapted from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (APA, 2000).

DSM-IV-TR (APA, 2000) differentiates between BD-I, BD-II, Cyclothymia, or BD Not Otherwise Specified (NOS). BD-I requires at least one manic or mixed episode with or without a previous mayor depressive episode. Current or more recent types of episodes can be specified as hypomanic, manic, depressed or mixed. Additionally, the last episode can be specified with catatonic, melancholic, or atypical symptoms, and longitudinal course, with seasonal pattern, or postnatal onset. Typically, manic episodes alternate with depressive episodes. BD-II requires at least one hypomanic episode and at least one previous mayor depressive episode; it also requires lack of manic or mixed episodes, as they would imply a BD-I diagnosis. Cyclothymia refers to chronic mood swings with multiple mild mood disturbances of hypomanic and depressive symptoms that are not high enough in intensity, persistence or duration to meet complete diagnoses of manic or mayor depressive episodes. Diagnosis of cyclothymia requires two years of recurrent hypomanic episodes and depressive symptoms. Finally, BD not otherwise specified is a residual diagnostic category for disorders characterized by bipolarity

features that do not meet criteria for BD-I, BD-II, or Cyclothymia (Ministerio de Salud, 2013; Grupo de Trabajo de la Guía de Práctica Clínica sobre Trastorno Bipolar, 2012).

Under the diagnosis of BD not otherwise specified, there are some manifestations of mania of clinical importance that are not specifically classified in the *DSM-IV-TR* or in the *ICD-10* (e.g., BD-III -hypomanic episodes induced by antidepressants or lasting less than four days- and BD-IV –recurrent depressive episodes and previous hyperthymic mood states that are a lesser form of hypomania states) (Grunze et al., 2009; Piver, Yatham, & Lam, 2002). Unlike the *DSM-IV-TR*, the *ICD-10*, the beta draft of the *ICD-11* (WHO, 2016) and the *DSM-5* (APA, 2013) acknowledge a spectrum of BD (de Dios et al., 2014; NCCMH, 2014). *DSM-5* (APA, 2013) overall criteria for a diagnosis of BDs are presented below (see Tables 15-25). Detailed criteria for each BD episode specifiers (severity/psychosis/remission specifiers; with anxious distress; with mixed features; with rapid cycling; with melancholic features; with atypical features; with mood-congruent psychotic features; with mood-incongruent psychotic features; with catatonia; with peripartum onset; and with seasonal pattern) can be consulted in the *DSM-5* (APA, 2013).

Table 15

Bipolar and related disorders (296.xx Bipolar I disorders, 296.89 Bipolar II disorder, 301.13 cyclothymic disorder, substance/medication-induced bipolar and related disorders, bipolar and related disorder due to another medical condition, 296.89 other specified bipolar and related disorder, and 296.80 unspecified bipolar and related disorder) and mood episodes (hypomanic, manic, and mayor depressive episodes) classification from the DSM-5

	Bipolar disorder classification and table-index		ICD-9-CM codes	ICD-10 codes
Bipolar disorders	Bipolar I disorder [a]	See Table 16	296.xx	(F31.xx)
	• Current or most recent episode manic		296.xx	(F31.xx)
	Mild		296.41	(F31.11)
	Moderate		296.42	(F31.12)
	Severe		296.43	(F31.13)
	With psychotic features		296.44	(F31.2)
	In partial remission		296.45	(F31.73)
	In full remission		296.46	(F31.74)
	Unspecified		296.40	(F31.9)
	• Current or most recent episode hypomanic		296.40	(F31.0)
	In partial remission		296.45	(F31.73)
	In full remission		296.46	(F31.74)
	Unspecified		296.40	(F31.9)
	• Current or most recent episode depressed		296.xx	(F31.xx)
	Mild		296.51	
	Moderate		296.52	
	Severe		296.53	
	With psychotic features		296.54	
	In partial remission		296.55	
	In full remission		296.56	
	Unspecified		296.50	
	• Current or most recent episode unspecified		296.7	(F31.9)
	Bipolar II disorder [a] *	See Table 17	296.89	(F31.81)
	Cyclothymic disorder**	See Table 18	301.13	(F34.0)
	Substance/medication-induced bipolar and related disorder***	See Table 19	___.__	(___.__)
	Bipolar and related disorder due to another medical condition	See Table 20	293.83	(__.__)****
	Other specified bipolar and related disorder	See Table 21	296.89	(F31.89)
	Unspecified bipolar and related disorder	See Table 22	296.80	(F31.9)
Mood episodes	Hypomanic	See Table 23		NA
	Manic	See Table 24		NA
	Depressive	See Table 25		NA

**Specify* current or most recent episode: hypomanic, depressed; *Specify* course if full criteria for a mood episode are not currently met: In partial remission. In full remission; *Specify* severity if full criteria for a mood episode are not currently met: mild, moderate, severe.

***Specify* if: with anxious distress

***Note: See the criteria set and corresponding recording procedures for substance-specific codes and *ICD-9-CM* and *ICD-IO-CM* coding. *Specify* if: With onset during intoxication; with onset during withdrawal
**** *Specify* if: With manic features (F06.33); with manic- or hypomanic-like episode (F06.33); with mixed features (F06.34).
[a] *Specify:* With anxious distress *(specify* current severity: mild, moderate, moderate-severe, severe); with mixed features; with rapid cycling; with melancholic features (only for Bipolar I disorder); with atypical features (only for Bipolar I disorder); with mood-congruent psychotic features; with mood-incongruent psychotic features; with catatonia (use additional code 293.89 [F06.1]); with peripartum onset; with seasonal pattern.

Table 16

DSM-5 diagnostic criteria for 296.4x Bipolar I disorder

A.	Criteria have been met for at least one manic episode (Criteria A-D under "Manic Episode" in Table 24). Note. The manic episode may have been preceded by and may be followed by hypomanic (See Table 23) or major depressive episodes (See Table 25).
B.	The occurrence of the manic and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.
Coding and Recording Procedures	The diagnostic code for bipolar I disorder is based on type of current or most recent episode and its status with respect to current severity, presence of psychotic features, and remission status.
Indicate	(if full criteria are currently met for a manic or major depressive episode): Indicate current severity and psychotic features. (if the full criteria are not currently met for a manic, hypomanic or major depressive episode): Remission specifiers.
Specify	With anxious distress With mixed features With rapid cycling With melancholic features With atypical features With mood-congruent psychotic features With mood-incongruent psychotic features With catatonia. Coding note: Use additional code 293.89 With peripartum onset With seasonal pattern

Copied and adapted from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5* (APA, 2013).

Table 17

DSM-5 diagnostic criteria for 296.89 Bipolar II disorder

A.	Criteria have been met for at least one hypomanic episode (Criteria A-F under "Hypomanic Episode" in Table 23) and at least one major depressive episode (Criteria A-C under "Major Depressive Episode" in Table 25).
B.	There has never been a manic episode.
C.	The occurrence of the hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.
D.	The symptoms of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Coding and Recording Procedures	Bipolar II disorder has one diagnostic code: 296.89 (F31.81). Its status with respect to current severity, presence of psychotic features, course, and other specifiers cannot be coded but should be indicated in writing (e.g., 296.89 [F31.81] bipolar II disorder, current episode depressed, moderate severity, with mixed features; 296.89 [F31.81] bipolar II disorder, most recent episode depressed, in partial remission).
Specify	current or most recent episode: Hypomanic Depressed
Specify if	With anxious distress With mixed features With rapid cycling With mood-congruent psychotic features With mood-incongruent psychotic features With catatonia. Coding note: Use additional code 293.89 (F06.1). With peripartum onset With seasonal pattern: Applies only to the pattern of major depressive episodes.
Specify	Course if full criteria for a mood episode are not currently met: In partial remission In full remission Severity if full criteria for a mood episode are currently met: Mild Moderate Severe

Copied and adapted from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5* (APA, 2013).

Table 18

DSM-5 diagnostic criteria for 301.13 cyclothymic disorder

A.	For at least 2 years (at least 1 year in children and adolescents) there have been numerous periods with hypomanic symptoms that do not meet criteria for a hypomanic episode and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode.
B.	During the above 2-year period (1 year in children and adolescents), the hypomanic and depressive periods have been present for at least half the time and the individual has not been without the symptoms for more than 2 months at a time.
C.	Criteria for a major depressive, manic, or hypomanic episode have never been met.
D.	The symptoms in Criterion A are not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.
E.	The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
F.	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Specify if	With anxious distress

Copied and adapted from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5* (APA, 2013).

Table 19

DSM-5 diagnostic criteria for substance/medication-induced bipolar and related disorders

A.	A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by elevated, expansive, or irritable mood, with or without depressed mood, or markedly diminished interest or pleasure in all, or almost all, activities.
B.	There is evidence from the history, physical examination, or laboratory findings of both (1) and (2): 1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication. 2. The involved substance/medication is capable of producing the symptoms in Criterion A.
C.	The disturbance is not better explained by a bipolar or related disorder that is not substance/medication-induced. Such evidence of an independent bipolar or related disorder could include the following:

The symptoms precede the onset of the substance/medication use.
The symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication.
Or there is other evidence suggesting the existence of an independent non-substance/medication-induced bipolar and related disorder (e.g., a history of recurrent non-substance/medication-related episodes).

D. The disturbance does not occur exclusively during the course of a delirium.

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Coding note. The ICD-9-CM and ICD-10-CM codes for the [specific substance/medication]-induced bipolar and related disorders are indicated in the table below.
Note that the ICD-10-CM code depends on whether or not there is a comorbid substance use disorder present for the same class of substance.

		ICD-10-CM		
	ICD-9-CM	With use disorder, mild	With use disorder, moderate or severe	Without use disorder
Alcohol	291.89	F10.14	F10.24	F10.94
Phencyclidine	292.84	F16.14	F16.24	F16.94
Other hallucinogen	292.84	F16.14	F16.24	F16.94
Sedative, hypnotic, or anxiolytic	292.84	F13.14	F13.24	F13.94
Amphetamine (or other stimulant)	292.84	F15.14	F15.24	F15.94
Cocaine	292.84	F14.14	F14.24	F14.94
Other (or unknown) substance	292.84	F19.14	F19.24	F19.94

Specify if (see Table 1 in the chapter "Substance-Related and Addictive Disorders" for diagnoses associated with substance class in the DSM-5):
With onset during intoxication: If the criteria are met for intoxication with the substance and the symptoms develop during intoxication.
With onset during withdrawal: If criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, withdrawal.

Copied and adapted from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5* (APA, 2013).

Table 20

DSM-5 diagnostic criteria for bipolar and related disorder due to another medical condition

A.	A prominent and persistent period of abnormally elevated, expansive, or irritable mood and abnormally increased activity or energy that predominates in the clinical picture.
B.	There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
C.	The disturbance is not better explained by another mental disorder.
D.	The disturbance does not occur exclusively during the course of a delirium.
E.	The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning, or necessitates hospitalization to prevent harm to self or others, or there are psychotic features.
Coding note.	The ICD-9-CM code for bipolar and related disorder due to another medical condition is 293.83, which is assigned regardless of the specifier. The ICD-10-CM code depends on the specifier (see below).
Specify if	With manic features (F06.33): Full criteria are not met for a manic or hypomanic episode. With manic- or hypomanic-like episode (F06.33): Full criteria are met except Criterion D for a manic episode or except Criterion F for a hypomanic episode. With mixed features (F06.34): Symptoms of depression are also present but do not predominate in the clinical picture.
Coding note.	Include the name of the other medical condition in the name of the mental disorder (e.g., 293.83 [F06.33] bipolar disorder due to hyperthyroidism, with manic features). The other medical condition should also be coded and listed separately immediately before the bipolar and related disorder due to the medical condition (e.g., 242.90 [E05.90] hyperthyroidism; 293.83 [F06.33] bipolar disorder due to hyperthyroidism, with manic features).

Copied and adapted from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5* (APA, 2013).

Table 21

DSM-5 diagnostic criteria for 296.89 other specified bipolar and related disorder

This category applies to presentations in which symptoms characteristic of a bipolar and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the bipolar and related disorders diagnostic class.

The other specified bipolar and related disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific bipolar and related disorder. This is done by recording "other specified bipolar and related disorder" followed by the specific reason (e.g., "short-duration cyclothymia").

Examples of presentations that can be specified using the "other specified" designation include the following:

1. Short-duration hypomanic episodes (2-3 days) and major depressive episodes: A lifetime history of one or more major depressive episodes in individuals whose presentation has never met full criteria for a manic or hypomanic episode but who have experienced two or more episodes of short-duration hypomania that meet the full symptomatic criteria for a hypomanic episode but that only last for 2-3 days. The episodes of hypomanic symptoms do not overlap in time with the major depressive episodes, so the disturbance does not meet criteria for major depressive episode, with mixed features.
2. Hypomanic episodes with insufficient symptoms and major depressive episodes: A lifetime history of one or more major depressive episodes in individuals whose presentation has never met full criteria for a manic or hypomanic episode but who have experienced one or more episodes of hypomania that do not meet full symptomatic criteria (i.e., at least 4 consecutive days of elevated mood and one or two of the other symptoms of a hypomanic episode, or irritable mood and two or three of the other symptoms of a hypomanic episode). The episodes of hypomanic symptoms do not overlap in time with the major depressive episodes, so the disturbance does not meet criteria for major depressive episode, with mixed features.
3. Hypomanic episode without prior major depressive episode: One or more hypomanic episodes in an individual whose presentation has never met full criteria for a major depressive episode or a manic episode. If this occurs in an individual with an established diagnosis of persistent depressive disorder (dysthymia), both diagnoses can be concurrently applied during the periods when the full criteria for a hypomanic episode are met.
4. Short-duration cyclothymia (less than 24 months): Multiple episodes of hypomanic symptoms that do not meet criteria for a hypomanic episode and multiple episodes of depressive symptoms that do not meet criteria for a major depressive episode that persist over a period of less than 24 months (less than 12 months for children or adolescents) in an individual whose presentation has never met full criteria for a major depressive, manic, or hypomanic episode and does not meet criteria for any psychotic disorder. During the course of the disorder, the hypomanic or depressive symptoms are present for more days than not, the individual has not been without symptoms for more than 2

months at a time, and the symptoms cause clinically significant distress or impairment.

Copied and adapted from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5* (APA, 2013).

Table 22

DSM-5 diagnostic criteria for 296.80 unspecified bipolar and related disorder

This category applies to presentations in which symptoms characteristic of a bipolar and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the bipolar and related disorders diagnostic class. The unspecified bipolar and related disorder category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific bipolar and related disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

Copied and adapted from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5* (APA, 2013).

Table 23

DSM-5 diagnostic criteria for hypomanic episode

A.	A distinct period of persistently elevated, expansive, or irritable mood, and abnormally and persistently increased activity or energy, lasting at least 4 days, and present most of the day, nearly every day.
B.	During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree: 1. Inflated self-esteem or grandiosity. 2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep). 3. More talkative than usual or pressure to keep talking. 4. Flight of ideas or subjective experience that thoughts are racing. 5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed. 6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation. 7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
C.	The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual 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 hospitalization. If there are psychotic features, the episode is, by definition, manic.
F.	The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment). Note. A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persist at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.
Note.	Criteria A-F constitute a hypomanic episode. Hypomanic episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

Copied and adapted from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5* (APA, 2013).

Table 24

DSM-5 diagnostic criteria for manic episode

A.	A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).
B.	During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior: 1. Inflated self-esteem or grandiosity. 2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep). 3. More talkative than usual or pressure to keep talking. 4. Flight of ideas or subjective experience that thoughts are racing. 5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed. 6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity). 7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
C.	The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D.	The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition. Note. A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I disorder.
Note.	Criteria A-D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder.

Copied and adapted from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5* (APA, 2013).

Table 25

DSM-5 diagnostic criteria for major depressive episode

A.	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. Note. Do not include symptoms that are clearly attributable to another medical condition. 1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). Note. In children and adolescents, can be irritable mood. 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation). 3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note. In children, consider failure to make expected weight gains. 4. Insomnia or hypersomnia nearly every day. 5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down). 6. Fatigue or loss of energy nearly every day. 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick). 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others). 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B.	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C.	The episode is not attributable to the physiological effects of a substance or a general medical condition.
Note.	Criteria A-C constitute a major depressive episode. Major depressive episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.
Note.	Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.* *See the *DSM-5* (APA, 2013, p. 126) for detailed information.

Copied and adapted from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5* (APA, 2013).

Both the *DSM-IV-TR* and the *ICD-10* provide similar criteria for the diagnosis of mania, hypomania, mixed or depressed episodes. According to *DSM-IV-TR* criteria, mania is understood as presenting abnormally and persistently elevated, expansive/grandiose or irritable mood and related symptoms for at least one week —or less if a hospitalization is required— (e.g. inflated self-esteem, increased talkativeness, decreased need for sleep, and increase in impulsive risk-taking behavior) with severe functional impairment or psychotic symptoms (Kendall et al., 2014). *DSM-5* and *ICD-11* include the requirement of increased level of activity or energy as a diagnostic criterion of both hypomania and mania, thus increasing the diagnostic threshold (de Dios et al., 2014; NCCMH, 2014). Hypomania is defined as abnormally and persistently elevated or irritable mood and related symptoms lasting at least four days, without requiring hospitalization or presenting psychotic features. *DSM-5*, under "bipolar disorders not otherwise specified" allows the possibility of identifying people who do not meet all the required hypomania symptoms or who present hypomania symptoms lasting between one

and three days, but not four as required for hypomanic episode. Reducing the length criterion for hypomanic episodes could probably augment the specificity for the diagnostic of BD-II, but it could also reduce the sensitivity; that is, it would increase lifetime prevalence estimates of BD-II—due to higher specificity—but it would also identify more unipolar depressed people showing bipolarity signs in subtle ways—due to lower sensitivity—(de Dios et al., 2014; NCCMH, 2014). Mixed episodes in BD imply that some aspects of manic episodes and some of depressive episodes are experienced for at least one week. González-Pinto, Aldama, Mosquera, and Gómez (2007) concluded that the dimensional and broader approaches to the diagnosis of mixed or dysphoric mania have firmly proved that the mixed form is best demarcated by the presence of substantial depressive symptoms not overlapped with classical manic symptomatology. Depression in BD is understood as depressed mood, profound sadness, loss of interest, pleasure and motivation in daily activities, and related symptoms during two-week period (e.g., feelings of worthlessness, weight loss or gain, and suicidal thoughts or actions; Kendall et al., 2014), with work, educational and social functioning also being negatively impaired and in some cases, developing psychotic symptoms (Grupo de Trabajo de la Guía de Práctica Clínica sobre Trastorno Bipolar, 2012).

The *DSM-5*, instead of considering the diagnostic category of mixed episode — as do the *DSM-IV-TR*, *ICD-10* and *ICD-11* (beta draft)—, considers mixed affective episodes not with diagnostic purposes but as a course specifier applicable to the current manic or depressive episode in BD-I or BD-II (APA, 2013; De Dios et al., 2014; NCCMH, 2014). Tables 26 and 27 include *DSM*-5 criteria for a manic or hypomanic episode with mixed features and for a depressive episode with mixed features (see below). Finally, the *DSM-5*, in contrast to the other manuals— *DSM-IV-TR*, *ICD-10*, and *ICD-11* (beta draft)—, includes subthreshold presentations of bipolar spectrum under the "other

bipolar disorders" diagnostic category. The *ICD-10*, in contrast to *DSM-IV-TR*, *DSM-5*, and *ICD-11* (beta draft), requires two discrete mood episodes (of mania or hypomania) for the diagnosis of BD, and when only one single mania or mixed episode has occurred, it does not merit a diagnosis of BD until another mood episode of any type is experienced, defining it as a separate category (F30) (de Dios et al., 2014; Grunze et al., 2009; NCCMH, 2014). Another key difference between *DSM* classifications and the *ICD-10* is that the latter does not separate BD-I from BD-II, and in turn, it can be coded within the category "other bipolar disorders" (code F.31.8) (NCCMH, 2014). In contrast, the beta version of the *ICD-11* incorporates BD-II as a separate diagnostic entity (de Dios et al., 2014).

Table 26

DSM-5 criteria for manic or hypomanic episode, with mixed features

A.	Full criteria are met for a manic episode or hypomanic episode, and at least three of the following symptoms are present during the majority of days of the current or most recent episode of mania or hypomania: 1. Prominent dysphoria or depressed mood as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). 2. Diminished interest or pleasure in all, or almost all, activities (as indicated by either subjective account or observation made by others). 3. Psychomotor retardation nearly every day (observable by others; not merely subjective feelings of being slowed down). 4. Fatigue or loss of energy. 5. Feelings of worthlessness or excessive or inappropriate guilt (not merely self-reproach or guilt about being sick). 6. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
B.	Mixed symptoms are observable by others and represent a change from the person's usual behavior.
C.	For individuals whose symptoms meet full episode criteria for both mania and depression simultaneously, the diagnosis should be manic episode,

	with mixed features, due to the marked impairment and clinical severity of full mania.
D.	The mixed symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).

Copied and adapted from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5* (APA, 2013).

Table 27

DSM-5 criteria for depressive episode, with mixed features

A.	Full criteria are met for a major depressive episode, and at least three of the following manic/hypomanic symptoms are present during the majority of days of the current or most recent episode of depression: 1. Elevated, expansive mood. 2. Inflated self-esteem or grandiosity. 3. More talkative than usual or pressure to keep talking. 4. Flight of ideas or subjective experience that thoughts are racing. 5. Increase in energy or goal-directed activity (either socially, at work or school, or sexually). 6. Increased or excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments). 7. Decreased need for sleep (feeling rested despite sleeping less than usual; to be contrasted with insomnia).
B.	Mixed symptoms are observable by others and represent a change from the person's usual behavior.
C.	For individuals whose symptoms meet full episode criteria for both mania and depression simultaneously, the diagnosis should be manic episode, with mixed features.
D.	The mixed symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment). Note. Mixed features associated with a major depressive episode have been found to be a significant risk factor for the development of bipolar I or bipolar II disorder. As a result, it is clinically useful to note the presence of this specifier for treatment planning and monitoring of response to treatment.

Copied and adapted from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5* (APA, 2013).

1.1.3. Differential diagnosis

Hypomania, mania, cyclothymia and depressive episodes of BD could be difficult to differentiate from other mental disorders because they share some prominent symptoms. For example, psychotic symptoms during mania in BD-I could be similar to the acute phases of schizophrenia or schizoaffective disorders. An important aspect to differentiate between those diagnoses is regarding the stability, duration and the congruency of the content of delusions and hallucinations. Furthermore, attention must be also paid to differentiating cyclothymia resulting from BD-II from that due to personality disorders (NCCMH, 2014). In this case, it is important to consider the length of the episodes and the long-term history. Additionally, differential diagnosis must also consider substance misuse and organic brain syndromes. However, recurrent mayor depression is the primary differential diagnosis for BD-II (Grupo de Trabajo de la Guía de Práctica Clínica sobre Trastorno Bipolar, 2012).

Usually, differential diagnosis of BDs during the first years after the onset of the disease is difficult due to a number of reasons. Firstly, bipolar episodes are often under-identified (hypomanic and manic mood episodes are sometimes perceived as positive experiences and thus they are not necessarily mentioned during the clinical evaluation) or misidentified as unipolar (i.e., depression). Secondly, it is usual for BD to present with comorbidities. Therefore, the diagnosis of BDs is a continuous and complex process that, in most cases needs, more than a single interview for several reasons—e.g., short-lived periods of hypomania may go unnoticed, elevated mood and increased activity levels may be difficult to distinguish from normal mood experiences and from artistic and creative personalities, and bipolar experiences may overlap with psychological problems such as borderline personality disorder—(de Dios et al., 2014; Division of Clinical Psychology, 2010; NCCMH, 2014). Together with the diagnostic criteria, suicidal risk and family

history of mental illnesses should also be evaluated for the differential diagnosis in order to improve the reliability and validity of the diagnosis (de Dios et al., 2014; NCCMH, 2014; NICE, 2014).

1.1.4. Prevalence

In a recent epidemiological survey using the Composite International Diagnostic Interview (CIDI) as a diagnostic assessment instrument, Merikangas et al. (2011) described the aggregate lifetime prevalence rates considering 11 countries of the Americas, Europe, Asia, and Oceania for BD, reporting similar rates for BD-I and BD-II (0.6% and 0.4%, respectively) and according to previous studies, higher prevalence rates for subthreshold BD (1.4%), with the worldwide total prevalence estimate for bipolar spectrum disorders (BSDs) of 2.4%; twelve-month prevalence for BD-I, BD-II and the subthreshold BD were slightly lower (0.4%, 0.3%, and 0.8%) yielding a total worldwide twelve-month prevalence rate for BSD of 1.5%.

As reported by Basso, Argimon, and Arteche (2013), findings on the prevalence of BDs are heterogeneous. In their international literature review, Basso et al. (2013) reported that lifetime prevalence of BD in adults (from general population samples) based on studies strictly in accordance with the CIDI—which (1) is based on the *DSM* criteria and (2) is associated with increased diagnostic accuracy in epidemiological studies (Kessler et al., 2006)—ranged from 0.5 to 2.1%, reporting double rates of prevalence (from 2.4 to 4.4%) for BSDs. Differences in prevalence regarding BDs and BSDs—considering not only BD-I and BD-II, but also subthreshold BDs—could be explained by the fact that, for the diagnosis of BSD, subthreshold criteria are considered, for which symptomatic patterns are more moderate (Angst et al., 2003; Basso et al., 2013).

1.1.5. Sociodemographic correlates

1.1.5.1. *Gender*

Despite gender ratio of BD prevalence being relatively similar, studies have shown that gender slightly influences the incidence and course of BD, especially for the case of BD-II (Diflorio & Jones, 2010; Pini et al., 2005). For example, Pini et al. (2005) showed slightly higher prevalence in females than in males in most of the reviewed EU epidemiological studies. Specifically, for each type of BD, Merikangas et al. (2011) reported that whereas lifetime prevalence rates of BD-I and subthreshold BD were higher in males, females had greater rates of BD-II. Angst et al. (2003) and Baldassano et al. (2005) also reported higher rates of BD-II in women than in men. Despite these results, according to the NICE guideline (NCCMH, 2014) and Basso et al. (2013), the evidence towards higher incidence of BD-II in women is scarce and disrupted with only a few studies showing statistically significantly higher prevalence in females, and other studies showing no gender differences in BD-II prevalence rates (e.g. Kroon et al., 2013).

Gender distinctions regarding rapid cycling and depressive episodes in BD are inconsistent (Diflorio & Jones, 2010; Tondo & Baldessarini, 1998), some researchers report equal rates of lifetime history of rapid cycling (Baldassano et al., 2005; Schneck et al., 2008) and depressive episodes (Baldassano et al., 2005; Hendrick, Altshuler, Gitlin, & Hammen, 2000), and therefore doubt the validity of studies suggesting that women may be more likely to present the rapid cycling subtype and depressive episodes. In contrast, important gender differences are found related to comorbidity of somatic and psychiatric disorders, showing, for example, that women are more likely to have comorbid posttraumatic disorder, bulimia and thyroid disease (Arnold, 2003; Baldassano et al., 2005; Burt & Rasgon, 2004; Diflorio & Jones, 2010). In contrast, Vega et al. (2011) found that women were adhered to treatment more than men, and that whereas non-

adherent women had experienced more suicide attempts in comparison with women who complied with treatment, non-adherent men had higher substance abuse, more mixed and manic episodes and more hospitalizations in comparison with men who complied with treatment. Thus, important adherence differences are also found regarding sex.

1.1.5.2. Other sociodemographic correlates

Merikangas et al. (2011) found that there was no other significant difference, apart from gender, between BSDs and other sociodemographic variables (i.e., marital and employment status and family income). In contrast, Basso et al. (2013) reported that, in some of the studies reviewed, higher prevalence rates of BDs and/or BSDs rates were found for people without a partner and in lower-income populations. Similarly, the NICE guideline (NCCMH, 2014) reported higher and more severe incidence of BD among minority ethnic groups in the US (Kupfer, Frank, Grochocinski, Houck, & Brown, 2005) and in the UK (Lloyd et al., 2005). Finally, Basso et al., found few studies reporting contradictory evidence regarding educational level, and concluded that this variable did not significantly influence prevalence rates of BD.

1.1.6. Age at onset

BDs generally present during adolescence and young adulthood, with the peak of BD symptoms appearing for the first time between ages 15 and 19 (median age: 17.5 years; mean age: 19.8 years) (Kupfer et al., 2002). Pini et al. (2005) showed that the highest rates of BD diagnoses occurred in subjects aged 18-34 in the reviewed EU epidemiological studies, and that, when considering those studies with wider age range samples (18-65), the mean age for the first manic or hypomanic episode (when the diagnosis of BD-I or BD-II becomes easier to differentiate; (Grunze et al., 2009) was 26.2 years (Pini et al., 2005; ten Have, Vollebergh, Bijl, & Nolen, 2002). Accordingly, Basso et al. (2013) reported that, in more than half of the studies reviewed, younger individuals

presented higher prevalence of BD and/or BSD. The NICE guideline (NCCMH, 2014) also reports that a second smaller peak of onset of BD-I and BD-II may be found in later adulthood, between 45 and 54 years. González-Pinto et al. (2009) found three subgroups according to the following ages at onset of BD-I: 18.2 ± 2 years (34% of the patients), 26.1 ± 5.5 years (44% of the patients), and 50.9 ± 9.1 years (22% of the patients), with this latter subgroup being significantly different from the other two subgroups; Pinto et al. (2009) concluded that these three subgroups could be regrouped into two groups due to similarities with respect to family, clinical and prognostic features shared by the first and the intermediate subgroups.

1.1.7. Comorbidity

European and international studies on comorbidity have suggested that BD often presents comorbidity with a variety of other Axis I mental disorders. Comorbidity prevalence rates range from 69.1% to 88.2% for BSDs (Merikangas et al., 2011; Pini et al., 2005; Sasson, Chopra, Harrari, Amitai, & Zohar, 2003). Considering BSDs, Merikangas et al. (2011) reported that comorbidity prevalence rates with anxiety disorders were about two thirds (62.9%)—49.8% of which were panic attacks—followed by behavior disorders (44.8%) and substance use disorders (36.6%), showing that, overall, the greatest prevalence rates of comorbid disorders were for BD-I, and the lowest for BSDs, and that patterns of comorbidity with the mentioned disorders were similar across different countries. Besides, comorbid Axis I disorders are present both within and between episodes, and even in early stages of BD (Merikangas et al., 2011; Pini et al., 2005). For example, Tohen et al. (2007) demonstrated that comorbid anxiety symptoms in patients with BD and a current depression episode have a detrimental effect on treatment outcome.

Personality disorders from Axis II of the *DSM*, and especially those within cluster B (the dramatic, emotional, and erratic cluster) and cluster C (the anxious and fearful cluster), are also associated with BDs—both during acute bipolar episodes as well as during euthymic periods—(Kay, Altshuler, Ventura, & Mintz, 1999; Sasson et al., 2003; Turley, Bates, Edwards, & Jackson, 1992). Among them, borderline personality is the most common comorbid disorder in BD, sometimes sharing the characteristic rapid-cycling presented in borderline personality disorder. In fact, when people experience a comorbid disorder, they are also more likely to have rapid-cycling. Additionally, when a person diagnosed with BD has a substance use comorbid disorder, prevalence rates for also presenting a personality comorbid disorder rise (Grupo de Trabajo de la Guía de Práctica Clínica sobre Trastorno Bipolar, 2012; NCCMH, 2014; NICE, 2014).

1.1.8. Course

BD follows a phasic and recurrent course for most people (Grupo de Trabajo de la Guía de Práctica Clínica sobre Trastorno Bipolar, 2012; NCCMH, 2014). The illness manifests early in life, usually as acute episodes of depression and followed by periods of remission (Goodwin & Jamison, 2007). Affective episodes usually repeat and become more frequent, severe, and prolonged over time, with euthymic periods lasting less and presenting mild subsyndromic symptomatology (NCCMH, 2014). Although the key characteristic of BD is the experience of hypomania or mania, depressive symptoms are more usual than manic ones during the course of the disease (NCCMH, 2014). Judd et al. (2003) informed that patients with BD usually spend more time in depression episodes than in hypomania or mania. In this line, González-Pinto et al. (2010) found that of the patients with BD-I analyzed, the majority of them had predominantly depressive episodes rather than manic ones, and the predominantly depressive polarity group had a worse prognosis and more difficulties to abstain from alcohol and other substance abuse.

Similarly, Baldessarini et al. (2010) concluded that depressive-dysthymic-dysphoric polarity presented higher morbidity than manic-hypomanic-psychotic polarity among patients with BD-I onset, with the depressive polarity being markedly predicted by the polarity of the first-episode. Lifetime affective episodes in BD are estimated to be about ten (Mackin & Young, 2005), with greater lifetime number of affective episodes and higher risk of suicide for BD-II than for BD-I (Goodwin & Jamison, 2007; Nordentoft, Mortensen, & Pedersen, 2011). Nevertheless, the onset and course of the illness varies among individuals (Michalak, Murray, Young, & Lam, 2007; Vázquez, 2014).

There is often a substantial delay of 5-10 years between onset time (first episode of BD) and the time of first hospital treatment (APA, 1994). For example, Baldessarini, Tondo, and Hennen (2003) reported that the average latency from the first episode of BD to first treatment was 7.8 years. Similarly, Mantere et al. (2004) reported that, on average, there is an 8-year delay from the first affective episode—perceived by the person—to the diagnosis of the illness. BD could go unrecognized and therefore underdiagnosed or misdiagnosed, delaying the appropriate diagnosis and subsequently being ineffectively treated (Morselli, Elgie, & Cesana, 2004). The usual delay in the diagnosis of bipolar (versus unipolar) depression could be related to the absence of a previous hypomanic report or identification. In fact, half of the patients diagnosed with unipolar depression could be diagnosed with BD in the long-term (Angst, 2006; Goldberg, Harrow, & Whiteside, 2001). On another hand, manic episodes with delusional symptomatology could lead to the misdiagnosis of schizophrenia. Additionally, rapid-cycling could led to the misdiagnosis of borderline personality disorder (Akiskal & Vázquez, 2006).

1.1.9. Impact and burden

BSD, both depressive and (hypo)manic syndromes, are associated with negative social, functional, and quality of life outcomes, even during euthymic periods, showing

that inter-episode occupational and social functioning remains affected by functional impairments even after symptomatic recovery (Angst et al., 2003; MacQueen, Young, & Joffe, 2001; Michalak et al., 2007). Haro et al. (2011) found that of the patients who achieved remission or functional recovery after a manic/mixed episode at the 2-year follow-up, 64% achieved remission, and 34% achieved functional recovery. Haro et al. (2011) also found that work and social functioning impairment was associated with lower remission and recovery rates. In fact, high rates of comorbidity, especially with anxiety and substance use disorders, increase the negative consequences of BD (Hirschfeld, Lewis, & Vornik, 2003; San et al., 2016).

Moreover, 15% of people with BD are likely to die by suicide (Grupo de Trabajo de la Guía de Práctica Clínica sobre Trastorno Bipolar, 2012), most of these occurring during depression (Novick, Swartz, & Frank, 2010) and mixed episodes (NCCMH, 2014). In fact, Merikangas et al. (2011) reported that one fourth of people with BD-I and one fifth of people with BD-II had made suicide attempts. A study using a sample of BD-I patients from northern Spain reported that 33% of them had made one or more suicide attempts, and the authors suggested that the risk of suicide in patients with an early age at onset may be related to variables such as drug abuse, family history of affective disorders, and history of hospital admissions during severe depressive episodes that were significantly associated with attempted suicide in these participants (Lopez et al., 2001).

Currently, patient evolution is not only tracked through clinical outcome reports, but also through measures of psychosocial functioning and quality of life (Grupo de Trabajo de la Guía de Práctica Clínica sobre Trastorno Bipolar, 2012). In this line, the WHO estimated that BD was the sixth leading cause of disability-adjusted life years worldwide among young adults (Murray & Lopez, 1997), actually, the fifth after schizophrenia (Grupo de Trabajo de la Guía de Práctica Clínica sobre Trastorno Bipolar,

2012). Costs related to BD were about $45 billion in the US in 1991 (Wyatt & Henter, 1995).

Considering together that approximately three-quarters of people with BDs report severe symptoms, comorbidity with other lifetime *DSM-IV*-TR disorders, role impairment and high risk of suicide (Merikangas et al., 2011), this implies a high socioeconomic and health burden (NCCMH, 2014). The underdiagnoses or misdiagnoses of BD consequently leads to inappropriate treatment, which could worsen the illness course and increase the burden for the patient and relatives (Angst, 2004; Merikangas et al., 2007; Morselli et al., 2004; Nordentoft et al., 2011; Woods, 2000).

1.2. Evaluation and Treatment of BD

1.2.1. Assessment methods

Although there are some screening instruments and specific scales to assess the intensity of the symptomatology in BD, they should never replace the clinical interview (Division of Clinical Psychology, 2010; Grupo de Trabajo de la Guía de Práctica Clínica sobre Trastorno Bipolar, 2012). For example, some of the self-rating instruments for (hypo)mania are the Self-Report Manic Inventory (Shugar, Schertzer, Toner, & Di Gasbarro, 1992), the Mood Disorder Questionnaire (Hirschfeld et al., 2003), the Hypomania Checklist-32 (Angst et al., 2005), and the Altman Self-Rating Mania Scale (Altman, Hedeker, Peterson, & Davis, 1997). Some of the self-rating questionnaires for screening bipolar spectrum symptoms are the Bipolar Spectrum Diagnostic Scale (Ghaemi et al., 2005), the Mood Spectrum Questionnaire (Dell'Osso et al., 2002), and the Internal States Scale (Bauer et al., 1991).

The most frequently used and validated interview instrument to assist in the diagnosis of mental disorders is the CIDI, a structured clinical interview to diagnose according only to *DSM-IV* diagnostic criteria. Additional interview instruments for

generating a bipolar diagnosis are the Mini International Neuropsychiatric Interview (MINI), which allows making diagnoses under the international classifications (i.e., the *DSM-IV* and *ICD-10*), and the Schedules for Clinical Assessment in Neuropsychiatry(SCAN), which only allows *ICD* diagnoses. While the validity in clinical samples of the *DSM-IV* criteria are high, *ICD*-based diagnoses must be performed by a semi-structured interview and, as no *ICD*- based interviews have been validated, clinical experience is required (Grupo de Trabajo de la Guía de Práctica Clínica sobre Trastorno Bipolar, 2012; NCCMH, 2014), increasing the difficulties of its use for research purposes.

There are also interview-based instruments to assess the severity of symptoms of mania, such as the Young Mania Rating Scale (Young, Biggs, Ziegler, & Meyer, 1978) or the Bech-Rafaelsen Mania Scale (Bech, Bolwig, Kramp, & Rafaelsen, 1979), and of depression, such as the Hamilton Rating Scale for Depression (Hamilton, 1960) and the Montgomery-Asberg Depression Rating Scale (Montgomery, 2000). Additionally, the Clinical Global Impressions for Bipolar Disorders-Modified (Spearing, Post, Leverich, Brandt, & Nolen, 1997) assesses the severity of BD illness, and the Global Assessment of Functioning, according to Axis V of the *DSM-IV-text revision* (APA, 2000), measures the overall severity of illness in psychiatry—from positive mental health to severe psychopathology—, rather than being a diagnosis-specific scale.

Finally, there are other instruments evaluating work and social functioning, such as the Work and Social Adjustment Scale (Mundt, Marks, Shear, & Greist, 2002) and other diagnostic-specific scales evaluating quality of life, such as the Quality of Life in Bipolar Disorder (Michalak & Murray, 2010) and personal recovery, such as the Bipolar Recovery Questionnaire (Jones, Mulligan, Higginson, Dunn, & Morrison, 2013).

1.2.2. Interventions/treatments for BD

The general aim of treatment in BD is centered on the improvement of the clinical course, which includes not only a decrease in symptoms but also an increase in levels of autonomy and quality of life. Depending on the patient's characteristics, different main therapeutic goals are agreed upon between the therapist and the patient and then, treatment strategies, including pharmacological and psychosocial approaches, will be chosen considering the area of intervention. Additionally, for the development of the therapeutic plan, physical health should be monitored, a crisis plan should be designed, and the treatment plan should be guided from a recovery approach that empowers the patient. Within the three stages of treatment (i.e., acute phase, continuation phase, and maintenance phase), there are some key elements to consider such as: (1) the therapeutic alliance establishment and reinforcement of treatment adherence (2) educating, supporting and treating the socio-familiar environment, (3) management of comorbid illnesses, and (4) an integral and multidisciplinary therapeutic approach, among others (Grupo de Trabajo de la Guía de Práctica Clínica sobre Trastorno Bipolar, 2012). The main pharmacological and psychological therapies are discussed below.

1.2.2.1. *Pharmacological therapies*

Commonly, pharmacological treatments are used to decrease affective symptomatology, prevent acute episodes, and complementarily, for different clinical situations during the course of the illness (NCCMH, 2014; NICE, 2014).

As stated in the NICE guideline (NCCMH, 2014), antipsychotic drugs (replacing the "first-generation" ones by "second-generations" ones), supplemented with benzodiazepines, and lithium and valproate, have traditionally been used for manic episodes.

Acute depression episodes are more difficult to treat, usually needing combined strategies with a mood stabilizer (lithium, lamotrigine, or both), together with the antipsychotic quetiapine (approved for treating bipolar depression), or with the cautious use of antidepressants (Pacchiarotti et al., 2013).

Lithium mood stabilizer has traditionally been indicated as the first line drug to prevent relapse (Kendall et al., 2014) and, after the decline in its use (given its slow onset of action), it was again used for its effects in reducing suicidal risk (Gonzalez-Pinto et al., 2006) and due to its unquestionable effect in preventing relapses of bipolar episodes. In sum, given that each pharmacological treatment is effective for different aspects of the illness and the necessity to protect patients from both poles, polypharmacy is usual in relapse prevention of BD (NCCMH, 2014; NICE, 2014).

1.2.2.2. *Psychological therapies*

Generally, psychological therapies aim to provide information about the illness and assist in developing self-management, mood regulation and self-care strategies to increase adherence, decrease recurrence/relapse probabilities and more effectively address issues of living with BD. Some psychosocial therapies have been validated as effective treatments for these purposes. According to the NICE guideline (NCCMH, 2014; NICE, 2014), treatment approaches that address psychological factors can improve outcomes in BD. Among psychological therapies for BD, the main evidence-based approaches are relapse prevention psychoeducation (Lobban et al., 2010), cognitive-behavioral (González-Isasi, Echeburúa, Limiñana, & González-Pinto, 2012; González-Isasi, Echeburua, Liminana, & Gonzalez-Pinto, 2014; González-Isasi, Echeburúa, Limiñana, & González-Pinto, 2010; Meyer & Hautzinger, 2012), interpersonal and social rhythm (Frank et al., 2005), and family-focused therapies (Miklowitz, George, Richards, Simoneau, & Suddath, 2003).

Literature supports psychoeducation therapy for relapse prevention in the maintenance phase (Miziou et al., 2015). For example, Torrent et al. (2013) concluded that the combined treatment of neurocognitive, psychoeducation, and problem-solving strategies obtained significantly better functional outcomes than pharmacotherapy alone in euthymic patients with BD. In line with the results of Torrent et al. (2013) proving that functional remediation is a promising treatment to improve daily functional outcomes of euthymic bipolar patients, Solé et al. (2015) suggested that this treatment appeared to be effective in improving functional outcome and in reducing subdepressive symptoms in euthymic patients diagnosed with BD-II. Additionally, Bonnin et al. (2016) concluded that the psychosocial functioning improvement in euthymic BD-I and BD-II patients who received functional remediation was maintained at 1-year follow-up.

Another study of euthymic bipolar patients (with deficits in functioning) reported that those receiving psychoeducation together with pharmacological therapy presented the lowest relapse rates (35.3%), followed by those receiving cognitive rehabilitation in combination with pharmacotherapy (64.7%), and those receiving only pharmacotherapy (76.5%) (Barbeito et al., 2014); In addition, patients receiving psychoeducation together with the usual pharmacological therapy reported (Barbeito et al., 2014) the highest rates of treatment adherence; cognitive rehabilitation was also related to improvement in functional outcome. Miziou et al. (2015) also concluded that, although some data have evidenced the valuable outcomes of cognitive behavioral therapy and interpersonal and social rhythm therapy in acute phases of the illness, more data are needed for the maintenance phase of BD. For example, patients with a refractory BD receiving cognitive behavioral therapy in combination with psychotherapy and pharmacotherapy obtained better results from hospitalization, affective symptoms and socio-occupational functioning than patients in the control group receiving only traditional pharmacotherapy

(González-Isasi et al., 2014). Finally, although family intervention appears to be effective for caregivers, there is only limited evidence of its effect on patient outcomes (Miziou et al., 2015).

Despite the scarce evidence on the effectiveness of psychosocial interventions in BD, it seems that psychosocial interventions, together with the usual pharmacological treatment, are beneficial therapeutic resources (Kendall et al., 2014). It is widely recommended that interventions should be personalized to patients' needs and their illness characteristics and stage (Barbeito et al., 2014; Tse et al., 2014). Furthermore, as stated by the NCCMH (2014), main targets of interventions in BD should be clinical recovery, symptom control, relapse, functional outcomes, personal recovery, and quality of life.

1.3. Recovery in BD

1.3.1. The concept of recovery in mental health

1.3.1.1. Historical evolution of the concept

Recovery is defined by the Oxford English Dictionary (2013) as "the restoration of a person (…) to a healthy or normal condition (…) the regaining or restoration of one's health or a mental state (…) restoration or return to health from illness. (…) the cure or healing *of* an illness, wound, etc." Furthermore, the negative prognosis of severe mental illnesses, as expressed by Kraepelin (Kyziridis, 2005) has led to the assumption that recovery occurs only when suffering is gone, symptoms disappear, and functioning is fully restored to premorbid levels (Harrison, 1984). Thus, the clinical or medical approach to recovery has traditionally considered recovery as the reduction of symptoms and a return to baseline levels of functioning. This understanding excludes people with serious mental illnesses and chronic diseases from the possibility of recovering (i.e., recovery

becomes an unrealistic goal) (Anthony, 1993; Davidson, O'Connell, Tondora, Lawless, & Evans, 2005; Jacobson & Greenley, 2001; Whitley & Drake, 2010).

Nevertheless, this clinical understanding of recovery and, in turn, expectations for people with a serious mental illness to recover, began to change with the discovery of antipsychotic medication in 1950 (Frese et al., 2009) and the publication of several longitudinal studies showing that people with mental illness could achieve functional improvement in their health status (DeSisto, Harding, McCormick, Ashikaga, & Brooks, 1995; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987; Harding & Zahniser, 1994; Harding, Zubin, & Strauss, 1992; Harrison et al., 2001; Ralph & Corrigan, 2005). Despite the acknowledgement that people with mental disorders could function in society, there were difficulties reintegrating them into the community. Thus, "psychosocial rehabilitation" and "psychiatric rehabilitation" movements, defended the importance of consumers' psychosocial functioning despite the presence of their psychiatric symptoms, and advocated for integrating it with the medical considerations (Frese et al., 2009). Meanwhile, the consumer-survivor movement, the human rights movement, and the Independent Living Movement (DeJong, 1979) fought to restore control, rights, responsibilities, dignity, empowerment and freedom in people with mental disorders (Fisher & Chamberlin, 2004; Jacobson & Greenley, 2001; Slade et al., 2008; Zinman, 1986). Additionally, a number of autobiographical studies, qualitative research, and literature review studies have argued that recovery is not synonymous with "cure" and that it is not necessarily a return to a "normal" health and functioning (Anthony, 1993; Jacobson & Greenley, 2001).

1.3.1.2. *Recovery domains in mental health*

Recovery in mental health cannot be explained solely by psychopathology or symptomatic dimension (i.e., clinical recovery) but also by personal changes related to

values, attitudes, and social roles despite symptoms and vulnerabilities (Agrest & Druetta, 2011; Davidson et al., 2001; Davidson, O`Connell, Tondora, Styron, & Kangas, 2006; President's New Freedom Commission on Mental Health, 2003; Slade, Amering & Oades, 2008). The main up-to-date approaches to recovery are "clinical recovery"—understood as the cure of the illness or remission of symptoms (Andresen, Oades & Caputi, 2003; Slade, 2009a) and the capability to function in community (Harding, 2005)—and "personal recovery"—derived mainly from the consumer movement (Andresen et al., 2003; Slade et al., 2008), and defined most frequently as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles… a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness" (Anthony, 1993, p 15). More recently, Whitley and Drake (2010) extended the framework for recovery and reintegrated aspects of clinical and personal recovery, as suggested by Slade et al. (2008). As a result, they proposed a multidimensional approach of recovery in mental illness that integrates five dimensions: 1) clinical, 2) existential or personal, 3) functional, 4) physical, and 5) social.

As Agrest and Druetta (2011) pointed out, some authors equate the concept of recovery with remission or cure, whereas others equate it with functionality or physical or social care, and still others place more emphasis on the existential or experiential perspective of consumers. Notwithstanding the absence of a consensus on the minimal number of recovery dimensions or about which of these must exist to consider a person recovered (Andreasen et al., 2005; Bellack, 2006; Schrank & Slade, 2007), recovery approach is at present internationally established in mental health policies and guidelines (Department of Health, 2011; President's New Freedom Commission on Mental Health, 2003). Currently, personal recovery—most widely defined as the personal and unique process of changing attitudes, values, goals, skills, and roles by which people can live

fulfilling and contributing lives despite experiencing mental health symptoms and limitations (Anthony, 1993)—is not receiving the needed systematic attention in BD (Jones et al., 2013).

1.3.1.3. Conditions and characteristics included under the recovery concept

Some theoretical and practical models have explored conditions that promote recovery in people with serious mental illnesses (Davidson & Strauss, 1992; Fisher, 1994; Spaniol, Koehler, & Hutchnson, 1994) but most probably due to the lack of consensus on the recovery concept, they ignored important aspects in recovery such as the consumer's perspective: (Noiseux et al., 2009).

Different models and frameworks of recovery (e.g. see Andresen et al., 2003; Lapsley, Nikora, & Black, 2002; Leamy, Bird, Le Boutillier, Williams & Slade; 2011; and Vogel-Scibilia et al. (2009)) have included a number of recovery domains that are achieved at different stages. For example, Vogel-Scibilia et al.'s (2009) model of recovery match the recovery concepts of hope, understanding, acceptance, active participation in life, active coping, self-redefinition, empowerment, and self-determination proposed by Ridgway (2001). Based on the qualitative study carried out from the narratives of people living with a serious mental illness (SMI), Lapsley et al. (2002) described the developed "recovery framework," including a variety of journeys (i.e., the recovery journeys, turning points, and the road to recovery), where fundamental processes of changes in hope, esteem, agency, relationships, and transitions in identity occur. Finally, Leamy et al. (2011) proposed the so-called "CHIME" recovery framework for personal recovery in mental health—later validated by Slade et al. (2012)—including a number of characteristics of the recovery journey, processes, and stages among which they

highlighted the following: connectedness, hope and optimism about the future, identity, meaning in life, and empowerment.

1.3.2. Evidence for recovery in serious mental illnesses

The assumptions underlying the personal recovery approach in mental health are supported by some primary studies—including autobiographical or first-person accounts (Deegan, 1996; Fisher, 1994), key theoretical writings of experts who supported people with mental illness (Anthony, 1993; Mead & Copeland, 2000; Spaniol et al., 1994), qualitative studies (Davidson, Ridgway, Kidd, Topor, & Borg, 2008; Jacobson & Greenley, 2001; Lapsley et al., 2002), and quantitative studies on recovery (Corrigan, Giffort, Rashid, Leary & Okeke, 1999; Jääskeläinen et al., 2012)—, and some secondary studies—including literature reviews, systematic reviews, and meta-analyses of recovery (Andresen et al., 2003; Bellack, 2006; Drake & Whitley, 2014; Leamy et al., 2011; Slade et al., 2012).

The evidence on recovery varies depending on its approach. For example, autobiographical and key theoretical writings highlighted the following common themes in recovery: 1) Recovery as a process and deeply personal experience and the regaining of a satisfying life (Deegan, 1988; Ridgway, 2001, Sacks, 2007); 2) Recovery as a normative life process (Mead & Copeland, 2000); 3) Recovery as supporting patients' autonomy, personal responsibility and agency; and 4) Recovery as empowerment and peer support (Jamison, 1995). Qualitative studies of recovery in SMI documented overlapping results, such as the understanding of recovery as a process and as a subjective experience (Davidson et al., 2008; Jacobson, 2001; Ridgway, 2001; Smith, 2000; Whitley, Gingerich, Lutz, & Mueser, 2009) and as a journey of small steps and realistic goals even in the presence of symptoms (Davidson et al., 2005). As Drake & Whitley (2014) indicated in their review, common themes in those studies were: 1) sense of

agency, control, responsibility (Sells et al., 2006); 2) Meaningful social roles, community integration and sense of normalcy (Davidson et al., 2005); and 3) Social connectedness (Smith, 2000), being understood and accepted (Sells et al., 2006), and having supportive people (Spaniol, Wewiorski, Gagne, & Anthony, 2002). Drake and Whitley (2014) and Jääskeläinen et al. (2012) performed large meta-reviews that aimed to assess good recovery-related outcomes among people with SMI. In both studies Hegarty, Baldessarini, Tohen, Waternaux, and Oepen's (1994), Menezes, Arenovich, and Zipursky' (2006) and Warner's (2004) meta-analytical reviews, which included rates of recovery ranging from 11% to 42% depending on the recovery criteria, are referenced; Jääskeläinen et al. (2012), for example, identified that 13.5% of people with schizophrenia recovered, understanding recovery as a persistent (at least two years) improvement in clinical or social/functional domains.

Although systematic reviews (Leamy et al., 2011), randomized controlled trials (Greenfield et al. 2008; Barbic, Krupa, & Armstrong, 2009; Slade et al., 2011), intervention manuals (Bird et al., 2011), scholarly overviews (Slade, 2009b; Andresen, Oades, & Caputi, 2011), and practice guides (Davidson, Ridgway, Wieland, & O'Connell, 2009; Slade, 2009a) add growing evidence of recovery, most of the evidence proceeds mainly from autobiographical accounts, qualitative studies, and expert opinions. Furthermore, quantitative meta-analytical reviews of recovery outcomes—including clinical ones—do not investigate core aspects of personal recovery (e.g., process of pursuing independence and community integration) reported in qualitative and autobiographical literature of people with SMI (Drake and Whitley, 2014). Therefore, quantitative evidence of those recovery aspects (i.e., empowerment, autonomy, agency, structure, meaningful activities, gainful employment, safe and secure housing, social connectedness and support) is much less than for variables related to symptoms and other

clinical correlates, stressing the fact that recovery must yet receive additional supporting data (Drake and Whitley, 2014; Slade et al., 2012). Consequently, health institutions have pointed out the need to map—quantitatively, with multi-perspective evaluations and using standardized measures—the development of recovery over time (Department of Health, 2004; National Institute for Mental Health in England [NIMHE], 2005; Slade et al., 2012).

Other studies refer to recovery as the management of one's illness that pursues regaining a sense of self and a place in society and, accordingly, have developed questionnaires (e.g., the Illness Management and Recovery Scale; Salyers, Godfrey, Mueser & Labriola, 2007) that significantly correlate with a popular recovery scale (i.e., the Recovery Assessment Scale; Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995) and with less frequent psychiatric symptoms and better community functioning (McGuire et al., 2014; Salyers et al., 2007). Besides, the implementation of an Illness Management and Recovery program (IMR) reported positive changes in illness self-management, knowledge (Mueser et al., 2006), hope (Salyers et al., 200), and coping (Mueser et al., 2002) but not in social support (Hasson-Ohayon, Roe, & Kravetz, 2007). At any rate, it should be emphasized that the IMR program is based on a partial understanding of recovery including only the management of the illness and the improvement of social functioning, and therefore, results should be interpreted cautiously.

Although interventions with a specific focus on personal recovery are increasing (Jones et al., 2015), and some researchers have developed questionnaires to assess recovery in mental health (e.g., the Bipolar Recovery Questionnaire by Jones et al., 2015; the Recovery Assessment Scale by Giffort et al., 1995, and the Questionnaire about the

Process of Recovery by Neil et al., 2009), the rate of clinical recovery from mental illness has remained relatively low over the past century (Drake & Whitley, 2014).

Among the scarce literature on the subject, the Questionnaire about the Process of Recovery (QPR) showed high positive associations with quality of life, general health, and empowerment in people with experience of psychosis (Neil et al., 2009), in line with other studies measuring those variables in people with SMI such as schizophrenia, BD, or major depression (Corrigan, Salzer, Ralph, Sangster, & Keck, 2004; Davidson, 2003; Resnick et al., 2004). On the other hand, the significant negative correlations found by Law et al. (2014) between the QPR and symptoms of psychosis supported the understanding of recovery as associated with symptom reduction (National Institute for Health and Clinical Excellence, 2010). Furthermore, factor analyses carried out with the QPR indicated that the questionnaire is composed of one intrapersonal and one interpersonal subscale (Neil et al., 2009). The intrapersonal subscale is in line with internal conditions of recovery—such as hope, empowerment (Andresen, Caputi & Oades, 2006) and personal confidence (Corrigan et al., 2004)—and the interpersonal subscale is in line with external conditions of recovery—such as connectedness and reliance on others (Spaniol et al., 2002; Anthony, 1993; Jacobson & Greenley, 200; WHO, 2001).

1.3.3. Achieving recovery from BD

Among the features that assist recovery, Slade (2009) highlighted the following key issues in personal recovery: positive identity, framing the mental illness, self-management of mental illness, and developing valued social roles. Jones et al., (2010) listed opinions on recovery expressed by service users with BD in different studies, such as taking control of one's life, self-management strategies—e.g., learning about the illness, identifying trigger factors and warning signs, managing sleep, and making

lifestyle adjustments (Russell & Browne, 2005)—, redefining one's sense of self, separating their personal identity from the BD label (Van der Gucht, 2009), recovering from the stigma of being diagnosed (Campbell, 1996), learning self-acceptance, and not engaging in excessive self-criticism, among others. Those studies also evidenced a variety of coping strategies for recovery. Division of Clinical Psychology (2010, p. 50) numbered the most common ones, such as mood management and self-awareness, learning to be more empathic towards oneself, recognizing biased cognitions, interpersonal skills, identity issues, support from services, spirituality, self-care, hope, optimism, and responsibility.

Mansell, Powell, Pedley, Thomas, and Jones (2010) reviewed qualitative studies of recovery from BD and qualitatively explored the process of recovery from BD-I, providing a summary of important themes and subthemes in recovery, such as ambivalent approaches related to mania, medication and sense of identity following diagnosis, and the universal helpful approaches (e.g., understanding, life-style basics, and social support). Similar themes in recovery from BD were acknowledged in different qualitative studies. For example, Todd, Jones, and Lobban (2012) identified four fundamental themes for self-management and recovery in service users with BD: recovery is not the absence of symptoms, recovery requires taking responsibility for one's own wellness, self-management based on current skills, and overcoming obstacles—such as stigma and negativity—to recovery. Finally, Veseth, Binder, Borg, and Davidson (2012) found four main aspects that people with BD face to promote their own recovery: managing the ambivalence related to manic states, finding something to hang on to in intense bipolar moods, being aware of one's own and others' signals, and self-caring.

Personal recovery in BD—measured with the Bipolar Recovery Questionnaire—was associated with improvements in overall functioning, in mental health (i.e., bipolar symptomatology and well-being). The results indicated that symptoms and functioning contributed to recovery experiences in people diagnosed of BD (Jones et al., 2013).

2. Background

Resilience

2.1. What Is Resilience?

2.1.1. Historical review of the concept of resilience

In 1942, Scoville reported the traumatic events, risk factors, protective elements and surprising "resistance" of children who had to face the effects of World War II. Later, the developmental psychologist Werner published individually (1989, 1993) and with Smith (1982, 1992, 2001) the results of the developmental courses of resilient children living in extreme poverty and in dysfunctional families in a follow-up study of all the children born in 1955 on a Hawaiian island. The study followed these children from the perinatal period until they were 32 years old. The authors found that only a minority of the children developed serious psychological disturbances, and they described the qualities that differentiated these individuals from those who did not succeed. They used the term ‘invincible’ to refer to what was later termed ‘resilience’, referring to individuals who successfully adapted to life despite adversity. Werner and Smith highlighted the role of social support, the crucial importance of a lifespan approach and the finding that protective factors (which changed in various life phases) seemed to have a more general effect on adaptation than specific risk factors.

The *attachment theory* (Ainsworth, 1979; Ainsworth & Bowlby, 1991) complements the resilience theory by outlining the importance of secure and harmonious love relationships and refining the understanding of the types of relationship experiences necessary to promote positive adaptation (Atwool, 2006; Kotliarenco & Cáceres, 2011). Shortly afterwards, Rutter (1979) updated Bowlby’s work and indicated that maternal deprivation is a "vulnerability factor" rather than a causative agent of developmental difficulties. The attachment theory, which considers attachment the root of affective

resources for resilience, is a line of study that continues today (e.g., Cameron, Ungar, & Liebenberg, 2007).

In the 1970s and 1980s, many studies of competence, adversity and resilience aimed to promote health and prevent the development of psychosocial maladjustment were published. At that time, the study of temperamental characteristics, internal protective factors (e.g., Garmezy, 1971, 1974; Garmezy, Masten, & Tellegen, 1984) and external protective factors (e.g., Rutter 1985; Werner, 1984, 1995; Werner & Smith 1982, 1992, 2001) prevailed as "immunity" factors that prevented the person from succumbing to adversity.

There are two broad categories related to resilience: risk factors and protective factors. Whereas risk factors are used to refer to aspects that enhance the odds of maladaptation, protective factors are used to refer to characteristics that increase adaptation or to influences that alter or moderate a person's response to threat that predisposes to a maladaptive outcome (Rutter, 1985). Nevertheless, a meta-analytic study (Lee et al., 2013) concluded that correlations between resilience and risk factors (e.g., such as being diagnosed with depression, anxiety and posttraumatic stress disorder) were lower than correlations between resilience and protective factors (e.g., self-efficacy, positive affect and self-esteem). This is in line with the conclusions of Werner and Smith (1992), who also highlighted that protective factors, both individual (e.g., personality and self-help skills) and environmental (e.g., family relationships and community), seem to have a broader effect on adaptation than do specific risk factors. Furthermore, according to Lee et al. (2013) and to Tusaie and Dyer (2004), resilience protects one from adverse events and enhances individuals' psychological outcomes when facing risk factors such as depression and anxiety. Thus, Lee et al. (2013) suggested that the stronger relationship between resilience and positive factors than between resilience and risk factors (positive

and risk factors are exemplified by Lee et al., 2013, above) could be explained by the fact that resilience is in itself a kind of positive factor.

In the late 20th century, two new psychology perspectives about human potential, motivations and capacities further developed the concept of resilience. The first perspective is positive psychology (Seligman & Csikszentmihalyi, 2000), which incorporated resilience from a preventive perspective and highlighted the strengths and virtues of human beings (Cornum, Matthews, & Seligman, 2011). This perspective posits that positive emotions expand individuals' intellectual, physical and social resources, which grants them more endurance and increases the reserves that can be called upon when threats and opportunities arise (Fredrickson, 2001).

The second perspective is the salutogenic orientation proposed by Antonovsky (1979) and his vision of the consequences of the Nazi Holocaust. Without focusing on psychopathology, he explored the factors that helped individuals to maintain physical and psychological well-being in the face of stressors. Antonovsky used the phrase 'sense of coherence' to describe the attitude that leads people to identify and use resources during stressful situations (e.g., money, intelligence, self-esteem, preventive health orientation, social support and cultural capital) to maintain and develop their health. The sense of coherence consists of at least three dimensions: comprehensibility, manageability and meaningfulness (Antonovsky & Sourani, 1988; Eriksson & Lindström, 2007).

Also from a preventive perspective, Richardson, Neiger, Jensen, and Kumpfer (1990) and Richardson (2002) created a resiliency model as a model of health education. This model proposes that an individual has the opportunity to *consciously* or *unconsciously* choose the outcomes of disruptions and begin what they call the *reintegration process*. This process leads to one of four outcomes: *resilient reintegration* (where disruption leads people to attain additional protective factors and a new, higher

level of homeostasis); *homeostatic reintegration* (where disruption leads people to remain in their comfort zones in an effort to "just get past" the disruption); *reintegration with loss* (where disruption leads people to lose protective factors and to develop a new, lower level of homeostasis); and *dysfunctional reintegration* (where disruption leads people to resort to destructive behaviors such as substance abuse). Richardson (2002) does not conceptualize resilience as merely a protective factor or a process that may be acquired but as a force within everyone that drives them to seek self-actualization, altruism, wisdom and harmony with a spiritual source of strength. Thus, in the late 20th century, resilience is not only understood as innate personality traits (characteristics of the individuals referred to as protective factors) that people either have or do not have, but also as a process that changes over time. This new conceptualization of resilience acknowledged that protective factors will vary contextually and temporally (Fletcher & Sarkar, 2013), and that resilience qualities could also be acquired and learned at any point in life (Richardson et al., 1990).

At the turn of the 21st century, interest in the relationships between resilience, culture and community factors has increased.

2.1.2. Current definition of resilience

Despite various studies reviewing the resilience concept (Fletcher & Sarkar, 2013; Luthar, Cicchetti, & Becker, 2000; Rutter, 2013; Vanderbilt-Adriance & Shaw, 2008; Windle, 2011), researchers acknowledge the complexity, variability and inconsistency when defining resilience. As a consequence, according to Windle (2011) and Windle, Bennett, and Noyes (2011),there is a wide variability of prevalence rates of resilience depending on the definition used, varying from 25 to 84% across levels of risk, time and domains of competence (Vanderbilt-Adriance & Shaw, 2008).

According to the American Psychological Association (2010), resilience is the process of *adapting well* in the face of adversity, trauma, tragedy, threats or significant sources of stress such as family and relationship problems, serious health problems or workplace and financial stressors. Resilience has also been described as preserving the same level of functioning or rebounding back to that level after an initial setback (Netuveli, Wiggins, Hildon, Montgomery, & Blane, 2006). Wathen et al. (2012) add relevant information to the understanding of resilience, defining it as a 'dynamic process in which psychological, social, environmental and biological factors interact to enable an individual at any stage of life to develop, maintain, or regain their mental health despite exposure to adversity' (p. 10). The understanding of resilience as a dynamic multidimensional process is also supported by other key researchers in the arena (Luthar et al., 2000; Masten, 2001; Shastri, 2013; Windle, 2011), who state that personal and dispositional resilient qualities and skills allow functioning or adapting when facing a significant adversity.

However, it should be noted that resilience does not refer to a magical state of invulnerability (Arrington & Wilson, 2000; Deegan, 2005). As Walsh (2002, p. 7) highlights, 'the quality of bouncing back, inherent in resilience, is not simply about "breezing through" a crisis, as if unscathed.' Windle (2011) reviewed 271 research studies to determine the definition of resilience and identified three requirements for resilience after stress or trauma: 1) the need for significant adversity/risk, 2) the presence of assets or resources to offset the effects of the adversity and 3) positive adaptation or the avoidance of a negative outcome. In this line, Fletcher and Sarkar (2013) agreed that there is consensus about two issues on resilience, first, the antecedent of resilience is an adversity of any kind and, second, the key consequence of resilience is positive adaptation (Fletcher & Sarkar, 2013).

2.1.3. Resilience components

Resilience factors are classified as individual or environmental. Table 28 presents the most frequent resilience factors found in the literature.

Among the individual resilience factors most frequently addressed are: (1) self-esteem, self-worth, self-reliance and self-efficacy; (2) self-help and active coping skills; (3) acceptance of self and of life events or circumstances; (4) flexibility or easy temperament; (5) self-determination and sense of purpose; (6) personal agency and self-control; (7) sense of humor; (8) optimism; (9) sense of coherence; (10) perseverance; (11) hope; (12) search for social support and connectedness; (13) finding meaning in life; and (14) emotional regulation (Ahern, Kiehl, Lou Sole, & Byers, 2006; Friborg, Hjemdal, Rosenvinge, & Martinussen, 2003; Garcia-Dia, DiNapoli, Garcia-Ona, Jakubowski, & O'Flaherty, 2013; Haase, Heiney, Ruccione, & Stutzer, 1999; Lee et al., 2013; Masten, Powell, & Luthar, 2003; Shastri, 2013; Truffino, 2010; Werner & Smith, 1992; Windle, 2011).

The most referenced environmental resilience factors are: (1) emotional bond and close and secure relationships with an adult who is sensitive to one's needs; (2) family support; (3) social support; and (4) health resources (Friborg et al., 2003; Garcia-Dia et al., 2013; Haase et al., 1999; Lee et al., 2013; Shastri, 2013; Werner & Smith, 1992). As shown in Table 28 family is frequently mentioned as an external factor in personal resilience because it is perceived as a source of strength (Marsh, 2003; Walsh, 1996, 2002).

Table 28

Common Individual and Environmental Factors of Resilience

Individual Factors of Resilience	Easy Temperament	– To be active, affectionate, cuddly, good-natured and easy to address; the ability to gain other people's positive attention (Werner, 1984, 1995). To have an "easy" temperament and the ability to actively recruit competent adult caregivers (Egeland, Jacobvitz, & Sroufe, 1988; Elder, Liker, & Cross, 1984). – To present little distractibility, impulsivity and inhibition (Keogh, 2003; Wachs, 2006). – To take decisive action (Everly, 2009; Everly, McCormack, & Strouse, 2012; Everly, Smith, & Welzant, 2008; Everly, Strouse, & Everly, 2010).
	Emotional Stability	– To hold a positive view of oneself and confidence in one's own strengths and abilities (American Psychological Association, 2013). – To be able to manage strong feelings and impulses (American Psychological Association, 2013). – To develop a coping pattern that combines autonomy and asking for help (Werner, 1984, 1995) – To be self-controlled (Everly, 2009; Everly et al., 2012; Everly et al., 2008; Everly et al., 2010) – To be autonomous (Werner, 1984, 1995) – To have an internal locus of control and positive self-concept (Werner, 1984, 1995) – To have good self-esteem and self-efficacy (Friedli, 2009) – To be nurturing and emotionally sensitive (Werner, 1984, 1995)
	Social Competence	– To have communication skills (Werner, 1984, 1995; American Psychological Association, 2013) – To have interpersonal connectedness (Everly, 2009; Everly et al., 2012; Everly et al., 2008; Everly et al., 2010). – To have a positive social identity (Friedli, 2009)
	Cognitive Competence	– To be able to make realistic plans and take steps to carry them out (American Psychological Association, 2013) – To be skilful in problem solving (American Psychological Association, 2013; Werner, 1984, 1995)
	Outlook On Life	– To take an active approach to solving life's problems, a tendency to perceive experiences constructively and the ability to use faith to maintain a positive vision of a meaningful life (Werner, 1984, 1995)

		– Optimism and a positive perspective on life; presence d´esprit (calm, innovative, non-dogmatic thinking); honesty; the ability to express positive emotions in the wake of adversity (positive emotionality) (underlying constructs: confidence, optimism and the ability to find meaning); tenacity (Everly, 2009; Everly et al., 2012; Everly et al., 2008; Everly et al., 2010). – To be ready to learn (Friedli, 2009)
Environ-mental Factors of Resilience	Family Support	– To have caring and supportive relationships within and outside the family. Relationships that create love and trust, provide role models and offer encouragement and reassurance, which help bolster a person's resilience (American Psychological Association, 2013) – To establish a close bond with at least one stable person. Families with religious beliefs that provide stability and meaning. Figures of reference that promote resilience, accepting children's temperamental idiosyncrasies, allowing children to have experiences that challenge rather than overwhelm their coping abilities, encourage children to develop special interests and activities, model the conviction that life makes sense and encourage children to reach out beyond their nuclear family for interpersonal contacts (Werner, 1984, 1995) – To count on the presence of a close, confiding relationship with parents or another reference figure. Families that share beliefs and narratives that foster a sense of coherence, collaboration, competence and confidence (Garmezy & Masten, 1986; Garmezy, Masten, & Tellegen 1984)
	Community Support	– To count on supportive teachers and social support. To find opportunities in major life transitions (Werner, 1984, 1995) – To be in connection with social organizations (sporting clubs, church groups), environmental quality (public safety, recreational facilities) and good quality of health services (Benard, 1996; Norris, Stevens, Pfefferbaum, Wyche, & Pfefferbaum, 2008; Sonn & Fisher, 1998)

In addition to individual and environmental factors of resilience, other predictive factors of resilience have been identified, including key turning points in people's lives (Rutter, 1987, 2013) that represent a break with the past, provide new opportunities and change people's trajectory. A turning point can set a person back on a previous life

trajectory or onto a different course. Furthermore, it is important to consider the person-process-context to study the relationship between adversity and resilience factors. For example, it is well known that an easy temperament functions as a protective mechanism, but to increase resilience, the goodness or poorness of fit between the person's temperament and the environmental demands is also important (Wachs, 2006). In fact, Rutter (1987, 2012) promoted the use of the term *protective process*, which captures the dynamic nature of resilience rather than the more common *protective elements*.

In the resilience acquisition process, resilience qualities are contextual (i.e., context dependent, from situation to situation). Thus, they do not ensure that an individual will be resilient in all circumstances (Luthar, et al., 2000; Rutter, 1987, 1999), and they are temporary (i.e., individual's lifespan dependent) (Fletcher & Fletcher, 2005; Fletcher, Hanton, & Mellalieu, 2006; Fletcher & Scott, 2010). As stated before, resilience acquisition can be taught and acquired at any moment in life (Flach, 1988, 1997; Pesce, Assis, Santos, & Oliveira, 2004).

2.1.4. Sociodemographic characteristics and resilience

Additionally, resilience has also been studied in relation to demographic variables such as age and sex, but the relationships of these variables with resilience are not consistent. For example, one study found that males (vs. females) are more resilient, and also that age is positively related to higher levels of resilience (Campbell-Sills, Forde, & Stein, 2009). Nonetheless, others have found the opposite -i.e., a negative relationship between resilience and age, with women being more resilient (Beutel, Glaesmer, Decker, Fischbeck, & Brähler, 2009; Davidson et al., 2005). From the meta-analytic study of resilience, Lee et al. (2013) concluded that, among the psychological variables related to resilience, the demographic factors of age and sex were those with the smallest effect on resilience.

Lee et al. (2013) indicated that, although age and sex did not consistently relate to resilience, individual and cultural differences in resilience could arise due to different historical, social and geographical environments, also in accordance with Ungar (2008). However, in resilience, attention is more directed towards factors that contribute to the development of resilience and towards the reinforcement of mental health (Shastri, 2013; Truffino, 2010).

2.1.5. Differentiating resilience from other related psychological concepts

When defining psychological resilience, it is important to distinguish it from other related but conceptually distinct constructs such as stress-coping (Campbell-Sills, Cohan, & Stein, 2006), resistance or hardiness, posttraumatic growth (Windle, 2011), adaptive behaviors and recovery (Fletcher & Sarkar, 2013).

Table 29 shows the definitions of other constructs related to resilience, including coping, hardiness, thriving and ego resiliency. These constructs should not be considered synonymous even though they explain ways of adapting. For example, not everyone who uses coping skills is resilient because some attempts to cope are not successful (i.e., not resilient). Hardiness is not the only way to develop resilience, but those who reach higher levels of hardiness (commitment, control and challenge) are more likely to be resilient (Fernández-Lansac & Crespo, 2011). Finally, the concept of thriving comes from the literature on resilience and adds value to it, indicating that adaptation offers an opportunity for change and growth (O'Leary & Ickovics, 1995).

Table 29

Differences between Resilience and Other Related Constructs

Coping
Coping refers to the ways people actually respond to stress, such as through problem solving, seeking help, denial or acceptance (Skinner, Edge, Altman, & Sherwood, 2003). Compas, Connor-Smith, Saltzman, Thomsen and Wadsworth (2001) define coping as "conscious volitional efforts to regulate emotion, cognition, behavior, physiology and the environment in response to stressful events or circumstances" (p. 89). Not all outcomes of coping are reflected in resilience. Some attempts to cope are unsuccessful, and if the coping response does not lead to a good outcome, the result is not resilient (Glennie, 2010).
Hardiness
The term hardiness (Kobasa, 1979) refers to a broad personality factor composed of three dimensions: commitment (a lasting conviction that life is interesting and worth living), challenge (an exploratory and brave way of facing the world) and control (the belief that one can control and influence results). It is just one of the possible ways to develop resilience (Bonanno, 2004; Maddi, 2005).
Resiliency or ego resiliency
Ego resiliency is a personality trait that characterizes human adaptability. It refers to the level of control over the impulsivity of response and affection. The individual learns to regulate his/her behavior to respond appropriately to events (in terms of adequate levels of impulsivity and affection adapted to the context), which helps him/her avoid adverse consequences (Block & Kremen, 1996; Windle, 2011).
Thriving
The foundation of this concept comes from the literature on resilience, but it goes beyond the common view of resilience as homeostasis. Instead, it suggests a value-added construct whereby challenge provides an opportunity for change and growth (O'Leary & Ickovics, 1995).
Positive growth
Positive growth refers to the positive psychological change that occurs as a result of the struggle with trauma, usually involving an increased appreciation of life or setting new life priorities (Tedeschi, Park, & Calhoun, 1998). Resilient outcomes typically provide opportunities for posttraumatic growth (Westphal & Bonanno, 2007).

Several authors (Robertson & Cooper, 2013; Youssef & Luthans, 2007) and health campaigns have considered resilience an *asset* of the recovery process. For example, the recent 2012 campaign by the Royal College of Psychiatrists (UK) indicated that "central to the theme of recovery is resilience, which allows for individual strengths and coping skills to surface in spite of adversity". Similarly, some models or frameworks of recovery (Andresen et al., 2003; Slade, 2009a; Vogel-Scibilia et al., 2009), a US federal government report (The Surgeon General's Report on Mental Health; U.S. Public Health

Service Office of the Surgeon General, 1999) and the President's New Freedom Commission (2003) highlighted the need to manage symptoms and build resilience in order to promote recovery and a fulfilling life with improved vital roles. In that way, the term resilience was introduced and aligned with the recovery construct. The American Psychological Association (2009) in the resolution of the concept of recovery for people with SMI maintained that the challenges of life associated with recovery are common human experiences that require resilience, stating also that the system should foster not only recovery, but also resilience. Finally, Galvez, Thommi, and Ghaemi (2011) reviewed positive psychological aspects in BD —among which was included resilience—, recommending that clinical and research attention should be directed to promote those positive features that could improve outcomes in BD.

There are a great number of similarities between the terms of resilience and recovery. In both constructs, the main antecedent is an adversity of any kind, the key consequence is considered to be a positive adaptation, and both are reflected by some identical qualities such as hope and self-determination. Given the theoretical overlap between resilience and recovery constructs, it is important to elaborate further on their differences in order to clearly articulate the relationship between them. Thus, an extensive review on the similarities, differences and implications of psychological resilience and personal recovery is provided—as recommended by Fletcher and Sarkar (2013)—in the first empirical study of this thesis: *The Confluence of Resilience and Recovery in the Context of Mental Health.*

2.2. Measuring Resilience

Among the resilience measures most frequently used are the Brief Resilience Scale (BRS) (Smith et al., 2008),which measures the ability to bounce back or recover from stress; the Resilience Scale for Adults (RSA) (Friborg et al., 2003), which measures

five resilience domains including personal and social competence, family coherence, social support and persona structure; the Resilience Scale (RS) (Wagnild & Young, 1993), measuring personal competence and acceptance of self and life domains; and the Connor Davidson Resilience Scale (CD-RISC) (Connor & Davidson, 2003), measuring personal competence, acceptance of change and secure relationships, spiritual influences, and strengthening effects of stress.

Windle et al. (2011) reviewed 15 resilience measurement scales and concluded that, for an adult population, the RSA, the BRS, the RS, and the Psychological Resilience (Windle, Markland, & Woods, 2008) were the most valid measures of resilience. In their review, Windle et al. (2011) stated that the instruments rating the best in terms of psychometric properties were the CD-RISC, the RSA, and the BRS. Nevertheless, these authors also stated that the overall quality of these questionnaires was considered moderate because none of them rated high in all the psychometric criteria (for example, a resilience measure could have good scores for construct validity, moderate scores for content and internal consistency, and poor scores for criterion validity). On the other hand, they considered that, among the resilience measures that focus on resilience at the individual level only (i.e., measures that only explore the personal or individual resilient qualities that stem from the individual, such as positive self-attitude or perseverance, excluding the measurement of external or environmental resources that could also be considered as resilient, such as social support), the Ego-Resiliency Scale (ER 89) (Block & Kremen, 1996) and the Psychological Resilience (Windle et al., 2008) presented better theoretical basis to justify item selection. These authors argued that the CD-RISC had dubious theoretical adequacy because to develop the content of the measure, the literature review was incomplete and the definition of resilience was based on restricted terms.

Additionally, when examining resilience across multiple levels, only five questionnaires complied with this conceptual understanding of the term, among which the RSA was the only one created for adults, and not for children or young people (Windle et al., 2011). In addition, the RSA obtained the highest rates of test-retest reliability (Windle et al., 2011). Notwithstanding, RSA conceptualizes resilience as a strategy to prevent psychopathology (Hjemdal, Friborg, Stiles, Rosenvinge, & Martinussen, 2006), which excludes people with a mental disorder from the resilience experience. The RS-25 and CD-RISC have been widely used in a number of studies with different samples, but as explained before, the theoretical adequacy of the CD-RISC is controversial (Windle et al. (2011). Ahern et al. (2006) also reviewed the measurement tools of resilience and concluded that the RS was the most satisfactory measure of resilience for adolescents, but Windle et al. (2011) pointed out that, if rigorous criteria were to be applied for content validity, other conclusions would have been reached.

Despite that several scales have been developed for measuring resilience, as discussed previously, there is no consensus about the `gold standard´ instrument of resilience (Windle et al., 2011). According to Tusaie and Dyer (2004) and Truffino (2010), complications when measuring resilience arise from the absence of an agreed upon definition of the concept and from the difficulties identifying its characteristics.

For example, because there are different conceptualizations of resilience, different studies have developed measures of resilience that define resilience in different ways. Some define resilience as a stable trait, others as a dynamic process, or other studies have focused only on individual or on environmental resilient factors but not on both of them. According to Windle et al. (2011), most of the resilience measures are focused on the individual level of resilience only. Additionally, some studies researching resilience use measures that are actually measuring other concepts related to resilience—such as

hardiness and coping— but not resilience itself. Moreover, some studies on resilience have selected multiple indicators and questionnaires to measure resilience, such as self-esteem, life satisfaction, and sense of coherence, but not instruments designed specifically to measure resilience (Wagnild, 2009). Furthermore, the majority of resilience measures were based only on literature reviews (theoretically driven), not considering primary accounts based on qualitative data, which provide more direct and empirical indicators.

Given that the study of resilience on people suffering mental illnesses has started recently, there are very few measures that were elaborated combining both theoretical data and evidence-based data to develop their content. Instead, the majority of these measures were based on the accounts of people from the general population and, in most instances, resilience has been contemplated as a preventive asset to avoid psychopathology. Therefore, to the best of our knowledge, there are no resilience instruments developed understanding resilience as an asset that may be generated in people who are suffering a mental disorder. That is, resilience measures conventionally considered as theoretically adequate (e.g., RSA) consider resilience as a set of protective factors that prevent the person from suffering psychopathology (Windle et al., 2011), which implies that the presence of psychopathology in the individuals is evidence of the absence of resilience (i.e., if they were resilient, they would have never developed a psychopathology). Therefore, during the development of these questionnaires, authors did not contemplate people who were already suffering a psychological disorder.

According to Shastri (2013), 'operationalizing and measuring resilience' may increase evidence about the central factors for regaining and maintaining mental health for a variety of patients (p. 227). Thus, there is a solid claim for developing, evaluating and using reliable, valid (both in content and construct) and responsive measures of resilience. Furthermore, as recommended by Michalak and Murray (2010), disorder-

specific questionnaires are also needed in order to assess psychological variables, and this statement also applies to resilience. When developing the content of a disorder-specific scale, it is recommended to not only to perform a literature review but also to carry out some empirical research based on qualitative reports on the specific research field (in this case, on resilience as experienced by people diagnosed with BD) (Michalak & Murray, 2010; Michalak, Murray, Young, & Lam, 2007). Finally, as stated above that generic measures of resilience considered individual or environmental factors but not both, it would be desirable for questionnaires that measure resilience as a multifaceted concept to include both individual and environmental qualities in their content.

2.3. The Study of Resilience in the Context of Mental Health

The majority of research of resilience in the context of mental health has been done from the preventive approach, providing a list of protective factors that counteract the effects of adversity and thus avoid a person's developing any psychopathology or mental health disorder. Another particularity is those cases in which the person who overcame an adversity was referred as to recovered but not as resilient (e.g., Bonanno, 2004; Bonanno, Westphal, & Mancini, 2011). Despite evidence showing that resilience is associated with a variety of desired health outcomes in physical, emotional and mental domains (Truffino, 2010; Wagnild, 2009; Windle et al., 2011), and evidence of resilience in people who are experiencing a somatic illness (e.g. Stewart & Yuen, 2011), and in caregivers of ill people (e.g. Wilks, Little, Gough, & Spurlock, 2011), there are few studies that explore resilience in people suffering from a mental health disorder. Nonetheless, the disciplines of psychiatry and psychology may benefit from the study of resilience (Luthar & Brown, 2007).

Studies on resilience in people suffering from psychopathologies are scarce. Nonetheless, all of them conclude that there is a positive relationship between resilience

and mental health improvement (e.g., referred to as well-being, psychosocial functioning, and symptomatology) (Bomyea et al., 2013; Johnson et al., 2010; Las Hayas et al., 2014; Torgalsbøen, 2012). For example, Torgalsbøen (2012) indicated a robust positive relationship between resilience (measured with the CD-RISC) well-being and psychosocial functioning in a 15-year follow-up study carried out with people recovered from schizophrenia.

Other resilience studies have explored the resilience qualities activated in patients experiencing symptoms of depression (Dowrick, Kokanovic, Hegarty, Griffiths, & Gunn, 2008; Griffiths et al., 2014), or the interaction between resilience (assessed with the CD-RISC) and trait anxiety in predicting outcomes in depressed patients (Min et al., 2013; Min, Lee, Lee, Lee, & Chae, 2012). Similarly, resilience was shown to act as a moderator in the relationship between depression and anxiety symptoms with suicidal ideation in patients suffering from mood disorders (Min, Lee, & Chae, 2015).

With respect to BD, only two studies have contemplated the study of resilience. The first was carried out by Edward, Welch, and Chater (2009), exploring resilience qualities in eight participants in remission from different mental illnesses, including BD. Edward et al. (2009) argued that resilience might enhance recovery from mental illness. Later, Choi et al. (2015) concluded that lower levels of resilience in outpatients diagnosed with BD—who were in remission—were associated with higher levels of impulsivity and depressive symptoms.

2.4. Future Directions in Resilience

In sum, there is a gap in knowledge about the resilience experience in people suffering from a mental disorder. Additionally, the quantitative studies mentioned above—e.g., Choi et al. (2015) and Torgalsbøen (2012)—present an important contradiction that affects their conclusions. In their studies, both authors used resilience

measures developed under the theoretical framework that resilience prevents a person from developing a mental disorder, while at the same time, they applied that measure in participants with a mental disorder.

A paradigm shift in the conceptualization of mental health should occur soon. Researchers and clinicians should not only strive to alleviate negative symptoms, but they should also promote the acquisition and the experience of positive factors—such as the resilience factors—that will help lasting recovery. Thus, facilitating progression toward positive and salutogenic interventions complements those that are entirely focused on restoring functioning and symptomatology (Fava & Sonino, 2007; Fava & Tomba, 2009; Ryff & Singer, 1996).

The concept of resilience should be better delimitated and clarified so as to become more operative and practical. That would help to develop instruments of resilience with greater content and construct validity. Vanderbilt-Adriance and Shaw (2008) and Windle (2011) also recommended the development of resilience subtypes or domains that would represent resilience strengths for each person. Identifying the process of resilience and the specific resilience qualities that lead to positive adaptation in a specific type of patients could help clinicians to plan individualized resilience interventions to strengthen these resilience qualities (Wright, Masten, & Narayan, 2013).

Resilience-grounded interventions consider both competencies and maladjustments, that is, at-risk individuals' strengths and deficits or processes that explain vulnerability and risk factors (Luthar & Cicchetti, 2000; Luthar et al., 2000). Some recent interventions on resilience that have been empirically tested (Leppin et al., 2014) are called the "Moving forward" (Tenhula et al., 2014) and the "Master Resilience Trainer" (Reivich, Seligman, & McBride, 2011). Richardson and Waite (2002) also proposed a five-day resiliency-training program to offer the opportunity to improve

personal resilience and self-actualization. Recently, Padesky and Mooney (2012) offered a four-step cognitive behavioral therapy-based model to aid people to build resilience.

There is still much to learn about resilience across the lifespan, and even more about resilience in specific psychopathologies. First, qualitative studies should study resilience in mental health from the subjective accounts of people who have witnessed it, both from first-person accounts and/or from the perspective of health professionals (Michalak et al., 2007). Second, quantitative or mixed studies on resilience in people with a mental illness are also recommended to be carried out in order to assess the role of resilience in the recovery process of people diagnosed with mental disorders. For example, given the relevance of resilience in the recovery process and in well-being (Fava & Tomba, 2009), future research could study whether resilience predicts recovery in specific psychopathologies (Fava, Ruini, & Belaise, 2007; Fava & Tomba, 2009). Finally, taking into account that resilience may be acquired in patients either with mental illnesses or with chronic mental disorders, future interventions could incorporate specific sessions on resilience, thereby preventing further deterioration (Windle et al., 2011).

Despite of the acceptance that positive psychological factors, such as resilience, have a favorable impact on mental health, these aspects have been little explored in the context of BD.

3. Aims, Hypothesis, Ethical Considerations, and Internal Structure of the Doctoral Thesis

3.1. Aims and Hypothesis of the Doctoral Thesis

3.1.1. Aims

The empirical design of this doctoral thesis focuses on four main aims:

1. To carry out a literature review on the constructs of resilience and recovery in order to further understand the theoretical concepts of resilience and of recovery in mental health, and to list the similarities and differences between both concepts as well as their convergences in the mental health area.
2. To build a theoretical model of resilience in persons with BD in order to explore and understand the meaning of resilience for BD patients.
3. To develop a psychometrically sound questionnaire of resilience specifically for BD patients.
4. To explore, both cross-sectionally and prospectively, whether resilience domains are associated with positive mental health outcomes in BD.

3.1.2. Hypothesis

1. The hypothesis for the first aim is that resilience and recovery concepts will share a number of similarities, but remarkable differences between both concepts will also be presented. It is hypothesized that both concepts will play different roles in the mental health area.
2. For the second aim, people in remission from BD and health professionals will recognize the experience of resilience, and will explain the resilience process and resilience qualities that were the key to the achievement of a positive adaptation to BD.
3. For the third aim, it is hypothesized that the BD-specific measure of resilience developed will be psychometrically valid. Specifically, (a) regarding construct

validity, it is hypothesized that the questionnaire will be composed of different resilience domains that will be correlated (b) regarding reliability, the questionnaire will be internally consistent and stable; (c) regarding concurrent validity, the questionnaire will be positively associated with a generic resilience measure, with quality of life and with personal recovery, and negatively associated with bipolar symptomatology; (d) regarding known-groups validity, it is hypothesized that recovered patients from BD will score higher in resilience than not recovered patients from BD; and (e) regarding responsiveness, it is hypothesized that the instrument will be sensitive in detecting changes in those patients with BD who report to have changed over the time before follow-up according to other measures.

4. For the fourth aim, it is hypothesized that some of the resilience dimensions will explain cross-sectionally the variability of the scores on personal recovery, quality of life, well-being, bipolar symptomatology, and psychosocial functioning deficit; it is also hypothesized that some of the resilience dimensions will prospectively predict better results in personal recovery, quality of life, well-being, bipolar symptomatology, and psychosocial functioning.

3.2. Ethical Considerations

The ethical approval to carry out this doctoral thesis was obtained from the Clinical Research of Basque Country's Ethics Committee (Spain) (see Appendix 1). The doctoral thesis involved the recruitment of the clinical sample (people diagnosed with BD) coming from different public health systems in the Basque Country (Osakidetza) and from associations focused on BD.

The Clinical Research of Basque Country's Ethics Committee approved the doctoral thesis based on detailed information about the study justification, aims, and methodology. All the ethics issues in carrying out this thesis were described in detail in the report approved by the ethics committee, summarized below. Appendix 2 includes all the informed consents given to the participants (i.e., BD patients and general population).

With reference to the informed consent, each participant will give informed consent after receiving sufficient information to evaluate the study and choosing to participate. The participant must know that participation in the study is voluntary and can be stopped at any time; the participant should also be informed of the right to not answer certain questions, or to change the decision to take part, and that the participant has the option of withholding consent to the study at any time without giving any reason and without any kind of negative consequence to the participant.

Confidentiality of the patient is respected through a variety of means. Interviews, focus groups, and field study will be carried out by the main researcher of the study. Once a patient has agreed to collaborate in the study, the main researcher will only have access to the patient's identity and address data—not to the clinical history of the patient—and the patient's therapist will release this data to the main researcher.

In order to safeguard privacy and confidentiality, a code will be assigned for each participant. In order to preserve participants' confidentiality, the identity and address of each participant and the corresponding participant code will be safeguarded in a different database that requires a secret key only known to the main researcher. The database storing the results of this survey will only contain the participants' codes—not their identity details. Therefore, only the main researcher will be able to relate the code of each participant to the corresponding identity. The identity of the participant will not be

revealed to any person, nor to any scientific publication derived from this study. No biologic nor genetic samples of the individuals will be collected.

3.3. Internal Structure of the Doctoral Thesis

According to the aims presented earlier, the present doctoral thesis consists of four studies. All the studies are presented in English, in an article format. All of the studies have been submitted to indexed international journals and are actually under review process. In addition, the studies have been presented at different international conferences targeting psychiatry and psychology, resilience, and positive psychology issues.

Since the articles derived from this doctoral thesis were submitted in English to the journals, we have maintained the same style and presentation in this doctoral thesis as used when they were sent to the journals. Additionally, the acknowledgments, the initial abstract, and the abstracts from each study are also available in Spanish to facilitate the understanding of non-English-speaking readers.

3.3.1. Overview of the four studies comprising this Doctoral Thesis

1) There is a great deal of confusion about the terminology and concepts around resilience and recovery. The aim of the Study 1 was to explore the theoretical background on resilience and recovery concepts, to clarify the meaning and role of both concepts, and to integrate them in the area of mental health. A narrative synthesis of the relevant literature on resilience and recovery was performed using electronic search engines of scientific literature databases. A total of 84 documents on resilience and recovery were reviewed. As a result of this study, we wrote the first manuscript, entitled *The Confluence of Resilience and Recovery in the Context of Mental Health.*

2) There is a lack of knowledge on the resilience experience in BD. The Study 2 explored qualitatively the resilience process in BD. The study aimed at obtaining a model of resilience in BD that could integrate perspectives of patients in remission from BD and

of mental health clinicians who had witnessed resilience in their patients diagnosed with BD. The BD sample (N = 15) and clinician sample (N =6) were recruited from public mental health and psychiatry services in Basque Country, with the collaboration of psychiatrists. The qualitative study was based on semi-structured in-depth interviews with patients (N = 9), on a focus group with other patients (N = 6), and on two other focus groups with clinicians (N = 4; N = 2). Grounded theory, integrating perspectives of both sources of information, was followed across the stages of data analysis to obtain a model of resilience in BD. As a result of this study, we wrote the second manuscript entitled *Resilience in Bipolar Disorder: A qualitative study of the viewpoints of patients and health professionals.*

3) Given the lack of availability of a BD-specific resilience measure, the Study 3 study presents the development and psychometric validation of a newly created resilience questionnaire specifically for BD: the Resilience for Bipolar Disorder (RBD). The RBD was developed based on the results from the previous qualitative study as well as on a literature review on resilience. This study recruited a clinical sample of patients diagnosed with BD (N = 125), according DSM-IV-TR (APA, 2000) criteria confirmed by their therapists, and a comparison sample from the general population (N = 107). Patients were recruited from nine public mental health and psychiatry services of the Basque Country as well as through non-governmental BD associations from a number of regions in Spain. Both samples completed the RBD at baseline (Time 1 (T1)) and follow-up (Time 2 (T2)), along with a number of mental health-related measures. As a result of this study, we wrote the third manuscript, entitled *The Resilience Questionnaire for Bipolar Disorder: Development and Validation.*

4) For the Study 4, only a clinical sample of patients diagnosed of BD was required. Participants within this sample were the same as for the clinical sample in the

third empirical study. Patients with BD completed self-reports of sociodemographic and clinical data and a battery of self-reported tests in order to examine cross-sectional and prospective relationships about resilience domains (measured with the developed and validated 23-item RBD) and mental health adjustment indicators of personal recovery, bipolar symptomatology, impairment in psychosocial functioning, and quality of life at T1 (N = 125) and T2 (N = 63). Although the procedure and characteristics of the patients were the same as for the clinical sample of Study 3, their answers were analyzed differently, carrying out cross-sectional and prospective path analyses to explore the associations between resilience domains and mental health-related outcomes. As a result of this study, the fourth manuscript, entitled *Resilience Predicts Improvements on Well-being, Personal Recovery, Psychosocial Functioning and Quality of Life in Bipolar Disorder in a Follow-up Study,* was written.

Table 30 presents a summary of the main analyses carried out based on the aims and designs of the studies. Table 31 summarizes characteristics of the samples for each study. Table 32 summarizes the completed measures for each study. The battery of tests is copied in Appendix 3. Manuscripts of this doctoral thesis explain in more detail the analyses, sample' characteristics, and measures used in each study of this doctoral thesis.

Table 30

Summary of Aims, Design, and Main Analyses for the Studies

	Aims	Design	Main analyses
Study 1	To review the theoretical understanding of the concept of resilience and of recovery in mental health. To list the similarities and differences between both concepts as well as their convergences in the mental health area.	Theoretical study	Electronic search of relevant databases published on peer-reviewed journals with "mental health," "resilience," and "recovery" keywords.
Study 2	To explore the resilience process through the viewpoints of patients in remission from BD and of health professionals. To build a model of resilience in BD.	Qualitative study.	Grounded theory principles across different stages of data recruitment and analyses.
Study 3	To develop BD-specific a resilience questionnaire. To examine psychometric properties and validate the new measure of resilience for BD in people diagnosed with BD.	Questionnaire development based on the Study 2 results and on a literature review. Quantitative prospective study: psychometrical validation of a questionnaire.	Construct validity, reliability, concurrent validity, known-groups validity, and responsiveness (at follow-up).
Study 4	To identify cross-sectionally and prospectively the resilience domains associated with positive mental health outcomes in BD.	Quantitative prospective study.	Cross-sectional and prospective descriptive, bivariate correlations, and path analyses.

Table 31

Summary of Samples for the Studies

Type of sample	General characteristics of the participants		
	N	Mean age (*SD*)	Women (%)
Study 1			
Articles on resilience	53	–	–
Articles on recovery	29	–	–
Articles on recovery and resilience [a]	2	–	–
Study 2			
Individual interviews:			
Clinical (BD remission) sample	9	42 (14.98)	5 (55.55%)
Focus groups:			
Clinical (BD remission) sample	6	44.17 (6.31)	6 (100%)
Health professional (experts in BD) sample	6	NA[b]	2 (33.33%)
Study 3			
Clinical (BD) sample			
T1	125	46.13 (10.89)	77 (62.10%)
T2 (50.40% participants of T1 responded at T2)	63	45.13 (11.06)	36 (58.10%)
Comparison sample			
T1	107	35.42 (10.61)	83 (77.60%)
T2 (50.47% participants of T1 responded at T2)	54	35.28 (9.30)	42 (77.80%)
Study 4			
Clinical (BD) sample			
T1	125	46.13 (10.89)	77 (62.10%)
T2 (50.40% participants of T1 responded at T2)	63	45.13 (11.06)	36 (58.10%)

[a]These two articles were not theoretical reviews studying the relationships between the target concepts. [b]The age of health professionals was not asked. Instead, all of them reported having more than 20 years of expertise in mental health treatment.

Table 32

Summary of Measures Completed by the Participants of Each Study

Measures	Authors	Study 2	Study 3		Study 4
		Clinical sample	Clinical sample	Comparison sample	Clinical sample
Self-reported measures [a]					
Sociodemographic and clinical measures		√	√	√	√
Bipolar Spectrum Diagnostic Scale (BSDS), Spanish version.	Ghaemi et al. (2005), Vázquez et al. (2010).	√			
Resilience Scale (RS-25), Spanish version.	Wagnild and Young (1993), Las Hayas et al. (2014).	√	√	√	
Resilience Questionnaire for BD	New measure developed in this thesis		√ [b]	√ [b]	√ [b]
Brief Quality of Life in Bipolar Disorder (Brief-QoL.BD), Spanish version.	Michalak and Murray (2010), Morgado and Tapia (2013)		√	√	√
Internal States Scale (ISS), Spanish version.	Bauer et al. (2000), Ruggero et al. (2004).		√ [c]	√ [c]	√
Bipolar Recovery Questionnaire (BRQ), Spanish version.	Jones et al. (2013), translated and validated to Spanish in the Study 2		√	√	√
Measurement of the stages of changes.	Developed based on Prochaska and DiClemente (1986).		√	√	
Work and Social Adjustment Scale (WSAS), Spanish version.	Mundt et al. (2002), translated and validated to Spanish in the Study 4				√
Clinician-reported measures			T2: NA[d]	NA[e]	T2: NA[d]
Clinical measures		√	√		√
Clinical Global Impressions for Bipolar Disorder- modified (CGI-BP-M), Spanish version.	Spearing et al. (1997), Vieta et al. (2002).	√	√		√
Global Assessment of Functioning (GAF), Spanish version.	APA (2000)	√	√		√

[a]All self-reported measures that were not BD-specific were adapted to BD (referring to BD), and measures that were BD-specific were adapted to the comparison sample (referring to a problem). [b]At T2 of the Study 3, and at T1 and T2 of the Study 4,

participants completed the final 23-item version of the BD-specific resilience measure, instead of the initial 41-item version of the RBD. [c]Only Activation and Depression index were used. [d]Not asked at T2 because psychiatrist-reported data received at T1 was not enough (N = 57) to continue the assessment at T2. The general subscore of the CGI-BP-M and GAF indicated that participants' bipolar symptomatology and global functioning, respectively, was not severe (Mean = 4.02, *SD* = 1.82, range = 1-7; Mean = 66.00, *SD* =17.61, range = 1-100; respectively). General subscale of the CGI-BP-M and the GAF correlated negatively ($r = .81$; $p \leq .01$). Depression and mania subscales were positively correlated with the general score of the CGI-BP-M (r = .38; $p \leq .01$; $r = .58$; $p \leq .01$; respectively), negatively with the GAF ($r = -.35$; $p \leq .05$; $r = -.61$; $p \leq .01$; respectively), negatively between each other ($r = -.28$; $p \leq .05$). [e]Not asked because clinician-reported measures are not pertinent for the comparison sample from the general population.

The first three studies were made in collaboration with the professors Steven Jones and Fiona Lobban, co-directors of the Spectrum Centre at Lancaster University (UK), during which we worked on joint projects. The collaboration in the first three manuscripts was possible thanks to the three-month doctoral stay (from 15 September 2014 to 15 December 2014) in the Spectrum Centre, Lancaster University (UK), which is required for the "International Doctor" mention. An example of this collaboration was the translation, back-translation, and face validation of the developed RBD questionnaire, through an English-speaking sample (from the UK) who were diagnosed with BD, that was obtained thanks to the doctoral stay.

4. Study 1

The Confluence of Resilience and Recovery in the Context of Mental Health

The Confluence of Resilience and Recovery in the Context of Mental Health

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Conflict of interest: The Author(s) declare(s) that there is no conflict of interest.

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Abstract

Objective: To develop a narrative synthesis of the relevant literature on the similarities and differences between of resilience and recovery, and to build an argument for the integration of these two concepts. Method: A review of the literature on both concepts was carried out. An electronic search of the PsychInfo, Web of Science, and Ebscohost databases was performed to identify relevant peer-reviewed studies. Results: A total of 53 articles on resilience, 29 articles on recovery, and two articles on both were reviewed. Conclusions: In the field of mental health, resilience and recovery, having several factors in common, are different constructs which converge in the recovery journey. This merger occurs because resilience moderates the impact of risk factors (e.g., having a mental disorder) on the recovery process. Interventions promoting resilience could help to adapt positively to adversities, and to moderate the impact of stressors on the clinical and personal recovery process.

Keywords: resilience, recovery, mental health, moderator, psychological processes, integration

La Confluencia de la Resiliencia y Recuperación en el Contexto de la Salud Mental

Resumen

Objetivo: Realizar una síntesis narrativa sobre las similitudes y diferencias entre la resiliencia y la recuperación, en base a la literatura relevante, y desarrollar un argumento para la integración de estos dos conceptos en el contexto de la salud mental. Método: Se realizó una revisión de la literatura respecto a los dos términos. Se llevó a cabo una búsqueda electrónica en las bases de datos PsychINFO, Web of Science, y Ebscohost con el fin de identificar estudios relevantes publicados en revistas indexadas. Resultados: Se revisaron un total de 53 artículos sobre resiliencia, 29 artículos sobre recuperación y dos artículos sobre ambos conceptos. Conclusiones: A pesar de que la resiliencia y la recuperación en el contexto de la salud mental comparten varios factores en común, ambos son constructos con diferente significado y finalidad, pero que convergen en el proceso de la recuperación. Esta confluencia ocurre debido a que la resiliencia modera el impacto de los factores de riesgo (i.e., sufrir un trastorno mental) en el proceso de la recuperación. Las intervenciones que promueven la resiliencia podrían ser de ayuda en la adaptación positiva ante las adversidades y en moderar el impacto que los estresores tienen durante el proceso de recuperación clínica y personal.

Palabras clave: resiliencia, recuperación, salud mental, moderador, proceso psicológico, integración

The Confluence of Resilience and Recovery in the Context of Mental Health

Interest in the concepts of resilience and recovery in mental health has increased substantially since the 1980s. The present article first introduces each concept in order to afterwards build on a theoretical comparison between them based on the existing research within the field of mental health. Therefore, this review of the literature first aims to clarify the meaning and role of each concept. And second, based on this literature review, we will develop an argument for the integration of these two concepts, proposing how resilience contributes to clinical and personal recovery in patients with a mental disorder.

Within the mental health context, there are a multitude of definitions of resilience. For instance, Rutter (1987, p. 316) defined it as "protective factors which modify, ameliorate or alter a person's response to some environmental hazard that predisposes to a maladaptive outcome." Rutter's definition synthesizes the traditional understanding of resilience, emphasizing that it is made up of protective factors (where "protective" means preventing a person from developing maladaptive responses such as psychological disorders) and that it is triggered by certain external—or to use his term, "environmental"—hazards (excluding the possibility of internal hazards such as a mental disorder). Rutter (1987), Garmezy (1991), and Werner & Smith (1992) explored resilience mainly among children and adolescents who thrived while living in difficult environments (for example, children living in extreme poverty or in dysfunctional families). They found that only a minority of these children developed serious psychological disturbances, and they described the qualities that differentiated these individuals from those who did not thrive. They used the term "invincible" to refer to what was later termed "resilient," that is, individuals who successfully adapt to life despite adversity. Werner and Smith (1992) highlighted the role of social support, the crucial importance of a lifespan approach, and the finding that protective factors—which varied

across distinct phases of life—seemed to have a more general effect on adaptation than specific risk factors.

More recently, the definition of resilience has changed. Whereas it previously highlighted a set of protective factors in the face of adversity, it now emphasizes a process characterized by the use of innate resources, external resources, and newly acquired resources to adapt positively to adversity. The recent definition provided by Wathen et al., (2012) represents the new approach: "Resilience is a dynamic process in which psychological, social, environmental and biological factors interact to enable an individual at any stage of life to develop, maintain, or regain their mental health despite exposure to adversity" (p. 10). Also, it has been argued that resilience can be acquired by anyone (Connor & Davidson, 2003) and at any point in life (American Psychological Association, 2010).

Traditionally, resilience has been ascribed only to those individuals who have overcome adversity and show no signs of maladaptive outcomes (which include mental disorders). Where a person has developed a mental health problem in the face of adversity, scholars have referred to him/her as an individual in the process of recovery from adversity, but not as resilient (Bonanno, 2004). For this reason, several studies have investigated factors that promote recovery in people with a mental illness (Drake & Whitley, 2014), but very few studies—most of which have a qualitative design—have explored resilience in people with mental illnesses (Deegan, 2005).

The current literature on recovery in mental health defines the term according to two main approaches. One approach is called "clinical recovery" and focuses on the remission of symptoms (Andresen, Oades, & Caputi, 2003; Slade, 2009a) and the ability to function in society (Harding, 2005). The second approach is called "personal recovery" and is derived mainly from the consumer movement (Andresen et al., 2003; Slade,

Amering, & Oades, 2008). This approach has been defined as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles . . . a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness" (Anthony, 1993, p. 15). Whitley & Drake (2010) extended the framework of personal recovery to include aspects of clinical recovery, as had been suggested by Slade et al. (2008). As a result, they proposed an approach that integrates five dimensions to create a holistic understanding of recovery in mental illness: (1) clinical, (2) existential or personal, (3) functional, (4) physical, and (5) social.

Although there is an increasing interest in interventions with a specific focus on personal recovery (Jones et al., 2015), over the past century the rate of clinical recovery from mental illness has remained relatively low (Drake & Whitley, 2014). This can be interpreted as a failure of medication and other forms of treatment.

The understanding of the role of resilience within the recovery journey of people suffering a mental illness could improve practitioners' understanding of the process their mentally ill patients may be going through. Moreover, a better understanding of the role of resilience in patients with mental disorders may prompt the development of new interventions aimed at its promotion, so that better treatment options become available to patients with mental disorders. These interventions could more effectively augment rates of recovery from mental illnesses.

In this report, through the discussion of the relationships and differences between the constructs of resilience and recovery — using empirically based arguments— we first aim to clarify their respective meaning and role in the area of mental health. Second, drawing on this narrative synthesis on previous research about the evidence on resilience and recovery, this article will argue that resilience is a construct that complements that of recovery (either clinical or personal) but is not interchangeable with it (Fletcher & Sarkar,

2013). Based on the relevant literature, we support that resilience is experienced by persons with mental disorders who may or may not end up recovering from their illness.. We hypothesize that resilience acts as a moderator variable between the severity of the mental disorder and the level of recovery (either clinical and/or personal recoveries), thus increasing the probability that people with mental disorders will recover.

Method

The aim of this report is not to provide a comprehensive theoretical review of each concept, since this is already stablished -though separately for each concept- in the literature. For comprehensive reviews of resilience, we refer the reader to the excellent reports by Zautra, Hall, Murray, & Resilience Solutions Group (2008), Davydov, Stewart, Ritchie, & Chaudieu (2010), and Richardson (2002); for reviews of recovery, we refer the reader to Davidson, O'Connell, Tondora, Lawless, & Evans (2005), Leamy, Bird, Le Boutillier, Williams, & Slade (2011) and Anthony (1993).There were not found theoretical reviews on the resilience concepts and/or factors.

Therefore, this article does not present a systematic review of the literature on either resilience or recovery, but rather develops a narrative synthesis of the relevant literature to build an argument for the integration of these two concepts in the field of mental health. Nonetheless, in this section, we provide a general description of our procedure for identifying the relevant literature.

An electronic search of the PsychInfo, Web of Science, and Ebscohost databases was performed to identify relevant peer-reviewed studies published between 1950 and 2014. We searched for the keywords “mental health” along with either “resilience” or “recovery,” in the title of the article, in either English or in Spanish, and only in humans. More than a thousand articles were identified. We defined relevant studies as those concerned with at least one of the following: primary data from adult populations in a

physical or mental health-care setting; systematic reviews and concept analyses of either construct published in journals targeting the subject areas of medicine, psychology, nursing, or health professions; studies concerned with developing, testing, and/or validating resilience or recovery scales. All articles were published in peer-reviewed journals.

We focused only on articles dealing with psychological resilience and excluded studies that explored other forms of resilience, such as environmental resilience, social resilience, neuronal resilience, and family resilience, because they investigated resilience using many theoretical dimensions that are not of primary importance for the study of psychological resilience. We excluded articles that incorrectly refer to the study of resilience or recovery in mental health when they were actually measuring other different variables, as it is the case of the study "resilience-recovery factors in post-traumatic stress disorder as hardiness" by King, King, Fairbank, Keane, and Adams (1998) that studied "hardiness" rather than resilience. We also excluded studies that dealt with physical illness, because although physical illness is related to resilience and recovery, the studies diverged from this review's focus on mental disorders.

Results

Our final sample included a total of 53 articles on resilience, 29 articles on recovery, and two articles on both, but these two articles were not theoretical reviews studying the relationships between the target concepts. Table 1 compares the definitions, antecedents (i.e., criteria that must come before the concept in order for it to occur), attributes, consequences (i.e., end points that result from the antecedents and attributes), and interventions and empirical referents (i.e., questionnaires that measure the construct's defining attributes) of both resilience and recovery. The following lines present the main results regarding the aim of exploring the relationships, similitudes and differences,

between resilience and recovery. Similarities between the two constructs are presented in Table 1.

Both concepts share a common similarity with respect to antecedents. Resilience and recovery require that an individual has undergone a traumatic experience before the phenomenon manifests (Garcia-Dia et al., 2013; and Brennaman & Lobo, 2011; respectively).

Another important similarity is related to the attributes of both concepts. The reviewed literature lists several attributes that appear in both studies of recovery and studies of resilience. For instance, Ridge & Ziebland (2006) interviewed 38 persons who had previously experienced depression and who identified authenticity, responsibility, and rewriting depression into the self in a way that re-energized life as the specific components involved in recovery; these factors have also been identified as factors of resilience (see Emlet, Tozay, & Raveis, 2010). In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2004, 2012) listed the following factors among the guiding principles of recovery: hope, self-determination, and the presence and involvement of people who believe in the person's ability to recover, and the importance of addressing emotional trauma. Several studies that address resilient qualities have identified the same principles as attributes of resilience: hope (Gillespie, Chaboyer, Wallis, & Grimbeek, 2007; Lloyd & Hastings, 2009), self-determination (Subhan & Ijaz, 2012), the presence and involvement of people who believe in the person's ability to recover (Glymour, Weuve, Fay, Glass, & Berkman, 2008), and the importance of addressing emotional trauma (Zaghrout-Hodali, Alissa, & Dodgson, 2008).

Another example from the scientific literature is the phenomenon of turning points, which have been proposed as key moments in both resilience and recovery

frameworks [see Bennett, (2010), and Kogstad, Ekeland, & Hummelvoll, (2011), respectively].

This match of attributes had already been identified by Mountain & Shah (2008), who noted that when patients in the "movement for recovery" narrated the skills and individual strengths that helped them on their road to recovery, they were naming resilience factors. It follows that there is substantial overlap between the qualities considered facilitators of recovery and those traditionally considered aspects of resilience.

The positive consequences of both resilience and recovery are a better level of health, improved social functioning, and greater well-being (Haase, Heiney, Ruccione, & Stutzer, 1999; Luthar, Cicchetti, & Becker, 2000; Windle, 2011; and Davidson et al., 2005; Leamy et al., 2011; respectively). Related to this, another attribute shared by recovery and resilience is the importance of external resources for overcoming adversity and achieving the already stated consequence of recovering their well-being. However, the role of this attribute is different in recovery and resilience. External resources of resilience include perceived support from family or friends and the availability of health services and economic resources. The availability of external resources, such as economic or health-care resources, facilitates the development or activation of resilient qualities, though these external resources are not essential for the development of intrapersonal resilient qualities (Ungar, Brown, Liebenberg, & Othman, 2007). By contrast, the recovery framework considers the integration of a person into the community (for example, by having a job) to be a reflection of the person's level of recovery. That is, an important factor in recovery is the degree to which the person is successfully integrated as an active member of society, with a role in the community (Leamy et al., 2011).

Yet another difference between the two concepts related to each consequence is that whereas the final consequence of recovery is understood as improved functioning in

terms of emotional, physical, and social health, the consequence of resilience is understood strictly in relation to the type of adversity experienced. That is, theorists (Rutter, 2013; Vanderbilt-Adriance & Shaw, 2008; Windle, 2011) argued that if the adversity is a mental illness, a resilient behavior refers only to overcoming the adversity of mental illness and does not necessarily entail resilience to other types of adversity (e.g., job loss) that may occur simultaneously

There are some more other discrepancies between the terms. For instance, the difference between clinical recovery and the experience of resilience is clear-cut. Whereas resilience involves the development and use of specific skills (cognitive and behavioral) in order to adapt positively to adversity, clinical recovery focuses on only two factors: (1) the reduction of physical and psychological symptoms related to the disease, and (2) the return of the person to premorbid levels of social functioning (Bellack, 2006; Frank et al., 1991).

Another difference stems from the origins of the concepts. The concept of personal recovery was "coined" by a social movement involving psychiatric patients and their families who were protesting against a health-care system that robbed them of the right to feel confident that recovery was possible, to regain control over their own lives, and to be treated as persons with self-control. The concept of resilience, on the other hand, stems from the work of scholars in developmental psychology and social work who wanted to understand why certain people develop well despite adversity. These scholars sought to explain how certain internal and external factors determine successful adaptation to adverse circumstances.

Two final differences between the concepts are that in resilience (but not recovery) the degree of positive adaptation to be considered resilient depends on the magnitude of adversity, and that resilience (but not recovery) works in an accumulative fashion. As for

the former, Windle (2011) proposed that given the context of adversity, successful adaptation to a chronic illness can occur despite the continued presence of impaired functioning. An adaptation is also considered a sign of resilience (Windle, 2011) if the person maintains an average level of performance given the circumstances, for instance after a natural disaster, which is an adversity of great magnitude. The accumulative nature of resilience implies that exposure and positive adaptation to different risk factors increases an individual's level of resilience—such that the more adverse experiences are overcome, the more resilience is accumulated (Rutter, 2013). Nonetheless, there is evidence that a person can overcome only so many adverse experiences with resilience. There is no counterpart of this attribute in the recovery field.

Table 1 shows that many of the identified attributes of resilience coincide with attributes described by patients in phenomenological studies as necessary for recovery. Given the great number of similarities between the terms, the further elaboration on their differences enables to clearly articulate the relationship between the concepts, covering thus the first aim. In order to cover the second aim, in the following section we develop our proposal that resilience moderates the impact of stressors in patients' personal-recovery process. In addition, we will discuss the relevance of each concept for research and clinical practice.

Table 1

Comparing Evidence-Based Characteristics of Resilience and Recovery in Mental Health

	Recovery	Resilience
Origin of the term	– The medical model defined what is understood as clinical recovery. – Personal recovery was introduced by the addiction self-help movement (Davidson et al., 2005) and by patients with severe mental illness and their families who demanded "increasing control over his/her psychiatric condition, while reclaiming responsibility for his/her own life; a life that previously had been subsumed by the mental disorder or taken over by others" (pp. 482–483).	– Resilience was studied first in children born under chronic stress conditions or adverse circumstances beyond their control (such as being born in extreme poverty or to a severely dysfunctional family) (Garcia-Dia, DiNapoli, Garcia-Ona, Jakubowski, & O'Flaherty, 2013). – Within the mental health field, resilience was first studied in adults with posttraumatic stress disorder (Garcia-Dia et al., 2013).
Definitions	– Definitions for two types of recovery from mental illness: – Clinical recovery: The restoration of a person to a healthy or normal condition (*Oxford Dictionary*, 2013; Brennaman & Lobo, 2011), with an absence of symptoms and a restoration of social functioning (Slade, 2009). – Personal recovery: "A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Anthony, 1993).	– Three different definitions of resilience depending on its purpose: – Personality traits and protective factors that allow the individual to "bounce back" or thrive in the face of adversity (Garmezy, 1991; Connor & Davidson, 2003; Bonanno, 2004). The level of resilience depends on more than one factor; it depends on the interaction of internal (i.e., psychological and biological) and external (i.e., social and community support) factors (Garmezy & Rodnick, 1959). – Dynamic interplay of risk and protective processes occurring over time and involving individual, family, and larger sociocultural influences to adapt well in the face of adversity (Masten, Best, & Garmezy, 1990; Rutter, 1987; Werner & Smith, 1992).

	– There are inconsistencies in the interpretation of recovery. Some conceptualize recovery as a vision (Kuehnel & Liberman, 2011), others as a process (Anthony, 1993), and still others as an outcome (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987). Recovery is an active, unique, and nonlinear process. – Recovery consists of stages, is a struggle, is a multidimensional process, is gradual, is a life changing experience, does not require cure, is aided by a supportive and healing environment, can occur without professional intervention, and is a trial-and-error process (Leamy et al., 2011). – Recovery may not be universal. There is a medical stigma against the feasibility of personal recovery (Brennaman & Lobo, 2011; Drake & Whitley, 2014).	– A self-righting force within everyone that drives him/her to pursue self-actualization, altruism, wisdom, and harmony with a spiritual source of strength (Richardson, 2002). – Resilience fluctuates throughout life (Windle, 2011), and new vulnerabilities and strengths appear in challenging vital circumstances. – A person can be resilient in the face of specific forms of adversity, but not necessarily in response to all forms of adversity (Windle, 2011). – Resilience takes time to unfold (Zautra et al., 2008). – It is a nonlinear and nonstatic process (Zautra et al., 2008; Tusaie & Dyer, 2004). Resilience is universal; each individual possesses the potential for resilience (Zautra et al., 2008; Tusaie & Dyer, 2004), but it is likely that people are not all the same in this capacity, and the environmental forces that strengthen or weaken resilience to stress are distributed unequally in the population.
Antecedents (i.e., criteria that must come before the concept in order for it to occur)	– Personal disintegration (experience of isolation, hopelessness, and suffering) (Brennaman & Lobo, 2011).	– Encounter with adversity (Windle, 2011). – Subjective (not objective) interpretation of the adversity as severe and risky (Windle, 2011). – Presence of an adverse or traumatic event that is interpreted as traumatic; realistic understanding of the circumstances in order to accept the situation and become resilient (Garcia-Dia et al., 2013).
Attributes	– Internal resources: hope, healing, empowerment, and connection. External resources: implementation of the principle of human rights, a positive culture of healing, and recovery-oriented services (Jacobson & Greenley, 2001).	– Internal resources: cognitive skills, openness to experience, drive for mastery, conscientiousness, sense of self-worth. External resources: average or above average socioeconomic resources; close relationship with parents, adult support outside the family (Garmezy & Rodnick, 1959).

	– Acceptance of the illness, hope and commitment regarding the future, finding a renewed sense of self, being involved in meaningful activities, overcoming stigma, assuming control, becoming empowered and exercising citizenship, managing symptoms, and being supported by others (Davidson et al., 2005). – Synthesis of the following attributes from phenomenological studies: (1) introspection with discovery of purpose and meaning in life, (2) pride of accomplishment and self-respect, (3) autonomy or freedom of action, (4) capacity for decision making, (5) goal-directed adaptation, (6) empowerment, (7) fighting spirit (resilience and perseverance), and (8) incremental advances (Brennaman & Lobo, 2011). – Connectedness (peer support, relationships, and being part of the community); hope and optimism regarding the future (belief in the possibility of recovery, motivation to change, hope-inspiring relationships, positive thinking and valuing success, having dreams and aspirations); identity (rebuilding a positive sense of identity, overcoming stigma); meaning in life (meaning of mental-illness experience, spirituality, quality of life, meaningful life and social roles, rebuilding life); empowerment (personal responsibility, control over life, and focusing on strengths) (Leamy et al., 2011). – Resilience, re-establishing relationships with others, being free of symptoms, maintaining a high level of functioning, being off medication, being employed and enjoying healthy social and romantic relationships (Torgalsbøen, 2012).	– Internal factors: personality traits, advanced motor and language skills, self-help skills. External factors: family, community, emotional bond with an adult outside the family who is sensitive to his/her needs (Werner & Smith, 1992). – Internal resources: courageous coping, hope, and spiritual perspective. External resources: family support, health resources, and social integration (Haase et al., 1999). – Resilience consists of coping skills such as searching for social support, moving forward with life, and accepting circumstances with hope (Bonanno, 2004). – Self-esteem, academic performance, physical health, coping, adaptation, absence of mental disease and delinquent behaviors, connectedness, self-control, self-worth, mutuality, survival, hardiness (Ahern, 2006). – Personal competence, acceptance of self and life, finding meaning in life, perseverance, equanimity or acceptance of life events, and self-reliance (Garcia-Dia et al., 2013). – Genes that promote resilience under stress (Caspi et al., 2003). – Active coping, flexibility, personal agency, sense of purpose, positive emotional engagement in daily life at home, work, and play, emotion regulation, and indicators of physiological buoyancy such as heart rate variability (Connor & Davidson, 2003; Masten, Powell, & Luthar, 2003). – Personal control (Diehl & Hay, 2010). – Rebounding/reintegration, high expectancy/self-determination, positive relationships/social support, flexibility (easy temperament), sense of humor, self-

	– Relationships, trust, connectedness, social support, interdependence. Day-to-day functioning, coping, and managing, including work (having the ability to work). Connection to one's culture, cultural identity, drawing strength from one's culture (Gordon & Ellis, 2013).	esteem/self-efficacy (Friborg, Hjemdal, Rosenvinge, & Martinussen, 2003; Garcia-Dia et al., 2013). – Sense of coherence (Windle, 2011). – Life satisfaction, optimism, positive affect, self-efficacy, self-esteem, social support (Lee et al., 2013).
Consequences (i.e., end points that result from the antecedents and attributes)	– Living without disabilities; self-reliance; maintaining equilibrium between internal and external forces; efforts toward community integration; successful occupational performance; interdependence; growth; active coping rather than passive adjustment; improving quality of life; self-esteem (Leamy et al., 2011). – Recovery refers to overcoming the effects of being a mental patient, including poverty, substandard housing, isolation, unemployment, loss of valued social roles and identity, loss of sense of self and purpose in life, and the iatrogenic effect of involuntary treatment and hospitalization (Davidson et al., 2005).	– Recovery (Zautra et al., 2008).* – Sustainability: the capacity to move forward in the face of adversity (Bonanno, 2004; Zautra et al., 2008). – Absence or avoidance of psychopathology, or low level of symptoms (Windle, 2011). – Positive outcomes in the presence of adversity rather than positive adaptation in general (Luthar et al., 2000). – Effective coping process and sound mind and body even when faced with adverse situations (i.e., live life to the full); integration (i.e., achievement of age-appropriate developmental tasks) (Garcia-Dia et al., 2013). – Self-esteem, self-transcendence, confidence mastery, and quality of life (Haase et al., 1999).
Interventions	– Clinical recovery: Scientific studies in medicine measure parameters of recovery such as frequency of symptoms, treatment adherence, and scores in a range of psychosocial functioning scales (Brennaman & Lobo, 2011). Traditional clinical approaches to mental illness are "case management," "skills training," and "medication" (Drake & Whitley, 2014). – Personal recovery: Refers to interventions that tackle core aspects of the recovery-oriented movement (Drake & Whitley, 2014). The mental health system should begin to develop and implement services that emphasize financial, residential (e.g., supported	– Resilience-grounded interventions involve consideration of competencies as well as maladjustments; attention to at-risk individuals' strengths in addition to their deficits; systematic exploration of processes that might explain vulnerability and protective factors (Luthar & Cicchetti, 2000). – "From an intervention standpoint, applying the resilience perspective implies efforts to harness notable strengths of 'vulnerable populations' to derive significant impetus for positive change" (Luthar & Cicchetti, 2000, p. 861). – Some recent interventions on resilience have been developed and empirically tested (Leppin, 2014) such as "Moving

	housing programs), and personal independence; support anti-stigma initiatives; create further opportunities in society for people with disabilities through action and appropriate legislation; insist on normal adult roles such as education, employment, independent living, and intimate relationships, as well as personal agency and autonomy in illness management. – The implications of a recovery orientation for working practice are unclear, and guidelines are only recently becoming available (Leamy et al., 2011). – Interventions should encourage the rights of patients to choose what they want (for example, whether or not they want medication), take personal responsibility for their lives, hope, education, advocacy, and peer support (Mead & Copeland, 2000).	Forward" (Tenhula et al., 2014) and the Master Resilience Trainer (Reivich, Seligman, & McBride, 2011).
Empirical referents (i.e., questionnaires that measure construct's defining attributes)	– Recovery Assessment Scale: confidence/hope, willingness to ask for help, goal orientation, reliance on others, control over symptoms (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999). – Mental Health Recovery Measure: overcoming standing still, empowerment, learning, basic functioning, well-being, new potentials, advocacy/enrichment (Young & Bullock, 2003). – Peer Outcomes Protocol: demographics, service use, employment, community life, quality of life, well-being, program satisfaction (Campbell, Cook, Jonikas, & Einspahr, 2004).	– Resilience Scale: personal competence, acceptance of self and life (Wagnild & Young, 1993). – Connor Davidson Resilience Scale: personal competence, trust/tolerance/strengthening effects of stress, acceptance of change and secure relationships, control, spiritual influences (Connor & Davidson, 2003). – Resilience Scale for Adults: personal competence, social competence, family coherence, social support, personal structure (Friborg et al., 2003). – Brief Resilience Scale: ability to bounce back or recover from stress (Smith et al., 2008).

*The capacity for resilience does not necessarily imply that a person will recover (Brennaman & Lobo, 2011).

Discussion

This paper aimed to describe the similarities and differences between the concepts of resilience and recovery. This comparison between the concepts, clarified the meaning of each term and their respective role in the mental health field. Our second aim was to propose the integration of the concept of resilience into the recovery framework in mental health. Therefore, in the following lines, based on the current narrative review of each concept, we will argue about the proposition of considering resilience as a moderator of the process of recovery in people with mental disorders.

One of the conclusions of this review is that there is a strong relationship between resilience and recovery in the field of mental health. Although scarce, there are studies that show the importance of resilience in recovering from various mental disorders. For example, recent studies on resilience and recovery in people with schizophrenia (Torgalsbøen, 2012) and eating disorders (Las Hayas et al., 2014) showed that most of those who recovered exhibited higher levels of resilience.

Further, in a qualitative study, Edward, Welch, & Chater (2009) interviewed eight people who had recovered from a mental disorder (including depression, bipolar disorder, anxiety, postnatal depression, sexual identity crisis, and a personality disorder) and identified the following factors of resilience that helped these people overcome their illness: realizing the world is not a perfect place, realizing there are more people like them who are passing through the same experience, accepting the disease, accepting oneself, accepting the world as it is, having information about the disease in order to understand and control it, increased innocence and hope for a better life, self-regulation and taking time to get better, taking a more active role in the direction and content of one's life, understanding one's life as meaningful in itself and for others, doing things for their own sake, and doing things because they are good for oneself despite the limitations of the

disease. A limitation of the latter study (Edward et al., 2009) was its small sample size and the heterogeneity of mental disorders in its participants.

Similarly, Dowrick, Kokanovic, Hegarty, Griffiths, & Gunn (2008) interviewed 100 people who had recovered from depression about the attitudes and skills they had implemented and found useful in overcoming their disorder. The authors reported that resilience was among the reported attitudes; in terms of understanding resilience as "a common magic" – resilience is described as a personal medicine that consists of making use of social and emotional support - also creating new personal strengths and increasing and expanding positive emotions.

In line of the above studies demonstrating the relevance of resilience when recovering from mental illnesses, several authors (Robertson & Cooper, 2013; Youssef & Luthans, 2007) and health campaigns have considered resilience an *asset* of the recovery process. For example, the recent 2012 campaign by the Royal College of Psychiatrists (UK), entitled “Recovery and Resilience”, stated that “central to the theme of recovery is resilience, which allows for individual strengths and coping skills to surface in spite of adversity”. The American Psychological Association (2009) maintained that the challenges of life associated with recovery are common human experiences that require resilience. Accordingly, the classification of resilience as an asset in the recovery process is in agreement with our understanding of both terms. When a person experiences the adversity of a mental disorder, there eventually comes a time when the person wants to recover (i.e., the person does not want to be merely resilient but to recover fully); in general terms, recovery becomes the goal for the person with a mental disorder, for the community, and for the mental health providers. By contrast, the experience of resilience is desirable but is not the main goal. It is desirable because it empowers the person to achieve recovery.

In particular, we propose that resilience is an asset of the recovery process, and it interacts positively with risk factors (i.e., resilience acts as a moderator variable) to facilitate the recovery process. Figure 1 reflects graphically the moderating role of resilience. That is, during the recovery process the person experiences a certain level of mental distress (a risk factor). It is here that factors of resilience moderate the impact of this risk factor in the larger context of the recovery journey, so that the association between the degree of psychopathology and the clinical and personal experience of recovery is inverse and strong when the level of resilience is low and inverse and weak when it is high. Resilience—understood as a "self-righting force" (Richardson & Waite, 2001, p. 66-67) or a "sort of character strength" (Peterson & Seligman, 2004, p. 77)—varies in intensity during the recovery journey.

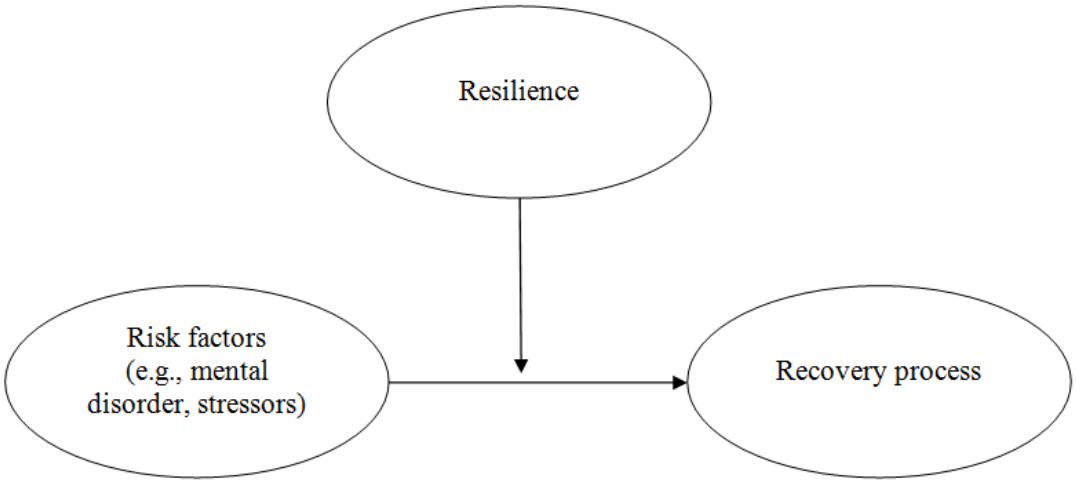

Figure 1. The moderating role of resilience.

Our proposal that resilience plays a moderator role in the process of recovery is supported by theoretical research (Godwin & Kreutzer, 2013) and recent empirical evidence from pilot clinical trials about the efficacy of resilience-based psychological interventions in reducing symptomatology and improving quality of life (Loprinzi, Prasad, Schroeder, & Sood, 2011; Steinhardt & Dolbier, 2008; Tenhula et al., 2014). For instance, a systematic review and meta-analysis of randomized trials centering on the

efficacy of resilience-training programs (Leppin et al., 2014) reported that trauma-focused resilience-training programs showed a moderate effect in reducing stress symptoms (pooled standardized mean difference (SMD) 20.53 [21.04 to 20.03] p = .04) and a moderate effect in reducing depression (pooled SMD 20.51 [20.92 to 20.10] p = .02). Nonetheless, a large-scale trial focusing on the efficacy and effectiveness of resilience-based psychological interventions has yet to be conducted, so we should interpret these preliminary results with caution.

Although scarce, some quantitative studies have also provided evidence that resilience plays a moderator role in the 'adaptive development' of the individual (which is different from the recovery process, but still relevant). Wingo et al. (2010) found that resilience plays a decisive moderating role between having been a victim of a traumatic experience in the past (e.g., child sexual abuse) and developing depression in adulthood. Using a sample of 77 people with schizophrenia spectrum disorders, another study Johnson et al. (2010) explored the moderating role of resilience factors in preventing suicide. It was observed that positive affirmations about oneself (a component of resilience) moderated the relationship between hopelessness and suicidal ideation. Additionally, Hjemdal, Friborg, Stiles, Rosenvinge, & Martinussen (2006) reported that the baseline presence of resilience factors interacted with stressful life events and protected healthy individuals from developing a psychiatric disorder at six-month follow-up. A final example is the study by Boardman et al. (2011), who interviewed people experiencing depressive symptoms and concluded that it would be therapeutically effective to clarify for these people that they are not expected to have pre-existing resilience and to affirm that they can develop resilience by drawing on support networks and expanding positive emotions and inner strengths.

Conclusions

Despite the commonalities between resilience and recovery, few of the reviewed articles on resilience or mental health recovery have investigated the relationship between the concepts; the concepts are usually treated independently. We also noted the paucity of empirical studies assessing the role of resilience within the journey to recovery. For example, a recent study by Chang, Heller, Pickett, & Chen, (2013), which examined the recovery process and related factors in people with a mental disorder, did not use the word resilience. The same is true of two recent articles on the application of evidence-based practices to the study of recovery (Gordon & Ellis, 2013; Mueser, 2012).

It is noteworthy that a concept so closely related to recovery is absent from most of the literature on recovery. Future studies on clinical or personal recovery from mental illness should explore resilience components and their role in recovery. A potential aim is to examine longitudinally whether resilience precedes recovery (Almedom, 2005) and interacts with risk factors to moderate the impact of risk factors on the recovery journey. Studies on the role of resilience in the sustainability of recovery are also recommended.

Implications for Clinical Practice

Resilience is an innate mechanism of self-righting (Masten, 2001; Werner & Smith, 1992) and is enhanced by individual traits such as high optimism, a tendency to extroversion, and a high intellectual ratio. However, it also includes qualities that can be acquired through training in therapy. An intervention aimed at building resilience offers knowledge and skills that help participants adapt positively to future adversity (Haglund, Nestadt, Cooper, Southwick, & Charney, 2007). Resilience itself is therefore a target for treatment, because it may moderate the impact of life stressors on the clinical and personal-recovery process. In fact, Leppin et al. (2014) conducted the first systematic

review and meta-analysis of resilience-training programs in adults, and they concluded that in general these programs improved a number of mental health outcomes (such as resilience, quality of life, stress, and depression or anxiety) at three-month follow-up. No studies have reported on a longer follow-up period. Among the moderating attributes of resilience that are commonly addressed in these programs are encouragement of positive emotions, cognitive flexibility, social support, life meaning, and active coping (Leppin et al., 2014; Sturgeon & Zautra, 2010).

Finally, Rutter (2013) argued that resilience does not require superior performance; rather, it means continuing a normal life course despite adversity. Therefore, clinicians should not expect positive posttraumatic growth—which refers to perceived positive self-changes in the aftermath of stressful events (Tedeschi & Calhoun, 1996)—as a result of treatment, even if patients demonstrate resilience factors in adapting to adversity.

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5. Study 2

Resilience in Bipolar Disorder: A Qualitative Study of the Viewpoints of Patients and Health Professionals

Resilience in Bipolar Disorder: A qualitative study of the viewpoints of patients and health professionals

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Study 2: Resilience in Bipolar Disorder: Qualitative Study

Abstract

Objectives: To explore the viewpoints on the psychological process of resilience both of patients in remission from Bipolar Disorder (BD) and health professionals. Methods: This qualitative study used thematic analysis methodology. Fifteen participants in remission from BD (mean age = 42.88 and *SD* = 11.99) were interviewed either individually (n = 9) or in a focus group (n = 6). Six mental health clinicians attended two focus groups (n = 4 and n = 2). Data were collected over 9 months in 2014-2015. Results: Through thematic analyses, the following themes about the psychological process of resilience in BD were identified: antecedent conditions for resilience, turning point experience, self-awareness and redefinition, reconsideration of the direction of their life, self-management of BD, lifestyle balance, positive personality qualities, and interpersonal support. Conclusions: Despite that data from patients was retrospective, which may reduce their reliability, the resulting model of resilience in BD provides a theoretical framework for the development of instruments and interventions on resilience in BD.

Keywords: bipolar disorder, mental health, resilience, qualitative

La Resiliencia en el Trastorno Bipolar: Un Estudio Cualitativo desde los Puntos de Vista de los Pacientes y de los Profesionales de la Salud

Resumen

Objetivos: Explorar los puntos de vista de pacientes en remisión del Trastorno Bipolar y de los profesionales de la salud sobre el proceso psicológico de la resiliencia. Métodos: Metodología cualitativa siguiendo los principios de la Teoría Fundamentada en las diferentes etapas de la recolección de datos. Se obtuvo la aprobación ética (abril de 2014). Quince participantes en remisión del Trastorno Bipolar (edad media = 42.88; *DT* = 11.99) fueron entrevistados ya sea en entrevistas individuales (n = 9) o en un grupo focal (n = 6). Seis clínicos en salud mental asistieron a dos grupos focales (n = 4 y n = 2). Los datos se recolectaron durante 9 meses desde 2014 hasta 2015. El modelo final de la resiliencia en el Trastorno Bipolar se consolidó mediante la integración de los resultados preliminares derivados del análisis iterativo basado en la Teoría Fundamentada. Resultados*:* En el modelo resultante de la resiliencia en el Trastorno Bipolar se destacaron los siguientes elementos: condiciones antecedentes para la resiliencia, experiencia del punto de inflexión, conciencia de uno mismo, autogestión del Trastorno Bipolar, estilo de vida equilibrado, cualidades positivas de la personalidad, y apoyo interpersonal. Conclusiones: A pesar del carácter retrospectivo de los datos de los participantes, hecho que puede reducir su veracidad, el modelo resultante de la resiliencia en el Trastorno Bipolar ofrece un marco teórico para el desarrollo de instrumentos e intervenciones dirigidas a evaluar y promover la resiliencia en personas diagnosticadas de este trastorno.

Palabras clave: Trastorno Bipolar, salud mental, resiliencia, estudio cualitativo

Practitioner Points

- According to the viewpoints of patients diagnosed with Bipolar Disorder and health professionals the psychological resilience process in this mental disorder is described as a dynamic process, which involves the activation of self-awareness, self-management of BD, balanced self-style, personality qualities, and interpersonal support.
- The main resilience themes in people with a Bipolar Disorder could provide insight to improve clinical practice in Bipolar Disorder. The resulting resilience model in Bipolar Disorder provides theoretical evidence as a basis for the development of measures to assess resilience in bipolar disorder.

Resilience in Bipolar Disorder: A qualitative study of the viewpoints of patients and health professionals

Although most research has focused on the clear negative aspects of Bipolar Disorder (BD) (Galvez, Thommi, & Ghaemi, 2011), some autobiographical reports indicate potential to experience wellness, manage mental health, and live a fulfilling life in BD. For example, Mansell, Powell, Pedley, Thomas, and Jones (2010) found that the key factors associated with positive outcomes in BD included understanding of bipolar experiences, lifestyle fundamentals (regarding stable sleep and diet, and routine in personal/occupational activities), social support and companionship (regarding openness and involvement with/from others). BD has been associated with positive psychological features, including creativity, enthusiasm, sensitivity/empathy, social outgoingness, and occupational or educational productivity, suggesting that preserving and enhancing these aspects may improve outcomes in BD (Galvez et al., 2011; Lobban, Taylor, Murray, & Jones, 2012; Murray & Johnson, 2010; Taylor, Fletcher, & Lobban, 2015; Weich et al., 2012).

Resilience was defined by Wathen *et al.* (2012) as the "dynamic process in which psychological, social, environmental and biological factors interact to enable an individual at any stage of life to develop, maintain or regain their mental health, despite exposure to adversity" (p. 10). Resilience and recovery factors overlap in the field of mental health, such as the presence of an adversity and several internal and external strategies to achieve better level of health. This could be the reason why sometimes resilience and recovery are used interchangeably (Las Hayas et al., 2016). Nevertheless, as Fletcher and Sarkar (2013) point out, resilience and recovery are different terms. For the aim of clarification between both terms, resilience has been described as an asset of the recovery process by several authors (Robertson & Cooper, 2013; Youssef & Luthans,

2007), health campaigns (Bhui & Dinos, 2011; Royal College of Psychiatrists, 2012) and the American Psychological Association (2009).

Resilience contributes to the promotion and maintenance of mental health and quality of life in general (Grotberg, 2003), and it is important in overcoming challenges associated with mental disorders, such as depression, eating disorders and schizophrenia (Dowrick, Kokanovic, Hegarty, Griffiths, & Gunn, 2008; Las Hayas et al., 2014; Torgalsbøen, 2012). For example, in a 15-year follow-up study of people with schizophrenia (Torgalsbøen, 2012), resilience was positively associated with later psychosocial functioning and negatively with negative symptoms. Consistent with this, Las Hayas et al. (2014) found higher levels of resilience in individuals *recovered* from eating disorders than in individuals currently diagnosed with one. The qualitative study by Edward, Welch, & Chater (2009) reported the presence of resilient qualities in participants in remission from six different mental disorders, including BD. This far, the only study that specifically looks resilience in BD has been carried out by Choi et al. (2015). Choi et al. (2015) made a quantitative study with participants diagnosed with BD (n = 62), and they concluded that resilience enhancement makes important contributions in improving treatment outcomes. Nevertheless, Choi et al. (2015) did not explore how resilience is experienced so it is not possible, based in their results, to plan any BD-specific intervention.

Despite the above mentioned evidence for the role of resilience in recovery from different mental disorders, resilience in the field of mental health is a relatively new concept. Furthermore, there are no qualitative studies whose main focus is exploring the experience of resilience in BD. It is important to understand the role of resilience in BD for theoretical and clinical reasons. Exploring the concept of resilience from the viewpoints of patients diagnosed with BD that have experienced resilience and from

viewpoints of clinicians that have witnessed their patients going through a resilience process could generate relevant information that will address the gap in the knowledge regarding resilience in BD.

Therefore, the present study aims to explore the experience of resilience in BD, from the viewpoints of BD patients and experienced clinicians. The researchers will explore the extent to which different information sources (patients and clinicians) might yield slightly different results. Additionally, triangulation method (using individual interviews and focus groups), which was also used in other scientific qualitative studies across the health field (Las Hayas et al., 2015; Morden, Jinks, Ong, Porcheret, & Dziedzic, 2014; Taylor et al., 2015; Weich et al., 2012), will be used in order to increase the validity and reliability of the results.

Methods

Design

This is a qualitative study following the main principles of grounded theory (GT) (Corbin & Strauss, 2015) to develop a descriptive model of the resilience process in BD. Thematic analysis was the method used to analyse the content. Data were iteratively gathered, and analysed until the consolidation of the final model by integrating results both from patients remitted from BD and clinicians.

Ethical Considerations

The study was given ethical approval (April 2014) by the Clinical Research of Basque Country's Ethics Committee (Spain).

Participants

The samples were intentionally selected based on the following inclusion criteria:

BD Sample: (a) in remission from bipolar I or II disorder: psychiatrist's symptom severity rating of "normal" or "minimal" on the Spanish version (Vieta et al., 2002) of

the Clinical Global Impression Scale for Bipolar Disorder Modified (CGI-BP-M) (Spearing, Post, Leverich, Brandt, & Nolen, 1997; Vieta et al., 2002) and a score < 13 in the self-rated Spanish version (Vázquez et al., 2010) of the Bipolar Spectrum Diagnostic Scale (BSDS) (Ghaemi et al., 2005); (b) between 18 and 65 years old; (c) fluent in Spanish; and (d) able to give informed and voluntary consent. Patients were excluded if they met the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000) criteria for substance abuse disorder within the previous four weeks, evaluated by their therapist. The remission criterion was established because being recovered acts as a guarantee of having experienced resilience, according with Zautra (2009), who stated that recovery is an indicator of resilience. The sample was heterogeneous in diagnosis subtypes (participants diagnosed with BD could have different subtypes of the disorder, such as BD-I and BD-II).

Clinician sample: (a) more than two years of experience in treating patients with BD and (b) agree to participate in an informed and voluntary way.

Both samples were recruited from two public mental health centres and one public hospital (psychiatry service) from the Basque Country. The first author of this study sent a letter to 27 therapists (psychiatrists or psychologists) experienced in the treatment of BD to collaborate in the study. From those, six agreed to participate in the focus groups and also helped in the recruitment of former patients in remission from BD. Therapists approached a number of current patients meeting study criteria via post mail (the total number was not reported). Those patients and clinicians who agreed to participate signed a consent form and gave their contact details to the research team.

Data Collection

Data were collected over 9 months along 2014-2015.

Individual interviews and focus groups. Individual interviews and focus groups

took place either in a public hospital from the Basque Country or in a private room of a university from the Basque Country. At the beginning of the interviews and focus groups, the interviewers provided a generic definition of psychological resilience to the patients and clinicians: *"Resilience refers to a process of changes in behaviours, cognitions, and attitudes that drive people to overcome or adapt to adversity*". Interviews and focus groups were semi-structured and they consisted on a list of open questions about resilience. See the Appendix for detailed information about the content of the semi-structured interviews and focus groups.

Each interview and focus group lasted approximately two hours. The same facilitator (AE) led all the sessions, which were audiotaped (with participants' consent) and transcribed verbatim (names of participants were changed to ensure anonymity). Figure 1 indicates the iterative sequence of the data gathering and analysis.

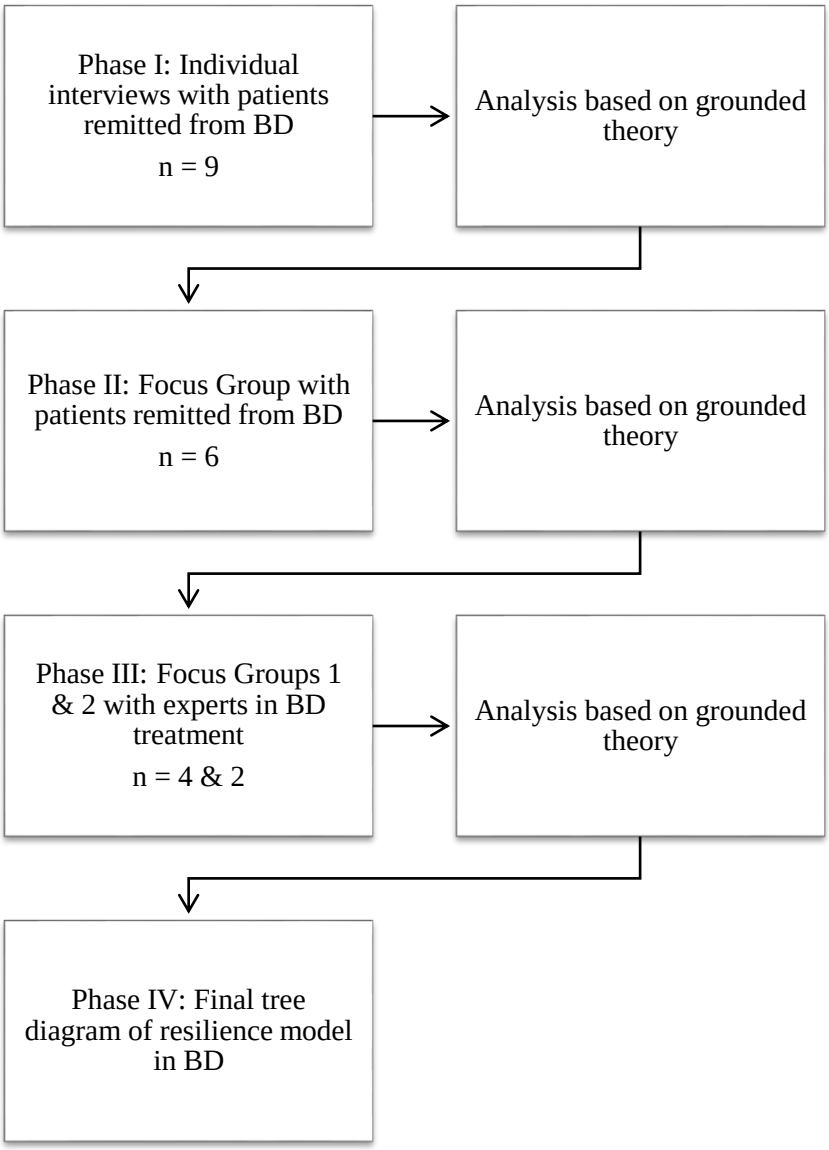

Figure 1. Graphical representation of the process of collecting and analyzing qualitative data (thematic analysis). The first semi-structured interviews (Phase I) were conducted with individuals remitted from Bipolar Disorder (BD) to initially explore resilience issues and to create a knowledge base of the phenomenon. In Phase II, a focus group with patients remitted from BD was carried out; these participants were first asked about the phenomenon of resilience and later were presented with the preliminary results from the individual interviews to explore whether our interpretations were correct or needed revision. Phase III consisted of two focus groups with experienced clinicians in BD treatment. Guidelines used in the focus groups with clinicians were developed based on the key findings derived from patients' individual and group interviews. They were asked about resilience in BD and were then presented with the patients' results from individual interviews (phase I) and the focus group (phase II). Clinicians were later asked to what extent they agreed with the preliminary results. The Appendix contains the guideline that was used to carry out individual interviews and focus group with patients, as well as focus groups with clinicians. Qualitative analyses were carried out iteratively after each phase of data gathering (Corbin & Strauss, 2015). Finally, in Phase IV, all the data was analyzed and integrated to obtain the final tree diagram of the resilience model in BD.

Instruments. Clinicians self completed the Spanish version (Vieta et al., 2002) of the CGI-BP-M (Spearing et al., 1997) to assess the severity of the BD illness. It consists of three independent items that provide an overall illness score and sub-scores for manic and depressive symptoms. Symptom severity is rated in a 7-point ordinal scale ranging from 1 "normal" to 7 "extreme".

Patients self completed two instruments. The Spanish version (Vázquez et al., 2010) of the BSDS (Ghaemi et al., 2005) identifies milder forms of BD. The BSDS consist of a paragraph with 19 phrases describing bipolar symptomatology. The questionnaire is answered in two sections: first the person answers to which degree he/she feels identified with the whole narrative in general, rating his/her answer in an ordinal scale from 1 "this story fits me very well, or almost perfectly" (equivalent to 6 points) to 4 "this story doesn't really describe me at all" (equivalent to 0 points); and second, the person goes back and rates each sentence with a 0 (when a phrase does not describe the person) or a 1 (when the phrase describes the person). BSDS scores range from 0 to 25, where higher scores indicate a higher likelihood for BD. Vázquez et al. confirmed the sensitivity and specificity (0.70 and 0.89, respectively) of the BSDS, using the previously established threshold of 13 points (Ghaemi et al., 2005) as a cut-off point.

Also, patients self completed the Spanish version (Las Hayas et al., 2014) of the Resilience Scale-25 (RS-25) (Wagnild & Young1993). The RS-25 consists of 25 items answered through a Likert scale of 7 points, ranging from 1 "totally disagree" to 7 "totally agree". The scale comprises two factors (personal competence, and acceptance of self and life) and a global index. The total score ranges from 25 to 175 (the higher the score, the higher the resilience). Las Hayas et al. (2014) reported excellent fit index and internal reliability results for the Spanish version of the RS-25 (Cronbach's alpha for the global index of the RS-25 = .93).

Data Analyses

A thematic analysis method (Boyatzis, 1998), which is based on inductive analysis, was used due to its appropriateness when aiming to discover themes. Following this design, themes are developed iteratively until a main theme is identified. Figure 2 summarizes the steps followed for the analysis. The constant comparison allowed to reach theoretical saturation (Corbin & Strauss, 2015) for every phase of the study, which was indicated by finding repeated concepts or categories when collecting new qualitative data (Guest, Bunce, & Johnson, 2006). Divergences between patients and clinicians on their viewpoints about resilience were noted and analysed for each case, and they were accordingly expressed in the results.

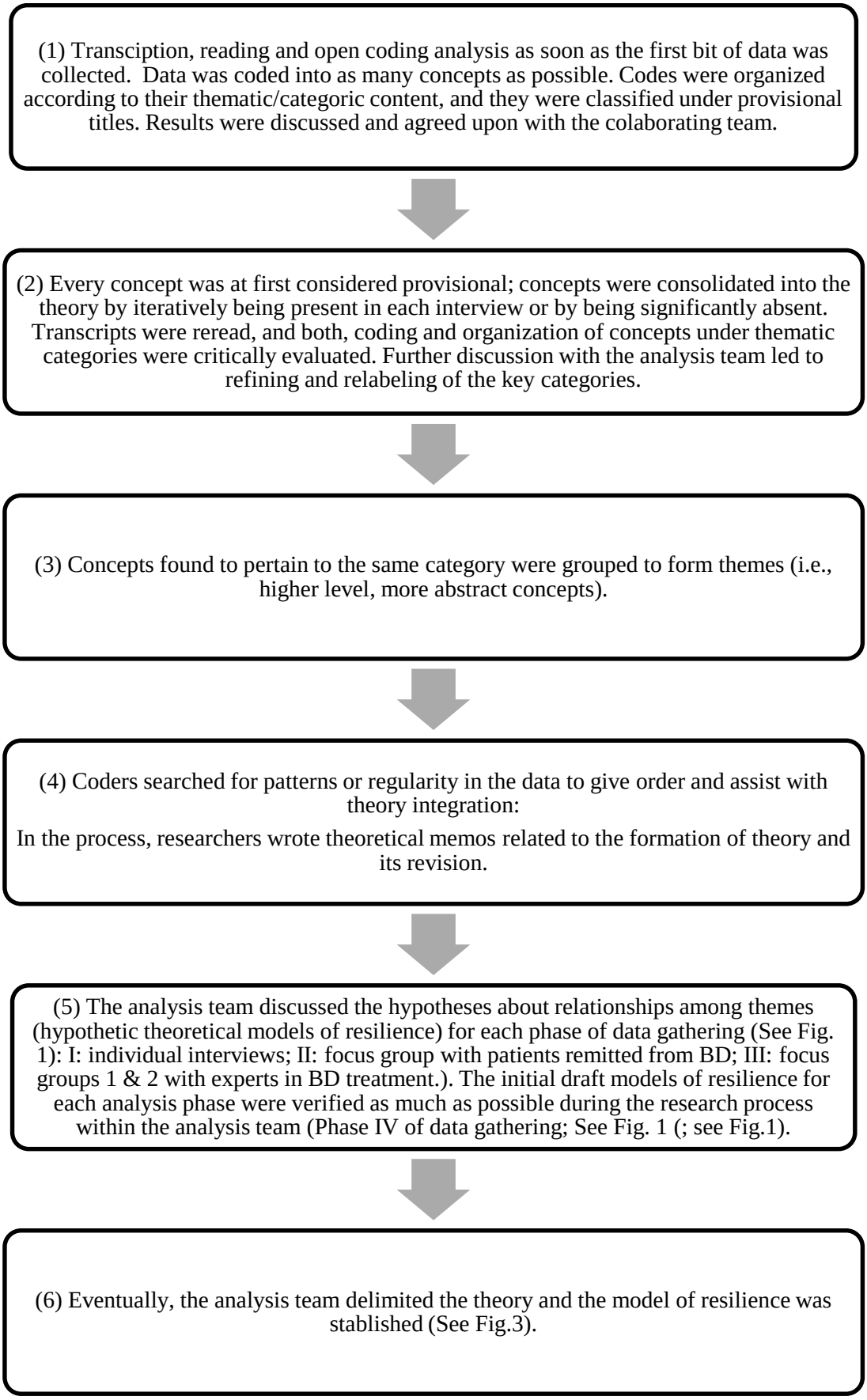

Figure 2. Steps followed for the data analysis as stated by Corbin and Strauss (2015).

The statistical package SPSS for Windows version 20 was used to compute descriptive statistics.

Validity and Reliability of Results

As part of our analysis method and its evaluation, a reflexive exploration of our research (i.e. the analysis of how subjective and intersubjective elements influenced our research) was discussed at regular meetings with our research team. Team members come from different training backgrounds (psychiatrist, clinical psychologists, and public health researchers) to facilitate the plurality in the interpretation of the research results.

Results

Clinical sample: Nine individual interviews with 5 women and 4 men in remission (mean age = 42 years old, *SD* = 14.98), and one focus group (n = 6) with women in remission (mean age = 44.17 years old, *SD* = 6.31), were conducted with patients. Socio-demographic and clinical characteristics from patients are shown in Table 1. Professional sample: Six clinicians, two women and four men with more than 20 years of expertise in BD treatment, took part in two focus groups (n= 4 and n = 2 respectively).

Table 1

Clinical Data to Describe Participating Patients

	Individual Interviews N = 9	%	Focus Groups N= 6	%	All patients N= 15	%
Female	5	55.60	6	100	11	73.30
Education level						
Primary education	2	22.20	0	0	2	13.30
Secondary education	2	22.20	0	0	2	13.30
University degree	4	44.40	4	66.70	8	53.30
Post-degree education	1	11.10	2	33.30	3	20
Marital status						
Married/living together	3	33.30	4	66.70	7	46.70
With partner	1	11.10	0	0	1	6.70
Single	4	44.40	2	33.30	6	40.00
Divorced/separated	1	11.10	0	0	1	6.70
Employment situation						
Unemployed	7	77.80	3	50	10	66.70
Employed	2	22.20	3	50	5	33.30
Prescribed drug therapy	9	100	6	100	15	100
a (Mood stabilizers) only	2	22.20	1	16.70	3	20
b (Antipsychotics) only	0	0	0	0	0	0
c (Anticonvulsants) only	0	0	1	16.70	1	6.70
d (Antidepressants) only	0	0	0	0	0	0
a + b	1	11.10	4	66.70	5	33.30
b + c	2	22.20	0	0	2	13.30
a + b + c	3	33.30	0	0	3	20
a + c + d	1	11.10	0	0	1	6.70
Received psychological therapy	8	88.90	4	66.70	12	80
	Mean (*n* = 9)	*SD*	Mean (*n* = 6)	*SD*	Mean (*n* = 15)	*SD*
Age	42.00	14.98	44.17	6.31	42.88	11.99
Age at BD onset	24.22	11.70	26.17	6.49	25	9.71
CGI-BP overall	1.67	1.00	1.00	0.00	1.47	.83
BSDS	3.56	2.65	1.50	1.38	2.73	2.40
RS-25	137.00	18.60	139.00	15.80	137.80	16.97

Note. CGI-BP-M: Clinical Global Impression Scale for Bipolar Disorder, Modified, thresholds: 1 (normal), 2 (minimum), 3 (mild) 4 (moderate), 5 (marked), 6 (severe), and 7 (extreme); BSDS: Bipolar Spectrum Diagnostic Scale, the cut-off score of 13 points indicates a positive predictive value when screening BD; RS-25: Resilience Scale-25, thresholds: a) scores > 145 (moderately-high to high resilience), b) scores 116-144 (moderately-low to moderate resilience), and c) scores ? 115 (very low resilience).

Findings from the Content Analysis

Participants reported feeling identified with the process of resilience after the brief and generic definition of resilience was given to them. Resilience attributes were interrelated with each other and developed without a specific sequence. Participants affirmed that resilience could exist alongside BD symptoms and that it played an important role in their recovery status, referring to both clinical (symptom remission) and personal recovery (as described by Anthony (Anthony, 1993).

The model of resilience to BD is described below and represented in Figure 3. If not specified otherwise, data presented reflects viewpoints shared between clinicians and patients.

Thematic Categories

Resilience as a dynamic process. All patients affirmed having experienced resilience subsequent to the onset of their BD. Clinicians also affirmed having observed resilience in some patients. Resilience was described as a slowly progressing, dynamic, and non-linear process that emerges when an additional inner strength is needed to face adverse situations. Once resilience was displayed, it played a protective role against future adversities related to BD.

> *"Well, I think that it is a slow process, which skips back and forth, (...) it is not a process that goes at the same rate all the time, but rather, it is bumpy. (…). The mobilization of resources aimed at my resilience increased dramatically (…) Until the pace began to drop (...), as it is not so necessary, you don't deploy it [resilience],"* Uxue, female patient in remission from BD in an interview.

Antecedent conditions for resilience. The following conditions create the basis of experiencing the process of resilience:

Minimum level of mental health. Participants agreed that for resilience to emerge,

the person has to have low level of psychotic symptoms or of other severe comorbid psychopathologies, such as drug dependence.

> *"Maybe they [people who do not develop resilience] have more serious problems (...) maybe [they are in] a very bad state [of mental health]."* Izaskun, female patient in remission from BD in the focus group.

Acceptance and awareness of BD. Both patients and clinicians felt that acceptance of diagnosis and recognition of negative features of mania and depression were important for resilience. However, both also affirmed that patients found it more difficult to judge (hypo)manic episodes negatively than depressive episodes.

> *"There comes a time when, if they become aware, this helps them to endure the treatment, the problem is that they do not accept the disorder, and when they undergo this process is when they make a sudden change."* Miguel, male psychiatrist from a focus group.

Turning point. Participants reported about the experience of a turning point—in the course of resilience—defined as a moment in which they felt committed to move steadily, firmly, and determinedly out of their present adversity. The following subthemes were identified:

Refusal of suffering. Participants described a refusal to remain immersed in the BD related adversities and the need to get over them.

> *"I had to reflect, analyse why my life was like a boat at the mercy of the waves (...) and I realized that I could not go on like this, because so much instability was hurting me so much, (...) and from the moment when you become aware that you cannot go on like that, you begin to emerge from it a little [from BD]."* Miriam, female patient in remission from BD in the focus group.

Sometimes, the rejection of the adverse situation was motivated by a sense of

responsibility for the well-being of relatives.

> *"There comes a time when you see the people you love the most suffering, when the responsibility is too much, because you don't want to go back—not just that you can't put yourself in that situation, but you can't put the people who are closest to you in that situation."* Uxue, female patient in remission from BD in an interview.

Participants stressed the importance of not adopting a "victim role," which implies a passive attitude and feeling powerless about recovering from BD.

> *"People who do not break free [of the disorder, it is] because in the end, instead of seeing the goal of breaking free, they say, well, here I am, and they don't see why they have to evolve to the next step."* Silvia, female patient in remission from BD in the focus group.

Hope for getting better. Participants stressed the importance of experiencing hope that a more positive life is possible.

> *"Remembering happy moments of my childhood, in order to relive them, I say, if I have experienced this, why can I not relive it? In other words, I draw on those memories. That is, you must remember that moment to reflect on it and feel it again. And that gives you the strength [to fight against the disorder]."* Clara, female patient in remission from BD in the focus group.

Determination to change. Despite the challenges, patients affirmed the resilience was linked to persisting with positive efforts towards wellness.

> *"Where does that motivation for change come from [determination to change]? Bah! Sometimes it's rage! For example, I don't feel at all like... I'm a little low... and I say, this cannot be! I cannot go on like this! I'm going to put on my shoes and I'm going [to run] without giving it another thought."* Iñaki, male patient in

remission from BD in an interview.

Making use of resilience assets and resources. Once patients felt they were making progress, several key attributes and strategies came into play and interacted. For some people, certain resilience attributes were developed from scratch, while for others, the attributes were assets and resources that the person already had but were dormant. Resilience assets and resources included the following:

Self-awareness and redefinition. Participants reported that they had analysed their strengths, weaknesses, goals, and hobbies in order to know themselves better. They agreed that introspection was essential to realize and understand how and why they react to or feel about different situations. This effort allowed them to redefine their identity and differentiate it from the illness.

> *"Seeing what we really are, that is the most important thing, what am I, who am I, and what am I like. (...) That's why it's important to know what is inherent to your personality and what is due to the BD."* Silvia, female patient in remission from BD in the focus group.

Reconsideration of the direction of their life. Participants identified the role of re-planning their life to do what nourishes them and reengage with life.

> *"Until you have a crisis, you do not consider what to do with your life."* Jorge, male psychiatrist in a focus group.

> *"I had to stop to reflect, to analyse my life and rebuild my future from the ground up, with what I had, [seeing] what resources I have, setting a goal [in terms of] what I want to do, [and in terms of] what I want to be as a person."* Izaskun, female patient in remission from BD in the focus group.

Self-management of BD. Participants reported the need to learn about the disorder; thus, all patients had read books on the clinical features of BD (e.g., symptoms,

consequences, and self-management strategies for having BD), and some of them went to psychoeducational groups and individual therapies. All had tried to understand in depth how BD affects them as individuals, including consideration of their past bipolar experiences. All participants agreed that this information was helpful to critically examine the resources to deal with BD that were available and to search for suitable resources when the appropriate ones weren't available.

> *"I have sought enough information: I read quite a few books on psychology, then books more focused on BD to see how combat it and all that. (...) And I related the methods in those books with the way I was and what I was going through and so on. (...) It's a little, I'd say, it is like comparing the information that you obtain, contrasting it with your past and with that, you make your own particular manual."* Mikel, male patient in remission from BD in an individual interview.

This knowledge also helped in the attempt to anticipate and identify BD symptoms and early warning signals or stimuli that triggered the symptoms, and to decrease their impact on the life course of the patient.

> *"You learn to realize when you're going wrong and you get back on the track with the strategies that you're acquiring, knowing it [BD] makes you manage it better."* Sofia, female patient in remission from BD in the focus group.

> *"They interpret the symptoms correctly and begin to set limits to stop the phase".* Mari Luz, female psychiatrist in a focus group.

Adherence to drug therapy was highlighted by all participants as a resilience attribute, because they felt empowered to manage BD by participating actively in the pharmacological therapy agreed to between the psychiatrist and the patient.

> *"[I'm] compliant [about the medication] but not submissive (...) you should trust the one who is guiding you [in the medication] and if you don't trust them, you*

should tell them. You're smart enough to know that what they are saying is valid for you but other times, no, you accept what you believe [benefits you].” Clara, female patient in remission from BD in the focus group.

Lifestyle balance. During the resilience process, having good mental health was made a priority. In this sense, having a balanced lifestyle, involving healthy habits, discipline, and trying to achieve harmony between their personal, familiar/social, and work/study spheres, was fundamental. Participants highlighted the importance of hammering out their day-to-day life, which in turn had a positive effect by improving their self-worth.

“I believe that an orderly life is essential. That is, an orderly life, physical exercise, the environment, the family environment, the social environment you have, which, of course, may or may not favour you.” Estibaliz, female patient in remission from BD in an interview.

Positive personality qualities. Participants described a variety of positive personality characteristics that emerged during the resilience process, particularly initiative, perseverance, willpower, extraversion, good social skills, sense of humour, and creativity.

“I've been an extrovert, with a lot of social skills, I had a great sense of humour (...) Yes, I think I'm a positive person (...) I was self-confident, I knew that I could make it, that I was worthy, then, that's why I still went on trying.” Angeles, female patient in remission from BD in an interview.

“At least I was brave, I always had enough courage. (...) I've always had a lot of willpower.” Oscar, male patient in remission from BD in an interview.

Interpersonal support. Both Informal external support from family, friends, colleagues and formal external support from mental health clinicians and mental health

associations were considered beneficial during the whole resilience experience. Such interpersonal support was described as having at least one person who loved them unconditionally and who they trusted to share their experiences. Participants also described the benefit of having a closer person who knows when the patient is starting to show signals of instability and can warn him/her.

> *"The bipolar association has been very good too; we have taken many self-esteem courses which have done us good. (...)The two psychologists have also been there helping us a lot and telling us things that we didn't know. (...) In fact, I have felt the most support in the hospital. (...) My husband was always with me, because, when I took Haloperidol, I couldn't breathe because of the side effects, and he would tell me: 'now breathe, come, now, come on, now' and he would cry, and those are the moments when you realize the difficult times that we have gone through together and we have got ahead."* Alazne, female in remission from BD in an interview.
>
> *"Yes, Yes, all that stuff of them loving me and giving me a hug and telling me 'Don't worry, you're going to be OK, because you've been through this before and you got out OK, this time too, why not this time?' (...) For example, my kids tell me that I am the best mother in the world."* Lucía, female patient in remission from BD in an interview.

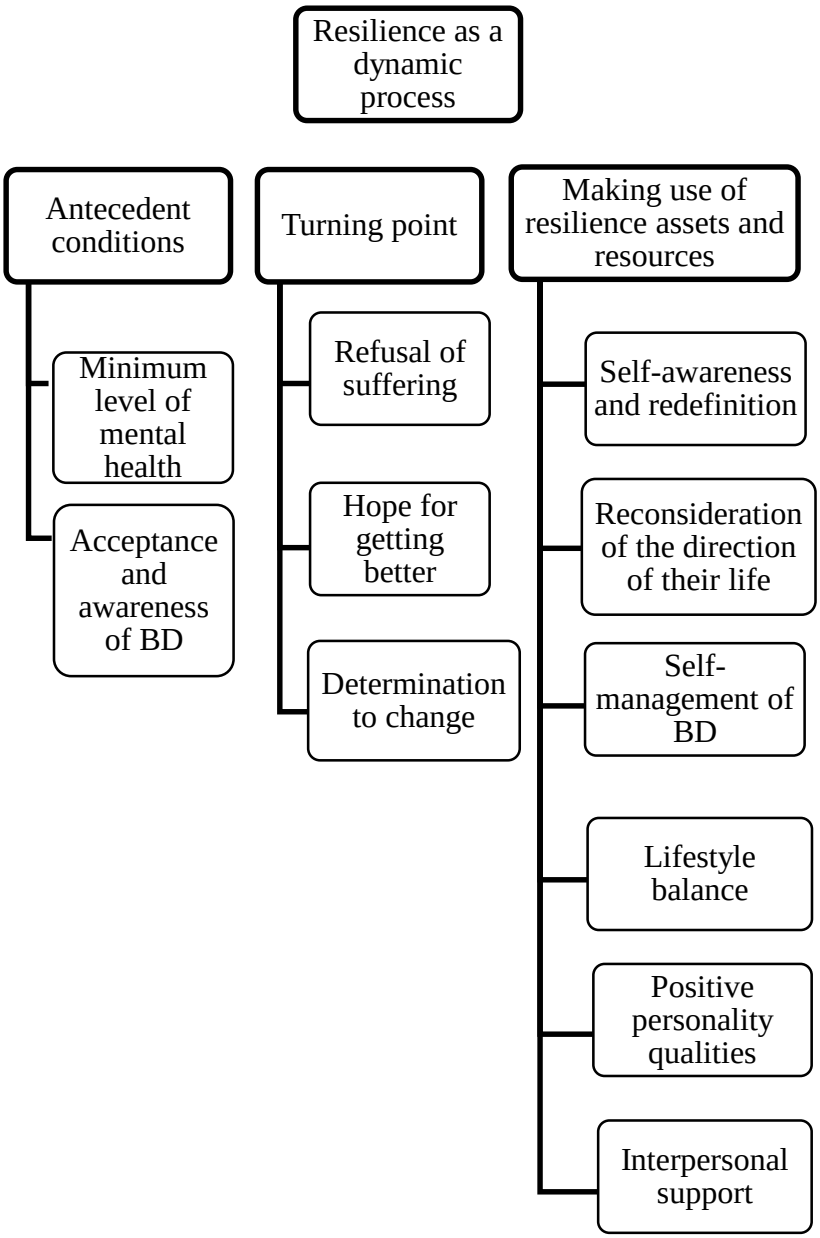

Figure 3. Model of the resilience process in BD.

Discussion

This qualitative study has explored the experience of resilience in BD from the perspectives of patients in remission from BD as well as from clinicians. All of the participants reported having experienced resilience and all clinicians reporting observing it in some of their patients. This finding is consistent with other studies that reported resilience in people with other mental disorders (Dowrick et al., 2008; Torgalsbøen, 2012) including BD (Choi et al., 2015; Edward et al., 2009). In the present study, all the participants affirmed that resilience played an important role in recovery. This is in line with studies in mental health more broadly that support the role of resilience as a contributor to the promotion and maintenance of mental health and quality of life (Choi et al., 2015; Dowrick et al., 2008; Torgalsbøen, 2012).

The definitions of resilience given by participants of the present study coincide with the psychological definitions of resilience given by key authors of research on resilience (Grotberg, 1995, 2003; Wathen et al., 2012). The participants described resilience as a dynamic process in which a variety of conditions and strategies interacted, allowing them to regain mental health and personal recovery. However, as stated by the American Psychological Association (2010) all the participants noted that experiencing the resilience process was not free from pain or suffering.

The majority of resilient attributes that participants started to develop after the turning point coincide with the traditional qualities of resilience (See Garmezy (1991)). Regarding the antecedent conditions presented as a resilience theme in this study, our participants highlighted the importance of acceptance of having a disorder and awareness of how the disorder affects the person negatively. Most of the patients having received some treatment, either in the form of psycho-education, individual psychotherapy, or support groups; we speculate that any of these treatments could have helped in the

acceptance and awareness of bipolarity (Gaudiano & Herbert, 2006). Nonetheless we did not go in-depth about their specifics. Thus, we cannot confirm that they received an evidence-based treatment.

The turning point category was described in the present study as taking decisive action and being determined and committed to the struggle for change in the patient's suffering, as indicated by key authors of research on resilience (Garmezy, 1991; Rutter, 2013).

Some of the resilience attributes reported after the turning point in the present study are comparable to the attributes of resilience that other studies have reported, though the majority of these studies were carried out in non-clinical contexts. For example, Wolin and Wolin (2010) affirmed that acknowledgment of one's own strengths/limitations and self-analysis were resilience attributes; these were described in the present study under the "self-awareness" subtheme. In contrast, other resilience attributes were specific to the BD sample studied in the present study, such as the redefinition of the personality and the idea of differentiating it from the illness.

The pursuit of a meaningful life (as stated by Wagnild and Young (1993) and Werner (1995)), making realistic plans, and taking steps to carry them out (as stated by Fletcher and Sarkar (2013)) were important features of resilience from the existing research that were also described in the present study, under the "reconsideration of life direction" subtheme.

In reference to the "self-management of BD" subtheme of the present study, some of its components were also found in other studies of resilience, such as "problem solving" and "management of strong feelings and impulses" (Fletcher & Sarkar, 2013; Werner, 1995), "personal agency" (Rutter, 2013), and "being ready to learn" (Friedli, 2009). In contrast, other aspects of this subtheme, such as the importance of detecting

warning signals and the importance of treatment compliance, were not reported as resilience attributes in other studies, but they were reported in studies of well-being (Russell & Browne, 2005), personal recovery (Mansell et al., 2010), and quality of life (Michalak, Yatham, Kolesar, & Lam, 2006) in BD. An explanation could be that the self-management of BD, found as a resilience quality in the present study, could also play an important role in well-being, personal recovery, and quality of life. We recommend to confirm whether these aspects of resilience in BD are specific qualities of resilience for this diagnostic group.

"Lifestyle balance" as a resilience asset in BD is explained as having healthy habits and has been related to disease prevention and health promotion in mental health in other studies (Mrazek & Haggerty, 1994). The importance of having a balance between the personal, familiar/social, and work/study areas of life was addressed in the present study and is referenced by Everly, McCormack, and Strouse (2012) as one of the seven characteristics of highly resilient people.

The main "positive personality qualities" found in the present study, such as perseverance and social and communication skills, also appear in the wider research literature about resilience (Wagnild & Young, 1993; Werner, 1995). Optimism, sense of humour and creativity (Everly, 2012; Vanistendael, 2007; Wolin & Wolin, 2010) were also referred in other studies on resilience. While in the current study it was not clear whether the resilient qualities of optimism, sense of humour and creativity were personality traits of the participants or were BD signs, a psychiatrist suggested that these features, especially creativity, could become problematic, as they may lead to a manic episode. In contrast, Johnson et al. (2012) suggested that both optimism and creativity could contribute to the improvement of outcomes in BD. Despite the controversial risky or beneficial roles that may entail optimism, sense of humour and creativity in BD, those

aspects were indicated within "positive personality qualities" subtheme in the present study.

Finally, interpersonal support is also reported as an external resilience quality in other studies (Fletcher & Sarkar, 2013; Garmezy & Masten, 1986; Werner, 1995). The majority of the participants of the present study affirmed the importance of having at least one person with whom they established a permanent close bond. Under the "interpersonal support" subtheme, participants also pointed out the importance of a formal support network, such as psychiatrists, psychologists, support groups, and mental health associations. We speculate that the importance given to formal support networks could be explained by the composition of our study sample being patients of a mental health service or clinicians. This could be a reason why formal support is not addressed as a resilience resource in studies whose participants came from the general population instead of from mental health services.

Limitations

A possible limitation is related to the restrictions in the inclusion criteria. For example, patients were included if they were in remission of a BD and came from a limited number of mental health centres. Thus, we included as a criterion of eligibility to be in remission from the BD because that acted as a guarantee that the patients had overcome the disorder [as Zautra (2009) pointed out], and that increases the chances that they had experienced resilience. Future studies should explore whether the features of resilience in the current study are also observed in participants recruited from more diverse sources and with higher levels of subsyndromal symptoms. Further, participating clinicians were all psychiatrist, so the participation of health professionals coming from other backgrounds would also be worth considering to enrich the information.

In addition, the retrospective nature of the information could be influenced by

recall bias. This limitation could be overcome by gathering information from proxies.

Furthermore, the starting points of the researchers might have influenced findings, but this subjectivity was explicitly discussed between the members of the analysis team thus facilitating the identification and correction of potentially misleading assumptions and capturing a higher level of reflexivity (Mauthner & Doucet, 2003).

Conclusions

The limitations of the study—such as limiting the clinical sample only to patients recovered from BD, the retrospective nature of the obtained data, and the possible biases within the analysis team—were discussed and managed in order to achieve higher level of reflexivity and reliability. Still, caution is needed in generalizing the results to people not recovered from BD.

Resilience was described as a dynamic process involving the interaction of a variety of strategies and attributes, such us self-awareness and redefinition, to regain mental health and move towards personal recovery. A better understanding of the resilience process is crucial to the development of better interventions and assessment processes to improve personal recovery in mental health. The evidence from the present research is consistent with other studies of resilience and mental health, and adds new findings for the concept of resilience within BD diagnostic group, and further it describes the experience of resilience not only from the point of view of patients but also from that of clinicians. In addition, the current research reports a model of psychological resilience in BD offering insight into the main resilience themes emerged in people with BD that enabled them to maintain or regain their mental health. The present study balances the previous focus on negative characteristics that created a biased picture of BD by presenting phenomenon, such as resilience, that is experienced by people with BD.

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Appendix. Guideline for the interviews and focus groups

Patients in the interviews and focus group and clinicians in the focus group were presented an introductory generic definition of resilience. Next, the participants were interviewed about resilience in BD following as a guideline similar semi-structured questions for a) both, individual interviews and the focus group with patients remitted from BD ("Do you recognize having gone through a process of resilience during your BD?, If so, how would you describe your resilience process with BD?", "How did resilience originate in you?" "What qualities, behaviors, and resources were put in practice to overcome the adversity of having BD?", "Which changes and qualities do you think makes you different from those who don't achieve your level of recovery?", "What advice would you give to a person to overcome BD?", and "Did resilience play an essential role in your remission from BD?"), and b) focus groups with clinicians ("Do you agree that people in recovery have gone through a resilience process to face bipolar?", "How would you describe a typical person with BD who is experiencing resilience?", "How do you think resilience is originated in those people?", and "What qualities, behaviors, and resources (regarding resilience) were put in practice to overcome the adversity of having BD?").

In addition, patients participating in the focus group were also presented with the preliminary results from the individual interviews, and were then asked whether they considered those results valid in order to determine their perceptions of whether the data interpretations were correct or needed revision. Similarly, clinicians were presented the results from patients (individual interviews and the focus group), and they were asked if they considered the resilience model of BD correct, in order to validate and complete the draft model.

6. Study 3

The Resilience Questionnaire for Bipolar Disorder: Development and Validation

The Resilience Questionnaire for Bipolar Disorder: Development and Validation.

Echezarraga, A. [1]; Las Hayas, C. [1]; González-Pinto, A. M. [2]; Jones, S. [3]

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Abstract

There is currently no measure of resilience in Bipolar Disorder (BD) available. The aim of the present study is to develop and validate a measure of resilience specific for BD patients. Based on a previous qualitative study on resilience in BD, we developed the new *Resilience Questionnaire for Bipolar Disorder* (RBD). In order to examine its psychometric properties, we carried out a prospective cohort study. A Spanish sample of 125 patients diagnosed with BD (62.10% women, mean age = 46.13, *SD* = 10.89) and a comparison sample of 107 people from the general population (77.60% women, mean age = 35.42, *SD* = 10.61) completed measures of generic resilience, quality of life, personal recovery, BD symptoms, and the new RBD. Both samples were followed up from 6 to 12 months (including reminders) to determine the sensitivity to change of the RBD (i.e., responsiveness). Exploratory factor analysis for the RBD yielded a 23-item, 5-factor solution (self-management of BD, turning point, self-care, self-confidence, and interpersonal support), and confirmatory factor analysis indicated adequate fit indices (RMSEA = .07, CFI = .93, NNFI = .92) with satisfactory Cronbach alphas—from .76 to .91—and significant test-retest correlations ($p < .001$) over a 15-day period. The RBD correlated positively with established measures of resilience, quality of life, and personal recovery, and negatively with depression. Known-groups' validity was also supported. In the BD sample, the RBD obtained higher responsiveness than the generic resilience scale. We conclude that the RBD is a new, robust measure to monitor resilience in patients with BD.

Keywords: resilience, bipolar disorder, questionnaire development, psychometrics, reliability

El Cuestionario de Resiliencia para el Trastorno Bipolar: Desarrollo y Validación

Resumen

Actualmente no existen instrumentos de medida de resiliencia para el Trastorno Bipolar (TB). El objetivo es desarrollar y validar un instrumento de resiliencia específico para pacientes con TB. El nuevo cuestionario de Resiliencia para el Trastorno Bipolar (RTB) se desarrolló en base a un estudio cualitativo previo de resiliencia en el TB. Asimismo, se llevó a cabo un estudio prospectivo de cohortes en España para examinar sus propiedades psicométricas. Pacientes diagnosticados de TB (n = 125; 62.10% mujeres, edad media = 46.13, *SD* = 10.89) y una muestra de comparación de 107 personas de la población general (77.60% mujeres, edad media = 35.42, *SD* = 10.61) completaron medidas de resiliencia genérica, calidad de vida, recuperación personal, síntomas bipolares, y el nuevo RTB. Realizamos un seguimiento de 6-12 meses (incluyendo recordatorios) con ambas muestras para determinar la sensibilidad al cambio del RTB. El análisis factorial exploratorio del RTB determinó una solución de cinco factores (autogestión del TB, punto de inflexión, autocuidado, confianza en uno mismo, y apoyo social) (23 ítems) y el análisis confirmatorio de esta estructura produjo índices de ajuste adecuados (RMSEA = .07, CFI = .93, NNFI = .92) con alfas de Cronbach satisfactorios (.76 - .91) y correlaciones test-retest (15 días) significativas ($p < .001$). El RTB correlacionó positivamente con medidas de resiliencia, calidad de vida y recuperación personal, y negativamente con depresión. Se confirmó la validez de grupos conocidos. El RTB obtuvo mayor sensibilidad al cambio para la muestra con TB que la escala genérica de resiliencia. Se concluye que el RTB es una medida robusta para monitorizar la resiliencia en pacientes con TB.

Palabras clave: resiliencia, trastorno bipolar, desarrollo cuestionario, psicométricas, fiabilidad

The Resilience Questionnaire for Bipolar Disorder: Development and Validation.

Bipolar Disorder (BD) is characterized by recurrent and cyclical periods of extreme moods, including depression and mania (American Psychiatric Association [APA], 2000), affecting up to 2.4% of the worldwide population (Merikangas et al., 2011). A serious public health problem, it accounts for 2.5% of total global Years Living with Disability and is the sixth leading cause of disability (Woods, 2000). Consistent with these reports, BD has a strong impact on patients' family, work, social functioning, and quality of life (Hirschfeld, Lewis, & Vornik, 2003), even during euthymia (Michalak, Yatham, & Lam, 2005).

The construct of resilience has received increasing attention over the last decades. Resilience is "a dynamic process in which psychological, social, environmental, and biological factors interact to enable an individual at any stage of life to develop, maintain or regain their mental health, despite exposure to adversity" (p.10, Wathen et al. (2012). Thus resilience applies beyond resistance to the development of illness to include the ways in which the individual responds once illness has developed. Resilience relates to salutogenic and positive psychology approaches, as it contributes to promoting and maintaining mental health and quality of life (Grotberg, 2003).

Evidence supports the importance of resilience in overcoming the challenges associated with mental health issues, such as depression (Dowrick, Kokanovic, Hegarty, Griffiths, & Gunn, 2008), schizophrenia (Torgalsbøen, 2012), and other mental disorders (Edward, Welch, & Chater, 2009). For instance, Torgalsbøen (2012), in a 15-year follow-up study, found a robust relationship between resilience,—measured with the Connor Davidson Resilience Scale ([CD-RISC] Connor & Davidson, 2003)—well-being, and psychosocial functioning in schizophrenia. Few studies have explicitly explored resilience in patients with BD. For example, Edward et al. (2009) found resilient qualities

in a sample of eight participants with various mental disorders, including BD, in remission. Choi et al. (2015) have recently studied resilience—also using the CD-RISC resilience questionnaire—in 62 euthymic outpatients with BD, and concluded that, given the inverse relationship between resilience and impulsivity, enhancing resilience may significantly contribute toward patient treatment by reducing impulsivity (a known risk factor for worse clinical outcomes in BD, (Jimenez et al., 2012).

Several scales to measure resilience have been developed. A recent systematic review of the psychometric properties of resilience measures concluded that no measure was satisfactory in psychometric terms, and most measures—such as the CD-RISC—were questionable on theoretical grounds; for example, the literature review on which the CD-RISC was based is limited and furthermore, resilience was defined as a personal quality reflecting the ability to cope with stress (Windle, Bennett, & Noyes, 2011) whereas established definition highlights that resilience is a dynamic process encompassing multidimensional factors (e.g. psychological, environmental and biological factors) that includes other attributes (e.g., self-esteem, self-efficacy, competence, hope, self-determination, and pro-social attitude) apart from coping (Windle, 2011). In addition, resilience and coping are conceptually distinct constructs, "resilience influences how an event is appraised, whereas coping refers to the strategies employed following the appraisal of a stressful encounter" (Fletcher & Sarkar, 2013 p. 16), and not all outcomes of coping are mirrored in resilience (Glennie, 2010). Another limitation of theoretically adequate resilience measures (i.e. questionnaires that for their development were based in a sound revision of the literature on resilience, and therefore covered appropriately the theoretical understanding of resilience)—such as the Resilience Scale for Adults ([RSA] Friborg, Hjemdal, Rosenvinge, & Martinussen, 2003)—is that, in fact, they were developed focusing on protective factors against psychopathology

(Windle et al., 2011), therefore excluding the assessment of resilience in people with an ongoing psychological disorder.

Therefore, instead of exploring resilience in people with a mental illness, most research has studied recovery (Drake & Whitley, 2014), resulting in a knowledge gap in regards to the experience of resilience in people with a mental disorder. The limited amount of quantitative research in this area such as the Choi et al. (2015) and Torgalsbøen (2012) studies above is that they measured resilience using existing questionnaires developed for individuals without mental disorders. Few studies have qualitatively explored resilience in mental disorders (Edward et al., 2009). Previous qualitative research (Echezarraga, Las Hayas, González-Pinto, Lobban, & Jones, 2016; Echezarraga et al., 2014) described a variety of resilience factors experienced by recovered BD patients. These factors were not covered in the existing measures of resilience, indicating the need for developing a questionnaire of resilience specific to BD that covers them. In addition, past research has pointed out the need for resilience measures intended for people diagnosed with a mental disorder, and the need for developing disease-specific scales that target psychological variables, as it is resilience (Michalak & Murray, 2010; Ungar, 2008).

The development of a resilience measure specific for BD patients would improve the monitoring of patient responses and evolution better than using existing generic measures of resilience. Unspecific measures of resilience may not be able to capture specific changes in resilience, given the unique fluctuating course of the disorder, since they do not contain the specific items that are considered relevant by BD patients when conceptualizing resilience. Thus, this paper reports the development and psychometric validation of a new measure, the Resilience Questionnaire for Bipolar Disorder (RBD). The development of this new measure was based on resilience experiences reported by

both people living with BD and experienced clinicians during qualitative interviews (Echezarraga et al., 2015; Echezarraga et al., 2016; Echezarraga et al., 2014).

The objectives of this study are to (1) develop an instrument to measure resilience in BD, (2) explore its construct validity, (3) analyze its reliability, (4) explore its concurrent validity with measures of mental health, hypothesizing positive associations with quality of life and personal experience of recovery, and negative associations with bipolar symptomatology, (5) explore its known-groups validation, and (6) determine its responsiveness at follow-up.

Methods

Participants and Procedure

The study was approved by the Basque Country Mental Health Ethical Committee. It also satisfied ethical requirements of informed consent, voluntary participation, and confidentiality.

Inclusion criteria for the clinical BD patient sample of this study were: (1) a confirmed diagnosis of of BD according to Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (APA, 2000) criteria; (2) age 18–65 years; (3) sufficient fluency in Spanish for completing the battery of tests; (4) no clinically serious multi-organic disorder, acute psychosis, or cerebral organic deterioration that would prevent the participant from completing the questionnaires; (5) informed consent for voluntary participation after being personally informed by his/her therapist.

The patient sample (N = 125, 62.10% female, mean age = 46.13 years old, SD = 10.89) was recruited from nine public mental health services distributed across the three regions of the Basque Country (Spain) and through non-governmental BD associations of several regions in Spain (i.e.,, the associations of BD “El Ascensor” from Murcia, “Esperanza Bipolar” from Vizcaya, “Bipolares Andalucía Oriental” from Andalucía).

The therapists or coordinators of the associations of people with BD invited the patients to participate in the study, based on inclusion criteria. Patients coming from non-governmental associations participated in the study through a web based portal. Participants recruited from the public mental health services completed the questionnaire either by the web based portal, by telephone (a psychologist called the participant, read the questions and took note of responses), by paper at their homes, or in the company of a psychologist if required.

Participating patients received detailed information about the purpose of the study, signed the informed consent and were free to leave the study at any time.

A control group sample (N = 107, 77.60% female, mean age = 35.42, SD = 10.61) was recruited from the general population. Inclusion criteria were identical to those for the BD sample, except that diagnosis of BD as exclusion criterion (screening negatively for bipolar pathology when they were asked about being diagnosed of any mental illness including BD). Participants in the control group sample were younger than BD patients ($t(232) = -7.56$, $p = <.05$) and that the proportion of women was also higher in the control group than in the patient sample (X^2 (1, N = 231) = 6.46, < .05). The control sample recruitment process was online, displaying the survey's URL link in different TV panels at the University of Deusto, as well as by sending emails to colleagues and posting information in public websites and social media, like Facebook. They also completed the battery of test only via online.

The website hosting the battery of tests included information about the research's purpose and characteristics, the study's voluntary nature, inclusion criteria for participation, and stating the freedom to withdraw from the study at any time. Participants agreed to participate by simply checking a box, a prerequisite for access to the battery of tests. To facilitate a 6-month follow-up assessment (T2), all participants provided a

contact address. This was saved in an independent database which only the main researcher could access using an encrypted access code. The participants' identity was safeguarded by an alphanumerical identification code. Four modes for completing the questionnaire at baseline (T1) and follow-up (T2) were offered, depending on participant preferences: via telephone interview with a a clinical psychologist paper and pencil in their mental health center (a clinical psychologist interviewed participant, or the battery was self-completed with the personal help of a clinical psychologist if required) in their home (self-completed, returning the questionnaires by post using pre-stamped envelopes provided), or online (self-completed). Two reminders were sent at 1-month intervals to the participants who failed to complete the survey at both T1 and T2.

Sixty three (50.40%) BD participants and 54 (50.47%) controls completed T2 assessment. with an inter-measurement time lapse of between least six months to one year (window time: 6 months) due to sending reminders. Table 1 shows sociodemographic and clinical characteristics of the BD patients at T1 and T2.

Table 1

Sociodemographic and Clinical Data of the BD Sample

	T1		T2	
Variables	*n*	%	*n*	%
Sex (Female)	77	62.10	36	58.10
Age (Mean, *SD*)	46.13	10.89	45.13	11.06
Marital status				
Single	38	30.60	18	29.00
Stable partner	17	13.70	8	12.90
Civil union/Married	42	33.90	23	37.10
Separated/Divorced/Widowed	27	21.70	13	20.90
Educational level				
No studies	1	.80	0	0
Primary education	10	8.40	5	8.10
Secondary education/High school	17	14.30	9	14.50
Professional training	35	29.40	18	29.00
University education	45	37.80	23	37.10
Postgraduate studies	11	9.20	7	11.30
Employment status				
Unemployed	69	58.00	24	38.80
Employed	50	42.00	38	61.20
BD onset age (Mean, *SD*)	29.46	10.79	na	na
Number of hospitalizations due to bipolar episodes				
0	23	19.00	11	17.70
1-3	62	51.30	36	58.10
4-6	16	13.20	7	11.30
7-9	10	8.30	7	11.20
≥10	10	8.20	1	1.60
≥ 4 bipolar episodes in the last year	15	12.30	9	14.5
Time (in months) passed since the last bipolar episode (Mean, *SD*)	44.13	63.89	34.31	36.96
Medication prescribed for BD				
Antidepressants with/without mood stabilizers or antipsychotics	32	27.10	22	35.50
Mood stabilizers with/without antipsychotics	84	71.20	46	74.20
Antipsychotics	54	45.80	26	41.90
Anticonvulsants	19	16.10	10	16.10
Other medication for BD	28	23.70	16	25.80
No medication for BD	3	2.50	1	1.60
Has received any psychotherapy for BD	78	63.90	36	58.10

Note. $N_{T1} = 125$, $N_{T2} = 63$. The number of responses to the RBD ($N = 113$) does not match the number of participants ($n = 125$) because some individuals did not respond to all questionnaires. na = not asked.

RBD Questionnaire Development (Version 1)

RBD Questionnaire development took place in three phases. The first stage of development for the RBD questionnaire involved a series of qualitative interviews and focus groups with patients with BD and experienced clinicians. Thus, semi-structured in-depth interviews were carried out, asking participants about the resilience process in BD: (1) nine patients recovered from BD participated in individual interviews, (2) another six patients recovered from BD participated in a focus group, and (3) six clinical experts who had witnessed the resilience process in their patients with BD took part in two different focus groups ($n = 4$ and $n = 2$). A qualitative analysis as per the grounded theory (Corbin & Strauss, 2015) was used with all interview-transcribed content. The phase is reported in detail elsewhere (Echezarraga et al., 2016; Echezarraga et al., 2014). The key resilience themes in BD identified were: antecedent conditions, turning point, self-awareness and redefinition, reconsideration of the direction of their life, self-management of BD, lifestyle balance, positive personality qualities and interpersonal support.

Second, we carried out an extensive literature review (Echezarraga et al., 2016) in order to examine articles and questionnaires assessing resilience [see for example the studies by Ahern, Kiehl, Lou Sole, & Byers (2006) and Windle et al. (2011) in which they provide an extensive review of resilience tools]. We listed the main factors of the questionnaires already developed and compared them with the themes identified in the previous qualitative study. We concluded that there were resilience specific topics in BD not covered in existing resilience tools for adults.

Third, based on the information from phases one and two, a 41-item Spanish language version of the RBD was generated to measure resilience in patients with BD,

creating between three and five items for each main resilience theme emerged from the qualitative study. To test content validity of the RBD, cognitive interviews were carried out with five mental health experts experienced in research and with four BD patients. Based on their feedback, the research team reworded some items and added two additional items to assess retrospective (finally 41 items were debveloped for the draft version of the RBD) and current levels of resilience prior to the quantitative phase reported here.

Measures

All measures were completed in relation to the "last two weeks". All participants completed the following measures.

Sociodemographic and clinical data. All participants provided self-reported sociodemographic data on age, sex, education, and marital and employment status. Patients also provided self reports data on age at BD onset, number of psychiatric hospitalizations due to bipolar episodes, whether or not they had experienced four or more bipolar episodes in the last year, time elapsed since the last bipolar episode, medication prescribed for BD, and whether or not they had received psychological therapy. Controls answered four clinical questions about their mental health, and whether they had ever been diagnosed with a mental disorder.

The 41-item RBD. The questionnaire was comprised 41 items, in Spanish, gathering information about resilience in BD across the following domains: antecedents of resilience, turning point, self-awareness and redefinition, reconsideration of life direction, self-management of BD, lifestyle balance, positive personality qualities, and interpersonal support. Each item was scored on a five-point Likert scale of agreement that ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). All items were scored positively, thus higher scores indicated higher resilience. The scale instructions included a brief

definition of resilience ("Resilience is a dynamic process in which the person aims to overcome or adapt to adverse situations, through the development and/or regaining of positive strategies and skills"). Participants also rated two independent items: one about their degree of certainty of having experienced resilience at some time ("Do you consider that you have experienced (at any time in your life) this resilience process to manage your BD?") on a scale ranging from 1 (*not at all*) to 5 (*yes, for sure*) and one about their current level of resilience ("Thinking about the last two weeks, my present level of resilience to BD is:…") on a scale ranging from 1 (*very low*) to 5 (*very high*).

The Resilience Scale -25 (RS-25). The Spanish version (Las Hayas et al., 2014) of the RS-25 (Wagnild & Young, 1993) consists of a bi-factorial structure called Personal Competence and Acceptance of Self and Life used to measure generic resilience. The scale responses range from 1 (*totally disagree*) to 7 (*totally agree*). The total score for the scale ranges from 25 to 175 (the higher the score, the higher the resilience). RS-25 total scores of 145 or greater indicate moderately high to high resilience; total scores from 116 to 144 indicate moderately low to moderate resilience; and total scores of 115 and below indicate very low resilience. Different reviews of resilience instruments (Ahern et al., 2006; Windle et al., 2011) have identified the RS-25 as the best in terms of psychometric properties and broadest application. Therefore, we selected the RS-25 as the criterion measure of resilience for this study. The RS-25 has been validated in Spanish by other authors (Heilemann, Lee, & Kury, 2003; Rodríguez et al., 2009; Ruiz-Párraga, López-Martínez, & Gómez-Pérez, 2012), but only Las Hayas et al.´s version was successful in reproducing the bi-factorial structure of the original RS-25 and in retaining the 25 items based on a general population sample and on an eating disorder sample (Las Hayas et al., 2014). The Cronbach alphas for the total score and the two factors of the RS-25 were

satisfactory both in current BD samples (alphas ranging from .84 to .95) and in the current comparison sample from the general population (alphas ranging from .84 to .93).

The Brief Quality of Life in Bipolar Disorder (Brief-QoL.BD). This is a 12-item BD-specific measure of quality of life (one item per each basic domain: physical, sleep, mood, cognition, leisure, social, spirituality, finances, household, self-esteem, independence, and identity) with a single-factor solution (Michalak & Murray, 2010). The Brief-QoL.BD is rated on a 5-point Likert scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), providing a total score ranging from 12 to 60 (higher scores indicating higher quality of life). Cronbach alphas were adequate (from .87 to .89) for this brief version (Michalak & Murray) as well as for the Spanish version (Cronbach´s α = .95) validated by Morgado and Tapia (2013). The internal reliability of the Brief-QoL.BD was also satisfactory in the present BD sample (Cronbach´s α = .89).

The Internal States Scale (ISS). This 15-item scale measures co-occurring manic and depressive symptoms through four subscales or indexes: Activation (ACT), Well-Being (WB), Perceived Conflict (PC), and Depression (DI) (Bauer, Vojta, Kinosian, Altshuler, & Glick, 2000). ISS provides indicators of (hypo)mania, mixed state, euthymia, or depression, depending on ACT and WB index scores. The validity of the ISS subscales as a discriminator of mood states and as identifier of mixed episodes has been confirmed (Bauer et al., 2000). Only the ACT and DI indexes were used for the current study. Participants rated the degree of internal state experienced on a rating scale ranging from 0 (*not at all*/*rarely)* to 100 (*very much so*/*much of the time*). Thus, the ACT (5 items) and the DI (2 items) subscale scores range between 0-500 and 0-200, respectively. The Spanish version of ISS had psychometric results comparable to the English version (Ruggero, Johnson, & Cuellar, 2004), and adequate internal reliability (Cronbach´s α = .84 for ACT, and α = .78 for DI) for our study's BD sample.

The Bipolar Recovery Questionnaire (BRQ). This instrument is a reliable and valid measure of personal experiences of recovery in BD (Jones, Mulligan, Higginson, Dunn, & Morrison, 2013). The original version of the BRQ consists of a 100mm visual analogue scale where the total score ranges from 0 to 3600, which our study replaces with a 10-point Likert scale ranging from 1 (*strongly disagree*) to 10 (*strongly agree*) to facilitate its completion. The BRQ contains 36 items, of which 12 are reversed. Thus, once these 12 items are recoded and the individual scores across the 36 items are summed, a total score ranging from 36 to 360 is calculated (according with the changes in the type of answering and scoring way), where higher scores indicate higher degree of recovery. The BRQ presented good psychometric properties of internal consistency and reliability (Cronbach´s α = .88) in participants diagnosed with BD-I or BD-II (Jones et al., 2013). We translated and back-translated the BRQ to and from Spanish for the current study, as recommended by Acquadro, Conway, Hareendran, and Aaronson (2008). Cronbach´s alpha (α = .90) for the translated BRQ in our BD sample (N = 109) supported its reliability. Regarding the validity of the BRQ in the current BD sample, bivariate correlations indicated that BRQ total score correlated negatively with ISS DI scores (r = -.57, p < .01) and positively with QoL.BD (r = .72, p < .01) scores.

Stages of change. We created a self-reported question to assess the stage and processes of change referring to BD (for the clinical sample) or to a problem (for the comparison sample from the general population) drawing on Prochaska and DiClemente (1986) stages of change model. This question had six response options each representing a stage of change. Thus, participants chose, from the following options, the sentence that best described their actual level of change: (1) *"Other people think that I have a BD/problem, but I don't agree."* (Precontemplation); (2) *"I realize that I have a BD/problem, but I don't feel confident about being ready to change it."* (Contemplation);

(3) *"I am considering acting towards changing the BD/ problem in the next six months."* (Preparation); (4) *"I have taken specific actions towards the BD/ problem in the last six months."* (Action); (5) *"I am doing my best to maintain the changes I have made towards the BD/ problem."* (Maintenance), and (6) *"I have taken actions towards the BD/ problem and now I am recovered."* (Recovery). The first five options were developed according to Prochaska and DiClemente's stages of change, and the last option was added in this study. We consider the information derived from this questionnaire relevant for categorizing participants as "improved", "unchanged" and "worsened" with respect to their stage of change reported at T1 and that reported at T2. If a change in the score (T2 score – T1 score) resulted positive, that reflected improvement; otherwise, if the difference resulted negative it reflected deterioration or worsening. A difference of zero between T1 and T2 reflected the "unchanged" group.

Statistical Analysis

Construct validity. Exploratory factor analysis (EFA) is appropriate when developing a new questionnaire (Field, 2013) for identifying the underlying empirical structure and the relationships among variables. Principal axis EFA with oblique rotation (Promax) was conducted to determine the RBD's underlying structure. We used an oblique rotation because, based on the literature of resilience (Wathen et al., 2012) we assumed that factors will be correlated and oblique rotation allows for correlations between factors. EFA was carried out with the responses of the participants who completed the 41-item RBD. Items were retained in the questionnaire if they showed: (a) communalities of >.40, (b) factor loadings of >.40 in their corresponding domain, and (c) cross-loads of <.40 in other factors. Item retention was also determined according to its psychometric functioning within the scale (corrected item total correlation [ITC] and item discriminant validity), and qualitatively, according to the clinical relevance of item

content (i.e., based on the existing literature of resilience). Corrected ITC were acceptable if they were ≥ .40. Multitrait-scaling analyses were carried out to calculate convergent and discriminant validity (Fayers & Machin, 2013). Convergent validity was supported when the item-to-own-subscale correlations were ≥ .40. Discriminant validity was supported when correlations between the items and the hypothesized RBD subscale were higher than their correlations with other RBD subscales (Fayers & Machin, 2013). To consider scaling successful, an item-to-own-subscale correlation should be significantly higher than the correlations of the item with other subscales of the questionnaire (Fayers & Machin, 2013).

Additionally, confirmatory factor analysis (CFA) using the least squares estimation (LS) method was carried out with EQS 6.1 for Windows, testing three models based on the final EFA solution. Comparative fit index (CFI), non-normative fit index (NNFI) and root mean square error of approximation (RMSEA) were assessed for the goodness of fit of the models. According to (Hu & Bentler, 1999), in general, CFI and NNFI values of .90 or above, and RMSEA values between .60 and .08, indicate an acceptable fit. The model was tested in the clinical sample.

Reliability and stability. Internal consistency of each subscale was assessed using Cronbach's alpha coefficient. Stability was measured by performing a test-retest with a clinical subsample of patients who completed the final RBD a second time ($N = 9$) approximately 15 days after the first time, and who also indicated that no major event—which might have influenced their physical and/or mental state—had occurred since the last time they completed the questionnaire by responding negatively to the question "Has any major event occurred in your life since the last time you completed the questionnaire, which might influence your current physical and/or mental state?" Thus, for the total RBD

and for each scale, intraclass correlation coefficients (ICC) were calculated between the T1 and test-retest scores.

Concurrent validation. Despite the absence of a current gold standard measure of resilience, we will use the RS-25 as the criterion measure to explore the concurrent validity of the RBD. It was hypothesized that the RBD Questionnaire would correlate positively with generic resilience measured by the RS-25, with quality of life measured with the Brief QoL.BD, and with personal recovery measured with the BRQ, and negatively with measures of bipolar symptoms measured with the ACT and DI subscales of the ISS.

Known-groups validity. Patients were grouped according to their total scores on the BRQ. Patients with total scores above the percentile 75 (BRQ $\geq$ 277) were labeled as "recovered", while patients with scores below this percentile were labeled as "not recovered". We hypothesized that recovered patients would score higher than not recovered patients on the RBD because, according to Zautra (2009), recovery is a sign of resilience. Cohen´s *d* values were calculated to indicate the magnitude of the differences between means of each group on the RBD. Cohen's *d* values of 0.2 are considered small effect, around 0.5 medium effect and above 0.8 large effect (Cohen, 1992). Analysis of variance (ANOVA) with Tukey post hoc test for multiple comparisons and nonparametric Welch post hoc test (as applicable) were used to compare scores on the RBD and RS-25 of the recovered (N = 28), not recovered (N = 83), and control group (from the general population) (N = 71). Items were adapted for the general population group so that references to Bipolar Disorder were substituted by 'the personal problem'. To facilitate interpretation of the comparison between these two measures, RBD and RS-25 scores were standardized to range from 0 to 100 (exclusively for the ANOVA). We hypothesized

that recovered patients would score higher in resilience than not recovered patients and the general population group.

Responsiveness. Responsiveness is understood as a measure of an instrument's sensitivity to changes in health status or other outcome being measured or as the ability of a measure to detect change in an individual over time. The question about the stage of change, based on Prochaska and DiClemente (1986), was used to measure whether the participant had changed from baseline (T1) to follow-up (T2). Using the scores of the difference between T1 and T2 on this question, we divided the clinical sample into three groups: “improved” (if T2 - T1 = > 0), “unchanged” (if T2 - T1 = 0), and “worsened” (if T2 - T1 = < 0). Then, we carried out one way ANOVA analyses to compare the differences between the RBD and RS-25 between each group.

Responsiveness indexes (Effect Size [ES], standardized response mean [SRM] and responsiveness statistic) of the RBD were compared with the RS-25. Effect sizes (calculated as the score difference between follow-up and baseline divided by the SD of the group's baseline), standardized response mean (SRM; calculated as the score difference divided by the SD of the group's score differences), and the responsiveness statistic (calculated as the score difference between follow-up and baseline divided by the SD of the general population’s score differences) (Deyo, Diehr, & Patrick, 1991) were calculated for each scale. To obtain the responsiveness indexes we divided the clinical sample into improved (N = 20), unchanged (N = 21), and worsened (N =20). Positive values reflect (standardized) improvements in resilience. ES, SRM, and responsiveness statistic values of 0.00-0.19 are considered very small, 0.20-0.49 small, 0.50-0.79 moderate, and ≥ 0.80 large (Kazis, Anderson, & Meenan, 1989).

Results

Construct Validity of the RBD

113 patients fully completed the 41-item RBD questionnaire. Analyses for construct validity were carried only with the patient sample. The Kaiser-Meyer-Olkin (KMO) measure verified sampling adequacy, which was .84 for the total index (Kaiser, 1970). Bartlett´s sphericity test ($p < .001$) indicated that the principal axis EFA was appropriate for the sample size (Bartlett, 1950). First, EFAs (with Promax rotation) were carried out to explore the number of factors to retain. Items that did not comply with the requirements for retention were eliminated. EFA analyses were repeated after the elimination of each item, as the deletion of a single item may greatly impact the overall internal structure. A final EFA was performed with the retained 23 items (i.e., removing 18 items in total), extracting five factors, which conjointly explained 57.04% of the variance. All items loaded >.46 on their corresponding domain and all presented communalities >.40. Table 2 shows factor loadings, corrected ITC, means and standard deviations for each item. Factors of the RBD were intercorrelated (see Table 3).

Of the total variance, the first factor explained 35.46%; the second explained 11.39%; the third explained 7.82%; the fourth explained 6.08%; and the fifth factor explained 5.44%. The factor structure of the 23-item RBD derived from the final EFA was examined within the clinical sample by carrying out a CFA using LS estimation. Because multivariate kurtosis revealed that the distribution was not normal, robust methods were used to analyze the data. Apart from this model, we also estimated two alternative models: a unifactorial model, and a first-order five-factor model; the unifactorial model reported unsatisfactory fit index: $\chi^2(230, N = 113) = 683.91$, $p = .000$, RMSEA = .133 (90% confidence interval, CI [.121, .144]), NNFI = .78, CFI = .80. The first-order five factor model reported more satisfactory fit indices than the previous, but

still poor: $\chi^2(220, N = 113) = 395.68$, $p = .000$, RMSEA = .084 (90% CI [.071, .097]), NNFI = .91, CFI = .92.reThe hierarchical CFA model with five first-order latent factors and one second-order factor produced acceptable fit indexes: $\chi^2(225, N = 113) = 374.38$, $p = .000$, RMSEA = .077 (90%cCI [.063, .090]), NNFI = .93, CFI = .93. All factor loadings were significant (see Figure 1). Appendix 1 and 2 include the Spanish and English versions, respectively, of the 23-item RBD questionnaire.

The corrected ITC with the total RBD (> .54) were acceptable (see Table 2). Regarding the multitrait-scaling analyses, convergent validity was supported, as item-to-own subscale correlations were .40 or greater (range self-management of BD factor of the RBD = .64 - .83; range turning point factor of the RBD = .73 - .80; range self-care factor of the RBD = .70 - .86; range self-confidence factor of the RBD = .79 - .85; range interpersonal support factor of the RBD = .81- .83; $p < .05$). Additionally, each item maintained significantly ($p < .05$) higher correlations with its hypothesized RBD subscale than with the other RBD subscales.

Table 2

Exploratory Factorial Structure of the 23-item RBD with the BD Sample

Item content	Corrected ITC	Communalities	Mean (*SD*)	Factor loadings (Inter-factor correlations [r]) SM	TP	SC	SCF	IS	r
6. Identifying and managing trigger symptoms	.67	.59	3.92 (1.10)	**.87**	-.02 (.35)	-.03 (.65)	-.13 (.51)	-.05 (.30)	SM
14. Active seeking and taking creative actions to manage bipolar disorder	.75	.68	3.56 (1.19)	**.70**	-.07	.00 (.25)	.26 (.33)	-.07 (.05)	TP
16. Regulating emotions	.64	.47	3.43 (1.11)	**.66**	-.04	-.04	-.01 (.39)	.16 (.39)	SC
12. Adapting to setbacks as a result of BD	.60	.41	2.89 (1.18)	**.64**	-.07	.05	-.01	.00 (.16)	SCF
20. Self-understanding	.54	.52	4.05 (.90)	**.59**	.05	-.24	.35	-.02	
7 Seeking empowerment, responsibility and active management of BD	.65	.59	3.58 (1.17)	**.51**	-.12	.37	-.03	.03	
13. Analyzing problems and resources	.69	.59	3.66 (1.07)	**.46**	-.01	.23	.16	.10	
1. Suffering BD transforms into the determination to change the situation	.66	.61	3.98 (1.13)	-.04	**.82**	-.09	-.06	.02	
3. Expecting to feel more positive in the future	.60	.54	4.47 (.84)	-.25	**.75**	-.05	.16	.03	
2. Experiencing ups and downs transforms into the determination to struggle with BD	.54	.44	3.67 (1.32)	-.02	**.68**	.11	-.16	-.01	

4. Hoping to face up to my BD to improve my life	.59	.46	3.90 (1.08)	.07	**.56**	.06	.15	-.05
15. Trying to go on with daily life	.58	.61	3.91 (1.03)	.38	**.50**	-.10	.17	.05
10. Prioritizing and caring for my mental health and well-being	.55	.54	4.27 (.92)	-.35	.03	**.74**	.30	.06
11. Maintaining healthy habits for my well-being	.63	.49	3.90 (1.02)	.15	-.04	**.67**	-.14	-.04
9. Setting limits as regards harmful situations	.75	.71	3.77 (1.17)	.32	-.12	**.61**	-.02	.07
5. Making the utmost effort to minimize the impact of BD on my life	.68	.73	3.62 (1.14)	.35	.32	**.52**	-.19	-.03
8. Get involved in self-managing my BD	.68	.63	4.11 (.90)	.32	.03	**.49**	.16	-.11
19. Unchanging identity	.63	.70	4.08 (.94)	-.02	-.01	-.03	**.86**	.01
17. Confiding in my self-efficacy	.58	.51	4.07 (.87)	.13	.08	.12	**.56**	-.09
18. Persevering in the face of difficulties	.61	.55	3.88 (1.11)	.05	-.05	.35	**.50**	.05
22. Feeling loved (by at least one person)	.64	.72	4.36 (.97)	-.14	-.08	.06	.14	**.83**
21. Feeling supported (by at least one person)	.57	.58	4.12 (1.16)	.02	.16	.08	.22	**.72**
23. Being alerted by someone when symptoms of	.54	.46	3.71 (1.37)	.33	-.05	-.15	.03	**.59**

BD become active/apparent																							

Note. N = 113. Factor loadings over .40 appear in bold. Items are in descending order by factor loadings.
Abbreviation: 23-item Resilience to Bipolar Disorder Questionnaire (23-item RBD); SM: self-management of BD, TP: turning point, SC: Self-Care, SCF: Self-Confidence, IS: Interpersonal Support.

Table 3

Bivariate Inter-Scale Correlations of the 23-Item RBD Questionnaire, Convergent Validity with the RS-25 Questionnaire, and Concurrent Validity with other Clinical Measures in the BD Sample

Questionnaires (score range)	Mean (*SD*)	Pearson's Correlation Coefficient					
		23-item RBD	SM	TP	SC	SCF	IS
23-item RBD (*23-115*)	88.91 (14.20)						
SM (*7-35*)	25.10 (5.80)	.88**					
TP (*5-25*)	19.94 (4.06)	.59**	.32**				
SC (*5-25*)	19.66 (4.07)	.85**	.73**	.34**			
SCF (*3-15*)	12.03 (2.42)	.71**	.60**	.34**	.54**		
IS (*3-15*)	12.19 (2.87)	.52**	.36**	.10	.36**	.21*	
Brief QoL.BD (*12-60*)	40.53 (9.63)	.60**	.57**	.10	.65**	.56**	.27**
ACT (ISS) *(0-500)*	200 (137.61)	-.07	-.09	.08	-.09	-.10	-.07
DI (ISS) *(0-200)*	70.09 (66.86)	-.38**	-.37**	-.07	-.35**	-.46**	-.13
BRQ (*36-360)*	243.76 (45.04)	.74**	.72**	.23*	.67**	.63**	.42**
RS-25 (*25-175*)	126.75 (28.59)	.63**	.62**	.21*	.57**	.68**	.20**
PCP (*17-119)*	85.75 (19.89)	.62**	.61**	.22*	.55**	.69**	.20*
ASL (*8-56)*	41.00 (9.68)	.59**	.60**	.19*	.55**	.59**	.16

Note. N = 115. Inter-Scale Correlations of the RBD questionnaire are indicated in bold typeface.
Abbreviation: 23-item RBD: 23-item Resilience to Bipolar Disorder Questionnaire. SM: self-management of BD, TP: turning point, SC: Self-Care, SCF: Self-Confidence, IS: Interpersonal Support. Brief QoL.BD: Brief Quality of Life Bipolar Disorder. ACT (ISS): Activation index from the Internal State Scale; DI (ISS): Depression index from the ISS. RS-25: Resilience Scale-25; PCP: Personal Competence, ASL: Acceptance of Self and Life.
**$p < .01$. *$p < .05$.

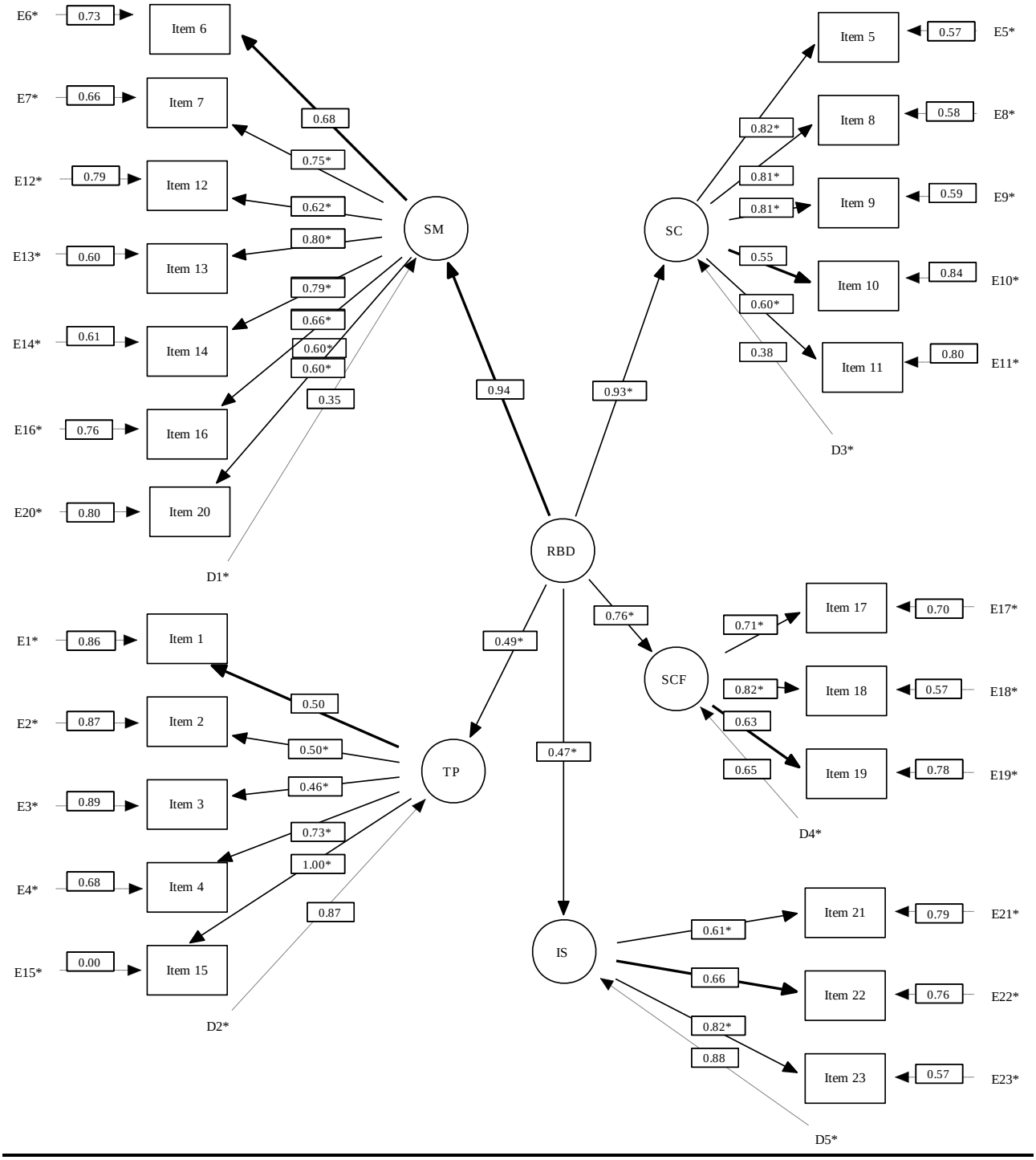

Figure 1. Confirmatory factor analysis results of the theoretical model of the internal structure of the RBD. *Note*. *N* = 113. Fixed variables and factors lines are in bold. Abbreviation: 23-item RBD: 23-item Resilience to Bipolar Disorder Questionnaire. SM: self-management of BD, TP: turning point, SC: Self-Care, SCF: Self-Confidence, IS: Interpersonal Support.
*All factor loadings were significant.

Reliability

The Cronbach alpha coefficient of the total score of the RBD was satisfactory (α = .91) as well as for all the RBD domains (ranging from .76 to .87; i.e., higher than the required .70). Regarding test-retest stability (N = 9), ICC was satisfactory for the total score (ICC = .97; $p \leq .001$) as well as for the RBD domains (self-management of BD = .95, $p \leq .001$; self-care = .97, $p \leq .001$; self-confidence = .78, $p \leq .01$; interpersonal support = .88, $p \leq .01$). The turning point factor's ICC was not significant ($p = .68$).

Concurrent Validity

Table 3 presents the correlation coefficients between the RBD factors and the RS-25 total scores, ranging from .19 to .69, $p < .05$. Also, RBD factors (except the turning point factor) correlated positively with the Brief QoL.BD ($.27 < r > .65$, $p < .01$) and with the BRQ ($.23 < r > .74$, $p < .05$). The DI index from the ISS showed negative correlations with both the total RBD score and with its factors ($-.35 < r > -.46$, respectively, $p < .01$) (except with the turning point factor). The ACT index from the ISS neither correlated with the total RBD score nor with its factors. The Turning point factor from the RBD only correlated significantly with the RS-25.

Known-groups Validity

Recovered (N = 28) patients scored significantly higher ($p < .001$) on total score of the RBD ($M = 100.07$, $SD = 10.16$) and its factors than not recovered (N = 83) patients ($M = 85.33$, $SD = 13.58$), except for the turning point factor, where differences were statistically non-significant (not recovered patients: $M = 19.77$, $SD = 3.81$; recovered patients: $M = 20.32$, $SD = 4.82$; comparison sample: $M = 19.11$, $SD = 3.61$). Post hoc Tukey analysis revealed that most of the differences were between not recovered and recovered patients, and between not recovered and the comparison sample (N = 71) (see

Figure 2). Cohen´s *d* ranged from -0.71 for the interpersonal support factor to -1.42 for the self-care factor (see Figure 2).

ANOVA comparing mean scores in both the RBD and the RS-25 standardized scores (only used for this particular analysis) showed that both resilience scores were higher for patients recovered from BD than for the general population and for patients with an not recovered BD (who scored the lowest). Mean standardized scores (and *SD)* in the global indexes of the RBD versus RS-25 for recovered patients were 83.77 (11.04) versus 85.62 (9.36), respectively; for the comparison group from the general population, they were 75.72 (11.23) versus 79.80 (13.74), respectively; and for not recovered patients, they were 67.74 (14.76) versus 61.83 (17.72), respectively, and all these mean group differences were statistically significant ($p < .001$). Thus, both resilience measures indicated similar levels of resilience.

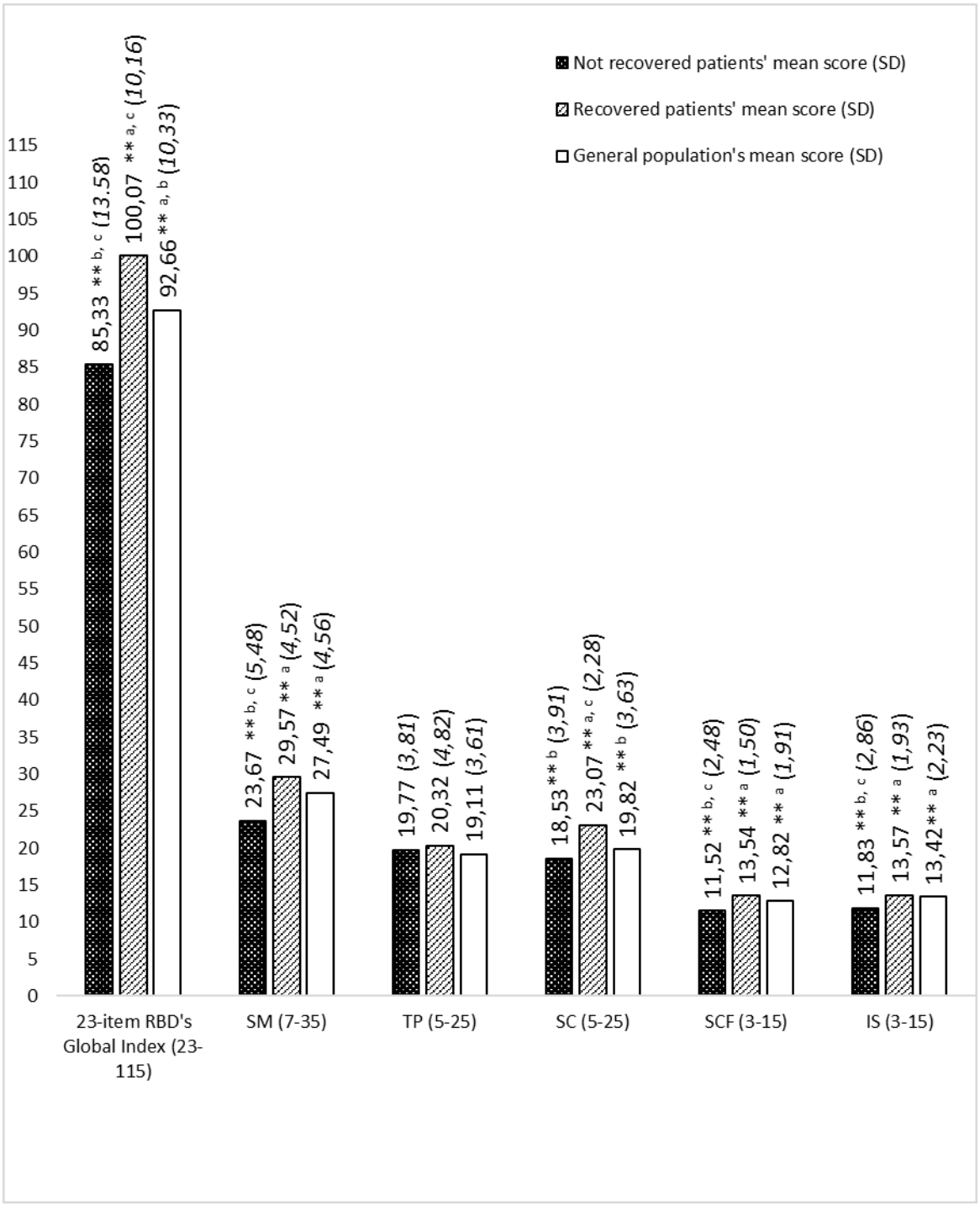

Figure 2. Known-groups validity of the 23-item RBD. *Note.* Not recovered patients [a] (N = 83): BRQ score < 277; Recovered patients [b] (N = 28): BRQ score ≥ 277. Comparison sample from the general population [c] (N = 71). Score ranges for RBD´s global index (i.e., total score), and per RBD domain are displayed in parentheses in the horizontal axis. *t*- test comparisons between not recovered and recovered patients were statistically significant at $p < .01$. Cohen´s *d* effect size is calculated for the statistically significant mean differences between not recovered and recovered patients on the RBD questionnaire.
Abbreviation: RBD: Resilience to Bipolar Disorder Questionnaire; SM: self-management of BD, TP: turning point, SC: Self-Care, SCF: Self-Confidence, IS: Interpersonal Support.

**Statistically significant differences between groups (ANOVA) were found at the $p <$ .001 level.
[a,b,c]Multiple comparisons are statistically significant at $p < .01$ level.

Responsiveness

Descriptive data (Mean and *SD*), one way ANOVA and post hoc Tuckey test results at baseline (T1), follow-up (T2) and their difference (T2-T1) for the clinical subsamples (improved N = 20; unchanged N = 21; and worsened N = 20) on the RBD are presented in Table 4. Additionally, to compare the responsiveness of the RBD within these clinical groups with the responsiveness of the RS-25, the ES, SRM and responsiveness statistic are also presented in Table 4.

One-way ANOVA showed statistically significant differences between the clinical groups for the RBD at T2 ($p < .05$) but not for the RS-25 at T2. Multiple comparison post hoc Tukey test for the RBD indicated statistically significant ($p < .05$) differences between improved and worsened clinical samples (Table 4).

ES for RBD was higher than that reported by the RS-25 for the improved and worsened group (ES for RBD: .55 and -.59, respectively; ES for RS-25: .40 and -.06, respectively).

Table 4

Responsiveness Data for the Clinical Sample that responded both at T1 and T2, grouped as Improved, Unchanged, and Worsened in RBD and RS-25 Scores at Follow-up

		T1		T2		Difference (T2-T1)		Responsiveness Coefficients		
Clinical samples	Measures	Mean	*SD*	Mean	*SD*	Mean	*SD*	ES	SRM	Responsiveness Statistic
Improved [a]	RBD	92.10	11.89	98.60	11.60	6.50 [c]	14.16	**.55**	.46	.65
(*N* = 20)	RS-25	128.75	28.36	140.10	26.50	11.35	23.52	.40	**.48**	**.76**
Unchanged [b]	RBD	89.91	13.01	90.05	10.13	.24	11.27	**.02**	**.02**	**.03**
	RS-25	125.57	24.87	124.62	23.86	-.95	26.30	-.04	-.04	-.06
(*N* = 21)										
Worsened [c]	RBD	88.80	9.19	83.35	13.38	-5.45 [a]	11.49	**-.59**	**-.47**	**-.55**
(*N* = 20*)										
	RS-25*	127.45	26.01	125.44	29.94	-1.67	22.71	-.06	-.07	-.11

Note. Total N = 61. * N_{RS-25} = 18. Clinical subsamples were identified using the difference score (T2-T1) in the question about change stages following Prochaska and DiClemente`s question: Improved: score > 0; Unchanged: score = 0; Worsened = score < 0. RBD range: 23-115; RS-25 range: 25-175. When comparing the responsiveness coefficients of the clinical samples in both resilience measures (RBD and RS-25), the best value is highlighted in bold.
Abbreviations: RBD: Resilience to BD; RS-25: Resilience scale 25; MCID: Minimal Clinically Important Difference in units of the ES (Effect Size), SRM (Standardized Response Mean).
[a,b,c]Post hoc Tukey test, $p < .05$.

Discussion

In contrast to other measures of resilience created so far, the theoretical basis of resilience on which the questionnaire is grounded considers resilience as a process that occurs in patients diagnosed with a BD. This study reports the development of a resilience measure specific for people with BD. The RBD is content-specific, given that its items stem from a qualitative study involving patients with BD and clinical experts, and from a literature review. The final EFA maintained 23 items of the initial RBD, divided into five factors.

The first factor was named Self-Management of BD (SM) because it dealt with a sense of personal agency in the management of BD (e.g., *"I try to watch and manage the early warning signs to anticipate and regulate the symptoms of bipolarity"*). The second was named Turning Point (TP) because it dealt with the determination and commitment to change (*"I have suffered so much because of having bipolar disorder that I am determined to change the situation and get over it").* The third factor was called Self-Care (SC) because it dealt with taking care of one's own health through a balanced and structured lifestyle (*"My mental health and well-being comes first and I have to take care of that before anything else"*). The fourth was named Self-Confidence (SCF) because it dealt with self-reliance and self-respectful attitudes and behaviors (*"I am confident that I can do most things if I try"*), as well as with perseverance. The fifth factor was called Interpersonal Support (IS), as it dealt with feeling supported and loved by significant others (*"I feel that at least one person (friend, spouse, family) loves me unconditionally"*). This factor also referred to having supportive health practitioners or clinicians involved in the patient´s BD treatment. Therefore, this domain included both formal and informal support. As a whole, the RBD scale content appears to capture dimensions noted in the more extensive literature on resilience (Everly, McCormack, & Strouse, 2012; Fletcher & Sarkar, 2013; Friborg et al., 2003; Garcia-Dia, DiNapoli, Garcia-Ona, Jakubowski, & O'Flaherty, 2013; Garmezy, 1991; Lee et al., 2013; Rutter, 2013; Shastri, 2013; Windle et al., 2011).

Conjointly, the RBD factors explained more than half of the total variance, with SM as the factor explaining the highest percentage of the total variance. On the basis of literature on resilience (Wathen et al., 2012), we hypothesized that the RBD factors would intercorrelate. The EFA and CFA results confirmed its factorial structure. Furthermore, the corrected ITCs with the total RBD were acceptable, and the scaling success (i.e.,

higher correlations of RBD items with their hypothesized subscales than with other subscales) achieved with multi-trait scaling analyses supported the construct validity of the RBD (Fayers & Machin, 2013). The 23-item RBD also presented good reliability (Cronbach´s alpha) both for the total score and for the five RBD domains.

Because the RBD works well as a total score and as a collection of subscales, we suggest using the total score to achieve a broad idea of the resilience level, and the subscales to obtain more precise knowledge of the strengths and weakness in resilience. Hence, subscales of the RBD could provide important clinical knowledge for interventions that promote resilience.

Concurrent validity of the 23-item RBD with the RS-25 was supported, as the RBD presented positive significant correlations with the instrument measuring generic resilience. It also correlated positively with health-related measures (i.e., quality of life and personal recovery) and negatively with measures indicating dysfunctionality (i.e., depression). This is in line with studies reporting that resilience contributes to the promotion and maintenance of quality of life (Choi et al., 2015; Dowrick et al., 2008; Torgalsbøen, 2012). Nevertheless, neither the RBD nor the RS-25 correlated significantly with the Activation index, suggesting that the experience of resilience is different from the experience of a manic episode.

Another notable result is that the turning point factor did not show significant correlations with quality of life, personal recovery, depression, or activation. The inclusion of this factor in our measure is in line with other studies (Las Hayas et al., 2015). Rutter (1999) described a turning point in the context of resilience as the determination to give up the disadvantageous situation and to move constructively toward a new situation. Bennett (2010), after re-examining data of two studies on widowhood, concluded that one of the groups experienced resilience following a turning point.

Therefore, based on the literature, we speculate that the inexistent relationship between the turning point factor and quality of life, personal recovery, depression and activation may suggest that the turning point is a key to activate the resilience process, but this does not necessarily mean that the person has already achieved other positive outcomes in quality of life, personal recovery, and/or symptomatology.

The 23-item RBD reproduces significantly different scores in different populations, showing statistically higher scores of resilience for recovered patients than for the comparison and not recovered patient groups. This result is consistent with those of Las Hayas et al. (2014) reporting higher levels of resilience in individuals recovered from eating disorders. We speculate that recovered patients present higher levels of resilience than healthy control subjects because the adversity implicated in BD prompts stronger resilience development.

We detected some noteworthy issues when comparing the RBD's structure, content and length with other sound resilience measures such as the RS-25 (Wagnild & Young, 1993), RSA (Friborg et al., 2003) and the CD-RISC (Connor & Davidson, 2003). Each questionnaire measures a different aspect of the concept of resilience. The RS-25 is a measure of personality characteristics related to resilience, the RSA is a measure of protective factors, and the new RBD measures resilient factors developed during the course of the BD. Despite good psychometric properties of the RS-25, RSA and CD-RISC, these measures have a higher number of items, with none developed for people experiencing psychopathology. In addition, according to Windle et al. (2011), the development methods and theoretical adequacy of the CD-RISC are questionable.

Our study compared the outcomes reported by the RBD with those reported by the criterion measure, RS-25. Despite the fact that both presented good psychometric properties and were similar in length, the RBD was more sensitive to changes occurring

in the patient with BD than the RS-25. Most likely, the RBD tapped some unique aspects of resilience in BD that the generic instrument of resilience (RS-25) did not.

Limitations and Recommendations

Intergroup differences regarding age and sex could be linked to the differences in the recruitment approaches for each sample (clinical vs control). The clinical sample was invited individually by a therapist/coordinator, whereas the control sample was invited in a more impersonal way, via flyers and TV panels with the invitation and Facebook. This different approached to recruitment may partially explain that participants from the control group were younger and generally female since participating in a study on psychology may result more attractive for a younger population, and in females than males. The sample size recruited was not large enough to divide it randomly into two subsamples in order to perform an EFA in one sample and the CFA in the other. Therefore, CFA results reported here are considered as preliminary results to be replicated in future studies. Test-retest analyses were carried out with a small sample size.

Another limitation refers to the lack of statistically significant correlation between the turning point factor of the RBD and the RS-25. Also, this factor did not discriminate between not recovered and recovered BD subsamples. We speculate that the turning point factor could have been misunderstood when the participants completed the corresponding items, and that they forgot the timeframe of the last two weeks and, instead, answered with regards to their whole lifetime. We consider that adding the phrase 'the last few days' to the turning point items would help participants to base their answers on their recent situation, perhaps changing the results related to this factor.

Future research on resilience should include differentiating between Type I and II BD to analyze the relationships between resilience and activation and impulsivity symptomatology, depending on each disorder type.

Conclusions and Clinical Implications

The 23-item RBD has proven to be a valid, reliable, and responsive instrument of resilience in BD. Clinicians should consider relevant to measure resilience in BD patients because our results show that there is a positive association of resilience with health-related measures, that resilience is higher in recovered patients than in not recovered patients, and that resilience is higher in those patients who are more advanced in their stage of change in relation to BD.

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Appendix 1. Spanish 23-item Resilience to Bipolar Disorder (RBD) questionnaire

Cuestionario de Resiliencia para el Trastorno Bipolar (RTB)

El cuestionario de Resiliencia ante el Trastorno Bipolar (TB) ha sido desarrollado con el fin de entender mejor el proceso de resiliencia en el TB. Se reconoce que la resiliencia es un proceso dinámico e individual. Por ello, no todos los datos incluidos en este cuestionario han de aplicarse a ti en la actualidad.

Para responder a las siguientes afirmaciones, por favor, indica con una "*X*" en qué grado estás de acuerdo con las siguientes afirmaciones en una escala del 1 (Muy en desacuerdo) al 5 (Muy de acuerdo). Para contestar, piensa cómo te han ido las cosas recientemente (durante las ÚLTIMAS DOS SEMANAS) en cuanto tu experiencia con el Trastorno Bipolar.
ÚLTIMAMENTE (en las ÚLTIMAS DOS SEMANAS)**…**

		Muy en desacuerdo	En desacuerdo	Ni de acuerdo ni en desacuerdo	De acuerdo	Muy de acuerdo
1.	**CONSIDERANDO LAS <u>DOS ÚLTIMAS SEMANAS:</u>** Ya he sufrido bastante por el TB, quiero sobreponerme al TB y cambiar esta situación.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
2.	**CONSIDERANDO LAS <u>DOS ÚLTIMAS SEMANAS:</u>** Creo que he tocado fondo tanto que me he comprometido a luchar para sobreponerme al TB.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
3.	**CONSIDERANDO LAS <u>DOS ÚLTIMAS SEMANAS:</u>** Quiero volver a vivir buenos momentos en mi vida.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
4.	**CONSIDERANDO LAS <u>DOS ÚLTIMAS SEMANAS:</u>** Tengo la esperanza de que puedo enfrentarme al TB para que me condicione menos la vida.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
5.	Lo he dado todo para que el TB impacte menos en mi vida.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
6.	Intento estar atento/a y manejar los signos o señales de alerta temprana para anticiparme y regular los síntomas del TB.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
7.	Tengo un margen de acción, control y responsabilidad sobre el TB.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
8.	Pongo de mi parte para intentar regular el TB.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
9.	Pongo mis límites y digo "no" a lo que me perjudica para buscar un equilibrio sociolaboral, tener relaciones positivas, escoger opciones de acuerdo a un estilo de vida sano (por ejemplo, limitando el consumo de alcohol).	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

10.	Mi salud mental y bienestar son mi prioridad y tengo que cuidarlos ante todo.	1 □	2 □	3 □	4 □	5 □
11.	Me obligo a mantener unos hábitos saludables (dormir y comer bien, hacer ejercicio, relajarme, etc.) para mi bienestar.	1 □	2 □	3 □	4 □	5 □
12.	Me adapto fácilmente a los cambios o contratiempos relacionados con el TB.	1 □	2 □	3 □	4 □	5 □
13.	Cuando tengo problemas procuro analizarlos objetivamente y detectar mis recursos.	1 □	2 □	3 □	4 □	5 □
14.	Soy una persona creativa para buscar y adoptar activamente los recursos que necesito para afrontar mi TB.	1 □	2 □	3 □	4 □	5 □
15.	**CONSIDERANDO LAS <u>DOS ÚLTIMAS SEMANAS:</u>** No puedo recuperarme del TB de un día para otro, pero intento centrarme para sacar adelante el día de hoy.	1 □	2 □	3 □	4 □	5 □
16.	Cuando mis emociones son demasiado intensas, intento calmarlas para reaccionar adecuadamente.	1 □	2 □	3 □	4 □	5 □
17.	Confío en que soy capaz de hacer la mayoría de las cosas si lo intento.	1 □	2 □	3 □	4 □	5 □
18.	Soy perseverante y ante las dificultades, al final no abandono.	1 □	2 □	3 □	4 □	5 □
19.	Mantengo mi forma de ser y soy fiel a mis valores.	1 □	2 □	3 □	4 □	5 □
20.	Trato de percibir y comprender cómo estoy y lo que me pasa.	1 □	2 □	3 □	4 □	5 □
21.	Cuento con al menos una persona (terapeuta, amigo, pareja, familiar, etc.) que me ayude a sobreponerme a momentos difíciles.	1 □	2 □	3 □	4 □	5 □
22.	Cuento con al menos una persona (amigo, pareja, familiar, etc.) que me quiere de manera incondicional.	1 □	2 □	3 □	4 □	5 □
23.	Cuento con alguien de confianza que me alerta cuando me desequilibro.	1 □	2 □	3 □	4 □	5 □

Por favor, responde a las siguientes preguntas marcando con una "*X*" la opción que corresponda en tu caso.

Si entendemos la **Resiliencia** como *"el proceso dinámico mediante el cual la persona está determinada a superar o adaptarse a la situación adversa, desarrollando para ello habilidades y estrategias positivas"…*

Según esta definición, ¿consideras que has experimentado la Resiliencia (en cualquier momento de tu vida) para luchar ante tu TB?

No, en absoluto				Sí, con certeza
1 □	2 □	3 □	4 □	5 □

Pensando en las últimas dos semanas, mi <u>actual</u> nivel de Resiliencia ante el TB es:

Muy bajo	Bajo	Medio	Alto	Muy alto
1 □	2 □	3 □	4 □	5 □

Appendix 2. English 23-item Resilience to Bipolar Disorder (RBD) questionnaire

The Resilience to Bipolar Disorder (RBD) Questionnaire

The Resilience to Bipolar Disorder (RBD) Questionnaire has been developed in order to better understand the resilient process in Bipolar Disorder (BD). Resilience is acknowledged as a dynamic and individual process. Therefore, not all of the questionnaire statements may apply to you.

Please, indicate with an "X" the extent to which you agree with the following statements on a scale from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*). When answering this questionnaire, please consider how things have been for you RECENTLY (during the LAST TWO WEEKS) regarding your experience with Bipolar Disorder (BD).

RECENTLY (during the LAST TWO WEEKS)…

		Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
1.	**CONSIDERING THE LAST TWO WEEKS**: I have suffered so much because of my BD that I am determined to change and overcome the situation.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
2.	**CONSIDERING THE LAST TWO WEEKS**: As a result of having experienced high and low moods, I have become determined to manage my BD effectively.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
3.	**CONSIDERING THE LAST TWO WEEKS**: I hope I will have good times in my life	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
4.	**CONSIDERING THE LAST TWO WEEKS**: I hope that I manage my BD so that it will lesser impact my life.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
5.	I've made my utmost effort so that my BP will lesser impact my life.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
6.	I try to be alert for and manage early warning signs of my BD to anticipate and regulate its symptoms.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
7.	Feeling that I exert a certain degree of control and responsibility as regards my BD, I play an not recovered role in managing it.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
8.	I do my part to try to self-manage my BD.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
9.	I know my own limits and say "no" to what is harmful for me and seek achieving a work-life balance, having positive relationships, making healthy lifestyle choices (such as limiting alcohol consumption, etc.).	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
10.	I prioritize my mental health and well-being and must care for these.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

11.	I force myself to maintain healthy habits (sleeping and eating properly, exercising, relaxing, etc.) for my welfare.	1 □	2 □	3 □	4 □	5 □
12.	I adapt easily to changes or setbacks associated with my BD	1 □	2 □	3 □	4 □	5 □
13.	When facing problems, I try to analyze these objectively and detect my resources	1 □	2 □	3 □	4 □	5 □
14.	I am a creative person in not recoveredly searching for and implementing the necessary actions to manage my BD	1 □	2 □	3 □	4 □	5 □
15.	CONSIDERING THE LAST TWO WEEKS: I cannot recover from BD from one day to the next, but I try to focus to get through the current day	1 □	2 □	3 □	4 □	5 □
16.	When I feel intensely emotional, I try to calm down so that I may react appropriately	1 □	2 □	3 □	4 □	5 □
17.	I am confident that I can do most things if I try	1 □	2 □	3 □	4 □	5 □
18.	I'm perseverant; although there could be difficulties, in the end, I don’t give up	1 □	2 □	3 □	4 □	5 □
19.	I remain loyal to my personality and values	1 □	2 □	3 □	4 □	5 □
20.	I try to perceive and understand how I am feeling and what is happening to me	1 □	2 □	3 □	4 □	5 □
21.	I count on at least one person (therapist, friend, partner, family member, etc.)	1 □	2 □	3 □	4 □	5 □
22.	I count on at least one person (friend, spouse, family member, etc.)	1 □	2 □	3 □	4 □	5 □
23.	I count on someone I trust who alerts me when I am destabilized	1 □	2 □	3 □	4 □	5 □

Please, answer the following statements related to resilient experience in Bipolar Disorder (BD) by marking an "X" in the appropriate option in your case.

If we understand Resilience as *"the dynamic process in which the person is determined to overcome or adapt to adverse situations, through the development and regaining of positive strategies and skills"...*

According to this definition, do you consider that you have experienced (at any time of your life) this resilience process to manage your BD?

Not at all.				Yes, for sure.
1 □	2 □	3 □	4 □	5 □

Thinking about the last two weeks, my <u>current</u> level of resilience to BD is:

Very low	Low	Medium	High	Very High
1 □	2 □	3 □	4 □	5 □

7. Study 4

Resilience Predicts Improvements on Well-being, Personal Recovery, Psychosocial Functioning and Quality of Life in Bipolar Disorder in a Follow-up Study

Resilience Predicts Improvements on Well-being, Personal Recovery, Psychosocial Functioning and Quality of Life in Bipolar Disorder in a Follow-up Study

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Study 4: Resilience Predicts Improvements in Bipolar Disorder

Abstract

Background: The individual process of resilience has been related to positive outcomes in mental disorders. Objectives: to identify both cross-sectionally and prospectively the resilience domains from the *Resilience Questionnaire for Bipolar Disorder* that are associated with positive mental health outcomes in bipolar disorder (BD). Methods: A clinical adult sample of 125 patients diagnosed with BD (62.10% female, mean age = 46.13, *SD* = 10.89) gave their informed consent and completed a battery of disease-specific tools on resilience, personal recovery, bipolar symptomatology, psychosocial functioning, and quality of life, at baseline and at follow-up (*n* = 63, 58.10% female, mean age = 45.13, *SD* = 11.06). Statistical analyses included descriptive statistics, bivariate correlations and path analyses. Results: Resilience domains that were significantly associated ($p < .05$) with mental health indicators were self-management of BD, self-care and self-confidence at baseline; turning point showed inverse associations with mental health indicators at baseline. Self-management of BD and turning point at baseline predicted significant associations ($p < .05$) with personal recovery at follow-up. Limitations: The small sample size at follow-up could have limited the statistical power and biased the results. Moreover, sample inclusion criteria included a great heterogeneity in diagnosis of BD. Conclusions: Resilience domains (Self-management of BD, Turning point, Self-care, and Self-confidence) were significantly associated with positive mental health outcomes in BD. Future studies should explore whether resilience-based psychological interventions increase rates of recovery in BD.

Keywords: bipolar disorder, resilience, recovery, path analysis, prospective, well-being

La Resiliencia Predice Mejoras en Bienestar, Recuperación Personal, Funcionamiento Psicosocial y Calidad de Vida en el Trastorno Bipolar en un Estudio Prospectivo

Resumen

El proceso individual de resiliencia se ha relacionado con resultados positivos en trastornos mentales. Los objetivos de este estudio fueron identificar transversal y prospectivamente los dominios de resiliencia del *Cuestionario de Resiliencia para el Trastorno Bipolar* asociados a resultados positivos de salud mental en el Trastorno Bipolar (TB). Pacientes adultos diagnosticados de TB (n = 125; 62.10% mujeres, edad media = 46.13, *SD* = 10.89) dieron su consentimiento informado y completaron una batería de cuestionarios sobre resiliencia, recuperación personal, sintomatología bipolar, funcionamiento psicosocial, y calidad de vida específicos para el trastorno en el tiempo base y seguimiento (*n* = 63, 58.10% mujeres, edad media = 45.13, *SD* = 11.06). Los análisis estadísticos incluyeron descriptivos, correlaciones bivariadas y path análisis. Transversalmente, los dominios de resiliencia significativamente asociados ($p < .05$) con indicadores de salud mental fueron autogestión del TB, autocuidado, y confianza en uno mismo; el punto de inflexión mostró asociaciones inversas con indicadores de salud mental. La autogestión del TB y el punto de inflexión en el tiempo base predijeron asociaciones significativas ($p < .05$) con la recuperación personal en el seguimiento. El tamaño de muestra en el seguimiento puede haber limitado el poder estadístico y sesgar los resultados. Además, el criterio de inclusión comprendió una amplia heterogeneidad en el diagnóstico de TB. Los dominios de resiliencia de autogestión del TB, punto de inflexión, autocuidado, y confianza en uno mismo se asociaron significativamente con resultados positivos de salud mental en el TB. Futuros estudios deberán explorar si intervenciones basadas en resiliencia incrementan las tasas de recuperación en el TB.

Palabras clave: trastorno bipolar, resiliencia, recuperación, path análisis, prospectivo, bienestar

Resilience Predicts Improvements on Well-being, Personal Recovery, Psychosocial Functioning and Quality of Life in Bipolar Disorder in a Follow-up Study

Bipolar Disorder (BD) is a chronic psychiatric illness characterized by recurrent, extreme episodes of depression and mania or hypomania (Goodwin & Jamison, 2007). Merikangas et al. (2011) described the following aggregate lifetime prevalence for the different classifications of BD in 11 countries of the Americas, Europe, Asia, and Oceania: 0.6% for BD Type I, 0.4% for BD Type II, 1.4% for subthreshold BD, and 2.4% for Bipolar Spectrum. A high proportion of the survey respondents also presented severe symptoms and impaired roles, thus confirming the deep impact of the disorder, which constitutes a serious public health problem (Merikangas et al., 2011; Woods, 2000).

BD impacts heavily on patients´ family, work, social functioning, and quality of life (Hirschfeld, Lewis, & Vornik, 2003) even during euthymic episodes (Michalak, Yatham, & Lam, 2005). Recovery outcomes in BD have generally been determined by the assessment of symptom reduction, rates of relapses, and psychosocial functioning (Martinez-Aran et al., 2007). However, a list of positive outcomes has also been related to recovery in BD. Recent autobiographical reports indicate the capability of BD patients to experience wellness, manage mental health, and live a fulfilling life. For example, Mansell, Powell, Pedley, Thomas, and Jones (2010) stated that understanding of bipolar experiences, as well as lifestyle fundamentals (sleep, diet and routine) and social support/companionship were related to positive outcomes in BD.

Resilience emerges as a key construct in this context. For the present study, we consider resilience as "a dynamic process in which psychological, social, environmental and biological factors interact to enable an individual at any stage of life to develop, maintain, or regain their mental health despite exposure to adversity" (Wathen et al., 2012, p. 10). A number of studies

have reported a positive association between resilience and positive mental health outcomes (i.e., improved well-being and psychosocial functioning, and symptom reduction) in patients diagnosed with a mental illness (Bomyea et al., 2013; Johnson et al., 2010; Las Hayas et al., 2014; Torgalsbøen, 2012).

Regarding affective disorders, Griffiths et al. (2014) showed that more than half of their participants experiencing depression symptoms used at least one of two key personal resilience strategies (61% were users of expanding inner resources, 25% of drawing on relationships, and 14% of both strategies) that were reported in a previous qualitative study (Dowrick, Kokanovic, Hegarty, Griffiths, & Gunn, 2008). Griffiths et al. (2014) found that expanding inner resources was positively associated with improvement of depression, whereas drawing on relationships (i.e., external resources) had no association with improvement in depression. In another study, Min, Lee, Lee, Lee, and Chae (2012) showed that, after adjusting for age and treatment duration, resilience—measured with the Connor-Davidson Resilience Scale [CD-RISC; Connor & Davidson, 2003)—, trait anxiety, and their interaction, significantly predicted treatment response at the 6-month follow-up in depressed patients. A later study showed the protective moderator role of increased resilience between depression and anxiety symptoms in suicidal ideation in patients diagnosed with depressive and/or anxiety disorders (Min, Lee, & Chae, 2015).

Very few studies have focused explicitly on exploring and measuring resilience in patients with BD. Edward, Welch, and Chater (2009), in their qualitative study, found resilient qualities in eight participants in remission from six different mental disorders—including BD—, concluding that resilience could increase recovery from mental illness. Choi et al. (2015) studied resilience in 62 euthymic outpatients with BD in clinical remission and found that patients with BD presented lower levels of resilience when compared with healthy

controls, and that low levels of resilience were related to higher levels of impulsivity and increased depressive symptoms.

Recently, Echezarraga and colleagues (Echezarraga, Las Hayas, González-Pinto, Lobban, & Jones, 2016; Echezarraga et al., 2014) qualitatively explored the construct of resilience in a sample of BD patients and in clinician experts on BD. Participants reported the following main resilient domains in BD: (a) antecedents to resilience (the basic conditions a BD patient needs to experience resilience: preventing of an extreme BD episode, accepting the bipolar diagnosis, and being aware of the bipolarity); (b) the existence of a turning point (taking decisive action and being determined and committed to changing one's lifestyle); (c) self-awareness and redefinition (using introspection to get to know themselves, their feelings and reactions, thereby redefining their identity); (d) reconsideration of life direction towards whatever nourishes them to reengage with life; (e) self-management of BD (understanding BD symptomatology in order to find assets and resources and anticipate solutions in the face of early warning signals that a BD episode is about to start; it also implies feeling self-empowered to manage BD); (f) prioritizing their mental health through a lifestyle balance between their personal, family/social, and work/study spheres; (g) positive personality qualities (perseverance, initiative, and extraversion among others); and (h) interpersonal support (having one person who loved and cared for them, as well as having formal external support from mental health clinicians and associations).

Self-management and self-care features have been related to positive cross-sectional and longitudinal outcomes in people experiencing BD, but they have not been studied as resilience attributes. For example, different self-management strategies (e.g., understanding BD, meditative strategies, ongoing monitoring, early warning signal awareness, and enacting a plan, among others) were related to relapse/ recurrence prevention, well-functioning and

wellness in BD (Berk, Berk, & Castle, 2004: Colom et al., 2003; Murray et al., 2011; Williams et al., 2008). Other issues related to self-care (e.g., sleep, diet and exercise regulation) were associated with functioning, symptomatology, quality of life, and wellness in BD (Murray et al., 2011; Michalak, Murray, Young, & Lam, 2007; Murray & Harvey, 2010).

Research on resilience in BD is still scarce and conclusions about which resilience factors lead to a positive adaptation in this disorder are still lacking. In the present study, we aimed to analyze both cross-sectionally and prospectively the associations of resilience factors with positive mental health outcomes. Specifically, this study tested the role of the above-mentioned resilience domains—self-management of BD, turning point, self-care, self-confidence, and interpersonal support—measured by the Resilience Questionnaire for Bipolar Disorder (RBD) (Echezarraga, Las Hayas, González-Pinto, & Jones, 2016) in the prediction of positive mental health outcome indicators—symptoms, psychosocial functioning, personal recovery, well-being and quality of life—in people diagnosed with BD.

Regarding cross-sectional associations, we hypothesized that: (a) The resilience dimensions of self-management of BD, self-care, self-confidence and interpersonal support would be cross-sectionally positively associated with the mental health adjustment indicators of personal recovery, quality of life and well-being and negatively with the mental health maladjustment indicators of bipolar symptomatology and psychosocial functioning deficit; (b) The other resilience quality, turning point, would be cross-sectionally negatively associated with the above-mentioned mental health adjustment indicators, given that it occurs at a moment of intense personal suffering (Garmezy, 1991; Rutter, 2013). In addition, turning point would be positively associated with the above-mentioned mental health maladjustment indicators. Regarding longitudinal associations, we also hypothesized that: (c) The resilience dimensions of self-management of BD, turning point, self-care, self-confidence and interpersonal support

would prospectively predict better results in personal recovery, quality of life, well-being, bipolar symptomatology and psychosocial functioning. Nonetheless, because of the contradictory role of interpersonal support within the resilience literature (Griffiths et al., 2014), we hypothesized: (d) lower relationships of this domain with any health-related indicators, when compared with other resilience domains.

Method

Participants

The sample was recruited from nine mental health services distributed across the three regions of the Basque Country (Spain) and through the non-governmental associations of BD from several regions in Spain. Individuals were invited to participate either by their respective therapist or by the coordinators of the bipolar associations, based on study inclusion criteria. Participating patients received detailed information about the purpose of the study, signed the informed consent, and were free to leave the study at any time.

Inclusion criteria were: (a) a clinician-confirmed diagnosis of Bipolar Disorder I, II, Cyclothymic/others, or Not Specified according to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*) criteria (American Psychiatric Association, 1994); (b) aged 18-65 years old; (c) sufficiently fluent in Spanish to be able to complete the battery of tests; (d) not having any clinically serious multiorganic disorder, acute psychosis, or cerebral organic deterioration that would prevent the person from completing the questionnaires; (e) providing informed consent based on voluntary participation after being informed personally by his/her therapist.

At baseline (T1), 145 patients fulfilled the inclusion criteria. A total of 125 patients (62.10% female, mean age = 46.13, *SD* = 10.89) completed the battery of tests. Follow-up (T2) took place between 6 and 12 months after the first contact (mean number of days passed:

236.57, *SD* = 40.18). Sixty-three BD patients (58.10% female, mean age = 45.13, *SD* = 11.06) were followed-up at T2. Table 1 shows the sociodemographic and clinical characteristics of the BD patients at T1 and T2.

Procedures

As this study aimed to carry out a 6-month follow-up (T2), all participants were invited to provide a contact address to allow the follow-up. The contact information was recorded in an independent data base with an encrypted access code. Participants' identity was safeguarded by an identification code composed of numbers and letters. Four modes for completing the questionnaire at T1 and T2 were offered depending on participants' preferences: via telephone (a clinical psychologist phone interviewed participant), paper and pencil in their mental health center (a clinical psychologist interviewed participant, or the battery was self-completed with the personal help of a clinical psychologist if required) or in their home (self-completed, returning the questionnaires by post using provided pre-stamped envelopes), or online (self-completed). All participants who agreed to participate but who did not complete the survey received two reminders with a one-month interval.

The study received approval (April 2014) from the Clinical Research of Basque Country's Ethics Committee (Spain). The study satisfied the ethical aspects of informed consent, voluntary participation, and confidentiality.

Measures

The temporal framework of the questionnaires was changed to the "last two weeks" to evaluate the same temporal framework in all measures. All participants completed the following measures, apart from sociodemographic and clinical data related to their illness.

Resilience. *The 23-item Resilience Questionnaire for Bipolar Disorder* (*RBD*; Echezarraga et al., 2016b) is a specific resilience measure for BD. It was developed based on

previous qualitative research on resilience with both, patients diagnosed with BD and health professionals with expertise in the treatment of this disease, as well as on a literature review (Echezarraga, Las Hayas, González-Pinto, Lobban, & Jones, 2016). RBD consists of 23 items, responded on a five-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). All the items are scored positively, such that higher scores indicate higher resilience. The psychometric assessment of the RBD (Echezarraga et al., 2015; Echezarraga, Las Hayas, González-Pinto, & Jones, 2016) showed it to be valid as a global index (score range 23–115) and as a scale with five factors: Self-management of BD (score range 7–35), Turning point (score range 5–25), Self-care (score range 5–25), Self-confidence (score range 3–15), and Interpersonal support (score range 3–15). In the current BD sample, Cronbach´s alpha at baseline for the global index of the RBD was α = .92, and for RBD factors, alphas ranged from .78 to .88.

Personal recovery. *The Bipolar Recovery Questionnaire (BRQ;* Jones, Mulligan, Higginson, Dunn & Morrison, 2013) is a reliable and valid measure of personal recovery in BD. The original version of the BRQ consists of an 100mm Visual Analogue Scale, which has been replaced for the present study by a ten-point Likert-type scale ranging from 1 (*strongly disagree*) to 10 (*strongly agree*). The BRQ contains 36 items, of which 12 are reversed. The total score ranges from 36 to 360, with higher scores indicating a higher degree of recovery. The Spanish version of BRQ showed comparable psychometric results to the English version. Internal consistency and reliability were satisfactory (Cronbach´s α = .88) in the English version (Jones et al., 2013) and in the Spanish version (α = .90; Echezarraga, Las Hayas, González-Pinto, & Jones, 2016). In the current BD sample, Cronbach´s alpha for the Spanish version was .90 at baseline.

Symptomatology. *The Internal States Scale (ISS;* Bauer, Vojta, Kinosian, Altshuler, & Glick, 2000) is a 15-item scale to measure co-occurring manic and depressive symptoms, and is composed of four subscales or indexes: Activation, Well-being, Perceived conflict, and Depression. The ISS also provides *(hypo)mania*, *mixed state*, *euthymic*, or *depression* indicators, depending on the scores in the activation and well-being indexes. The validity of the ISS subscales to discriminate mood states and identify mixed episodes has been confirmed (Bauer et al., 2000). Participants rated their degree of internal state experienced on a rating scale ranging from 0 (*not at all*/*rarely)* to 100 (*very much so*/*much of the time*). Thus, Activation (5 items), Well-being (3 items), Psychopathology (5 items), and Depression (2 items) index ranges are 0–500, 0–300, 0–500, and 0–200, respectively. The Spanish version of ISS has shown comparable psychometric results to the English version (Ruggero, Johnson, & Cuellar, 2004), and good internal reliability in a previous study with participants diagnosed with BD (Echezarraga, Las Hayas, González-Pinto, & Jones, 2016). In the present BD sample, consistency index at baseline and follow-up was satisfactory (Cronbach´s alphas ranging from .74 to .88).

Psychosocial functioning. *The Work and Social Adjustment Scale* (*WSAS*; Mundt, Marks, Shear, & Greist, 2002). This is a five-item measure of impaired functioning (in the domains of work, home management, social life, private leisure, and family) attributable to an identified problem (adapted for the present study to BD by changing the word "problem" to "BD"). Impairment is rated on a nine-point Likert scale ranging from 0 (*not at all*) to 8 (*very severely*). Scores range from 0 to 40, with lower scores indicating less severe psychopathology and functional impairment. Thus, scores below 10 are related to subclinical populations, scores between 10 and 20 are related to significant functional impairment but not severe clinical symptomatology, and scores above 20 suggest moderately severe or worse psychopathology.

The original version was reliable (Cronbach´s alphas ranging from .70 to .94) and valid (Mundt et al., 2002). We translated the scale to Spanish following translation and back-translation method (Acquadro, Conway, Hareendran, & Aaronson, (2008). As this is the first time that the Spanish version of this scale is used, we examined its factor structure. A confirmatory factor analysis conducted with Lisrel 9.2 indicated that a one-factor model explained the data satisfactorily, χ^2 (10, N = 116) = 16.262, p = .003, RMSEA = .147 (90% CI [0.076, 0.225]), NNFI = .904, CFI = .952, SRMR = .043. All factor loadings were statistically significant and ranged between .69 and .81. In the current BD sample, Cronbach´s alphas were satisfactory at T1 (α = .87) and T2 (α = .87).

Quality of life. *The Brief Quality of Life in Bipolar Disorder* (*Brief-QoL.BD;* Michalak & Murray, 2010). This is a BD-specific measure of quality of life consisting of 12 items (one item per each basic domain: physical, sleep, mood, cognition, leisure, social, spirituality, finances, household, self-esteem, independence, and identity) with a single factor solution. The Brief-QoL.BD is rated on a five-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), therefore providing a total score ranging from 12 to 60 (higher scores indicating higher quality of life). Cronbach´s alphas were adequate (α = from .87 to = .89) for this brief version (Michalak & Murray) as well as for the Spanish version (Cronbach's α = .95) validated by Morgado and Tapia (2013). Internal reliability of the Brief-QoL.BD was satisfactory in the current BD sample (Cronbach´s α = .89).

Statistical Analysis

Cross-sectional and prospective data were used for descriptive and bivariate correlation analyses between sociodemographic and clinical variables and the measured health-related indicators. Analyses were performed using the IBM SPSS Statistics 22 software.

Path analysis with the maximum likelihood method using LISREL 9.2 was used to test the hypotheses of the study. Following the recommendations of several authors (e.g., Hu & Bentler, 1999), the goodness of fit of the model was evaluated using the comparative fit index (CFI), the non-normative fit index (NNFI), the root mean square error of approximation (RMSEA), and the standardized root-mean-square residual (SRMR). Generally, CFI and NNFI values of .90 or higher reflect a good fit. RMSEA values lower than .06 indicate an excellent fit, and SRMR values of .08 or less indicate that the model adequately fits the data. All missing values were imputed using the expectation-maximization (EM) imputation algorithm with SPSS.

Results

Sociodemographic and Clinical Descriptive Analyses

Table 1 presents demographic data of the sample at baseline. Sixty-two percent of the sample was female with an average age of 46.13 years (*SD* = 10.88). Their average age at BD onset was 29.46 years (*SD* = 10.79). Student's *t*-test for independent samples revealed no significant sex differences in any of the variables of the study (not shown).

The ISS yielded moderate mean scores for activation, well-being, psychopathology and depression indices at T1.The *t*- tests for related samples revealed statistically significant differences in the mean scores at T1 and T2 (all *p*s < .05) for the following subscales: Activation, Psychopathology, and Depression. Cohen's *d* for these *t*-values were high for Activation (*d* = .83) and Psychopathology (*d* = .74), and moderate for Depression (*d* = .55).

Table 1

Sociodemographic and Clinical Data of the BD Sample

	T1		T2	
Variables	*N**	%	*N**	%
Sex (Female)	77	62.10	36	58.10
Age: Mean (*SD*)	46.13 (10.89)		45.13 (11.06)	
Marital status				
Separated/Divorced/Widowed	27	21.70	13	21.00
Single	38	30.60	18	29.00
Stable partner	17	13.70	8	12.90
Registered as partners/ Common law marriage	42	33.90	23	37.10
Educational level				
No studies	1	.80	0	0
Primary education	11	8.90	5	8.10
Secondary education /High school	18	14.50	9	14.50
Professional training	36	29.00	18	29.00
University	47	37.90	23	37.10
Postgraduate	11	8.90	7	11.30
Employment situation				
Unemployed	65	52.40	36	58.10
Student	6	4.90	2	3.20
Employed	53	42.70	24	38.70
BD onset age (Mean, *SD*)	29.46 (10.79)		30.34 (10.51)	
Number of hospitalization due to bipolar episodes				
0	23	19.00	11	17.70
1-3	62	51.30	36	58.10
4-6	16	13.20	7	11.30
7-9	10	8.30	7	11.30
≥10	10	8.20	1	1.60
≥ 4 bipolar episodes in the last year	15	12.30	9	14.50
Time (in months) passed since the last bipolar episode (Mean, *SD*)	44.13 (63.89)		34.31 (36.96)	
Nº of comorbid disorders				
None	90	73.80	14	77.80
1	2	1.60	2	11.10
≥2	30	24.60	2	11.10
Diagnosed with a medical illness	51	41.80	25	39.70
Medication prescribed for BD				
Antidepressants with/without mood stabilizers or antipsychotics	32	27.10	22	35.50

Mood stabilizers with/without antipsychotics	84	71.20	46	74.20
Antipsychotics	54	45.80	26	41.90
Anticonvulsants	19	16.10	10	16.10
Other medication for BD	28	23.70	16	25.80
No medication for BD	3	2.50	1	1.60
Received any psychological therapy for BD	78	63.90	36	58.10
Resilience Questionnaire for Bipolar Disorder total score (Mean, *SD*); range: 23-115	88.17 (15.39)		90.45 (13.03)	
Self-management of BD (Mean, *SD*); range: 7-35	24.90 (5.98)		26.23 (4.87)	
Turning point (Mean, *SD*); range: 5-25	19.77 (4.27)		19.90 (3.71)	
Self-care (Mean, *SD*); range: 5-25	19.50 (4.27)		20.40 (3.55)	
Self-confidence (Mean, *SD*); range: 3-15	11.92 (2.56)		11.89 (2.48)	
Interpersonal support (Mean, *SD*); range: 3-15	12.08 (2.98)		12.54 (2.71)	
Bipolar Recovery Questionnaire (Mean, *SD*); range: 36-360	243.72 (44.77)		253.92 (40.68)	
Brief Quality of Life for Bipolar Disorder (Mean, *SD*); range: 12-60	40.91 (9.66)		42.35 (9.51)	
Internal States Scale				
Well-being (Mean, *SD*); range: 0-300	163.91 (80.18)		169.17 (78.62)	
Depression (Mean, *SD*); range: 0-200	69.30 (66.62)		49.83 (54.91)	
Activation (Mean, *SD*); range: 0-500	196.52 (138.90)		141.33 (148.81)	
Psychopathology (Mean, *SD*); range: 0-500	167.75 (127.58)		121.67 (116.04)	
Work and Social Assessment Scale (Mean, *SD*); range: 0-40	14.49 (11.30)		11.97 (10.37)	

Note. *N_{T1} = 125; N_{T2} = 63.* The number of responses to the RBD (*N* = 113) does not match the number of participants (*n* =125) because some individuals did not respond to all questionnaires. Na = not asked

Cross-sectional Associations between Resilience Factors and Personal Recovery, Quality of Life, Well-being, Symptomatology, and Psychosocial Functioning Deficit

Table 2 shows the bivariate cross-sectional correlations between the variables. RBD's total index and factors presented generally moderate and positive significant correlations with well-being and with positive outcome indicators such as personal recovery, and were negatively related to psychosocial functioning deficit and depression. In contrast, neither of the RBD factors was significantly correlated with the activation or psychopathology index of the ISS. The Turning point factor was only significantly correlated with other resilience factors and Personal recovery (i.e., turning point did not correlate significantly with well-being, quality of life, psychosocial functioning deficit, or depression), whereas the Interpersonal support factor presented the lowest correlations with the other measures.

Next, a model was estimated by means of path analysis, including paths from the five resilience factors to the adjustment indicators (well-being, personal recovery, quality of life, and low psychosocial functioning deficit). Path analysis allows a more valid multivariate approach to associations between variables than correlation coefficients, as it controls for overlapping of variables. The results indicated that three resilience factors had positive associations with adjustment indicators: Self-management of BD was associated with higher scores on well-being and personal recovery, self-care was associated with higher scores on personal recovery and quality of life and lower scores on psychosocial functioning deficit, and self-confidence was associated with higher scores on well-being, personal recovery, and quality of life. In contrast, turning point was associated with less well-being and quality of life and higher psychosocial functioning deficit. The interpersonal support resilience factor was not significantly associated with any adjustment indicator. This model, which is displayed in

Figure 1, obtained excellent fit indices: $\chi^2(41, N = 115) = 2$, $p =. 73$, RMSEA=.00 (90% CI [0.0, 0.10], NNFI = 1, CFI = 1, SRMR = .009.

Longitudinal Associations between Resilience and Adjustment Indicators.

Next, we conducted new analyses including participants who also responded at follow-up (n = 60). Longitudinal correlations between resilience and health-related indicators are presented in Table 2. They were obtained with the subsample that completed measures at T2. However, some variables that were not significantly correlated cross-sectionally at T1 present small but significant prospective correlations (i.e., self-management of BD at T1 was significantly correlated with psychopathology at T2).

Next, we estimated a longitudinal path analysis model. The interpersonal support factor was not included in the final model, as preliminary analyses indicated that it was not significantly associated with any adjustment indicator. The initial model included autoregressive paths from T1 to T2 adjustment indicators (well-being, personal recovery, quality of life, and psychosocial functioning deficit) and paths from resilience factors at T1 to T2 adjustment indicators. We also included in the model age, time passed since the last bipolar episode, and sex. However, as these variables were not significantly associated with any other variable, they were removed. The results indicated that all autoregressive paths except for well-being were statistically significant (values ranging from .33 to .51). T1 self-management of BD and T1 turning point resilience factors predicted a significant increase of personal recovery at T2. In addition, T1 quality of life predicted the increase of T2 well-being. A more parsimonious model was estimated with only significant paths, which is displayed in Figure 2. This final model displayed moderate fit indices, $\chi^2(47, N = 60) = 38$, $p =. 06$, RMSEA= 0.0613 (90% CI [.00, .12]; NNFI = 1, CFI = 1, SRMR = .10.

.

Table 2

Bivariate Cross-sectional Correlations in BD between Clinical Variables at T1

Clinical Variables	T1 RBD	T1 SM	T1 TP	T1 SC	T1 SCF	T1 IS	T1 BRQ	T1 QoL.BD	T1 WB	T1 DI	T1 ACT	T1 PC	T1 WSAS
T1 Resilience Questionnaire for Bipolar Disorder													
T1 Self-management of BD	.89**												
T1 Turning point	.65**	.38**											
T1 Self-care	.87**	.75**	.41**										
T1 Self-confidence	.75**	.64**	.42**	.60**									
T1 Interpersonal support	.57**	.41**	.20*	.43**	.30**								
T1 Bipolar Recovery Questionnaire	.66**	.68**	.20*	.62**	.58**	.39**							
T1 Brief Quality of Life in BD	.51**	.53**	.07	.58**	.50**	.23*	.72**						
T1 Well-being	.46**	.51**	.06	.46**	.46**	.22*	.65**	.67**					
T1 Depression	-.30**	-.32**	-.03	-.30**	-.40**	-.10	-.56**	-.61**	-.52**				
T1 Activation	.01	-.04	.13	-.03	-.03	-.02	-.17	-.23*	.07	.42**			
T1 Psychopathology	-.06	-.10	.11	-.12	-.07	-.04	-.29**	-.41**	-.13	.60**	.65**		
T1 Work and Social Assessment Scale	-.45**	-.43**	-.08	-.51**	-.42**	-.27**	-.65**	-.76**	-.59**	.52**	.11	.28**	
T2 Resilience Questionnaire for Bipolar Disorder	.43**	.46**	.10	.41**	.12	.30*	.32*	.20	.29*	.04	.09	.13	-.19
T2 Self-management of BD	.37**	.52**	-.05	.41**	.24	.08	.39**	.36**	.37**	-.12	-.13	-.04	-.27*
T2 Turning point	.101	.11	.18	-.03	-.19	.19	-.14	-.26*	-.07	.37**	.25*	.32*	.23
T2 Self-care	.32*	.39**	-.05	.50**	.13	.06	.33**	.33*	.34**	.05	.08	.19	-.26*
T2 Self-confidence	.53**	.54**	.06	.53**	.48**	.19	.51**	.50**	.50**	-.29*	-.04	-.05	-.48**
T2 Interpersonal support	.26*	.18	.16	.09	-.14	.57**	.18	-.08	.08	.03	.12	.05	.12
T2 Bipolar Recovery Questionnaire	.45**	.47**	.02	.53**	.30*	.15	.58**	.46**	.46**	-.33*	-.10	-.21	-.50**

T2 Brief Quality of Life in BD	.29*	.37**	-.07	.42**	.24	-.00	.38**	.49**	.49**	-.41**	-.14	-.16	-.46**
T2 Well-being	.14	.23	-.20	.34**	.14	-.05	.29*	.44**	.44**	-.30*	-.07	-.06	-.37**
T2 Depression	-.20	-.23	.13	-.32*	-.27*	-.03	-.31*	-.52**	-.44**	.53**	.27*	.37**	.46**
T2 Activation	-.11	-.20	.11	-.04	-.14	-.12	-.12	-.30*	-.06	.34**	.47**	.30*	.06
T2 Psychopathology	-.14	-.34**	.22	-.19	-.23	.07	-.37**	-.44**	-.39**	.51**	.34**	.52**	.21
T2 Work and Social Assessment Scale	-.26*	-.25*	.06	-.40**	-.31*	-.03	-.39**	-.56**	-.38**	.45**	.25	.36**	.60**

Note: *N* T1 = 120. RBD: Global index for Resilience Questionnaire for Bipolar Disorder Questionnaire; SM: Self-management of BD; TP: Turning point; SC: Self-care; SCF: Self-confidence; IS: Interpersonal support; BRQ: Bipolar Recovery Questionnaire; QoL.BD: Brief Quality of Life for Bipolar Disorder (BD); WB: Well-being index from the Internal States Scale (ISS); DI: Depression index from the ISS; ACT: Activation index from the ISS; PC: Psychopathology index from the ISS; WSAS: Work and Social Assessment Scale.
**$p \leq .01$. *$p \leq .05$.

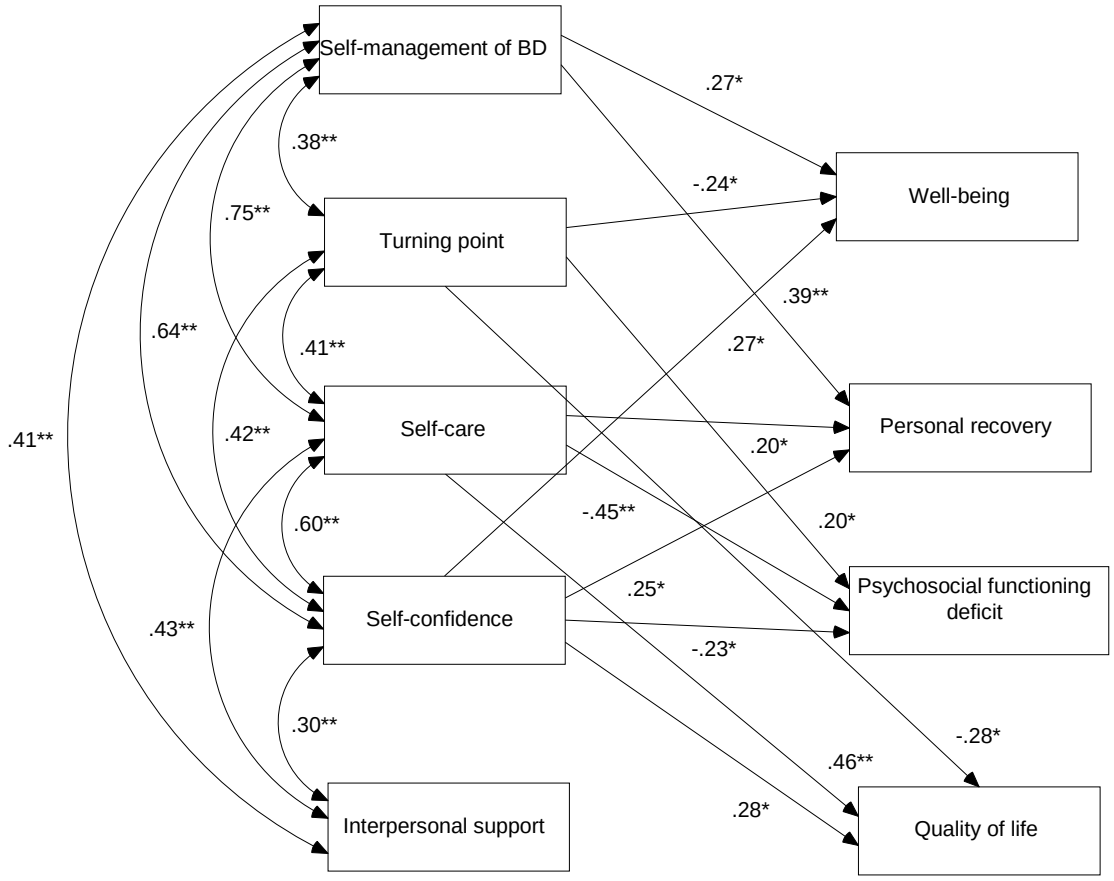

Figure 1. Cross-sectional paths between resilience factors and adjustment indicators. *$p < .05$. ** $p < .001$.

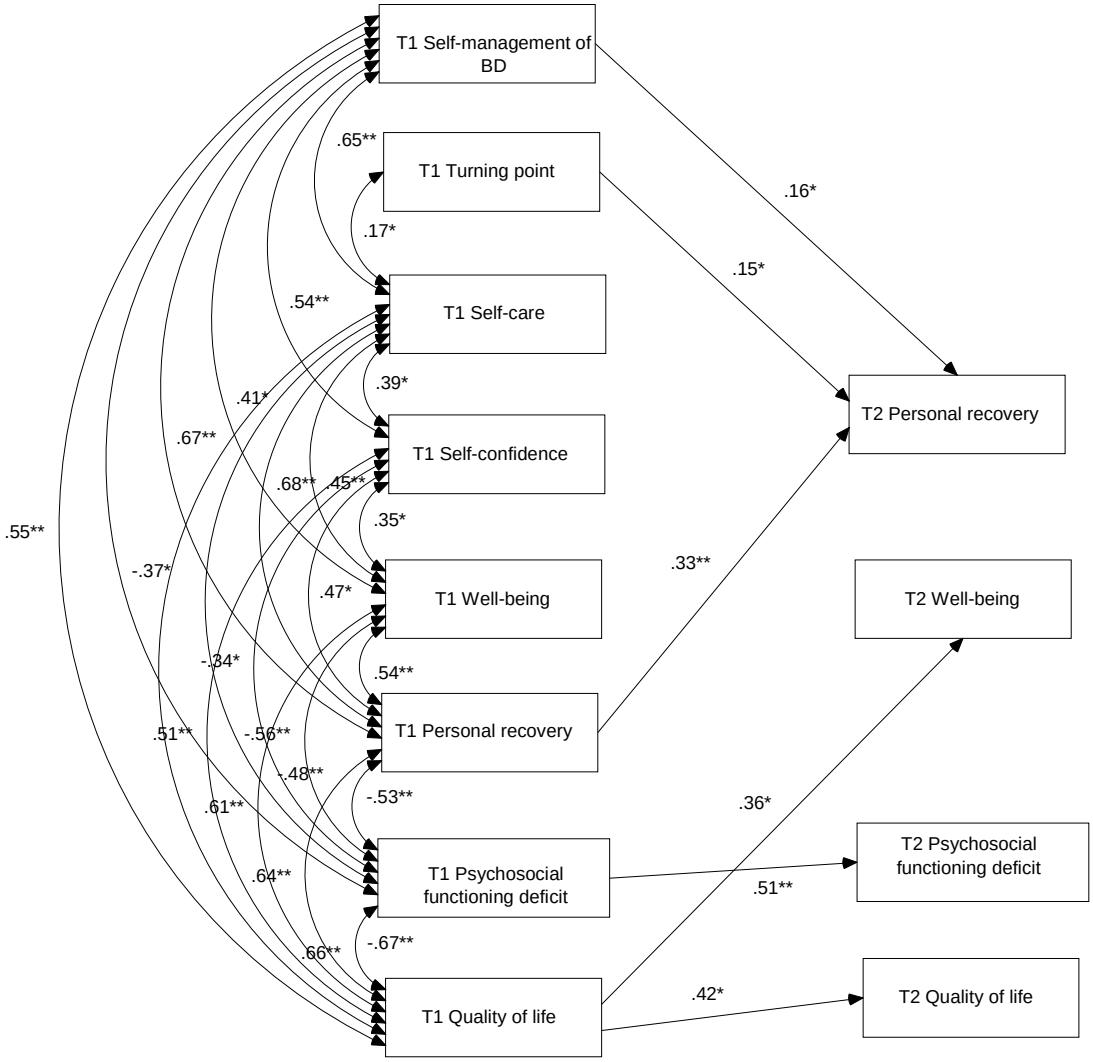

Figure 2. Longitudinal paths between resilience factors and adjustment indicators. *$p < .05$. **$p < .001$.

Discussion

Resilience is understood as a dynamic or developmental process that allows positive adaptation despite adversities (Fergus & Zimmerman, 2005; Shastri, 2013; Wathen et al., 2012) and it does not preclude the presence of illness or negative outcomes. In the current study, we aimed to study the role of resilience factors in health-related variables (well-being, quality of life, psychosocial functioning deficit, bipolar symptomatology, and personal recovery) in people diagnosed with BD.

Regarding the relationship of the variables at baseline, the resilience qualities of self-management of BD, self-care, self-confidence, and interpersonal support were significantly and positively correlated with adjustment indicators of mental health. However, path analysis revealed that these resilience qualities but not interpersonal support were associated with personal recovery, quality of life, and well-being. Furthermore, self-care and self-confidence but not self-management of BD or interpersonal support were associated with psychosocial functioning deficit. These results are consistent with the few studies that have previously examined the role of resilience in BD. Choi et al. (2015) found significant negative and weak correlations between resilience (measured with the CD-RISC) and severity of general symptomatology and number of depressive episodes in outpatients in clinical remission from BD. Findings of the current study are also consistent with those obtained in some previous qualitative studies with patients with diagnoses other than BD (Dowrick et al. 2008; Edward et al., 2009; Las Hayas et al., 2015). For example, Edward et al. identified some resilience components in people with mental health problems, which actually are similar to the resilience domains in BD (self-management of BD, self-care, and self-confidence). Las Hayas et al.'s (2014) results are in line with our results, affirming that self-care increased

well-being perception and that domains of personal competence and acceptance of self and life were significant and positively correlated with quality of life in eating disorders. Additionally, literature on BD has reported that self-management and self-care features were associated with positive outcomes in quality of life, wellness, functioning, and symptomatology (Michalak et al., 2007; Murray & Harvey, 2010; Murray et al., 2011; Williams et al., 2008). In sum, our results of resilience associated with recovery, quality of life, and well-being are supported by qualitative and quantitative research on resilience in other mental illnesses.

Turning point was cross-sectionally negatively associated with the desirable health outcomes of quality of life and well-being, and positively associated with psychosocial functioning deficit. A possible explanation of this result is that turning point takes place when the person is going through a stressful and painful experience (Garmezy, 1991; Rutter, 2013). At the same time, given that resilience domains were positively interrelated with each other, we think that the experience of a turning point led to a progressive and dynamic activation of other resilience features that in turn interacted with each other (Luthar, Cicchetti, & Becker, 2000).

Individuals with different mental illnesses (Echezarraga, Las Hayas, González-Pinto, & Jones, 2016; Edward et al., 2009; Las Hayas et al., 2015) have reported that, during the course of their illness, they experienced a turning point. Nevertheless, the turning point experience in our study was not associated with personal recovery, as expected. We found no significant association in the present study but neither did any of the previous studies provide evidence about this unique association in mental health. Still, the fact that turning point was negatively associated with quality of life and well-being is important and in accordance with the general comprehension of the turning point concept.

Our next hypothesis was that resilience qualities of self-management of BD, turning point, self-care, self-confidence and interpersonal support at T1 would prospectively predict better results in personal recovery, quality of life, well-being, bipolar symptomatology, and psychosocial functioning at T2. Self-management of BD, self-care, and self-confidence correlated significantly and negatively with psychosocial functioning deficit and depression. However, the prospective path analysis model indicated that not all resilience domains at T1 were significantly associated either with personal recovery or with the other mental health indicators at T2. The only resilience domains at T1 that predicted improvements in personal recovery at T2 were self-management of BD and turning point.

Reviewing the literature, few longitudinal studies have explored the positive effect of resilience strategies on mental health outcomes. Others have reported that the resilience strategy of expanding inner resources (which was described as drawing on personal strengths, changing attitudes and cognitions and taking direct action) was related to improved longitudinal outcomes in people experiencing depressive symptoms (Dowrick et al., 2008; Griffiths et al., 2014). Regarding previous research in BD, the self-management of BD resilience domain in the current study includes strategies that have been found to decrease rates of relapses and improve adherence and wellness in BD (Berk et al., 2004; Colom et al., 2003). Although the longitudinal paths between the resilience domains of self-management of BD and turning point at T1 and personal recovery at the 6-month follow-up represented small effect sizes, they are still relevant.

One of the more remarkable findings of this study is that turning point, although cross-sectionally negatively associated with positive outcomes, nevertheless has the capacity to predict personal recovery over time. We suggest that turning point may have

driven recovery in BD. The fact that turning point can predict constructive changes and opportunities over time is supported by Rutter (2013), who stated that "turning point involves a discontinuity with the past that removes disadvantageous past options and provides new options for constructive change" (p. 479).

As mentioned, our results showed that the resilience domains of self-management of BD and turning point predicted significant and positive personal recovery at the 6-month follow-up in people diagnosed with BD. These results are in line with the literature on resilience stating that resilience is a key component that improves psychosocial adjustment (Shastri, 2013). Furthermore, several authors (e.g., Robertson & Cooper, 2013), health campaigns (Bhui & Dinos, 2011; Royal College of Psychiatrists, 2012), the American Psychological Association (2009), and qualitative as well as quantitative results in mental disorders have stated that resilience is an asset of the recovery process. In this line, resilience has been prospectively related to improved clinical recovery outcomes of symptomatology and psychosocial functioning in other illnesses (Griffiths et al., 2014; Min et al., 2012; Torgalsbøen, 2012).

Regarding our last hypothesis, path analysis results but not correlations showed that the resilience domain of interpersonal support was not cross-sectionally associated with any mental health indicators (when controlling for overlap). Previous studies present a contradictory picture of the association between interpersonal support and positive outcomes in health. Whereas Dowrick et al. (2008) found in a qualitative study that interpersonal support was a consolidated resilience strategy for people with symptoms of depression, recently, Griffiths et al. (2014) reported that drawing on relationships was not longitudinally associated with improvement in patients with depressive symptoms, and Rea et al. (2003) reported that social support improved outcomes of relapse and

recurrence in BD. A possible explanation of our results is that, taking into account that in our study, interpersonal support was not associated longitudinally with any mental health indicators but it was correlated with them cross-sectionally, interpersonal support may have indirectly affected longitudinal outcomes in BD by nurturing the other resilience features at baseline. This is in line with the conceptualization that resilience is a construct built on the interaction of multiple factors (Shastri, 2013).

Limitations

The results obtained in this study could be biased by the limited sample size recruited at follow-up. Despite the fact that the results obtained in the longitudinal model from the path analysis were meaningful, the small sample size could have limited the statistical power. Furthermore, inclusion criteria for participants with BD from the current study were broad, including great diagnostic heterogeneity. In addition, subjective measures of mental health in BD might have been systematically influenced by the disorder's varying mood and severity and cognitive symptoms, as well as by psychological confounding variables that we did not control for, such as personality type or individual early maladaptive schemas (Michalak et al., 2007). Similarly, attachment patterns that are relevant to resilience development (Cyrulnik, 2009) were not assessed.

Conclusions

This is the first study providing cross-sectional and prospective data on the unique associations between resilience and health-related outcomes in BD. From the present study, we highlight that, when controlling for overlap among variables, self-management of BD and turning point predicted a positive association with personal recovery at follow-up.

Psychoeducational relapse prevention (Lobban et al., 2010), cognitive-behavioral (Meyer & Hautzinger, 2012), interpersonal and social rhythm (Frank et al., 2005), and family-focused (Miklowitz, George, Richards, Simoneau, & Suddath, 2003) therapies are the main evidenced-based effective psychological approaches to BD. These psychological therapies have in common that they aim to understand BD and provide the patient with self-management and self-care skills to better face the challenges of living with BD. However, aspects proven to be related to improved mental health also include other resilience domains such as self-confidence and turning point. Thus, the understanding of the of role resilience in the recovery process of BD could lead to the development of interventions that enhance patients' resilience domains in order to promote their mental health and in turn increase rates of recovery from BD. As some resilience preventive interventions were proven to be effective for youth at risk of developmental psychopathologies (Greenberg, 2006), we recommend conducting a large-scale trial studying the efficacy and effectiveness of resilience-based psychological interventions—as an adjunct to the commonly used pharmacological treatment—for this complex psychiatric disorder.

Future studies could also include the assessment of personality traits, attachment patterns, cognitive styles, and early maladaptive schemas that could act as distress/vulnerability factors or as protective factors, together with the mental health indicators covered in the present study.

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8. Discussion and Conclusions

The four empirical studies presented in the current doctoral thesis describe the resilience process, qualities, and role of resilience in the recovery process of people with BD. The conclusions that are presented below are derived from the four empirical studies of this doctoral thesis. The structure of this section is as follows. First, this chapter provides a general summary of the discussion and conclusions for each study. Second, the limitations that should be considered when interpreting the overall results are indicated. Third, future lines of research based on the findings will be presented. Fourth, practical implications derived from this doctoral thesis are discussed with respect to their contribution in the development of interventions for tertiary prevention to increase resilience in people diagnosed with BD. Last, an overview of the final conclusions of this doctoral thesis will be presented.

8.1. General Summary of the Discussion and Conclusions for Each Study

8.1.1. Study 1: *The Confluence of Resilience and Recovery in the Context of Mental Health*

The first aim of this doctoral thesis was to review resilience and recovery concepts in order to understand their similarities, differences, and convergences in the field of mental health.

Results indicated that there is a considerable overlap between aspects of resilience and facilitator qualities of recovery in the field of mental health. Discussing the differences between both concepts enabled us to understand the relationship between them. Some qualitative and quantitative studies, several health campaigns–e.g., Bhui & Dinos (2011) and American Psychological Association (2009)–have shown the importance of resilience when patients are recovering from different mental disorders, as

well as the factors of resilience that helped people who formerly had a mental disorder to overcome their disease (Dowrick et al., 2008; Edward et al., 2009).

After reviewing the literature, we concluded that resilience is a process and a moderator variable (not an outcome per se) consisting of the activation of various intrapersonal assets and environmental resources, which help in the person's adaptation to the adversity of the mental disorder. We support the consideration of resilience as an asset for recovery and, specifically, as a moderator of the impact of stressors on the personal recovery process in people with mental disorders. We base our argument on the evidence from theoretical research (Godwin & Kreutzer, 2013) and quantitative studies (Fredrickson, Tugade, Waugh, & Larkin, 2003; Hjemdal, Friborg, Stiles, Rosenvinge, & Martinussen, 2006; Johnson et al., 2010; Min et al., 2015; Min et al., 2014; Min et al., 2012; Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014; Vilete et al., 2014; Wingo et al., 2010), where it is argued that resilience factors buffer against stressful events in people, enhancing the probabilities that they will recover from mental and medical health problems. Additional evidence stems from pilot clinical trials (Loprinzi, Prasad, Schroeder, & Sood, 2011) and systematic reviews (Leppin et al., 2014) that show the efficacy of psychological interventions based on resilience to ameliorate the impact of physical illnesses.

For example, Min et al. (2014) concluded that resilience moderated the negative effects of pain, and it contributed independently to decrease depression and increase post-traumatic growth in people with spinal cord injuries. With respect to some factors of resilience, Vilete et al. (2014) found that positive effects–considered as a resilience factor by some authors (Tugade, Fredrickson & Barrett, 2004–work as a moderating factor; resilience was activated by trauma, buffering negative effects in people from the general population who were exposed to trauma. Johnson et al. (2010) found that the resilience

factor of positive self-appraisals (i.e., coping with emotions and difficult situations, and having the ability to gain social support) moderates the relationship between hopelessness and suicidal ideation in people suffering psychosis spectrum disorders. With respect to mood disorders, Min et al. (2015) found significant interaction effects of mood symptoms (i.e., depression and anxiety) and resilience on suicidal ideation in outpatients suffering depression and/or anxiety disorders. In a previous study, Min et al. (2012) found that a significant interaction between resilience and trait anxiety predicted treatment response in outpatients with depressive disorders. Finally, the epigenetic change, with respect to the neurobiology of resilience, was found to moderate the response to intervention (Southwick et al., 2014).

Thus, after reviewing the construct of recovery, we concluded that recovery is the desirable outcome to reach (Andresen et al., 2003; Drake & Whitley, 2014; Jones et al., 2015; Leamy et al., 2011), whereas resilience is the desirable process to experience in order to reach that outcome. Future research should endeavor to ascertain whether promoting resilience contributes to improving health, social functioning, quality of life, and well-being, and leads to increasing rates of recovery in mental health (Almedon, 2005; Grotberg, 2003; Leamy et al., 2011; Windle, 2011).

8.1.2. Study 2: *Resilience in Bipolar Disorder: A Qualitative Study of the Viewpoints of Patients and Health Professionals*

There have been only a few qualitative studies about resilience in people with mental disorders, but there are currently no qualitative research articles published on resilience in people with BD. Thus, the next aim of the present doctoral thesis was to provide information in this under-researched field of knowledge. Therefore, we carried out a qualitative study on the resilience process and qualities in BD through in-depth individual interviews and focus groups with patients in remission from BD, and with

health professionals who had witnessed the experience of resilience in their patients diagnosed with BD.

Results from this qualitative study support the importance of resilience in order to overcome adversities and improve mental health in persons with BD, consistent with other studies carried out with different mental disorders (Choi et al., 2015; Dowrick et al., 2008; Edward et al., 2009; Griffiths et al., 2014; Hofer et al., 2016; Kralik, Loon, & Visentin, 2006; Las Hayas et al., 2015; Min et al., 2015; Min et al., 2012; Torgalsbøen, 2012). This study covers the lack of knowledge about the experience of resilience in BD, acknowledging and describing the psychological resilience process experienced in BD. In accordance with other studies, resilience in BD was described as a dynamic process that did not necessarily imply lack of suffering (American Psychological Association, 2010; Fava & Tomba, 2009; Grotberg, 2003; Wathen et al., 2012).

Most of the emergent resilience themes in BD were similar to resilience factors found in both qualitative (Dowrick et al., 2008; Kralik et al., 2006; Las Hayas et al., 2015; Torgalsbøen, 2012) and theoretical review (Fletcher & Sarkar, 2013; Schultze-Lutter, Schimmelmann, & Schmidt, 2016; Shastri, 2013; Shrivastava & Desousa, 2016) studies of resilience. Despite the fact that some aspects of resilience in BD coincide with aspects of resilience reported in other studies, these aspects are sometimes described in different terms. For example, the assets that are highlighted within the positive personality qualities factor in the present study (e.g., perseverance, willpower, sense of humor, and creativity) are different than the same personality traits reported in the study by Las Hayas et al. (2015) (e.g., joy and vitality).

Past research is not conclusive whether optimism, sense of humor, and creativity aspects (belonging to the theme of positive personality qualities in our study) represent characteristics of patients' personalities or are symptoms of BD. Whereas in our study,

clinical experts reported that creativity may be an antecedent of a manic episode, Johnson et al. (2012) indicated that creativity and optimism could be helpful in the improvement of BD outcomes. In addition, other aspects of resilience in BD, such as the anticipation of early warning signals and the adherence to treatment (belonging to the theme of self-management of BD), and healthy habits (belonging to the theme of balanced self-style), are not acknowledged in the literature of resilience, as they are in our study. These aspects are acknowledged, instead, in the literature of BD, as relevant to prevention of bipolar episodes, promotion of well-being and personal recovery, and attainment of a better quality of life (Mansell et al., 2010; Michalak et al., 2006; Mrazek & Haggerty, 1994; Russell & Browne, 2005). Furthermore, the resilience aspects of redefinition of the identity and the differentiation of their identity from the illness seem to be specific to resilience in BD since they are not acknowledged in previous literature about resilience and mental health.

The theoretical framework of resilience in BD that is provided offers insight into the understanding of the resilience process and qualities experienced in BD. Other qualitative studies in resilience have provided insight into resilience in mental health, and they included not only participants diagnosed with BD, but also participants diagnosed with other mental illnesses, as in the case of the study of Edward et al. (2009). Our qualitative study of resilience was focused on BD; therefore, participating patients were diagnosed with BD. In our study, apart from considering the points of view of patients with BD, we also analyzed clinicians' points of view, integrating both sources of information, as was used in other qualitative studies in the mental health field (Las Hayas et al., 2015; Morden, Jinks, Ong, Porcheret, & Dziedzic, 2014; Taylor et al., 2015; Weich et al., 2012). In comparison with other qualitative studies on resilience which used only interviews as a method to gather data, our study employed not only individual interviews,

but also focus groups. Employing focus groups allowed us to contrast the information gathered from individual interviews and thus attain more trustworthiness. One exception to this exclusivity is the study of Las Hayas et al. (2015), who also employed both individual interviews and focus groups.

8.1.3. Study 3: *The Resilience Questionnaire for Bipolar Disorder: Development and Validation*

Results from the Study 2, together with a literature review on the resilience concept and on available resilience measurement tools, took us to the next step that consisted of the development and psychometric validation of a new self-report questionnaire of resilience specifically for patients diagnosed with BD: the Resilience Questionnaire for Bipolar Disorder (RBD).

Different psychometric analyses resulted in the validation of the RBD, composed of 23 items which yielded a general score of resilience (total score) and a profile of resilience, consisting of five domains: self-management of BD, turning point, self-care, self-confidence, and interpersonal support. Construct validity, reliability, and stability of the RBD were demonstrated in a BD sample. Additionally, the questionnaire showed good concurrent validity results, correlating positively with a generic resilience measure, quality of life, and personal recovery, and correlating negatively with depression. The positive relationship between resilience, personal recovery, and quality of life in BD are consistent with other studies that reported the positive role of resilience in the promotion and maintenance of mental health in other mental disorders (Choi et al., 2015; Dowrick et al., 2008; Torgalsbøen, 2012).

Since recovery is a likely consequence of resilience (Zautra, 2009), it was hypothesized that recovered BD patients would score higher in resilience than not recovered patients. Known-groups validity was supported since recovered BD patients

scored significantly higher on resilience (as measured by the total score of the RBD, and for each of the resilience factors) than both not recovered and the comparison sample from the general population. An exception occurred for the turning point factor, as to which intergroup differences were not significant. Post hoc Tukey test revealed that recovered patients scored the highest on resilience, followed by the comparison sample from the general population, and finally by not recovered patients. Similarly, Las Hayas et al. (2014) found higher levels of resilience in people recovered from eating disorders than in not recovered patients, but no significant differences emerged between recovered eating disorder patients and the general population sample. We hypothesized that resilience levels were higher in recovered patients than in the comparison and not recovered patient groups because, according to the theory of resilience, overcoming any adversity—in this case the adversity of BD—implies an intensive development of resilience. In contrast, when taking together all of the participants diagnosed with BD, this sample presented lower scores in resilience than the comparison group from the general population (Echezarraga, Las Hayas, González-Pinto, Lobban, & Jones, 2015).

Choi et al. (2015) and Mizuno et al. (2016), in their studies carried out in Asia, found lower levels of resilience in outpatients diagnosed with BD who were euthymic or clinically stable (respectively, and equivalent to our recovered sample) than in a comparison group of healthy individuals. Nevertheless, differences between our findings (with participants from a Western country) and those from the studies of Choi et al. and Mizuno et al. (with participants from Asian countries) may be related to transcultural variances. Different values are emphasized as relevant in each country and culture. For example, while self-determination, personal responsibility, and sense of control are assumed as qualities relevant in Western countries, spirituality and hope are of special relevance in Asian countries (Yee, 2003). Additionally, the measures used to assess

resilience in the present study (RBD) or in the studies of Choi et al. and Mizuno et al. (RS-25) refer to resilience qualities that are typically relevant in Western societies but not in Asian countries. Thus, it would imply that when resilience is measured with those tools in Asian countries, they could miss measuring some aspects of resilience that are of importance for participants from Asian countries. Therefore, transcultural differences could have influenced indirectly the findings on the degree and quality of resilience (Hofer et al., 2016). In fact, Hofer et al. found that schizophrenia patients from Austria scored higher in resilience (measured with the RS-25) than healthy individuals or schizophrenia patients from Japan (this latter sample achieving the lowest scores).

The lack of relationship between the turning point resilience factor and quality of life, personal recovery, and bipolar symptomatology could suggest that turning point is implicated as a trigger mechanism of the resilience process, but it may not denote the achievement of other positive mental health outcomes. The RBD covers some unique aspects of the resilience experience in BD, and this could explain why the RBD was more sensitive to changes in patients with BD than was the generic resilience measure, RS-25.

8.1.4. Study 4: *Resilience Predicts Improvements on Well-being, Personal Recovery, Psychosocial Functioning and Quality of Life in Bipolar Disorder in a Follow-up Study*

Literature on the relationship between resilience and mental health indicators in BD is scarce; only two studies have been carried out in Asian countries analyzing the cross-sectional relationship between resilience, social functioning, and depressive symptomatology in people diagnosed with BD who were euthymic (Choi et al., 2015) or clinically stable (Mizuno et al., 2016). Comparing our results from those obtained in Asia is difficult due to transcultural differences, differences in measured health-related variables, and limitations of the Asian studies to cross-sectional methodology. In order to

increase the evidence on resilience in BD, and surpass the limitations indicated in the study of Choi et al. (2015), we aimed to analyze the cross-sectional and prospective associations between resilience domains that are specifically relevant for BD patients (as measured by the new RBD questionnaire) and several mental health indicators (i.e., well-being, personal recovery, quality of life, bipolar symptomatology, and psychosocial functioning deficit) in people diagnosed with BD.

Cross-sectional path analysis results indicated that self-management of BD, self-care, and self-confidence were the resilience domains (measured with the RBD) that were positively associated with well-being, personal recovery, and quality of life, and that were negatively associated with psychosocial functioning deficit in BD. These results are consistent with other studies on resilience in patients with eating disorders that showed positive associations between resilience and quality of life domains of physical health, psychological health, social relationships, and satisfaction with the environment (Las Hayas et al., 2014). Other studies have also shown positive associations between resilience and recovery, resilience and subjective well-being, and resilience and functioning in schizophrenia (Torgalsbøen, 2012). Related to resilience and psychosocial functioning, Mizuno et al. (2016) showed a positive relationship between these variables in outpatients diagnosed with BD who were clinically stable.

Our cross-sectional results from path analysis showed that self-management of BD and self-care domains of resilience were positively associated with well-being and personal recovery, and that self-care was negatively associated with psychosocial functioning deficit in BD. These aspects have not been previously studied as resilience attributes in people diagnosed with BD. Nevertheless, the literature addressed that different aspects of self-management (e.g., understanding BD, ongoing monitoring, and early warning signals awareness) and aspects of self-care (e.g., sleep, diet, and exercise

regulation) are associated with positive outcomes such as relapse/recurrence prevention, well-functioning, and wellness in people diagnosed with BD (Berk, Berk, & Castle, 2004; Colom et al., 2003; Michalak et al., 2007; Murray et al., 2011; Williams et al., 2008; and Murray & Harvey, 2010, respectively).

With respect to the relationship between resilience and bipolar symptomatology, our study reported a significant negative correlation between resilience and depression. This is consistent with the studies of Choi et al. (2015) and Mizuno et al. (2016), where resilience was negatively related to depressive symptoms in outpatients diagnosed with BD who were euthymic or clinically stable, respectively. Regarding affective disorders, Griffiths et al. (2014) also found that the resilience factor of expanding inner resources was positively related to depression improvement in participants suffering depressive symptoms. Similarly, Min et al. (2015) reported that resilience was protective against suicide ideation in people with higher levels of depressive and anxiety symptomatology. Our path analysis did not explore the unique associations between resilience and depression. An initial cross-sectional path analysis including a depression variable revealed that the model did not converge, which was interpreted as a possible problem related to multicollinearity, leading us to decide to exclude the depression variable from the final cross-sectional path analysis.

Additionally, cross-sectional path analysis results indicated that the turning point resilience domain was negatively associated with well-being and quality of life, positively associated with psychosocial functioning deficit, and not associated with personal recovery at baseline in BD. It was expected that turning point would be cross-sectionally negatively associated with mental health adjustment indicators, since it occurs at a moment of suffering (Garmezy, 1991; Rutter, 2013). Thus, the negative association between turning point and quality of life and well-being is in accordance with the

understanding of the turning point concept. Other studies have also indicated that individuals with different mental illnesses experienced turning point during the journeys of their illnesses (Edward et al., 2009; Las Hayas et al., 2015). Even if turning point explained cross-sectionally negative mental health outcomes (i.e., if in the path analysis, turning point was negatively associated with quality of life and well-being, and positively with psychosocial functioning deficit), it was also positively associated with the other resilience domains from the RBD. In accordance with Luthar et al. (2000), resilience involves a developmental progression, where new strengths emerge with changing circumstances. Therefore, we hypothesize that the turning point experience could motivate the activation and development of self-management of BD, self-care, and self-confidence domains of resilience that do explain positively the variance in mental health indicators in BD.

Our cross-sectional correlation results also showed that correlations between interpersonal support domains of resilience and mental health indicators were significant but weak. For example, interpersonal support correlated positively with well-being, personal recovery, and quality of life, and negatively with psychosocial functioning deficit. These results are similar to the positive correlation found by Torgalsbøen (2012) between resilience and relational functioning. Our study reported a lack of significant correlation between the domain of resilience of interpersonal support and either depression or activation index of bipolar symptomatology. Despite interpersonal support constituted a resilience strategy in people experiencing depressive symptoms (Dowrick et al., 2008), and it improved outcomes of relapse and recurrence in BD (Rea et al., 2003), our result is consistent with the study of Griffiths et al (2014). Griffiths et al. reported that the external resilience strategy of drawing on relationship—that is similar to interpersonal support domain of resilience from our study— was not associated with improvements on

symptomatology in people with depressive symptomatology. Given the controversial evidence on interpersonal support in relation to mental health adjustment indicators, we hypothesized that their relationship would be weak. Despite the fact that our study reported significant but weak correlations between resilience and mental health adjustment indicators, path analysis results from our study indicated that interpersonal support was not significantly associated with any of the studied mental health indicators at baseline in BD. The understanding of resilience as a construct that is developed through the interaction of various factors (Shastri, 2013) may explain why interpersonal support domain of resilience was correlated with mental health positive outcomes, but it did not directly explain the variance of those indicators of mental health.

Regarding prospective relationships between resilience domains and mental health indicators in BD, path analysis results reported that self-management of BD and turning point were the resilience domains at baseline that predicted improved outcomes in personal recovery at follow-up. Despite turning point being negatively associated with positive mental outcomes in BD at baseline, this resilience domain was one of the predictors of improvement in personal recovery at follow-up, as expected. This is consistent with Rutter's (2013) conceptualization of turning point; he stated that the turning point experience implies a cutoff moment with disadvantageous past options, providing new options for a positive change. We found that, when controlling for overlap among variables, not only turning point but also self-management of BD resilience domain predicted higher personal recovery at follow-up. Other studies have found that strategies similar to the resilience domain of self-management of BD led to reducing relapse rates and enhancing adherence and wellness in people with BD (Berk et al., 2004; Colom et al., 2003). Our results are consistent with the literature indicating that resilience is a key factor that increases psychosocial adjustment (Shastri, 2013) and that it

constitutes an asset of the recovery process (American Psychological Association, 2009; Bhui & Dinos, 2011; Robertson & Cooper, 2013). The evidence on the effect of resilience on mental health is scarce, especially with respect to longitudinal studies. Griffiths et al. (2014) showed that resilience was prospectively related to improved symptomatology in people experiencing depression symptoms, and Torgalsbøen (2012), in her longitudinal study, reported a strong relationship between resilience and sustained recovery in people diagnosed with schizophrenia. Our study is the first research reporting both cross-sectional and prospective data on the unique associations between resilience and a number of health-related outcomes in BD.

8.2. Limitations of the Doctoral Thesis Research

The main limitation for the Study 1 is related to the methodology. The theoretical review did not follow a methodology for systematic literature reviews, which may have affected the completeness of the review and its conclusions.

The Study 2 presented some limitations related to the restrictions in the inclusion criteria of the participants. For the patient sample, we only included patients with BD who were in remission from this disorder, and patients were recruited from a limited number of mental health centers. This limited the variability of the data obtained. Despite the sample size limitation, theoretical saturation was reached; that is, the issues and themes became recurrent, and new interviews or focus groups provided little or no additional information (Corbin & Strauss, 2015; Guest, Bunce, & Johnson, 2006), and triangulation was used to improve reliability and internal consistency (Flick, 2014). Remission conditions of the participants, which increased the difficulties in patient recruitment, was required in order to better guarantee that patients had more chances to experience the resilience process. Still, when interpreting results, caution is needed in generalizing them to both outpatients and to people not recovered from BD. In addition,

the clinician sample was composed only of psychiatrists, so the viewpoints of other health experts were not considered. Furthermore, the qualitative data obtained had a retrospective nature, which could lead to recall bias. In this respect, recall bias could have been minimized through the data gathering from other sources of information, such as from significant people in the patients' lives. Besides, findings of this study might have been biased by the starting points, assumptions, and subjectivity of the analysis team; thus, in order to better identify and correct the possible misleading assumptions and achieve higher levels of reflexivity, the subjectivity of the researchers was discussed and expressed in the second manuscript, as recommended by Mauthner and Doucet (2003).

The clinical sample size recruited for the Study 3 was not large enough to divide it randomly into two independent clinical samples in order to conduct the EFA and CFA analyses with two independent samples. Thus, CFA results are considered as preliminary. In addition, the sample size for the test-retest analyses was small. Another limitation of this Study 3 is that the turning point factor of the RBD neither significantly correlated with the comparison measure of resilience, nor discriminated between recovered and not recovered clinical subsamples. We advocate that turning point questions could have been misunderstood by participants forgetting the timeframes of their last two weeks, and instead answering with respect to their entire lifetimes. We added the phrase "the last few days" to the turning point items in order to help participants remember their recent situations when answering these items. Additionally, the measure of personal recovery was used to divide the clinical sample into recovered and not recovered subsamples. Because this tool did not have a cut-off point, we assigned the 75^{th} percentile as a cut-off point to divide the clinical sample as recovered and not recovered; by using a 75^{th} percentile, we implied that patients included within the recovered subsample scored were the patients whose mean scores in recovery were greater than the mean score of 75%.

With this cut-off point, we aimed to ensure that, within the recovered subsample, there were no not recovered BD patients. Nonetheless, this cut-off point was not validated, so there is the possibility that some not recovered patients were included in the recovered sample and vice versa. Finally, a great number of the participants within the comparison sample of people from the general population were contacted by sending invitation emails to the employees of the university, which could explain the existing differences in employment statuses and educational levels between clinical and comparison samples.

The Study 4 also presented some limitations related to sample size, especially with respect to the sample size recruited at follow-up. Although the obtained results from the path analyses were significant, the statistical power could have been limited by the small sample size. Thus, results of this study could have been biased by the limited sample size, especially for the longitudinal path analyses. Similarly, due to the limited sample size and its influence on the statistical power, the symptomatology variable was not included within the cross-sectional path analysis model.

With respect to the clinical sample involved in this doctoral dissertation, we did not obtain enough psychiatrist reports to classify patients according to type of BD, and to carry out differentiated analyses for patients diagnosed with BD-I and for those with BD-II. Thus, the clinical sample presented a great diagnostic heterogeneity, and this could limit the generalizability of our findings. Furthermore, the diagnoses of BD were confirmed by the therapists of the patients, but we did not reconfirm these diagnoses using clinical interviews such as the SCID. Additionally, cultural differences may arise when replicating our studies in other cultures where other resilience qualities could be more relevant than those found in the present doctoral thesis studies (Hofer et al., 2016; Yee, 2003; Schultze-Lutter, Schimmelmann, & Schmidt, 2016). Finally, this thesis has no information regarding variables that could have relevantly influenced our results, such as

possible effects of pharmacological and/or psychological treatments, cognitive functioning, neurobiological factors, abnormalities in different brain areas, and personality traits (Franklin, Saab, & Mansuy, 2012; Hofer et al., 2016; Southwick et al., 2014). For example, given that cognitive deficits are related to higher impulsivity in BD, and high levels of impulsivity are associated with low levels of resilience, cognitive deficits may be related to negative effects on resilience (Choi et al., 2015; Jimenez et al., 2012). Thus, caution should be taken when interpreting the results of this doctoral thesis.

8.3. Future Lines of Research

For the Study 1, we suggested that future lines of research should study resilience qualities and their roles in the recovery journey. For example, we suggested that a potential aim in future studies would be to examine longitudinally whether resilience predicts greater recovery. For the second qualitative study, we considered that in the future, research should explore the resilience process in BD with a clinical sample of patients diagnosed with BD exhibiting higher levels of subsyndromal symptoms, and with a clinician sample of health professionals coming from other backgrounds than psychiatry.

With respect to the Study 3, we recommend replicating the CFA in future studies with a larger sample of people diagnosed of BD. Also, with respect to the limited clinical sample size in the third and fourth studies, it would be of interest to study the associations between resilience and mental health-related outcomes in BD using a larger sample. Increasing sample size would allow researchers to carry out other interesting path analyses (e.g., including other relevant variables such as bipolar symptomatology) or to conduct different analyses for recovered and not recovered BD patients. In addition, the inclusion of subthreshold bipolar diagnostics in the DSM-5 could lead to advances in the investigation and to provision of optimized treatment to patients who are actually

misdiagnosed and do not receive the most suitable treatment approaches. In this way, studies could examine how the resilience process and resilience characteristics are differently presented and associated with mental health indicators, depending on whether people are dealing with BD-I, BD-II, or subthreshold BDs. Additionally, inclusion of psychiatrist reports, beside self-reported measures, would allow comparison of results between different sources of information. This would increase the validity of the results about the relationships between resilience and mental health in BD (Costa, Bagby, Herbst, & McCrae, 2005). Furthermore, psychiatrist reports on the BD diagnostic classification and on the recovery status (recovered or not recovered) for each patient would allow us to analyze differences between patients in future studies.

Therefore, we recommend replicating the last three studies of this thesis, using clinical interviews such as the SCID to confirm patients' diagnoses, and using clinician-rated reports also, in addition to the self-rated reports. Additionally, future studies should explore the relationships between resilience in BD and other relevant variables not covered in this thesis, such as personality traits, whether the patient received pharmacological and/or psychological therapy, or transcultural differences (Cyrulnik, 2009; Hofer et al., 2016; Michalak et al., 2007; Schultze-Lutter et al., 2016; Yee, 2003).

Taken together, our findings, and those of Choi et al. (2015), who indicated that resilience is an important prognostic factor related to the course of BD, and Mizuno et al. (2016), we recommend conducting a large-scale trial in order to study the efficacy of a resilience-based psychological intervention in BD, and to assess whether this intervention increases rates of clinical and personal recovery from this complex psychiatric disorder. We also recommend carrying out longitudinal studies in order to assess whether resilience moderates the impact of risk factors on the recovery process of people diagnosed of a BD.

Finally, we would recommend that future studies explore the relationship of resilience to other relevant variables not included in the current thesis—such as attachment patterns, personality traits, cognitive functioning, early maladaptive schemas, and biological and genetic variables—that could play key roles in improving or worsening resilience and mental health in people diagnosed of BD (Cyrulnik, 2009; Hofer et al., 2016; Michalak et al., 2007; Schultze-Lutter et al., 2016).

8.4. Practical Implications of this Doctoral Thesis

Results from the different studies comprising this doctoral thesis have important practical implications. The following theoretical, methodological, and clinical implications are highlighted:

8.4.1. Theoretical implications

The Study 1 contributed to the theoretical understanding and clarification of the meaning and role of resilience and recovery constructs in the context of mental health. Understanding better the meaning of resilience in relation to mental health is relevant in order to strengthen the validity of the utilization of resilience in mental health research, and to facilitate the development of resilience-based interventions that aim at increasing the effectiveness of clinical interventions (Shrivastava & Desousa, 2016).

The Study 2 contributed to the theoretical understanding of the experience of resilience in mental health, adding new knowledge and insight into the experience of resilience in BD. This qualitative study, by considering the viewpoints of both people in remission from BD, and health professionals who had witnessed resilience experience in their patients diagnosed with BD, provided a model of psychological resilience in BD. This particular model of resilience explained the resilience process and resilient qualities that enable people diagnosed with BD to maintain or regain mental health. Findings from

this study covered the gap of knowledge about resilience in BD and complemented the understanding of BD as provided by epidemiological studies.

The Study 3 was the first providing cross-sectional associations between resilience and mental health-related variables in BD, and giving evidence on the comparative levels of resilience between recovered patients, not recovered patients, and a comparison sample from the general population. The Study 4 was the first offering comprehension of both cross-sectional and prospective unique associations between resilience and mental health indicators in BD. Thus, the study informed that (1) self-management of BD, turning point, self-care, and self-confidence resilience domains in BD cross-sectionally explained the variability on well-being, personal recovery, psychosocial functioning deficit, and quality of life, (2) self-management of BD and turning point resilience domains predicted personal recovery, and (3) quality of life at baseline predicted well-being at follow-up.

Although there have been visible advances in the recognition of the importance of the salutogenic approach and resilience in the context of mental health, it is essential to continue to raise awareness of the importance of resilience through the development and implementation of mental health campaigns and policies that show the importance of resilience when facing adversities. An adequate comprehension of the meaning and role of the resilience process and of its qualities is needed in order not only to promote campaigns and policies, but also to conduct research assessing what resilience means. The evidence reported in this study also supports the opening of pilot clinical trials studying the efficacy of resilience-based interventions in BD.

8.4.2. Methodological implications

Clarifying resilience and recovery constructs could help to better delineate both concepts when developing instruments to measure them, instead of measuring related, but different, constructs as hardiness or coping. The Study 2 is the only one available in the

literature that analyzes qualitatively the resilience process in the specific diagnostic group of BD. The provided model of resilience in BD may be useful for the development of a BD-specific questionnaire to measure resilience. The Study 3 provides a resilience questionnaire specific for BD.

It is important to measure resilience in BD in an optimum way, with an instrument that (1) was developed considering the viewpoints of people with BD who have experienced resilience, and (2) showed adequate validity, reliability, and responsiveness in people diagnosed with BD. The new 23-item RBD, which met the psychometric properties for measuring resilience specific for BD, could be used in future studies in BD as a self-report measurement of general resilience level (i.e., using the total score of the RBD) and/or as a combination of the different resilience domains to get a more detailed picture (i.e., using resilience subscales or the RBD). This is relevant both for research studying resilience relationships and for research analyzing the efficacy and effectiveness of psychological resilience-based programs.

The Study 4 is the first studying resilience in BD using a specific tool designed and developed specifically from and for this diagnostic group. Additionally, this study implies a methodological advance in the research of resilience, since it analyzed the unique associations—through path analyses—between resilience and mental health, not only cross-sectionally, but also longitudinally.

8.4.3. Clinical implications

The Study 1 helps us to better understand meanings and roles of resilience and recovery constructs in mental health, which could in turn help clinicians to identify resilience and recovery characteristics in their patients, distinguish both terms, and encourage those characteristics in their patients. Because resilience may moderate the impact of stressors on the recovery process (Haglund, Nestadt, Cooper, Southwick, &

Charney, 2007), we consider resilience itself as a target during psychological interventions.

The model of resilience in BD resulting from the Study 2 provides clinicians with a list of the main resilience topics in patients with BD. Clinicians may improve clinical practice in BD by the implementation of psychological resilience interventions complemented with interventions that also target the symptomatology (Shrivastava & Desousa, 2016). This could be a relevant step towards positive psychiatry (Jeste, Palmer, Rettew, & Boardman, 2015)

With respect to the Study 3, the RBD could provide relevant knowledge to clinicians who aim to measure resilience and plan interventions that promote resilience in their patients diagnosed with BD. The total score of the RBD could be used to get a general idea of the resilience level, while the subscales could be utilized to achieve more specific information about the strengths and weakness in resilience. Given the higher levels of resilience presented in people recovered from BD than in those not recovered, clinicians could consider the possibility of implementing resilience programs to increase patients' resilience, and thus improve recovery rates in BD.

Results from the Study 4 support the implementation of psychological therapies targeting specific resilience domains experienced in BD, which have been proved to be associated with positive mental health outcomes in people with this disorder. These kinds of interventions, based on evidence, could positively impact the well-being, personal recovery, and quality of life and decrease the psychosocial functioning deficit. For example, the efficacy (i.e., resilience studied under controlled situations) or the effectiveness of resilience has been shown in different studies, indicating that resilience can be modified and enhanced by, for example, cognitive and mindfulness training when facing different adversities (LeardMann, Smith, & Ryan, 2010; Leppin et al., 2014;

Moscardino, Axia, Scrimin, & Capello, 2007; Shrivastava & Desousa, 2016). More specifically, the intervention of individual training on resilience has proven to be effective in promoting resilience and recovery in people suffering first-episode psychosis (Meyer, Gottlieb, Penn, Mueser, & Gingerich, 2015; Mueser et al., 2015), and in reducing depressive symptoms and vulnerability in patients diagnosed with depression (Brunwasser, Gillham, & Kim, 2009; Fava & Tomba, 2009).

When conducting studies about the effectiveness of resilience-based programs for people diagnosed of BD, we propose that it would be more practical trying to enhance the resilience domains that are weaker rather than trying to foster resilience in general terms. Improving one resilience quality should help develop and strengthen other resilience qualities. It is important that the development of resilience-focused intervention programs in people with BD suit the needs of each individual, offering a customized treatment to individual patients (Shrivastava & Desousa, 2016). We regard as important for clinicians the evidence that turning point emerges in an adverse moment where mental health is damaged, while instead, the experience of turning point is a favorable sign of a future recovery. In fact, when a patient is at a crisis point, we consider that it would be helpful to stimulate them to move more promptly in the direction of making desirable changes. This is in accordance with Wright et al. (2013) and Masten and Cicchetti (2010), who stated that, during a turning point, interventions could be favorably relevant to activate progressive effects, which at the same time improve multiple indicators of adjustment. We also would like to note that interpersonal support did not explain the variability in well-being, personal recovery, psychosocial functioning deficit, or quality of life, but it was significantly associated with the other resilience domains; therefore, it is also important to consider bolstering interpersonal support. Interpersonal support as a resilience quality could also be fostered to act as a stimulator for the enhancement of other

resilience qualities. This needs to be clear for both patients and people considered important by the patient.

On the other hand, and based on the positive feedback reported by the patients from the focus group, we consider that the inclusion of end users in resilience group interventions would have beneficial effects. The reason for this inclusion is that patients who want to share their experiences with other patients would benefit from sharing experiences about both lived setbacks and achievement improvements related to resilience and mental health improvement.

Given the average time usually needed to get the right BD diagnosis (i.e., about 8 years' delay from the first episode perceived by the person to the diagnosis of BD (Mantere et al., 2004) and treatment (i.e., about 7.8 years' delay from the BD onset time to the first treatment (Baldessarini et al., 2003; Mantere et al., 2004)), and the fact that resilience entails the prevention of progression of a psychopathology (Johnson et al., 2010; Shrivastava & Desousa, 2016), preventive programs focused on enhancing resilience should be directed toward people who have recently experienced depressive or manic episodes, but who have not been yet diagnosed with BD. This resilience training could be useful for similar adverse situations experienced by those people in the future. The professionals in the health sector are often the ones who sympathize deeply with patients who are suffering; therefore, along with the emphasis on the therapeutic alliance and the efforts to decrease vulnerability qualities, those professionals are able to highlight better ways of achieving resilience qualities. For this reason, clinicians should be well-trained on resilience in order to handle, sometimes from a more preventive approach, the situation of the patient, and they should be able to detect resilience weaknesses and strengths in each patient.

To finalize, prevention programs could be directed towards the development of resilience strategies in people who are suffering emotional difficulties without prior diagnosis of any mental disorder. Even if these resilience strategies are not needed for a particular adversity, having learned or acquired them—even if as latent strategies—could facilitate resorting to them when needed. Therefore, professionals working in the educational sector may be trained in the identification of emotional problems and resilience resources and assets in order to react with more strategies. For example, teachers have an important role in providing support and redirecting difficulties in children and adolescents who are at risk of developing emotional problems due to their disadvantaged or vulnerable situations. In this line, some resilience-based preventive interventions have been demonstrated to be successful for youth at risk of developing psychopathologic problems (Greenberg, 2006). Thus, resilience can be established as a central theme of many treatments in order to accomplish many beneficial results, not only to people suffering from mental disorders, such as the case of BD, but also to the general public who face different kinds of challenges (Fava & Tomba, 2009; Rutter, 2013; Shrivastava & Desousa, 2016).

8.5. Final Conclusions

BD constitutes a chronic and recurrent mental illness, impacting negatively patients' psychosocial and work functioning, and quality of life. BD is a severe mental illness, and it is the sixth cause of years living with disabilities. The high rates of prevalence and the comorbidities of this disorder, as well as the consequences associated with this severe mental illness, lead BD to represent a high socioeconomic and health burden. Nonetheless, during the last decade, a growing body of studies has shown that people diagnosed with BD can experience a fulfilling and contributing life.

Resilience in mental health is being increasingly studied, but we have limited knowledge about this phenomenon in people suffering from BD. This is why the present doctoral thesis is aimed at studying the resilience process and its qualities in relation to personal recovery, quality of life, well-being, psychosocial functioning, and symptomatology in people with BD.

The present doctoral thesis used mixed methods to obtain its conclusions, combining both qualitative and quantitative approaches. The overall conclusion from this thesis is that resilience in BD is understood as a dynamic process that emerges as a strategy against adversities related to BD. Resilience in BD requires that the person be minimally mentally stable in order to develop. The experience of a turning point facilitates the emergence or development of a range of interrelated resilience assets and resources. The experience of resilience does not mean the absence of suffering. Nonetheless, resilience helps people in their recovery processes. Resilience plays a contributing role in the mental health of people diagnosed with BD, because it is positively associated with mental health indicators of quality of life, well-being, personal recovery, and psychosocial functioning. Furthermore, self-management of BD and turning point domains of resilience predicted positive variance in personal recovery at follow-up.

The particular conclusions of this thesis are:

- The theoretical study evidenced that resilience and recovery are different concepts that share several factors in the field of mental health, such as the presence of an adversity and the use of several internal and external strategies towards the improvement of subjective well-being. One of the main differences between resilience and recovery is that recovery is an outcome for therapy, whereas resilience is an asset that helps to reach that outcome (i.e.,

recovery). The acquired understanding of resilience and recovery shed light not only on their overlap, but also on the differences between both constructs. This knowledge led us to argue that resilience plays a moderating role on the impact of risk factors on the recovery process.

- The qualitative study with patients diagnosed with BD and clinicians accounted for the psychological resilience process that is experienced in BD. Resilience was described as a dynamic process which involves the activation and development of several qualities. The model of resilience in BD includes the following qualities: a minimal mental stability as a foundation for resilience, the experience of turning point as an experience that triggers the motivation and determination to change, and use of resilience assets and resources (e.g., the development of self-awareness and redefinition of the identity with BD, the development of an effective self-management of BD, living a balanced self-life style, expressing positive personality qualities, and making use of interpersonal support).
- A new instrument to measure resilience specifically in BD was developed, named the Resilience Questionnaire for Bipolar Disorder (23 items). It is composed of a global index and five domains based on the results from the past qualitative study: management of BD, turning point, self-care, self-confidence, and interpersonal support. The RBD presented appropriate psychometric properties in a clinical sample of people diagnosed with BD. Patients classified as recovered obtained the highest scores on the RBD, followed by the comparison group from the general population, and then patients not recovered from BD. Additionally, RBD was responsive to changes in BD.

- Resilience is positively related with positive mental outcomes in BD. Self-management of BD, self-care, and self-confidence domains of the RBD were positively associated with well-being, personal recovery, and quality of life, and negatively associated with psychosocial functioning deficit at baseline. In contrast, turning point was negatively associated with well-being and quality of life, and positively with psychosocial functioning deficit at baseline; nonetheless it predicted greater personal recovery at follow-up. In addition, self-management of BD at baseline predicted greater personal recovery at follow-up.
- Knowing and understanding how each resilience domain both relates to mental health and facilitates recovery in people diagnosed with BD, highlights the importance of planning psychological interventions that pursue the strengthening of resilience domains in order to improve patients' mental health, facilitate progress towards recovery, and increase recovery rates from this complex psychiatric disorder.
- Results from this doctoral thesis support the positive and contributing role of resilience on the recovery process and mental health improvement of people diagnosed with BD. Thus, development of interventions targeting resilience in BD are recommended, as well as the study of the effectiveness of those interventions.
- Based on the results presented in this thesis, future research should expand the study of resilience in persons with severe mental illnesses. Future research could extend the study of resilience in BD, including other aspects that could be associated to resilience and BD, such as attachment patterns, personality traits, and cognitive styles.

Even though the limitations of this study related to the sample size and the heterogeneity of the BD sample, the current doctoral thesis implies significant progress in the knowledge of resilience specifically in BD.

9. General References

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10. Appendices

Appendix 1. Ethical approval obtained from the Clinical Research of Basque Country's Ethics Committee (Spain)

CEIC E
Euskadiko Ikerketa Klinikoetarako Batzorde Etikoa
Comité Ético de Investigación Clínica de Euskadi

EUSKO JAURLARITZA
GOBIERNO VASCO
OSASUN SAILA
DEPARTAMENTO DE SALUD

INFORME DEL COMITE ETICO DE INVESTIGACION CLINICA DE EUSKADI (CEIC-E)

Dra. Iciar Alfonso Farnós como Vicepresidenta del CEIC de la Comunidad Autónoma de País Vasco (CEIC-E)

CERTIFICA

Que este Comité, de acuerdo a la ley 14/2007 de Investigación Biomédica, Principios éticos de la declaración de Helsinki y resto de principios éticos aplicables, ha evaluado el proyecto de investigación, titulado **Validación de la Resiliencia como predictora de mejora en síntomas, funcionalidad y calidad de vida en el Trastorno Bipolar: Estudio Cualitativo y Cuantitativo Longitudinal,** Código interno: PI2014009

Versión del Protocolo: Versión 4, 15 de Abril de 2014
Versión de la HIP:
DIRIGIDO A CLÍNICOS / Versión 1. 18 de Diciembre de 2013
GENERAL / Versión 4 15 de Abril de 2014

Y que este Comité reunido el día 26/03/2014 (recogido en acta 04/2014) ha decidido emitir **dictamen favorable** a que dicho proyecto sea realizado por los siguientes investigadores:

- Álvaro Iruin *Director Salud Mental Extrahospitalaria de Guipúzcoa.*
- Juan Carlos Irurzun *Centro de Salud Amara – Berri*
- Luis Pacheco *Ambulatorio Bombero Etxaniz*
- Begoña Mendibil Eguiluz *Centro de Salud Mental Uribe*
- Ainara Echezarraga Porto *Universidad de Deusto*
- Juan Bosco Anguiano *Ambulatorio Ortuella*
- Luis María Larrazabal *Centro de Salud Gernika*
- Nieves Basterretxe *Hospital de Zamudio*
- Gixane Gonzalez *Hospital Galdakao-Usansolo*
- Ana González-Pinto Arrillaga *Hospital Universitario de Araba (sede Santiago)*
- María del Pilar Martínez *Centro de Salud Mental Gasteiz Centro*

Lo que firmo en Vitoria, a 16 de abril de 2014

Fdo:

EUSKO JAURLARITZA GOBIERNO VASCO OSASUN SAILA DEPARTAMENTO DE SALUD
22 ABR 2014

Euskadiko Ikerketa Klinikoetarako Batzorde Etikoa
Comité Ético de Investigación Clínica de Euskadi (CEIC-E)

Dra. Iciar Alfonso Farnós
Vicepresidenta del CEIC de la Comunidad Autónoma del País Vasco (CEIC-E)

CEIC E

EUSKO JAURLARITZA
GOBIERNO VASCO
OSASUN SAILA
DEPARTAMENTO DE SALUD

LISTADO DE MIEMBROS DEL COMITÉ ÉTICO DE INVESTIGACIÓN CLÍNICA DE EUSKADI (CEIC-E)

ACTA Nº 4/2014 Fecha: 26/03/2014 Hora inicio 09:30 horas

REUNIÓN EN: sala nº 5 en el 3er piso del Edificio Aránzazu del Hospital Donostia

ASISTENTES:

PRESIDENTE	D. Jon Joseba Leonardo
VICEPRESIDENTA	Dª. Iciar Alfonso
VOCALES:	D. Txema González de Castro
	D. Pedro Gorrotxategi
	D. Jesús Rosa
	Dª Isabel Tejada
	Dª María José López Varona
	Dª Ana Aguirrezabal
	D José Antonio Fernández de Legaria
	Dª Nerea Egües
	D. Felipe Aizpuru
	D. Miguel Angel Goenaga Sánchez
	D. Carmelo Aguirre
	Dª Nekane Jaio
	Dª Amaia Martínez Galarza
	Dª María Rodríguez Velasco

AUSENTES: Excusan su asistencia: Arantza Hernández, Julio Audicana, Iñaki Tobalina, José Ignacio Pijoan, Javier Santamaría, Maite Audicana, Ernesto Pérez, Marianela Hernández, Antonio Escobar, Iñaki Fernández Manchola, Nekane Murga

En Vitoria, a 26 de Marzo de 2014

OSASUN SAILA
DEPARTAMENTO DE SALUD
26 MAR 2014

Fdo:

Dra. Iciar Alfonso Farnós
Vicepresidenta del CEIC de la Comunidad Autónoma del País Vasco
(CEIC-E)

Euskadiko Ikerketa Klinikoetarako Batzorde Etikoa
Comité Ético de Investigación Clínica de Euskadi (CEIC-E)

Referencia legal: DECRETO 3/2005, de 11 de enero, por el que se crea el Comité Ético de Investigación Clínica de la Comunidad Autónoma del País Vasco, y resto de normativa aplicable.

Appendix 2. Informed consents

HOJA DE INFORMACIÓN AL PARTICIPANTE

TÍTULO DEL ESTUDIO: "Comprender y Medir la Resiliencia en Pacientes con Trastorno Bipolar: Valoración de la Resiliencia como Predictora de Recuperación, Calidad de Vida y Funcionamiento Psicosocial".

INVESTIGADOR PRINCIPAL: Lda. Ainara Echezarraga Porto

INTRODUCCIÓN

Nos dirigimos a usted para informarle sobre un estudio de investigación en el que se le invita a participar. Queremos que usted reciba la información correcta y suficiente para que pueda evaluar si quiere o no participar en el presente estudio. Para ello, lea esta hoja informativa con atención. Además, puede consultar con las personas que considere oportuno.

¿A QUIÉN VA DIRIGIDO?

A personas como usted que están recibiendo o han recibido un tratamiento dirigido al padecimiento de un Trastorno Bipolar (TB) y que se encuentren funcionalmente mejorados, según la valoración de su psiquiatra. Todas las personas que firmen este consentimiento informado han de ser mayores de edad.

PARTICIPACIÓN VOLUNTARIA

Debe conocer que su participación en este estudio es voluntaria y que puede decidir no participar o cambiar su decisión de participar y retirar el consentimiento en cualquier momento.

DESCRIPCIÓN GENERAL DEL ESTUDIO

Este estudio se centra en estudiar el fenómeno de la resiliencia en los TB como factor de promoción de la salud en este tipo de población. La resiliencia se entiende como "el proceso que atravesaron para superar la adversidad que supone un TB, y envuelve los cambios en las actitudes, pensamientos, estrategias, y recursos que utilizaron para superar el TB". El estudio de la resiliencia implica identificar las cualidades resilientes (actitudes, pensamientos, fuerzas) que pusieron en marcha aquellas personas con TB que lograron una mejora funcional. En el presente estudio se pretende conocer este proceso resiliente a través de entrevistas individuales confidenciales. Hasta la fecha no se ha realizado ningún estudio cualitativo que valore cómo se origina el proceso resiliente y sus cualidades en los TB. Las entrevistas individualizadas tendrán una duración aproximada de una hora dentro de un contexto de entrevista respetuoso, humano y flexible para con la persona. Su psiquiatra se encargará de adecuar la fecha y hora para la entrevista a realizar en el Hospital Santiago Apostol (Álava) en el caso de que desee participar.

CONFIDENCIALIDAD

Los datos serán confidenciales. Por lo tanto, su identidad no será revelada a persona alguna ni en ningún tipo de publicación científica derivable de este estudio. Los datos para el estudio serán recogidos mediante una grabadora de audio con su consentimiento, para facilitar recoger la información más completa posible y mantener una escucha activa hacia el participante. Únicamente la entrevistadora tendrá acceso a estas conversaciones, las cuales no serán publicadas en ningún caso. Usted puede negarse a responder a las preguntas que no desee contestar, en cualquier momento de la entrevista individual.

BENEFICIOS DERIVADOS DE SU PARTICIPACIÓN

Usted contribuirá a aumentar el conocimiento y el interés científico hacia el área de la resiliencia en la mejora del TB.

HOJA DE CONSENTIMIENTO INFORMADO

TíTULO DEL ESTUDIO: " Comprender y Medir la Resiliencia en Pacientes con Trastorno Bipolar: Valoración de la Resiliencia como Predictora de Recuperación, Calidad de Vida y Funcionamiento Psicosocial". ".

INVESTIGADOR PRINCIPAL: Lda. Ainara Echezarraga Porto

YO (nombre y apellidos) _

He leído la hoja de información que se me ha entregado.
He recibido suficiente información sobre el estudio.
Comprendo que mi participación es voluntaria.
Comprendo que puedo retirarme del estudio:

- o Cuando quiera.
- o Sin necesidad de dar explicaciones.
- o Sin que esto repercuta negativamente hacia mí de ninguna manera.

Presto libremente mi conformidad para participar en el estudio y doy mi consentimiento para que mi psiquiatra concierte una cita con la investigadora para la realización de la entrevista individual.

Fecha (Día/Mes/Año): _____

Firma del participante dando la autorización para la participación en el estudio y para que mi psiquiatra concierte una cita para la entrevista individual:

Datos de contacto del investigador principal:

Lda. Ainara Echezarraga Porto
Equipo Deusto Stress Research.
Tel.: +34944139000. Ext: 2074
Dpto. de Personalidad, Evaluación y Tratamientos Psicológicos
Universidad de Deusto, Planta -1
Avenida de las Universidades, 24, 48007 Bilbao

HOJA DE INFORMACIÓN AL PARTICIPANTE

TÍTULO DEL ESTUDIO: "Comprender y Medir la Resiliencia en Pacientes con Trastorno Bipolar: Valoración de la Resiliencia como Predictora de Recuperación, Calidad de Vida y Funcionamiento Psicosocial".".

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¿A QUIÉN VA DIRIGIDO?

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PARTICIPACIÓN VOLUNTARIA

Debe conocer que su participación en este estudio es voluntaria y que puede decidir no participar o cambiar su decisión de participar y retirar el consentimiento en cualquier momento.

DESCRIPCIÓN GENERAL DEL ESTUDIO

Este estudio se centra en estudiar el fenómeno de la resiliencia en el TB como factor de promoción de la salud en este tipo de población. La resiliencia se entiende como "proceso que atravesaron para superar la adversidad que supone un TB, y envuelve los cambios en las actitudes, pensamientos, estrategias, y recursos que utilizaron para superar el TB". El estudio de la resiliencia implica identificar las cualidades resilientes (actitudes, pensamientos, fuerzas) que pusieron en marcha aquellas personas con TB que lograron una mejora funcional. En el presente estudio se pretende conocer este proceso resiliente a través de su participación en un grupo focal (grupo formado por personas recuperadas de TB) confidencial. Su participación en dicho grupo permitirá explorar si identifica haber atravesado por una fase de resiliencia, explorar en qué consistió el proceso personal de resiliencia. El grupo focal tendrá una duración aproximada de 45 minutos dentro de un contexto de entrevista respetuoso, humano y flexible para con la persona. Además, se le pedirá que complete una pequeña batería de cuestionarios, estimándose alrededor de 30 minutos para ello. Para concretar la fecha y hora del grupo focal (los gastos de desplazamiento hasta el lugar del grupo focal serán abonados a cada participante) se le llamará previamente por teléfono. En caso de que desee participar en el estudio, su psiquiatra o psicólogo nos facilitará su número de teléfono para ponernos en contacto con usted.

CONFIDENCIALIDAD

Los datos serán confidenciales. Por lo tanto, su identidad no será revelada a persona alguna ni en ningún tipo de publicación científica derivable de este estudio. Los datos para el estudio serán recogidos mediante una grabadora de audio con su consentimiento, para facilitar recoger la información más completa posible y mantener la escucha activa hacia el participante. Únicamente la entrevistadora tendrá acceso a estas conversaciones, las cuales no serán publicadas en ningún caso. Usted puede negarse a responder a las preguntas que no desee contestar, en cualquier momento de la entrevista individual.

BENEFICIOS DERIVADOS DE SU PARTICIPACIÓN

Usted contribuirá a aumentar el conocimiento y el interés científico hacia el área de la resiliencia en la mejora del TB.

HOJA DE CONSENTIMIENTO INFORMADO

TíTULO DEL ESTUDIO: " Comprender y Medir la Resiliencia en Pacientes con Trastorno Bipolar: Valoración de la Resiliencia como Predictora de Recuperación, Calidad de Vida y Funcionamiento Psicosocial". ".

INVESTIGADOR PRINCIPAL: Lda. Ainara Echezarraga Porto

YO (nombre y apellidos) _____

- He leído la hoja de información que se me ha entregado.
- He recibido suficiente información sobre el estudio.
- Comprendo que mi participación es voluntaria.
- Comprendo que puedo retirarme del estudio:
    - Cuando quiera.
    - Sin necesidad de dar explicaciones.
    - Sin que esto repercuta negativamente hacia mí de ninguna manera.

Presto libremente mi conformidad para participar en el estudio y doy mi consentimiento informado para que mi psiquiatra/psicólogo facilite los datos de contacto para concretar la fecha, hora y lugar para la realización del grupo focal.

Fecha (Día/Mes/Año): _____

Firma del participante dando la autorización para la participación en el estudio y para que el psiquiatra/psicólogo concierte una cita para la entrevista grupal:

Datos de contacto del investigador principal:

Lda. Echezarraga Porto, Ainara
Equipo Deusto Stress Research.
Tel.: +34944139000. Ext: 2074
Dpto. de Personalidad, Evaluación y Tratamientos Psicológicos
Universidad de Deusto, Planta -1
Avenida de las Universidades, 24, 48007 Bilbao

Directores de la investigadora principal:
Dra. Carlota Las Hayas y Dra. Ana González-Pinto.

HOJA DE INFORMACIÓN AL PARTICIPANTE

TÍTULO DEL ESTUDIO: "Comprender y Medir la Resiliencia en Pacientes con Trastorno Bipolar: Valoración de la Resiliencia como Predictora de Recuperación, Calidad de Vida y Funcionamiento Psicosocial". INVESTIGADORA PRINCIPAL: Lda. Ainara Echezarraga Porto

INTRODUCCIÓN: Nos dirigimos a usted para informarle sobre un estudio de investigación que se está realizando desde la Universidad de Deusto y en el que participan varios centros de salud mental y hospitales de la Red de Salud Vasca (Osakidetza), al cual se le invita a participar. La investigadora principal del estudio es Ainara Echezarraga, investigadora en la Universidad de Deusto y psicóloga. En esta hoja se le presenta información sobre el presente estudio para que usted decida de forma informada y voluntaria si consiente participar en él. Por favor, lea esta hoja de información con atención. Además, puede consultar con las personas que considere oportuno.

¿A QUIÉN VA DIRIGIDO?: A personas como usted que están recibiendo o han recibido un tratamiento dirigido al padecimiento de un Trastorno Bipolar (TB), bien estén en activo con TB, o en proceso de recuperación. Todas las personas que firmen este consentimiento informado han de ser mayores de edad.

PARTICIPACIÓN VOLUNTARIA: Debe conocer que su participación en este estudio es voluntaria y que tiene derecho de decidir no participar o de cambiar su decisión de participar y de retirar el consentimiento en cualquier momento, sin que esto le repercuta negativamente de ninguna manera.

DESCRIPCIÓN GENERAL DEL ESTUDIO: El presente estudio se centra en estudiar el fenómeno de la resiliencia en el TB como factor de promoción de la salud en este tipo de población. La resiliencia se entiende como "proceso que atravesaron las personas para superar la adversidad que supone un TB, y envuelve los cambios en las actitudes, pensamientos, estrategias y recursos que utilizaron para superar el TB". El objetivo del estudio es analizar si la resiliencia se relaciona con la mejora del en síntomas, en el funcionamiento social y en la calidad de vida a lo largo de la vida.

¿EN QUÉ CONSISTE SU PARTICIPACIÓN EN EL ESTUDIO? Su participación en el estudio consiste solamente en completar unos cuestionarios. Completar estos cuestionarios le llevará aproximadamente de 45 minutos a una hora. Principalmente, son cuestionarios para medir su estado sintomático, su funcionalidad psicosocial, su calidad de vida y su resiliencia respecto al TB. Las preguntas de los cuestionarios ofrecen varias posibles respuestas, y usted simplemente deberá escoger la respuesta que le describe a usted mejor. Le ofrecemos 4 formas para completar los cuestionarios: (1) ONLINE, (2) le llamamos por TELÉFONO o (3) la investigadora principal ACUDIRÁ A SU CENTRO DE SALUD MENTAL, y le hacemos las preguntas de la encuesta y usted solamente tiene que elegir las respuestas, (4) le enviamos el cuestionario a su DOMICILIO EN FORMATO PAPEL, para que usted elija el mejor momento para completarlo. En este caso, le incluiremos un sobre pre-franqueado para que nos envíe el cuestionario por correo postal. Dentro de 10 meses nos gustaría invitarle de nuevo a participar, y nos pondremos en contacto con usted (es libre de participar o no).

CONFIDENCIALIDAD:

Su identidad (nombre, apellidos, iniciales, dirección postal y nº de teléfono) no será revelada a persona alguna, ni en ninguna publicación científica derivable de este estudio. Por lo tanto, su confidencialidad quedará preservada. Además, los datos recogidos para el estudio estarán identificados mediante un código de identificación personal mediante su fecha de nacimiento (XX *[día]* / XX *[mes]* / XXXX *[año]*) más la letra de su DNI (X). *Por ejemplo: 03041980A (03: día; 04:mes; 1980: año; A (letra del DNI).*

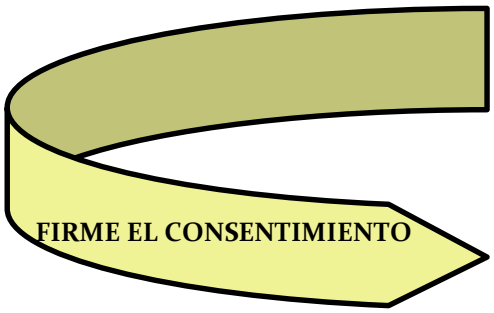
INDIQUE SU CÓDIGO AQUÍ: _____

BENEFICIOS DERIVADOS DE SU PARTICIPACIÓN: Sin su participación no se puede progresar en el conocimiento científico en el Trastorno Bipolar.

Si quiere participar, denos sus datos de contacto en la siguiente página.

Universidad de Deusto
University of Deusto
Deusto

Osakidetza
Servicio vasco de salud



HOJA DE CONSENTIMIENTO INFORMADO

Si ha recibido este documento vía email, puede completarlo, adjuntarlo y enviarlo por email a a.echezarraga@deusto.es. **Si ha recibido este documento en papel a su dirección postal, envíelo por favor dentro del sobre pre-franqueado que se encontraba en la misma carta de envío.**

TÍTULO DEL ESTUDIO: "Comprender y Medir la Resiliencia en Pacientes con Trastorno Bipolar: Valoración de la Resiliencia como Predictora de Recuperación, Calidad de Vida y Funcionamiento Psicosocial". INVESTIGADORA PRINCIPAL: Lda. Ainara Echezarraga Porto

Yo (indique su nombre y apellidos):_____

- He leído la hoja de información que se me ha entregado
- He recibido suficiente información sobre el estudio
- Comprendo que mi participación es voluntaria
- Comprendo que puedo retirarme del estudio:
    - Cuando quiera
    - Sin tener que dar explicaciones
    - Sin que esto repercuta negativamente hacia mí de ninguna manera

Presto libremente mi conformidad para participar en el estudio y doy mi consentimiento para que se pongan en contacto conmigo para poder informarme mejor de la investigación y tomar parte en ella.

Para participar prefiero hacerlo, marque su preferencia con una X:

☐ ***ONLINE:*** Use el siguiente Link para completar la encuesta online: http://www.encuestafacil.com/RespWeb/Qn.aspx?EID=1739709 Una vez entre a la página, le pedirá una contraseña. Escriba lo siguiente todo seguido y en minúsculas: **estudioresiliencia**

☐ ***POR TELÉFONO***. La investigadora principal le llamara al teléfono que usted indique y concertarán una cita para hacer la encuesta telefónicamente. La investigadora principal le hará las preguntas y usted indicará las respuestas. Por favor indique un número de teléfono.**TELÉFONO:_____**

☐ ***EN EL CENTRO***. La investigadora principal acudirá al centro de salud mental al que usted suele acudir, en el caso de que sea posible acordarlo así con el centro y concertarán una cita para hacer la encuesta personalmente. La investigadora principal le hará las preguntas y usted indicará las respuestas. Por favor indique un número de teléfono.**TELÉFONO y CENTRO DE SALUD MENTAL:_____**

☐ ***EN PAPEL EN MI DOMICILIO.*** Indíquenos una dirección postal con código postal y le haremos llegar la encuesta en papel. **DIRECCIÓN POSTAL DE ENVÍO:**

_____

Indíquenos en Centro de Salud Mental u Hospital al que acude para el tratamiento del trastorno bipolar: _____

Escriba "AUTORIZO" en el siguiente espacio para ratificar que ha comprendido las bases del estudio y que accede a colaborar: _____

Fecha de HOY (Día/Mes/Año):_____

Datos de contacto de la investigadora principal: Lda. Ainara Echezarraga Porto. Dpto. de Personalidad, Evaluación y Tratamientos Psicológicos Universidad de Deusto, Planta -1. Tel.: +34 944 139 000 Ext: 2668 email: a.echezarraga@deusto.es Avenida de las Universidades 24, 48007 Bilbao.
Directoras del estudio: Dras. Carlota Las Hayas y Ana González-Pinto.

Appendix 3. Battery of questionnaires

Questionnaires self-completed by patients (Study 2)

Appendix A: Bipolar Spectrum Diagnostic Scale (BSDS) Spanish version:

Instrucciones: por favor, lee todo el párrafo atentamente antes de marcar los espacios en blanco (____)

1. De vez en cuando, algunos individuos notan que su humor y/o su nivel de energía cambian drásticamente____.

2. También notan que a veces su energía es muy baja yotras es muy alta_____.

3. Durante su fase "baja" estos individuos sienten a menudo falta de energía, necesidad de quedarse en cama o de dormir de más, y poca o ninguna motivación para realizar las cosas que tienen que hacer_____.

4. A menudo suben de peso durante estos períodos_____.

5. Durante esta fase se sienten "bajoneados," tristes todo el tiempo o deprimidos_____.

6. A veces durante estas etapas se sienten desesperanzados y hasta con pensamientos suicidas_____.

7. Tienen dificultades laborales y sociales_____.

8. Habitualmente estas etapas duran semanas, aunque a veces pueden durar sólo unos pocos días_____.

9. Los individuos con estas características pueden experimentar un período de estado de ánimo "normal" entre los cambios de humor, durante estas fases su nivel de energía y su humor no son adecuados y sus capacidades no se ven alteradas_____.

10. Luego pueden sentir un marcado cambio en la manera en que se sienten_____.

11. Su energía aumenta por encima de lo que es habitual para ellos, y con frecuencia realizan más actividades de las que harían normalmente____.

12. A veces, durante estos períodos en "alta" los individuos sienten que tienen demasiada energía y hasta se sienten "excelentemente bien"____.

13. Algunos individuos en estas etapas también pueden sentirse irritables, intolerantes o más agresivos_____.

14. Algunos realizan muchas actividades al mismo tiempo durante estas fases____.

15. Durante estos períodos también algunos individuos pueden meterse en problemas por gastar más dinero_____.

16. También pueden estar más conversadores, más extrovertidos o tener más interés en la actividad sexual_____.
17. A veces durante esta fase su comportamiento puede ser extraño o incluso molesto para las demás personas_____.

18. A veces se meten en problemas con sus compañeros de trabajo o hasta con la policía en estos períodos_____.

19. A menudo aumentan su consumo de alcohol o de drogas no recetadas por un médico durante estos períodos____.

Ahora que has leído este párrafo, por favor marca alguna de las siguientes cuatro opciones:

( ) Esta historia me describe muy bien o casi perfectamente.
( ) Esta historia me describe bastante bien.
( ) Esta historia me describe hasta cierto punto pero no en todos los aspectos.
( ) Esta historia no me describe en lo absoluto.

En este momento, relee la historia y marca con una cruz al final de cada oración que te describa perfectamente.

ESCALA DE RESILIENCIA GENERAL

Se presentan 25 afirmaciones, y se te pide que indiques en qué medida te sientes reflejado/a (cómo de bien te describen a ti) por cada afirmación últimamente: en las ÚLTIMAS DOS SEMANAS…

	1 (No me describe para nada)	2	3	4	5	6	7 (Me describe perfecta-mente)
1. Cuando hago planes, los llevo a cabo.	☐	☐	☐	☐	☐	☐	☐
2. Normalmente, sea de un modo u otro, me manejo bien con los problemas.	☐	☐	☐	☐	☐	☐	☐
3. Dependo de mi mismo/a más que de cualquier otra persona.	☐	☐	☐	☐	☐	☐	☐
4. Para mí es importante mantener el interés por las cosas.	☐	☐	☐	☐	☐	☐	☐
5. Puedo estar solo/a si es necesario.	☐	☐	☐	☐	☐	☐	☐
6. Me siento orgulloso/a de haber logrado cosas en mi vida.	☐	☐	☐	☐	☐	☐	☐
7. Me suelo tomar las cosas con calma.	☐	☐	☐	☐	☐	☐	☐
8. Me acepto tal y como soy.	☐	☐	☐	☐	☐	☐	☐
9. Siento que puedo manejar muchas cosas al mismo tiempo.	☐	☐	☐	☐	☐	☐	☐
10. Soy decidido/a.	☐	☐	☐	☐	☐	☐	☐
11. Tengo claro qué es lo importante en mi vida.	☐	☐	☐	☐	☐	☐	☐
12. Afronto la vida día a día, paso a paso.	☐	☐	☐	☐	☐	☐	☐
13. Puedo salir de tiempos difíciles porque he pasado por tiempos difíciles.	☐	☐	☐	☐	☐	☐	☐
14. Soy disciplinado/a.	☐	☐	☐	☐	☐	☐	☐
15. Mantengo interés en las cosas.	☐	☐	☐	☐	☐	☐	☐
16. Usualmente puedo encontrar algo de qué reírme.	☐	☐	☐	☐	☐	☐	☐
17. Mi confianza en mí mismo/a me hace salir de tiempos difíciles.	☐	☐	☐	☐	☐	☐	☐
18. En una emergencia, soy alguien en quien la gente puede contar.	☐	☐	☐	☐	☐	☐	☐
19. Generalmente puedo ver una situación de muchas maneras.	☐	☐	☐	☐	☐	☐	☐
20. A veces me esfuerzo en hacer cosas quiera o no.	☐	☐	☐	☐	☐	☐	☐
21. Mi vida tiene sentido.	☐	☐	☐	☐	☐	☐	☐
22. No me estanco en las cosas que no tienen solución.	☐	☐	☐	☐	☐	☐	☐
23. Ante una situación difícil, suelo encontrar la manera de salir adelante.	☐	☐	☐	☐	☐	☐	☐
24. Tengo suficiente energía para hacer lo que tengo que hacer.	☐	☐	☐	☐	☐	☐	☐
25. No me importa no gustarle a todo el mundo.	☐	☐	☐	☐	☐	☐	☐

Questionnaires rated by clinicians (Studies 2, 3 and 4)

Encuesta: Psiquiatras y/o Psicólogos/as de los pacientes que participan en el estudio "RESILIENCIA EN EL TRASTORNO BIPOLAR"

En la fecha en la que el paciente completó el cuestionario, ¿en qué centro se ha tratado?

Hospital de Zamudio (Zamudio, Bizkaia)
Hospital de Galdakao (Galdakao, Bizkaia)
CSM Gernika (Gernika, Bizkaia)
CSM Bombero Etxaniz (Bilbao, Bizkaia)
CSM Uribe Kosta Adultos (Algorta, Bizkaia)
CSM Barakaldo (Barakaldo, Bizkaia)
CSM Ortuella (Ortuella, Bizkaia)
CSM Amara (Donostia, Gipuzkoa)
Hospital Universitario de Santiago Apóstol (Vitoria)
CSM Gasteiz (Gasteiz)

Nombre y apellidos del paciente:_____

Por favor, **indique el código del paciente. Este código se realiza indicando la fecha de nacimiento (día, mes, año, letra del DNI).** Ejemplo: 03041890A (03: Día; 04: Mes; 1980: Año; A: letra del DNI): **_____**

Si le ha facilitado un cuestionario al paciente, que contenía un código (por ejemplo, 0024.X), indique ese mismo código aquí también:_____

Tipo de Trastorno Bipolar:

Trastorno Bipolar Tipo I
Trastorno Bipolar Tipo II
Trastorno Bipolar No especificado.
Tiene historia de síntomas psicóticos, aunque actualmente no tiene síntomas psicóticos activos.
Sin historia de síntomas psicóticos.
Otro (Por favor especifique) _____

Por favor, indique la **medicación** que toma el paciente **para su Trastorno** Bipolar en el momento que completó el cuestionario:

Antidepresivos con o sin estabilizadores del ánimo o antipsicóticos.
Estabilizadores del ánimo con o sin antipsicóticos.
Antipsicóticos
Anticonvulsivos
Ansiolíticos
Otra medicación diferente a las anteriores.
El paciente no se adhiere adecuadamente al tratamiento farmacológico.
NS/NC

Dado que nos gustaría poder comparar los niveles de resiliencia en función del nivel de recuperación, a continuación se le pide que complete dos cuestionarios:• Escala de Evaluación de la Actividad Global, EEAG y • Escala de Impresión Clínica Global para el Trastorno Bipolar Modificada (CGI-BP-M).

El **CGI-BP-M** evalúa la gravedad actual de la enfermedad a través de dos subescalas de depresión y manía (que evalúan la gravedad de los síntomas agudos de depresión y manía, respectivamente) y de una subescala general (gravedad longitudinal de la patología) presentadas en una escala Likert de 7 puntos desde 1 (*normal*), hasta 7 (*muy grave*).

CGI**: DEPRESIÓN**	CGI: **MANÍA**	CGI: **GENERAL**
1 Normal	1 Normal	1 Normal
2 Mínima	2 Mínima	2 Mínima
3 Ligera	3 Ligera	3 Ligera
4 Moderada	4 Moderada	4 Moderada
5 Marcada	5 Marcada	5 Marcada
6 Grave	6 Grave	6 Grave
7 Muy grave	7 Muy grave	7 Muy grave

La **EEAG** muestra un índice de la enfermedad global y es equivalente al Eje V del DSM-IV. Está formada por un solo ítem de actividad general del paciente que debe ser juzgado por el clínico en una escala del 100 (*actividad satisfactoria*) al 1 (*expectativa clara de muerte*). Valora el funcionamiento psicológico, social y ocupacional. Considera el funcionamiento global en un continuum hipotético de salud-enfermedad mental. No hay que incluir alteraciones de la actividad debidas a limitaciones físicas (o ambientales). Cuando resulte apropiado usar los códigos intermedios, p. ej. 45, 68, 72.

100-91: Actividad satisfactoria en una amplia gama de actividades, nunca parece superado/a por los problemas de la vida, es valorado/a por los demás a causa de sus abundantes cualidades positivas. Sin síntomas.
90-81: Síntomas ausentes o mínimos (por ej., ligera ansiedad antes de un examen), buena actividad en todas las áreas, interesado/a e implicado/a en una amplia gama de actividades, socialmente eficaz, generalmente satisfecho/a de su vida, sin más preocupaciones o problemas que los cotidianos (por ej., una discusión ocasional con miembros de la familia).
80-71: Si existen síntomas, son transitorios y constituyen reacciones esperables ante agentes estresantes psicosociales (por ej., dificultades para concentrarse tras una discusión familiar); solo existe una ligera alteración de la actividad social, laboral o escolar (por ej., descenso temporal del rendimiento escolar).
70-61: Algunos síntomas leves (por ej., humor depresivo e insomnio ligero) o alguna dificultad en la actividad social, laboral o escolar (por ej., hacer novillos ocasionalmente o robar algo en casa), pero en general funciona bastante bien, tiene algunas relaciones interpersonales significativas.
60-51: Síntomas moderados (por ej., afecto aplanado y lenguaje circunstancial, crisis de angustia ocasionales) o dificultades moderadas en la actividad social, laboral o escolar (por ej., pocos amigos, conflictos con compañeros de trabajo o escuela).
50-41: Síntomas graves (por ej., ideación suicida, rituales obsesivos graves, robos en tiendas) o cualquier alteración grave de la actividad social, laboral o escolar (por ej., sin amigos, incapaz de mantenerse en un empleo).
40-31: Una alteración de la verificación de la realidad o de la comunicación (por ej., el lenguaje es a veces ilógico, oscuro o irrelevante) o alteración importante en varias áreas como el trabajo escolar, las relaciones familiares, el juicio, el pensamiento o el estado de ánimo (por ej., un hombre depresivo evita a sus amigos, abandona la familia y es incapaz de trabajar; un niño golpea frecuentemente a niños más pequeños, es desafiante en casa y deja de acudir a la escuela).
30-21: La conducta está considerablemente influida por ideas delirantes o alucinaciones o existe una alteración grave de la comunicación o el juicio (por ej., a veces es incoherente, actúa de manera claramente inapropiada, preocupación suicida) o incapacidad para funcionar en casi todas las áreas (por ej., permanece en la cama todo el día; sin trabajo, vivienda o amigos).
20-11: Algún peligro de causar lesiones a otros o a sí mismo (por ej., intentos de suicidio sin una expectativa manifiesta de muerte; frecuentemente violento; excitación maníaca) u ocasionalmente deja de mantener la higiene personal mínima (por ej., con manchas de excrementos) o alteración importante de la comunicación (por ej., muy incoherente o mudo).
10-1: Peligro persistente de lesionar gravemente a otros o a sí mismo (por ej., violencia recurrente) o incapacidad persistente para mantener la higiene personal mínima o acto suicida grave con expectativa manifiesta de muerte.
0: Información inadecuada

Si es necesario usar un código intermedio, se puede especificar a continuación:_____

Battery of questionnaires for the clinical sample of patients with BD (Studies 3 and 4)

Encuesta: LA RESILIENCIA EN EL TRASTORNO BIPOLAR

BREVE DESCRIPCIÓN DEL ESTUDIO Y DE SU PARTICIPACIÓN

El presente estudio forma parte de otro estudio más amplio titulado: "Validación de la Resiliencia como predictora de mejora en síntomas, funcionalidad y calidad de vida en el Trastorno Bipolar: Estudio Cualitativo y Cuantitativo Longitudinal" llevado a cabo por la investigadora y psicóloga Ainara Echezarraga, dentro del equipo Deusto Stress Research de la Universidad de Deusto.

La resiliencia, entendida como el proceso que atraviesan las personas para superar la adversidad, envuelve los cambios en las actitudes, pensamientos y estrategias utilizadas para superar la adversidad. Recientemente se ha observado cómo la Resiliencia predice la mejora en varios problemas de salud mental. El objetivo es estudiar la resiliencia ante el Trastorno Bipolar (TB). Es decir, estudiar la relación entre la resiliencia y la mejora en síntomas, en funcionalidad, y en calidad de vida en personas diagnosticadas de TB. Por favor, dedica unos minutos a completar esta encuesta. Tu participación es voluntaria y tienes derecho a retirar el consentimiento a participar en cualquier momento. Tus respuestas serán tratadas de forma confidencial y no serán utilizadas para ningún propósito distinto a la presente investigación. La información que nos proporciones será muy útil para estudiar el fenómeno de la resiliencia en el TB como factor de promoción de la salud en este tipo de población.

DATOS PERSONALES Y CÓDIGO PERSONAL DE IDENTIFICACIÓN

Si consientes participar en el estudio, a continuación se te pedirá que indiques algunos datos personales. Diez meses después se te pedirá que vuelvas a completar una encuesta similar a la presente, para evaluar los cambios que pudieran darse en ese intervalo de tiempo. Con la finalidad de volver a contactar contigo dentro de diez meses y enviarte el link de la encuesta, a continuación te pediremos por favor que indiques tu dirección de correo electrónico habitual. Para poder emparejar tus datos de esta primera vez que rellenes la encuesta, con tus datos de cuando vuelvas a rellenar la encuesta dentro de diez meses, a continuación te pediremos por favor que indiques un código de identificación personal. A continuación te indicaremos las instrucciones para crear este código de identificación personal. Esta encuesta dura aproximadamente una hora.

Ten en cuenta que, si estás realizando la encuesta *online*, una vez que salgas de la encuesta no podrás volver a acceder a ella para seguir completándola. De este modo, se te sugiere que comiences a realizarla cuando dispongas del tiempo suficiente para completarla.

Para cualquier información adicional, a continuación se indica el contacto de la investigadora principal del estudio: Ainara Echezarraga (94 413 90 00. Ext. 2668, email: a.echezarraga@deusto.es).

ANTES DE COMPLETAR LA ENCUESTA CERTIFICO QUE:

- **He recibido suficiente información sobre el estudio.**
- **Comprendo que mi participación es voluntaria.**
- **Comprendo que puedo retirarme del estudio:**
  - **Cuando quiera.**
  - **Sin tener que dar explicaciones.**
  - **Sin que esto repercuta negativamente hacia mí de ninguna manera.**

MARCA *SI* SI ACEPTAS PARTICIPAR EN ESTE ESTUDIO BAJO LAS CONDICIONES ANTERIORES.

MARCA *NO* SI NO ACEPTAS PARTICIPAR EN ESTE ESTUDIO BAJO LAS CONDICIONES ANTERIORES.

☐ **Si**

☐ **No**

Por favor, indícanos tu dirección de correo electrónico habitual para volver hacerte llegar la encuesta dentro de diez meses: _____

No es obligatorio que nos digas tu nombre y apellidos si no quieres. No obstante, nos ayuda a gestionar mejor los datos. Si lo deseas, puedes darnos aquí tu nombre y apellidos. Estos datos son almacenados en nuestra base de datos de forma segura.

_____

CÓDIGO DE IDENTIFICACIÓN PERSONAL: Por favor, indícanos tu código de identificación personal para poder relacionar tus datos de dentro de diez meses con los de ahora. Para crear el código, escribe seguido y sin líneas ni guiones, tu fecha de nacimiento *XX(día)XX(mes)XXXX(año)* y tu *letra del DNI* (Documento Nacional de Identificación).
Por ejemplo: *23041980A* (23: día, 04: mes, 1980: año, A: letra del DNI).

Indica tu código de identificación personal: _____

Fecha de HOY (Día/Mes/Año): _____

DATOS SOCIO-DEMOGRÁFICOS

Mi fecha de nacimiento es (Día/Mes/Año): _____

Sexo

☐ Hombre
☐ Mujer

Nivel educativo:

☐ Sin estudios
☐ Estudios primarios (hasta los 14 años)
☐ Estudios secundarios (hasta los 17 años)
☐ Estudios técnicos/Formación Profesional
☐ Estudios superiores/Universitarios (grado, ingeniería, diplomatura, licenciatura)
☐ Estudios post-universitarios (máster, doctorado)

Situación laboral actual:

☐ Trabajo remunerado a jornada parcial
☐ Trabajo remunerado a jornada completa
☐ Trabajo no remunerado (ejemplos: ama de casa, voluntariado, prácticas…)
☐ Estudiante
☐ Baja laboral temporal debido al Trastorno Bipolar
☐ Baja laboral temporal independiente del Trastorno Bipolar
☐ Incapacidad laboral por el Trastorno Bipolar
☐ Incapacidad temporal independiente al Trastorno Bipolar
☐ Jubilado/a
☐ En paro

Estado civil

☐ Soltero/a
☐ Tengo pareja
☐ Pareja de hecho o casado/a
☐ Separado/a o divorciado/a
☐ Viudo/a

DATOS CLÍNICOS

Edad de inicio aproximada del Trastorno Bipolar (TB) (para contestar puedes orientarte en la edad en la que tuviste el primer episodio bipolar):_____

Número aproximado de admisiones hospitalarias por el TB (debido a episodios depresivos, (hipo)maníacos, mixtos…):_____

En el último año, ¿has tenido cuatro o más episodios bipolares?

☐ Sí
☐ No

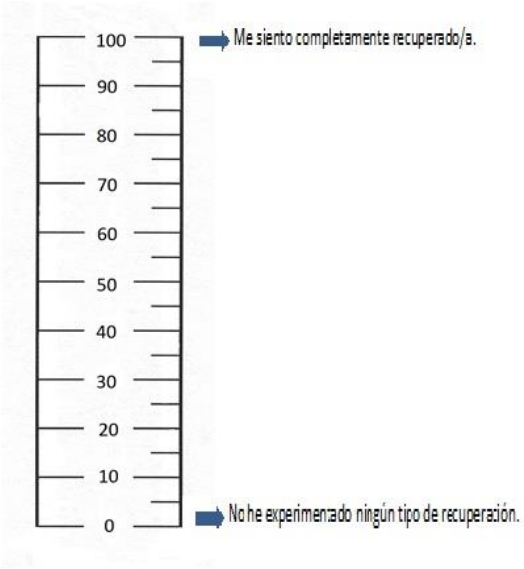
Aproximadamente, ¿Cuánto tiempo ha pasado desde que tuviste el último episodio bipolar?

_____

Para el TB se suelen prescribir varios tipos de medicaciones como antidepresivos (ejemplos: Fluoxetina [Prozac], Venlafaxina [Vandral, Dobupal])**, Estabilizadores del ánimo** (ejemplo: Litio [Plenur])**, Antipsicóticos** (ejemplos: Haloperidol, Clozapina [Leponex], Olanzapina [Zyprexa])**, y anticonvulsivos** (Ejemplo: Lamotrigina)**. Actualmente, tomo la siguiente medicación para el TB *(En esta pregunta se pueden marcar varias opciones):***

☐ Antidepresivos con o sin estabilizadores del ánimo o antipsicóticos.
☐ Estabilizadores del ánimo con o sin antipsicóticos.
☐ Antipsicóticos
☐ Anticonvulsivos
☐ Tomo otra medicación diferente a las opciones anteriores
☐ No tomo ninguna medicación para el TB.

En una escala del 0 al 100, donde 0 es "*no recuperado/a*" y 100 es "completamente *recuperado/a*", ¿dónde te situarías actualmente? Por favor, selecciona el número que mejor refleje tu nivel de recuperación:



Acudo o he acudido a un psicólogo (para hacer terapia individual y/o grupal) para el TB, además de al psiquiatra:

☐ Sí
☐ No

Elige la afirmación que mejor te describa ahora mismo o en las ÚLTIMAS DOS SEMANAS:

☐ Otras personas piensan que tengo un Trastorno Bipolar (TB), pero yo no.
☐ Me doy cuenta de que tengo un TB, pero no estoy seguro/a de que esté preparado/a para cambiarlo.
☐ Estoy pensando en actuar contra el TB en los próximos de 1 a 6 meses.
☐ He tomado acciones concretas contra el TB en los últimos 6 meses.
☐ Estoy trabajando para mantener los cambios que he hecho contra el TB.
☐ He tomado acciones contra el TB y ahora estoy recuperado/a.

Además del TB, me han diagnosticado otros trastornos mentales *(Se pueden seleccionar varias opciones):*

☐ Abuso de sustancias
☐ Ansiedad Generalizada
☐ Fobia social
☐ Trastorno Obsesivo Compulsivo
☐ Estrés Postraumático
☐ Trastorno de Alimentación
☐ Trastorno de personalidad
☐ Ninguno
☐ Otro (Por favor especifique)_____

Tengo otras enfermedades físicas:

☐ Sí
☐ No
☐ Si tu respuesta es "Sí", por favor, especifica:
_____

CUESTIONARIO DE CALIDAD DE VIDA EN EL TRASTORNO BIPOLAR

Los siguientes ítems corresponden a una serie de experiencias, comportamientos y sentimientos relacionados con la calidad de vida. Por favor, cuéntanos acerca de tu calidad de vida calificando las afirmaciones que se presentan a continuación, indicando tu grado de acuerdo o desacuerdo con cada una de ellas. No te tomes mucho tiempo en cada ítem, ya que son tus primeras impresiones las que nos interesan. Marca el número que mejor describa tu experiencia durante las ÚLTIMAS DOS SEMANAS.

Durante las últimas dos semanas, yo...

	1 Muy en Desacuerdo	2 En Desacuerdo	3 Ni de acuerdo ni en desacuerdo	4 De acuerdo	5 Muy de acuerdo
1. Me he sentido bien físicamente.	☐	☐	☐	☐	☐
2. Me he despertado con energía.	☐	☐	☐	☐	☐
3. He disfrutado las cosas igual que siempre.	☐	☐	☐	☐	☐
4. He tenido buena concentración.	☐	☐	☐	☐	☐
5. He estado interesado/a en mis actividades de recreación.	☐	☐	☐	☐	☐
6. He estado interesado/a en mis relaciones sociales.	☐	☐	☐	☐	☐
7. He practicado mi espiritualidad tal como deseo.	☐	☐	☐	☐	☐
8. He tenido suficiente tiempo para cosas extras.	☐	☐	☐	☐	☐
9. He mantenido mi casa ordenada.	☐	☐	☐	☐	☐
10. Me he sentido aceptado/a por otros.	☐	☐	☐	☐	☐
11. Me he transportado de un lugar a otro libremente (ej. Conduciendo, usando transporte público).	☐	☐	☐	☐	☐
12. He tenido una idea clara de lo que quiero y de lo que no quiero.	☐	☐	☐	☐	☐

AJUSTE LABORAL Y SOCIAL

Los problemas de la gente, a veces, afectan a su capacidad para hacer ciertas tareas del día a día en sus vidas. Por favor, determina cuánto afecta tu problema (en este caso referido al TRASTORNO BIPOLAR) en las ÚLTIMAS DOS SEMANAS a tu capacidad para llevar a cabo cada actividad. Esta evaluación no pretende ser un diagnóstico. Para responder, puntúa cada afirmación de acuerdo a la escala proporcionada, del 0 "no del todo afectada" al 8 "muy severamente afectada".
0 = No del todo 2 = Ligeramente 4 = Moderadamente 6 = Notablemente 8 = Muy severamente

Durante las últimas dos semanas...

	0 = No del todo	1	2	3	4 = Moderada-mente	5	6	7	8 = Muy severa-mente
1. Debido al TB, mi capacidad para trabajar o buscar un trabajo se ve deteriorada. ('0' Significa "en absoluto afectada" y ´8´ significa "muy gravemente afectada, hasta el punto de que no puedo trabajar").	☐	☐	☐	☐	☐	☐	☐	☐	☐

Si estás jubilado/a, en paro, incapacitado/a laboralmente o has escogido no tener un puesto de trabajo POR MOTIVOS AJENOS AL TRASTORNO BIPOLAR (TB), marca esta casilla:

☐

Durante las últimas dos semanas...

	0 = No del todo	1	2	3	4 = Moderada-mente	5	6	7	8 = Muy severa-mente
2. A causa del TB, mi capacidad de llevar a cabo las tareas domésticas (limpieza, ordenar la casa, hacer la compra, cocinar, cuidar la casa o los niños, llevar las cuentas y pagar los recibos) se ve deteriorada.	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Debido al TB, mis actividades sociales de ocio (con otras personas, por ejemplo, fiestas, bares, excursiones, visitas, citas, entretenerse en casas) están perjudicadas.	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. A causa del TB, mis actividades solitarias de ocio realizadas sin nadie más (realizadas a solas, como la lectura, la jardinería, la colección de cosas, la costura, pasear solo/a) están perjudicadas.	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. A causa del TB, mi capacidad de formar y mantener relaciones estrechas con los demás, incluidas las personas con las que vivo, está deteriorada.	☐	☐	☐	☐	☐	☐	☐	☐	☐

RESILIENCIA ANTE EL TRASTORNO BIPOLAR

El cuestionario de Resiliencia ante el Trastorno Bipolar (TB) ha sido desarrollado con el fin de entender mejor el proceso resiliente en el TB. Este cuestionario ha sido desarrollado gracias a entrevistas individualizadas y grupales realizadas a personas diagnosticadas de TB, preguntándoles sobre su experiencia resiliente ante el TB, y a psiquiatras y psicólogos expertos en el tratamiento del TB. Se reconoce que la resiliencia es un proceso dinámico e individual. Por ello, no todos los datos incluidos en este cuestionario han de aplicarse a ti en la actualidad. A continuación se te presentan una serie de afirmaciones relacionadas con la experiencia Resiliente ante el Trastorno Bipolar (TB).

Por favor, responde a las siguientes preguntas marcando con una "X" la opción que corresponda en tu caso.

Si entendemos la **Resiliencia** como *"el proceso dinámico mediante el cual la persona está determinada a superar o adaptarse a la situación adversa, desarrollando para ello habilidades y estrategias positivas"…*

	No, en absoluto				Sí, con certeza
Según esta definición, ¿consideras que has experimentado la Resiliencia (en cualquier momento de tu vida) para luchar ante tu TB?	☐	☐	☐	☐	☐

	1 Muy bajo	2 Bajo	3 Medio	4 Alto	5 Muy alto
Pensando en las dos últimas semanas, mi <u>actual</u> nivel de Resiliencia ante el TB es:	☐	☐	☐	☐	☐

Para responder a las siguientes afirmaciones, por favor, indica con una "X" en qué grado estás de acuerdo con las siguientes afirmaciones en una escala del 1 (*Muy en desacuerdo*) al 5 (*Muy de acuerdo*). Para contestar, piensa en tu TB como la situación adversa. Al rellenar el cuestionario, por favor, piensa en las ÚLTIMAS DOS SEMANAS. Últimamente (en las últimas dos semanas)...

	1 (Muy en desacuerdo)	2 (En desacuerdo)	3 (Ni de acuerdo ni en desacuerdo)	4 (De acuerdo)	5 (Muy de acuerdo)
1. Ya he sufrido bastante por el TB, quiero sobreponerme al TB y cambiar esta situación.	☐	☐	☐	☐	☐
2. Creo que he tocado fondo tanto que me he comprometido a luchar para sobreponerme al TB.	☐	☐	☐	☐	☐
3. Quiero volver a vivir buenos momentos en mi vida.	☐	☐	☐	☐	☐
4. He sentido una energía interior que me ha empujado a salir del sufrimiento del TB.	☐	☐	☐	☐	☐
5. Tengo la esperanza de que puedo enfrentarme al TB para que me condicione menos la vida.	☐	☐	☐	☐	☐
6. Lo he dado todo para que el TB impacte menos en mi vida.	☐	☐	☐	☐	☐
7. Estoy tratando de conocerme a mí mismo/a porque me ayuda a sobreponerme al TB.	☐	☐	☐	☐	☐
8. Me cuestiono qué parte de mí refleja mi personalidad y qué parte es debida al TB.	☐	☐	☐	☐	☐

9. Estoy reorientando mi camino en la vida, a pesar del TB.	☐	☐	☐	☐	☐
10. Hago actividades que me encantan o apasionan y conectan con mi interior (por ejemplo: pintar, tocar la guitarra, relacionarme con gente, con la naturaleza, el sol, etc.).	☐	☐	☐	☐	☐
11. Tengo afán de superarme o mejorar como persona.	☐	☐	☐	☐	☐
12. Estoy orgulloso/a de lo que he conseguido a pesar de padecer un TB.	☐	☐	☐	☐	☐
13. Estoy conociendo el TB (leyendo y aprendiendo de la experiencia personal).	☐	☐	☐	☐	☐
14. Me tomo muy en serio mi tratamiento psico-farmacológico porque confío en que me ayuda con el TB.	☐	☐	☐	☐	☐
15. Soy consciente de lo grave que es tener un TB.	☐	☐	☐	☐	☐
16. Intento estar atento/a y manejar los signos o señales de alerta temprana para anticiparme y regular los síntomas del TB.	☐	☐	☐	☐	☐
17. Tengo un margen de acción, control y responsabilidad sobre el TB.	☐	☐	☐	☐	☐
18. Pongo de mi parte para intentar regular el TB.	☐	☐	☐	☐	☐
19. Pongo mis límites y digo "no" a lo que me perjudica para buscar un equilibrio sociolaboral, tener relaciones positivas, escoger opciones de acuerdo a un estilo de vida sano (por ejemplo, limitando el consumo de alcohol).	☐	☐	☐	☐	☐
20. Mi salud mental y bienestar son mi prioridad y tengo que cuidarlos ante todo.	☐	☐	☐	☐	☐
21. Me obligo a mantener unos hábitos saludables (dormir y comer bien, hacer ejercicio, relajarme, etc.) para mi bienestar.	☐	☐	☐	☐	☐
22. Las pequeñas tareas diarias me ayudan a tener una vida más ordenada y estable.	☐	☐	☐	☐	☐
23. Cuando lo necesito, tengo o busco una persona cercana (amigos, familia, pareja) en quien apoyarme y desahogarme o expresarme.	☐	☐	☐	☐	☐
24. Me adapto fácilmente a los cambios o contratiempos relacionados con el TB.	☐	☐	☐	☐	☐
25. Cuando tengo problemas procuro analizarlos objetivamente y detectar mis recursos.	☐	☐	☐	☐	☐
26. Soy una persona creativa para buscar y adoptar activamente los recursos que necesito para afrontar mi TB.	☐	☐	☐	☐	☐
27. No puedo recuperarme del TB de un día para otro, pero intento centrarme para sacar adelante el día de hoy.	☐	☐	☐	☐	☐
28. Cuando mis emociones son demasiado intensas, intento calmarlas para reaccionar adecuadamente.	☐	☐	☐	☐	☐

29. Me baso en lo que le ha funcionado a los demás y a mí mismo/a para tomar la última decisión.	☐	☐	☐	☐	☐
30. Confío en que soy capaz de hacer la mayoría de las cosas si lo intento.	☐	☐	☐	☐	☐
31. Puedo estar solo/a.	☐	☐	☐	☐	☐
32. Soy perseverante y ante las dificultades, al final no abandono.	☐	☐	☐	☐	☐
33. Mantengo mi forma de ser y soy fiel a mis valores.	☐	☐	☐	☐	☐
34. Intento enfocar o dirigir el TB con actitud optimista.	☐	☐	☐	☐	☐
35. Puedo sentirme condicionado por el TB, pero aun así me acepto tal y como soy.	☐	☐	☐	☐	☐
36. Trato de percibir y comprender cómo estoy y lo que me pasa.	☐	☐	☐	☐	☐
37. Tengo una red sanitaria de apoyo (psiquiatra, psicólogo/a, etc.) donde me dan el tratamiento más adecuado para el TB.	☐	☐	☐	☐	☐
38. Mi terapeuta (psiquiatra y/o psicólogo/a) es una persona de apoyo importante para mí.	☐	☐	☐	☐	☐
39. Cuento con al menos una persona (terapeuta, amigo/a, pareja, familiar, etc.) que me ayude a sobreponerme a momentos difíciles.	☐	☐	☐	☐	☐
40. Cuento con al menos una persona (amigo/a, pareja, familiar, etc.) que me quiere de manera incondicional.	☐	☐	☐	☐	☐
41. Cuento con alguien de confianza que me alerta cuando me desequilibro.	☐	☐	☐	☐	☐

ESCALA DE ESTADOS INTERNOS

Para cada una de las siguientes declaraciones, indica el número que mejor describa la forma en que te has sentido durante las ÚLTIMAS DOS SEMANAS. Aunque puedan haberse dado cambios durante estos días, intenta dar una puntuación global para cada frase.

Últimamente (ÚLTIMAS DOS SEMANAS)…	0 (Para nada / Rara vez)	10	20	30	40	50	60	70	80	90	100 (Así es / La mayor parte del tiempo)
1. Últimamente mi ánimo es cambiante.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Últimamente me siento irritable.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Últimamente me siento como una persona capaz.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Últimamente siento como si la gente estuviera en contra de mí.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Últimamente, realmente, me siento muy bien interiormente.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Últimamente me siento impulsivo/a.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Últimamente estoy deprimido/a.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Últimamente mis pensamientos se mueven rápidamente.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Últimamente siento como que nada va a funcionar para mí nunca.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Últimamente me siento hiperactivo/a.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11. Últimamente siento como si el mundo estuviera en mi contra.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. Últimamente me siento acelerado/a.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13. Últimamente estoy inquieto/a.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14. Últimamente tiendo a discutir.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15. Últimamente me siento lleno/a de energía.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16. Indica en una escala del 0 al 10, donde 0 es " Deprimido o muy triste" y 10 es "Maníaco o irritable", cómo te has sentido últimamente (en las últimas dos semanas):	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

RECUPERACIÓN DEL TRASTORNO BIPOLAR

El Cuestionario de Recuperación Bipolar ha sido desarrollado con el fin de entender mejor la recuperación en el Trastorno Bipolar, qué es la recuperación y qué ayuda o dificulta la recuperación. Este cuestionario ha sido desarrollado gracias a entrevistas hechas a personas con diagnóstico de Trastorno Bipolar, preguntándoles sobre sus experiencias de recuperación. Reconociendo que todo el mundo es diferente y que se pueden tener diferentes experiencias y puntos de vista sobre la recuperación, no todas las afirmaciones incluidas en este cuestionario han de aplicarse a ti. Al rellenar el cuestionario, por favor considera cómo te han ido las cosas en las últimas dos semanas, respecto a tu salud mental y recuperación. Por favor responde a las siguientes afirmaciones marcando el número que mejor describa tu grado de acuerdo con cada afirmación.

En las ÚLTIMAS DOS SEMANAS

	Muy en desacuerdo		En desacuerdo				De acuerdo			Muy de acuerdo
	1	2	3	4	5	6	7	8	9	10
1. Me cuesta mucho dar sentido a las experiencias que he vivido.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Tengo los recursos para manejar eficazmente mi salud.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Estoy satisfecho/a con la persona que soy.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Tengo poco control sobre mi estado de ánimo.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Evito enfrentarme a los retos de la vida que me importan.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Entiendo que la recuperación es un proceso para toda la vida.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Algunas experiencias que he vivido, las veo ahora de forma distinta a cuando las tuve por primera vez.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Puedo acceder a la ayuda que necesito para estar bien.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Mis vivencias me han hecho ser quien soy ahora.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Reconozco cuándo estoy en situaciones que no son buenas para mi bienestar.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11. Soy capaz de implicarme en actividades que tienen un significado personal para mí.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. En mi opinión, recuperarse significa olvidarse de los propios problemas mentales.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13. Estoy inseguro/a acerca de los motivos de algunas experiencias que he vivido.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14. Siento que tengo control sobre las cosas que me pasan en la vida.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15. Soy productivo/a en las cosas de mi vida en las que me implico.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16. Dependo de otras personas para mantener mi bienestar.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

17. Tengo la suficiente confianza en mí mismo/a para implicarme en las cosas de la vida que me interesan.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18. Puedo tener experiencias de alteración del estado de ánimo y sin embargo continuar con mi vida.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19. Me hago una idea del origen de algunas experiencias que he vivido.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20. Puedo determinar cuándo necesito ayuda de otras personas para mantener mi bienestar.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21. Obtengo poca satisfacción personal de las cosas en la vida en las que me implico.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22. Tengo conocimientos para poder tomar decisiones informadas sobre mi tratamiento de salud mental.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
23. No me gusta la persona en la que me he convertido.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24. A veces dejo que mi estado de ánimo fluctúe, si tengo algo importante que hacer.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25. Mi alto grado de auto-exigencia no está relacionado con mis cambios de estado de ánimo.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26. Desempeño un papel fundamental en el mantenimiento de mi propio bienestar.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27. Soy capaz de lograr mis metas en la vida.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28. Mi capacidad para tomar decisiones informadas en mi tratamiento, está apoyada por mis amigos y familia.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
29. Me resulta difícil participar en una serie de actividades valiosas para mí.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
30. Puedo estar en recuperación aunque en el futuro tenga más episodios de alteración del estado de ánimo.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
31. Comprender el origen de los estados de ánimo experimentados me ayuda a manejarlos mejor.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
32. Tengo poco control sobre las decisiones importantes de mi vida.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
33. Soy capaz de participar en actividades valiosas para el conjunto de la sociedad.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
34. Lo que he aprendido me ayuda a cuidarme mejor.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
35. Las cosas que hago influyen positivamente en otras personas.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
36. En mi opinión, estar en recuperación implica que todo tiene que ir bien en todos los aspectos de la vida.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

ESCALA DE RESILIENCIA GENERAL

Se presentan 25 afirmaciones, y se te pide que indiques en qué medida te sientes reflejado/a (cómo de bien te describen a ti) por cada afirmación últimamente: en las ÚLTIMAS DOS SEMANAS…

	1 (No me describe para nada)	2	3	4	5	6	7 (Me describe perfecta-mente)
1. Cuando hago planes, los llevo a cabo.	☐	☐	☐	☐	☐	☐	☐
2. Normalmente, sea de un modo u otro, me manejo bien con los problemas.	☐	☐	☐	☐	☐	☐	☐
3. Dependo de mi mismo/a más que de cualquier otra persona.	☐	☐	☐	☐	☐	☐	☐
4. Para mí es importante mantener el interés por las cosas.	☐	☐	☐	☐	☐	☐	☐
5. Puedo estar solo/a si es necesario.	☐	☐	☐	☐	☐	☐	☐
6. Me siento orgulloso/a de haber logrado cosas en mi vida.	☐	☐	☐	☐	☐	☐	☐
7. Me suelo tomar las cosas con calma.	☐	☐	☐	☐	☐	☐	☐
8. Me acepto tal y como soy.	☐	☐	☐	☐	☐	☐	☐
9. Siento que puedo manejar muchas cosas al mismo tiempo.	☐	☐	☐	☐	☐	☐	☐
10. Soy decidido/a.	☐	☐	☐	☐	☐	☐	☐
11. Tengo claro qué es lo importante en mi vida.	☐	☐	☐	☐	☐	☐	☐
12. Afronto la vida día a día, paso a paso.	☐	☐	☐	☐	☐	☐	☐
13. Puedo salir de tiempos difíciles porque he pasado por tiempos difíciles.	☐	☐	☐	☐	☐	☐	☐
14. Soy disciplinado/a.	☐	☐	☐	☐	☐	☐	☐
15. Mantengo interés en las cosas.	☐	☐	☐	☐	☐	☐	☐
16. Usualmente puedo encontrar algo de qué reírme.	☐	☐	☐	☐	☐	☐	☐
17. Mi confianza en mí mismo/a me hace salir de tiempos difíciles.	☐	☐	☐	☐	☐	☐	☐
18. En una emergencia, soy alguien en quien la gente puede contar.	☐	☐	☐	☐	☐	☐	☐
19. Generalmente puedo ver una situación de muchas maneras.	☐	☐	☐	☐	☐	☐	☐
20. A veces me esfuerzo en hacer cosas quiera o no.	☐	☐	☐	☐	☐	☐	☐
21. Mi vida tiene sentido.	☐	☐	☐	☐	☐	☐	☐
22. No me estanco en las cosas que no tienen solución.	☐	☐	☐	☐	☐	☐	☐
23. Ante una situación difícil, suelo encontrar la manera de salir adelante.	☐	☐	☐	☐	☐	☐	☐
24. Tengo suficiente energía para hacer lo que tengo que hacer.	☐	☐	☐	☐	☐	☐	☐
25. No me importa no gustarle a todo el mundo.	☐	☐	☐	☐	☐	☐	☐

¡YA HAS TERMINADO! ¡MUCHAS GRACIAS POR TU COLABORACIÓN!

“Don´t lose sight of who you are, keep on course”

― Winston Groom, Gumpisms: The Wit and Wisdom of Forrest Gump.