

THE NATURE OF SELF-DIRECTED LEARNING AND
TRANSFORMATIONAL LEARNING IN SELF-MANAGING
BIPOLAR DISORDER TO STAY WELL

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THE NATURE OF SELF-DIRECTED LEARNING AND
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DEDICATION

I dedicate my dissertation to those of us with bipolar disorder waking daily with the best of intentions to stay well or in balance despite the ferocity and fickleness of our mental illness. Remember, staying well requires life-long learning and is a renewable state of being. Never give up exploring what works best for you to stay well. Never be afraid to ask others for help with managing your bipolar disorder. In memorial to Joe, always remember, “you’re not alone”

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ABSTRACT

THE NATURE OF SELF-DIRECTED LEARNING AND TRANSFORMATIONAL LEARNING IN SELF-MANAGING BIPOLAR DISORDER TO STAY WELL

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The purpose of the research was to explore the self-directed learning and transformational learning experiences among persons with bipolar disorder. A review of previous research pointed out how personal experiences with self-directed learning and transformational learning facilitated individuals' learning to manage HIV, Methicillin-resistant *Staphylococcus aureus* (MRSA), prostate cancer, and breast cancer to maintain their health. In addition, participants in a study examining self-management of bipolar disorder identified educating one's self as important for staying well. However, unexplored in the previous research was how self-directed learning and transformational learning experiences transpired among persons who were self-managing bipolar disorder.

The three research questions focused on experiences prompting learning, personal experiences with learning self-management, and personal experiences contributing to strategies for staying well.

Of the 12 individuals initially inquiring about participating in the research, 8 individuals voluntarily participated. These male and female participants' ages ranged from 25 to 67. The audio taped interviews ranged from 90 minutes to over two hours in length. Two participants provided feedback about the interview questions, which were refined to address their comments.

The research method was heuristic inquiry and consisted of six phases: (a) initial engagement, (b) immersion, (c) incubation, (d) illumination, (e) explication, and (f) culmination. The heuristic process permitted my being embedded in the conversations about learning how to self-manage bipolar disorder to stay well as both researcher and research participant. The culmination of analysis resulted in 14 emergent themes describing: (a) the role of meaning making and acceptance as prompts to learning, (b) how barriers were negotiated and resources engaged to facilitate learning to self-manage to stay well, and (c) the importance of acquiring strategies for staying well.

Emerging from these 14 themes were key experiential events among participants learning to self-manage bipolar disorder to stay well. Participants had to make meaning of bipolar disorder in order to accept the diagnosis and begin to engage in learning, which transpired through self-directed learning and transformational learning experiences. Taking ownership of learning to self-manage to stay well was an expression of personal autonomy and self-determination. Personal motivation and personal experiences were valuable resources supporting and enabling learning to stay well. Proactive behavior

facilitated taking action on one's behalf to stay well. The benefit of an autodidactic approach to learning to self-manage bipolar was participants' sharing their knowledge about managing bipolar disorder and their compassion for others with bipolar disorder.

Findings from the current research point out how individuals with bipolar disorder can learn to self-manage to stay well. Personal commitment to learning was essential for staying well. Commitment emerged from making meaning of the diagnosis, accepting of the diagnosis, and taking ownership of learning how to stay well. Transformational learning and self-directed learning transpired from participants' personal experiences in learning how to self-manage bipolar disorder. Through autonomous learning experiences, they gained confidence in self-management and they became proactive about taking actions best serving their well being.

A proactive approach empowered actions and led to autonomous decisions for staying well. Through self-directed learning, participants identified best practices for caring for self and informing treatment decisions. Reframing of personal experiences facilitated gaining new perspectives. Reflections on past experiences enabled participants to inform their future actions and decisions for self-managing bipolar disorder.

Engaging others in conversations made personal narratives about living with and self-management of bipolar disorder available as learning resources and personal stories to embrace. Stories of self or stories about others transpired as teaching moments through transformational learning and self-directed learning. By engaging others in the narratives of self, participants witnessed new views and dimensions of learning how self-manage their bipolar disorder to stay well.

CHAPTER I

INTRODUCTION

Statement of Problem

I'll admit it: there's a great deal of pleasure to mental illness, especially to the mania associated with manic depression. It's an emotional state similar to Oz, full of excitement, color, noise, and speed—an overload of sensory stimulation—whereas the sane state of Kansas is plain and simple, black and white, boring and flat. (Behrman, 2002, p. xix)

Bipolar disorder or manic depression is a mental illness. It presents as a major shift in mood which can last days or months. The National Institute on Mental Health (NIMH) estimates the 12-month prevalence of bipolar disorder in the United States at 2.6% (NIMH, n.d.). Approximately 5.7 million American adults have bipolar disorder (NIMH, 2006, February 1). The average age of onset is 25 (NIMH, n.d.). Because bipolar disorder often goes unrecognized, people may suffer for years before receiving a proper diagnosis and treatment. Episodic and chronic in nature, no single medication or therapy may be effective in treating bipolar disorder (NIMH, 2006, February 1).

Bipolar disorder also is a chronic illness. Like other chronic illnesses, such as diabetes or hypertension, bipolar disorder is a long-term illness requiring regular treatment and currently has no cure (Miklowitz, 2002). However, unlike diabetes and hypertension, a major risk factor of bipolar disorder is suicide.

Long-term, preventive treatment for bipolar disorder is very important. The goal of treating bipolar disorder is to stabilize an individual's mood to prevent relapse into mania or depression. Treatment typically includes pharmacotherapy and psychosocial interventions, such as psychotherapy and psychoeducation (Miklowitz, 2002; NAMI, 1996). The National Institute on Mental Health recommends a treatment strategy that combines medication and psychosocial treatments as the most optimal means for managing bipolar disorder over time (NIMH, n.d.). Maintaining treatment, even during periods of wellness, helps keep the illness under control and reduces the chance of recurrent, worsening relapse episodes.

Prescribing of mood stabilizing medication via pharmacotherapy is the primary treatment for preventing relapse (Castle, 2003; Miklowitz, 2002). "About 1 in 3 people with bipolar disorder will remain completely free of symptoms just by taking mood stabilizing medications, such as carbamazepine (Tegretol) or lithium, for life" (HealthyPlace.com, n.d., p. 1). In addition, those who maintain medication treatment experience greater reductions in the frequency and severity of relapse into mania or depression.

Psychosocial interventions include psychotherapy and psychoeducation. Psychotherapy provides a secure environment in which to talk about living and coping with bipolar disorder (Miklowitz, 2002; NAMI, 1996). The types of psychotherapy (i.e. talk therapy) include individual, family, and group. Research evidence suggests that the use of psychotherapy along with medication significantly reduces symptoms, relapse, and inpatient hospitalizations for persons with bipolar disorder (Bowden, 2005; Gutierrez & Scott, 2004).

Psychoeducation interventions provide a forum in which individuals with bipolar disorder and their families learn about bipolar disorder (Miklowitz, 2002; NAMI, 1996; NIMH, n.d.). Common topics in psychoeducation include understanding the physiology of bipolar disorder, understanding treatment options, recognizing the triggers and symptoms of relapse, building social support networks, and learning self-management skills and strategies (Miklowitz & Otto, 2006; NAMI). The benefits of participating in psychoeducation interventions include improvement in illness self-management and reduction in relapses and hospitalizations (Colom & Lam, 2005; Miklowitz & Otto). In particular, self-management skills and strategies aid individuals with early identification of symptoms in seeking timely treatment of relapse and with prevention of future relapse (Frank, Gonzales, & Fagiolini, 2006).

Lorig and Holman (2003) view individuals as responsible for the day-to-day self-management of their health. Individuals can achieve wellness by practicing health-promoting activities to prevent illness or by managing an illness (e.g., bipolar disorder). For most individuals, self-management is a lifetime practice. Lorig and Holman make this assertion:

One cannot not manage. If one decides not to engage in a healthful behavior or not be active in managing a disease, this decision reflects a management style.

Unless one is totally ignorant of healthful behaviors it is impossible not to manage one's health. The only question is how one manages. (p. 1)

Individuals can learn to self-manage chronic illness by participating in health education programs. Self-management education promotes skills for living the best possible life with a chronic illness (Bodenheimer, Lorig, Holman, & Grumach, 2006).

“Sometimes called ‘patient empowerment’ this concept holds that patients accept responsibility to manage their own conditions and are encouraged to solve their own problems with information, but not orders, from professionals” (Bodenheimer et al., p. 2470).

Within and outside the theoretical frameworks associated with adult learning, researchers have explored the experiences of adults learning to self-manage and cope after receiving chronic illness diagnoses. Examined within the theoretical framework of constructivism, Rhode and Ross-Gordon (2012) explored how and why people learn about Methicillin-resistant *Staphylococcus aureus* (MRSA). Among persons with MRSA primarily learning occurred as self-directed, experiential, and sometimes transformational.

Framed within transformational learning theory Courtenay, Merriam, and Reeves (1998) explored how adults made sense of being diagnosed as human immunodeficiency virus (HIV) positive. The meaning-making process involved an initial period of reaction to the diagnosis that served as a catalyst into reflection and action phases to learn about living with HIV. Within the framework of self-directed learning theory Rager (2003, 2004) interviewed women diagnosed with breast cancer to find out how they personally directed their learning to cope more effectively and to educate themselves about treatment and health management. Rager’s findings highlighted that self-directed learning was a critical coping mechanism, a means of empowerment, a method to learn selectively, a way to search for meaning, and a means to connect personally with others with breast cancer.

Other studies have provided indirect evidence that transformational learning and self-directed learning were common experiences when learning to self-manage chronic illnesses including bipolar disorder. In several studies, individuals diagnosed with breast cancer or Type I diabetes described experiences leading to their acknowledging or denying the necessity to engage in self-education for learning to cope with illness and to tailor self-management practices to meet personal needs (Carpenter, Brockopp, & Andrykowski, 1999; Paterson, Thorne, Crawford, & Tarko, 1999). In addition, Russell and Browne (2005) explored how adults with bipolar disorder learned to avoid episodes of illness to stay well. They discovered individuals transitioned through experiences leading to self-educating themselves to learn strategies and to gain information about self-managing bipolar disorder. Individuals with bipolar disorder gained new perspectives on self-managing the illness by observing and being mindful of their responses to their physical, mental, and social environments.

Previous research findings have highlighted the importance of transformational learning and self-directed learning experiences for gaining knowledge about coping with and self-managing chronic illnesses, although only one of these studies has focused specifically on bipolar disorder. Learning how to manage was particularly critical for persons with bipolar disorder, an illness carrying a high risk of suicide and relapse. In addition, symptoms of relapse can be difficult to acknowledge and often easier to ignore (Frank et al., 2006; Miklowitz, 2002). However, the data from a study by Russell and Browne (2005) demonstrated the importance of people with bipolar disorder learning about the illness. “Participants felt that the sooner they accepted their illness, and learnt [sic] about it, the better chance they had of managing it” (Russell & Browne, p. 190).

Although there were no universal solutions identified, participants learned from personal experience what worked best for them.

Education is a necessity for learning to manage and cope with a chronic illness such as bipolar disorder. Successful management depends on how individuals actively engage in managing their health (Lorig & Holman, 2003). Past research findings and discussions have highlighted the value of psychoeducation in gaining an understanding of bipolar disorder and how to manage it (Colom & Lam, 2005; Frank et al., 2006; Miklowitz, 2002; Miklowitz & Otto, 2006; NAMI, 1996; NIMH, n.d.). In addition, research findings have highlighted the importance of individuals' self-directing their learning about bipolar disorder through books, health care professionals, mental health organizations, seminars, support groups, internet, and talking with other persons (Russell & Browne, 2005). In addition, life experiences proved important for learning to recognize triggers and warning signs of relapse (Russell & Browne).

Findings from past research have identified self-directed learning and transformational learning experiences as critical for self-managing coping with the chronic illnesses of HIV, breast cancer, MRSA, and Type I diabetes (Carpenter et al., 1999; Courtenay et al., 1998; Paterson et al., 1999; Rager, 2003; Rager, 2004; Rhode & Ross-Gordon, 2012). Although these studies have pointed to the value and necessity of self-directing education and mindfulness about chronic illnesses, very little is understood about the nature of self-directed learning and transformation learning experiences among persons with bipolar disorder who engage in educational activities to stay well.

Purpose and Significance

The purpose of this research was to explore the nature of self-directed learning and transformational learning experiences among individuals with bipolar disorder. The intention was to find out how these learning experiences contributed to developing personalized strategies for staying well with bipolar disorder. The research was seen as significant for a number of reasons.

First, findings from past research presented evidence of the value of self-directed learning and transformational learning experiences for educating one's self about living with bipolar disorder. Data from a study by Russell and Browne (2005) illustrated the importance of persons with bipolar disorder learning about the illness. Participants educated themselves about the illness through written materials, health care professionals, the internet, and mental health organizations. In addition, data indicated that persons with bipolar disorder benefited from maintaining awareness or mindfulness in observing themselves in order to make changes as necessary to stay well.

Second, if not carefully managed, bipolar disorder carries increased risk of suicide or relapse greater than other chronic illnesses. Long-term preventive treatment for bipolar disorder typically includes pharmacotherapy, psychotherapy, and psychoeducation (Miklowitz, 2002; NAMI, 1996). In particular, participation in psychoeducation interventions provides the benefits of improving illness outcomes and self-management as well as reducing relapse episodes, suicide attempts, and hospitalizations (Colom & Lam, 2005; Miklowitz & Otto, 2006).

Third, unlike self-managing other chronic illnesses, self-management of bipolar disorder requires vigilant attentiveness to small changes in physical, mental, and

emotional status that signal an impending episode of mania or depression. Although participants in a study by Russell and Browne (2005) described health care professionals advising them to watch for relapse signals such as undue enthusiasm, poor judgment, or excessive behaviors, participants felt these were late signs of impending mania.

Recognizing early warning signs, which included small changes in sleep behavior, mood, thoughts, and energy levels, led to implementing intervening behaviors to avoid episodes of illness. Intervening behaviors included canceling work and social engagements, sleeping, and engaging in exercise, yoga, or meditation.

Fourth, unlike other chronic illnesses, manic warning signs (e.g., excessive spending, overextension of social commitments, and excessive thinking) are difficult to acknowledge and interrupt (Frank et al., 2006; Miklowitz, 2002). Castle (2003) explains in *Bipolar Disorder Demystified*:

Particularly when your normal mode of operations is depression, a manic episode can bring sweet relief. Marvelous surges of adrenaline fuel your boundless enthusiasm. . . . This, you think, is the “real me.” This, you think, is who I want to be. It’s as if you hadn’t been *present* in your life before. (p. 10)

Lastly, researchers have yet to examine the nature of self-directed learning and transformational learning experiences to develop a personalized approach to managing bipolar disorder. A participant in Russell and Browne’s (2005) study described her perspective on learning to manage bipolar disorder: “I had to make huge changes in my life to stay well. Taking medication religiously would be the smallest of these changes. I now lead a different but full life” (p. 191). Yet this learning was not the focus of Russell and Browne’s study, or any other study identified in the literature thus far.

Research Questions

The purpose of this research was to explore the nature of self-directed learning and transformational learning experiences in developing personalized strategies for staying well with bipolar disorder. The guiding questions were:

1. What experiences prompt learning among individuals with bipolar disorder?
2. How do individuals with bipolar disorder describe learning to self-manage their bipolar disorder?
3. How do personal learning experiences contribute to strategies for staying well?

Assumptions

Several assumptions influenced the research design, sample selection, data collection, and other aspects of this study. The sources of these assumptions were literature about designing qualitative research and about research examining the self-directed and transformational learning experiences of persons with chronic illnesses including bipolar disorder.

The first assumption was that the recruitment method via promoting participation through licensed mental health professionals would enable me to connect with individuals who meet all the criteria of participation: (a) age 18 or older, (b) diagnosis of bipolar disorder, (c) receive treatment of bipolar disorder from a licensed medical professional, (d) have not been hospitalized for the treatment of bipolar disorder in the past 12 months, and (e) engage in activities for learning to stay well with bipolar disorder.

The second assumption was that participants would recall experiences of engaging in self-directed learning and transformational learning in self-managing bipolar disorder. As the researcher, my inquiry through questions, prompts, and follow-up interviews allowed a participant time to reflect and recall past experiences (Janesick, 2000).

The third assumption was that my mode of inquiry would permit me to get to the authentic, lived experiences of self-directed learning and transformational learning. The structure of the interview questions permitted obtaining true or credible accounts of an individual's sense of the real lived experience of learning to stay well with bipolar disorder (Patton, 2002).

Definition of Key Terms

For understanding the context of this research, several key terms require definitions.

These key terms are self-directed learning, transformational learning, staying well, and self-management:

- *Self-directed learning* is a process of learning through which individuals engage, with or without assistance from others, in determining their learning needs, developing goals, identifying resources, implementing strategies, and assessing learning outcomes (Candy, 1991; Knowles, 1975; Rager, 2003; Rager, 2004).
- *Transformational learning* as a process involves “. . . making meaning out of experiences and questioning assumptions based on prior experience” (Cranton, 2006, p. 8). These experiences may arise from a dilemma that is a single dramatic event or a succession of cumulative events (Baumgartner,

2001). Transformational learning occurs when an individual acts on the learning (Cranton).

- *Staying well* means having control of illness symptoms or, being free of illness symptoms (Russell & Browne, 2005).
- *Self-management* involves active participation in the treatment and applying practical skills in problem solving, decision making, resource utilization, and taking action to stay health (Lorig & Holman, 2003).

CHAPTER II

LITERATURE REVIEW

Long-term survival with bipolar disorder requires knowledge, skills, and strategies for successfully self-managing to prevent relapses into manic and depressive episodes. Researchers have studied how individuals learn to manage a bipolar disorder.

Characterizing Bipolar Disorder

Psychiatrists and psychologists generally characterize bipolar disorder as a cluster of symptoms, which initially build (promodal phase), become worse (active phase), and begin to diminish (recovery phase) (Miklowitz, 2002). The primary characteristic of bipolar disorder is extreme mood swings from an episode of a manic high (e.g., euphoria, irritability, energetic) to that of severe depression (e.g., sadness, self-loathing, loss of energy). In addition, some individuals experience the manic and depressive modes simultaneously as a mixed episode.

The subtypes of bipolar disorder include bipolar I, bipolar II, and bipolar disorder with rapid cycling (Miklowitz, 2002). Miklowitz identifies the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) as psychiatrists' and psychologists' primary source for diagnosing the symptoms of bipolar disorder. Criteria for a bipolar I diagnosis are a minimum of one lifetime episode of mania or a mixed mood (i.e., feelings of mania and depression go

back and forth quickly within days or a day) and a minimum of one lifetime episode of a major depression. Criteria for a bipolar II diagnosis are a minimum of one lifetime episode of hypomania (i.e., a milder form of mania) and a minimum of one lifetime episode of major depression. Criteria for a diagnosis of bipolar with rapid cycling are either meeting the criteria for bipolar I or bipolar II disorder and four or more episodes of major depression, mania, mixed disorder, or hypomania in any one year.

Accounts of individuals' experiences with bipolar disorder are similar: (a) riding a roller-coaster of moods shifts among euphoria, irritability, and depression; (b) changing levels of activity, such as being overly busy or lethargic; (c) changing thoughts and perceptions, such as suicidal ideation or overly self-confident; (d) changing sleep patterns, such as insomnia or a constant need to sleep; and (e) engaging in impulsive or self-destructive behavior (Behrman, 2002; Blauner, 2002; Castle, 2003; Jamison, 1995; Miklowitz, 2002; Whybrow, 1997).

Treating Bipolar Disorder

Stabilizing a person's mood is a primary purpose of treating bipolar disorder (Kusumakar et al., 1997; Miklowitz, 2002). The primary treatment mode is pharmacotherapy (i.e., prescription medication). It includes mood stabilizers, antidepressants, and antipsychotics that slow down or reduce the occurrences of mood cycling rather than eliminating them. Discussions on the treatment of bipolar disorder identify taking medication as greatly reducing the risk of suicide (Kusumakar; Miklowitz). Secondary treatment typically involves participation in psychosocial interventions, which include psychotherapy and psychoeducation interventions (Miklowitz; NAMI, 1996).

Educating Persons about Bipolar Disorder

Education is a tool for preventing symptoms of bipolar disorder, as identified through a survey of psychiatrists (Chengappa & Williams, 2005). Psychosocial interventions provide forums within which to learn about the treatment and management of bipolar disorder. Psychosocial interventions complement and improve the efficacy of medications and enhance health outcomes for persons with bipolar disorder, as discussed in articles reviewing the benefits of treatment options for bipolar disorder (Colom & Lam, 2005; Gonzalez-Pinto et al., 2004; Gutierrez & Scott, 2004; Keller, 2004; Kusumakar et al., 1997; Miklowitz & Otto, 2006; Otto, Reilly-Harrington, & Sachs, 2003; Vieta et al., 2005; Weiss, Kolodziej, Najavits, Greenfield, & Fucito, 2000).

Psychotherapy permits persons with bipolar disorder working with a therapist to discuss issues affecting their moods and to learn about treatment and management of their moods (Miklowitz, 2002; NAMI, 1996). Research points to the addition of psychotherapy to pharmacotherapy treatment as an effective means of improving health outcomes for persons with bipolar disorder (Colom & Lam, 2005; Miklowitz & Otto, 2006; Colom, Vieta, Martínez-Arán, et al., 2003; Gonzalez-Pinto et al., 2004; Otto et al., 2003; Vieta et al., 2005). Through their review of randomized controlled trials of treatment interventions for bipolar disorder, Gutierrez and Scott (2004) found evidence suggesting that participating in psychotherapy along with taking medications for bipolar disorder significantly reduces symptoms, relapse, and inpatient hospitalizations. Research findings show that persons with bipolar disorder commonly follow treatment plans that include psychotherapy (Weiss et al., 2000).

Psychoeducation interventions educate persons about the treatment and management of their bipolar disorder (Miklowitz, 2002; NAMI, 1996). Common topics of psychoeducation about bipolar disorder include the physiology of bipolar disorder, understanding treatment options, identifying symptoms of relapse, building social support networks, and learning to self-manage moods (Callahan & Bauer, 1999; Colom & Lam, 2005; Gonzalez-Pinto et al., 2004; Guitierrez & Scott, 2004; Miklowitz & Otto, 2006; NAMI; Otto et al., 2003; Vieta & Colom, 2004). In addition, numerous authors suggest that the inclusion of psychoeducation with pharmacotherapy improves health outcomes for persons with bipolar disorder (Colom & Lam, Miklowitz & Otto; Colom, Vieta, Reinares, et al., 2003; Gonzalez-Pinto et al; Otto et al.; Vieta et al., 2005).

A number of studies provided evidence of the efficacy of psychoeducation in reducing relapse among persons with bipolar disorder. In a mental health services environment, Perry, Tarrier, Morriss, McCarthy, and Limb (1999) investigated the efficacy of teaching individuals with bipolar disorder, who had experienced a relapse in the previous 12 months, to identify early symptoms of relapse and to obtain treatment. Participants in the experimental treatment group participated in 7-12 individual treatment sessions with a psychologist and routine care, while subjects in the control group only received routine care. Using the Mann-Whitney U for a log rank test, Perry et al. calculated a survivor's curve to measure the difference in relapse rates into mania or depression between the two groups of participants. The results highlighted reductions in the total number of both depressive and manic relapses in the treatment group. A significant difference was found between the treatment and control groups for manic

relapse (log rank 7.04, $df = 1$, $P = 0.008$), but not for depressive relapse (log rank 1.65, $df = 1$, $P = 0.19$).

Findings from other studies support the role of psychoeducation in reducing occurrences of relapse in persons with bipolar disorder. In two studies, researchers performed single-blind randomized, prospective clinical trials to test the efficacy of group psychoeducation to prevent relapses in persons with bipolar disorder experiencing remission (Colom, Vieta, Martínez-Arán, et al., 2003; Colom, Vieta, Reinares, et al., 2003). After confirming remission from mania or depression with assessment scales, Colom, Vieta, Martínez-Arán, et al. randomly assigned 120 individuals with bipolar disorder to experimental treatment and control groups. The treatment group received standard psychiatric care plus 21 sessions of group psychoeducation. The control group received standard psychiatric care plus 21 sessions of unstructured group meetings. Comparisons of the mean number of relapses during treatment and the follow-up phase were assessed using the chi square with statistical significance set at $P < .05$. A statistically significant difference ($\chi^2 = 5.63$, $P < .01$) was reported for relapse (i.e., mania, hypomania, mixed episode, or depression) between treatment group participants ($n = 23$, 38.3%) and control group participants ($n = 36$, 60%). At the end of the two-year follow up phase, a significant difference ($\chi^2 = 11.36$, $P < .001$) was found between the treatment participants ($n = 40$, 66.7%) and control group participants ($n = 55$, 91.7%).

Colom, Vieta, Reinares, et al. (2003) also explored the efficacy of psychoeducation for persons with bipolar disorder in a two phase study. The researchers recruited 50 individuals from a sample of 400 patients enrolled in a clinical bipolar disorder program. They tested the significance of differences for the occurrence of

relapse with chi square at $p < .05$ between experimental and control groups. Phase one involved 20 weeks of psychiatric care and pharmacotherapy for both the experimental and control groups; the experimental group also received psychoeducation. Phase two comprised two years during which participants in both groups continued receiving standard medical treatment without the psychoeducation for experimental group. After phase one there was a significance difference for relapse ($\chi^2 = 8.68, p < .003$) between the experimental group participants ($n = 4, 56\%$) and control group participants ($n = 14, 56\%$). At two-year follow-up in phase two a significance difference resulted ($\chi^2 = 7.01, p < .008$) for relapse between the experimental group participants ($n = 15, 60\%$) and the control group participants ($n = 23, 92\%$).

Finally, Michalak, Yatham, Wan, and Lam (2005) examined the impact of group psychoeducation on perceived quality of life by conducting retrospective chart reviews. The treatment intervention involved a standardized, eight-week group psychoeducation course provided to 57 persons with bipolar disorder at a mood disorder clinic. Participants completed quality of life questionnaires the first week (baseline measure) at the eight-week, final group session. Using paired t tests, the mean post-test score ($m = 55.7$) was significantly higher than the pre-test score ($m = 60.9$) ($t = 2.4, P < .02$).

Self-Management Education for Bipolar Disorder

Individuals with bipolar disorder use a variety of self-management techniques to prevent relapse into a manic or depressive mood. Education provides a means of learning techniques that facilitate maintaining wellness with bipolar disorder (Chengappa & Williams, 2005). Self-management techniques include adhering to treatment guidance, changing lifestyle routines, drawing upon social support, and following stay-well plans

(Colom, Vieta, Martínez-Arán, et al., 2003; Colom et al., 2004; Michalak et al., 2005; Perry et al., 1999; Pollack, 1996; Russell & Browne, 2005; Weiss et al., 2000). Findings from research evaluating the benefits of psychoeducation for persons with bipolar disorder point to best practices for self-management including: (a) taking medication as prescribed; (b) maintaining healthy sleep habits; (c) charting daily mood variations, (d) establishing nutritious eating habits; (e) avoiding mood altering substances, such as alcohol and marijuana; (f) maintaining a network of social support; and (g) limiting stressful situations (Colom, Vieta, Martínez-Arán, et al.; Colom, Vieta, Reinares, et al., 2003; Colom et al.; Perry et al.).

The efficacy of self-management education for chronic diseases, including bipolar disorder, was apparent in the literature. Various authors suggest that achieving positive health outcomes relies on the successful application of self-management practices (Bodenheimer et al., 2002; Grumbach, 2002; Frank et al., 2006; Lorig & Holman, 2003; Stevens & Sin, 2005). As advanced by Lorig and Holman:

The issue of self-management is especially important for those with chronic disease, where only the patient can be responsible for his or her day-to-day care over the length of the illness. For most of these people, self-management is a lifetime task. (p. 1)

Adult Learning Experiences

In previous studies, researchers explored how adults learned to cope with and self-manage chronic illnesses including bipolar disorder. Some researchers focused on gaining insight or an understanding about adults' experiences in learning to live with day-to-day management of chronic illnesses (Brown, Sorrell, McClaren, & Creswell, 2006;

Carpenter et al., 1999; Curtin, Mapes, Petillo, & Oberley, 2002; Paterson et al., 1999; Rhode & Ross-Gordon, 2012; Russell & Browne, 2005). Other researchers explored adults' learning experiences within the frameworks of self-directed learning and transformational learning theories (Baumgartner, 2002; Courtenay et al, 1998; Courtenay et al., 2000; Rager, 2003; Rager, 2004; Rager, 2006).

Constructing Meaning

Individuals do not passively appropriate knowledge. They learn as active participants in the process of constructing meaning and transforming understanding (Candy, 1991). A central tenet of constructivism is individuals try to give meaning to or construe perplexing events or circumstances. Constructivism identifies the source of meaning as existing within individuals rather than emerging from external sources such as books or the media (Mezirow, 1991). This tenet underlies the theoretical frameworks of transformational learning theory and self-directed learning theory.

A qualitative study focused on delving deeper into the learning experiences of 10 persons diagnosed with the MRSA infection (Rhode & Ross-Gordon, 2012). Their engagement in learning occurred after receiving the diagnosis. Prevalent means of gaining an understanding of MRSA were primarily from self-directed and experiential learning and less often from transformational learning experiences. There were two primary emergent themes: (a) Learning – “I guess everything changes when it happens to you,” and (b) Adaptation – “People make the difference.” All participants identified learning as a critical step in their production of knowledge about MRSA. In addition, the knowledge affected how they adapted to the infection.

Transformational Learning

Transformational learning is epistemological in the sense that it relates to the way we know not what we know (Kegan, 2000). Learning occurs through shifts in frames of reference as an outgrowth of personal experiences (Mezirow, 1991). The construction of frames of reference occurs through two processes: (a) meaning forming through the shaping of coherent meaning from outer and inner experiences, and (b) reforming of meaning forming through changing the very form by which meaning is made (Kegan). Thus, “learning is understood as the process of using a prior interpretation to construe a new or revised interpretation of the meaning of one’s experience as a guide to future action” (Mezirow, 2000, p. 5).

Whether through forming or reforming, meaning exists internally to an individual rather than externally, such as in books or other people (Mezirow, 1991). Personal meanings materialize from outer and inner experiences of daily life and are validated through human interaction and communication. Acting effectively on experiences results from understanding them. Understanding results from using existing meaning to guide thinking, acting, or feeling about current experiences (Mezirow). “Transformative learning is a process of examining, questioning, validating, and revising our perspectives” (Cranton, 1996, p. 23). If individuals challenge their assumptions, the learning process becomes transformational (Pilling-Cormick, 1997). The way people learn can transform personal expectations through reinterpretation of an old experience or fresh interpretation of a new experience with a new set of expectations (Mezirow; Mezirow, 2000). “Transformative learning has to do with making meaning out of experiences and

questioning assumptions based on prior experiences” (Cranton, 2006, p.8).

Transformational learning also can be a process of making meaning of life’s dilemmas.

Transformational experiences. Several studies have focused on the outcomes of transformational experiences of living with chronic health conditions, such as diabetes, cancer, permanent kidney failure, end-stage liver disease, or HIV (Baumgartner, 2001; Brown, Sorrell, McClaren, & Creswell, 2006; Carpenter et al., 1999; Courtenay, Merriam, & Reeves, 1998; Courtenay, Merriam, Reeves, & Baumgartner, 2000; Curtin, Mapes, Petillo, & Oberley, 2002; Paterson et al., 1999). Gaining an understanding of the transformational experience of living with diabetes was the purpose of Paterson et al.’s qualitative study. Recruitment resulted in the selection of 22 persons with Type I diabetes. Over a two-year period, they collected data from multiple data sources, which included interviews with the participants. The themes defining transformation included engaging in a new awareness, sensing life could be different, recognizing the self in terms of diabetes and the everyday self, experiencing a continual dynamic evolution, and discovering control of diabetes.

In order to understand more fully the self-transformational experience following a diagnosis of a life-threatening disease, Carpenter et al. (1999) interviewed 54 breast cancer survivors. Their theoretical frameworks were a health within illness model and a transition model of cancer. The methodology included semi-structured interviews along with a series of self-esteem and well-being questionnaires. The narratives revealed several types of self-transformation. Positive transformation was described as an emerging self-awareness leading to changed self-expectations and reinventing the self. Minimal transformation was described as the experience of self-awareness and self-

acceptance. Feeling paralyzed was described as desiring personal change but not knowing where to begin.

Curtin et al. (2002) examined how kidney patients survived long-term dialysis through a qualitative exploratory study. They recruited participants using a modified snowball technique. Initially, they identified several information rich cases. These initial interviewees then identified other persons as potential interviewees. Eighteen persons participated in the interviews. Curtin et. al found survival involved transformation into comprehensive, active self-managers of their disease. Themes of successful transformation for achieving comprehensive self-management included self-preservation, recognizing self-worth, coming to terms with the risk of death and an uncertain future, coming to terms with dialysis, and coming to terms with repeated setbacks in treatment.

Brown et al. (2006) explored the meaning ascribed from personal experiences of persons with end-stage liver disease waiting for a liver transplant. The researchers used maximum variation sampling to select participants who had been on a waiting list for varying amounts of time; nine persons with end-stage liver disease participated in this phenomenological study. Through the interviews, three themes emerged: (a) loss of the norms of daily life and self, (b) transformation of self and situations, and (c) searching for meaning and signs while waiting for a liver transplant.

Transformational learning experiences. Within the framework of transformational learning theory, Courtenay et al. (1998), Courtenay et al. (2000), and Baumgartner (2001) examined the meaning making process among persons with HIV/AIDS. How HIV-positive persons made sense of their health circumstance was the focus of a study by Courtenay et al. (1998). A nonrandom purposeful sampling strategy

identified 18 HIV-positive participants. The participants described experiencing a transformational period of reaction to the diagnosis, a catalyst helping them break away from the initial reaction, and three phases of reflection and activity. The three phases were: (a) taking stock, making adjustments in perception, and making adjustments in activities; (b) continuation of assimilation in making adjustments to perceptions, and activities to the circumstance of being HIV-positive; and (c) taking the opportunity to make a meaningful contribution to life, heightening sensitivity to life, and being of service to others.

In a two-year follow-up study, Courtenay et al. (2000) interviewed 14 of the original 18 adults in the Courtenay et al. (1998) study to learn whether their perspectives on living with HIV had changed. Specifically, they explored the stability of a perspective transformation and the nature of ongoing meaning-making. From the data, two major findings presented. First, transformation maintained and proved irreversible. Individuals continued making meaningful contributions and in appreciating their lives and the lives of others. Second, they experienced changes in meaning schemes including: (a) adoption of a future-oriented perspective of life, (b) greater attention to issues relevant to caring for self, and (c) integration of one's HIV-positive status into self-determination.

Baumgartner (2001) examined the nature of learning during the incorporation of HIV or AIDS into personal identity over time. Baumgartner built on the studies of Courtenay et al. (1998) and Courtenay et al. (2000). Eleven of the original 18 participants from Courtney et al.'s (1998) study were interviewed about their continued meaning making and all sets of data, including Courtenay et al. (2000), were analyzed to examine a continued meaning making process. From the analysis, four major findings emerged:

(a) the nature of learning was transformational and the perspective of transformation stayed stable over time, (b) meaning changes schemes were acted upon, (c) meaning-making schemes included increased appreciation for the human condition and expanded perspective of intimacy, and (d) social interaction provided an integral element to the learning process.

Self-Directed Learning

Self-directed learning is a process that individuals may initiate as the result of some triggering experience. Individuals do not engage in autodidactic action, self-directed learning, without some goal or purpose in mind (Candy, 1991). Candy explains, “the nature of learning something entirely new (or solving a problem) produces the setting of objectives at the outset” (Candy, p. 171). He suggests individuals self-direct their learning to seek: (a) familiarity with a subject, its terms, and concepts; (b) knowledge about the steps or actions required for mastering a subject; (c) emotional support and encouragement; or (d) assist with specific problems or understanding information while engaging in learning.

When faced with a perplexing maelstrom of events or experiences, individuals try to construe or construct meaning for themselves (Candy, 1991). An event or experience, which Mezirow (1991) describes as a disorienting dilemma, requires personal interpretation and the learning of new knowledge (Candy; Mezirow). This dilemma may result from a single dramatic event or a long and cumulative process (Baumgartner, 2001). The self-constructing individual tends to act autonomously or to self-direct learning in the search of meaning (Candy).

Self-directed learning experiences. The self-directed learning of persons diagnosed with chronic conditions was the direct focus (Rager, 2003; Rager, 2004; Rager, 2006) and indirect outcome (Russell & Browne, 2005) of a limited number of studies. Rager (2003, 2004) examined the self-directed learning experiences of women with breast cancer. Employing purposeful sampling, Rager interviewed 13 women, who had a diagnosis of breast cancer within the past three years and engaged in at least seven hours of self-directed learning. Themes describing the women's experiences with self-directed learning included motivation to learn about living with breast cancer, identification of learning strategies and resources, time engaged in planning and learning, problems associated with assessing resources, and benefits of self-directed learning.

In her 2006 study, Rager explored the self-directed learning experiences of men with prostate cancer. The purpose of this study was to develop an in-depth understanding and insight into the experiences of prostate cancer patients who used self-directed learning. Using a purposeful sampling, Rager interviewed 12 men who engaged in self-directed learning about prostate cancer, for which they had received a diagnosis within the past five years. The themes emerging from the analysis included reluctance to talk about health problems or prostate cancer, difficulty living with the reality of the situation and treatment choices, struggle with emotional response to prostate cancer, and watchful waiting for the outcomes of prostate cancer and treatment.

Russell and Browne (2005) collected data from 100 participants replying to questions through interviews or written responses in order to discover how persons with bipolar disorder self-managed their lives to stay well, to identify early signs of relapse, and to prevent relapses into mania or depression. Through their qualitative study, Russell

and Browne discovered that individual stay-well plans centered on participants' specific needs and social contexts. Among participants, a common evolution of learning to stay well included: (a) accepting the diagnosis, (b) becoming mindful about their responses to their internal and external environments, (c) educating themselves about bipolar disorder through a variety of resources, (d) identifying trigger episodes and warning signs of illness, (e) managing sleep and stress, (f) making lifestyle changes, (g) understanding treatment options, (h) accessing social support, and (i) using stay well plans to prevent illness. One participant described learning to stay well: "Many people hope for instant recovery. It takes time to learn how to control it. We learn to monitor ourselves and accept what our bodies can do" (Russell & Browne, p. 190).

Learning How to Self-Manage Bipolar Disorder

Literature points to the importance of an array of strategies valuable to the maintenance of well-being among persons with bipolar disorder. Typical treatment has emphasized pharmacotherapy, psychotherapy, and psychoeducational interventions for learning to self-manage bipolar disorder. Russell and Browne (2005) findings point to the potential application of self-directed learning for self-management of bipolar disorder and transformational learning experiences. Yet this study did not take an in-depth look at the nature of self-directed learning and transformational learning. Other studies have taken a closer look at self-directed learning and its evolution through transformational experiences among individuals learning to live with chronic health conditions; however, the focus was not on bipolar disorder.

For persons with bipolar disorder self-management involves making informed decisions about their health behaviors and disease management techniques (Bodenheimer

et al., 2002; Bowden, Ketter, Sachs, & Thase, 2005; Callahan & Bauer, 1999; Colom & Lam; 2005; Gonzalez-Pinto et al., 2004; Guitierrez & Scott, 2004; Miklowitz & Otto, 2006; Otto et al., 2003; Vieta & Colom, 2004; Russell and Browne, 2005). This study sought to discover how persons with bipolar disorder learn to self-manage their illness to meet their daily and lifetime health needs.

CHAPTER III

METHODOLOGY

Overall Approach and Rationale

Learning can emerge through structured education or the experiences of daily life. Self-directed learning facilitates the exploration of information resources and engagement in transformational experiences to build knowledge and gain insight (Candy, 1991). A qualitative study of persons with MRSA revealed how they experienced a sequence of experiences, including self-directed learning and transformational learning, in discovering how to manage this infection (Rhode and Ross-Gordon, 2012). In several qualitative studies, women with breast cancer and men with prostate cancer described the utility, benefits, and challenges arising through their experiences with self-directed learning (Rager, 2003; Rager, 2004; Rager, 2006).

In addition, other qualitative studies highlighted how transformational experiences were integral for persons' learning to self-manage the chronic health conditions of end-stage liver disease, kidney disease, HIV, diabetes, and breast cancer, in learning self-management of and living with their conditions (Brown et al., 2006; Baumgartner, 2001; Carpenter et al., 1999; Courtenay et al., 1998; Courtenay et al., 2000; Curtin et al., 2002; Paterson et al., 1999). The findings from these studies provide evidence of the value, utility, and necessity of self-directed learning and transformational learning experiences in surviving chronic health conditions not involving mental illness

diagnoses. Although not focused on the dynamics of the adult learning process and not drawing on adult learning theories, the findings from Russell and Browne's (2005) qualitative study highlighted the importance of personal experiences and education in learning to stay well with bipolar disorder. The current research built upon the exploration of adult learning experiences in trying to stay well.

Heuristic inquiry was the research method. This method of inquiry permitted my asking the question posed by Patton (2002), "What is my experience of this phenomenon and the essential experience of others who also experience this phenomenon?" (p. 107). As both researcher and an individual experiencing the phenomenon, I steeped myself in the highly personal experiences of learning how to self-manage bipolar disorder to stay well. My immersion permitted illuminating the complexities or dimensions of the participants' and my personal experiences with learning to self-manage bipolar (Patton, 2002).

The heuristic approach consisted of six phases (Janesick, 2000; Moustakas, 1990; Patton, 2002). Phase one involved initial engagement in the environment or context of interest, which research was learning to self-manage bipolar disorder. Phase two involved immersion in the context. This inductive process included exploring, acquiring knowledge, and gaining an understanding of learning how to stay well with bipolar disorder. Phase three was the incubation process that "allows for thinking, becoming aware of nuance and meaning in the phenomenon or setting, and capturing intuitive insight, to achieve understanding" (Janesick, p. 391). During phase four or illumination, information, impressions, and awareness gained through the interviews were captured by the researcher. During the fifth phase, explication involved extracting meaning via review

of interview transcripts and research journal entries. Culmination, phase six, involved the synthesis of participants' personal experiences to create a gestalt or an organized experiential whole about educating one's self about self-management of bipolar disorder. Creating a gestalt provided broader insight than merely employing synthesis as a mere summation of participants' personal experiences. Moustakas states, "The heuristic researcher is seeking to understand the wholeness and the unique patterns of experiences in a scientifically organized and disciplined way" (p. 16).

Research Questions

Through this study, I explored the nature of self-directed learning and transformational learning experiences in developing personalized strategies for staying well with bipolar disorder. The questions of interest were:

1. What experiences prompt learning among individuals with bipolar disorder?
2. How do individuals with bipolar disorder describe learning to self-manage their bipolar disorder?
3. How do personal learning experiences contribute to strategies for staying well?

Sample Selection

The strategy for identifying subjects was with purposeful sampling through criterion case sampling. As Patton (2002) explained, "Purposeful sampling focuses on selecting information-rich cases whose study will illuminate the questions under study" (p. 23). Purposeful and criterion-based sampling proved valuable for recruiting

individuals who would likely be information rich as volunteers for this study. The criteria for inclusion were those individuals who self-reported:

- being age 18 or older;
- having a diagnosis of bipolar disorder;
- receiving treatment for bipolar disorder from a licensed mental health professional;
- having not been hospitalized for the treatment of bipolar disorder in the past 12 months; and
- engaging in activities for learning to stay well with bipolar.

These criteria served a number of purposes. The criterion for persons age 18 or older ensured recruitment of individuals who were legally identified as adults. Recruiting only persons with diagnoses of bipolar disorder provided confirmation of a medical diagnosis. Recruiting persons receiving treatment from licensed mental health professionals ensured readily available mental health support (i.e., safety net) for participants, if needed. In addition, the research consent form listed several available Central Texas mental health resources from which to receive mental health care if the need arose. The criterion regarding absence of hospitalization for bipolar disorder in the past 12 month filtered out persons who still may have been recovering from their hospitalizations. The final criterion for persons actively engaged in learning to stay well supported the recruitment of an information rich sample to discuss learning activities.

Interviews were conducted to the point of redundancy when no new information emerged through newly the interviewed participants. The use of purposeful sampling with criteria enabled the selection of a homogeneous sample of participants. As a result,

redundancy was anticipated at approximately 10-15 participants. Sampling resulted in 12 potential participants of whom 7 individuals and I signed consent forms to voluntarily participate in the research. Post-interview comparisons of emergent concepts from the interview transcripts allowed for assessment of saturation, which was achieved with the eighth interview.

During the immersion phase, recruitment involved four steps. First, to ensure recruitment of individuals with currently established mental health support in place, I sent recruitment letters to 67 licensed psychologists and psychiatrists in the Central Texas area. They received letters requesting their assistance in distributing a recruitment flyer about my dissertation research to their clients with bipolar disorder who met the research inclusion criteria (see appendices A and B). Two of the licensed mental health professionals inquired with questions about the research or recruitment method. In addition, formal inquiries with the recruitment letter and follow-up telephone calls to request assistance from several large, Central Texas non-profit mental health clinics were not successful. Management at these clinics indicated their policies restricted the recruitment of clients for research.

Second, potential participants voluntarily followed up the research after reading the recruitment flyer. Third, through follow-up contacts, their questions and requests for further information were addressed. Fourth, those expressing interest to participate in the research received the consent form by e-mail or postal mail. Participants submitted a signed consent form at their interviews; each participant kept a second signed consent form for their records (see Appendix C).

Data Gathering Method

Data gathering involved the heuristic phases of initial engagement and immersion. Initial engagement began in October 2006 with exploration through personal observations, conversations with others, and reviews of literature about how individuals with bipolar disorder learned to stay well. From September 2007–May 2008, this informal exploration aided the development of the research questions and the open-ended interview guide (Appendix D). Immersion occurred through a number of my actions:

- Recruitment of participants
- Completion of pilot interviews
- Performance of my self-interview
- Carrying participant interviews
- Personal notations about interviews and my observations
- Self-journaling after each interview

I chose a semi-structured interview format to permit me to exercise flexibility when interviewing participants (e.g., taking questions out of sequence, revisiting questions, probing further with additional follow-up questions, and skipping questions if requested). I conducted all but one of the interviews in the office of a private residence. One participant asked to be interviewed in her private home. Each interview ranged from 90 minutes to over two hours in length. Interviews were captured in notes (i.e., information shared, researcher's personal observations) and with an audio recorder. Each participant answered all the questions and no one asked to retract or delete any portion of their interview responses.

In addition, I wrote field notes during and personal journal entries after each interview. In my field notes, I jotted down my observations about each participant such as personal demeanor, level of engagement, and body language. Self-journaling allowed me to capture my personal experience after each interview. In addition, my journal allowed self-reflection about how my personal experiences during an interview affected how I felt about an interviewee, what they said, and myself.

The initial two participants agreed to serve as pilot tests of interview questions. The first participant said the questions were fine but recommended rewording the questions to sound less impersonal or formal. Using this recommendation, the questions were rewritten to sound more personal and less formal. The second participant liked the questions and recommended no additional changes to the questions. The breadth of the participants' responses in their initial interviews did not necessitate conducting second interviews.

Data Analysis and Synthesis

Data analysis involved the heuristic phases of incubation through culmination. Incubation involved the interview transcription process. First, I reviewed my field notes and interview journal entries. My reviewing of interview documents allowed me to identify potential gaps and to revisit my experiences during an interview. Next, an audiotape was transcribed verbatim immediately after an interview; labeling transcripts with pseudonyms protected the confidentiality of the participants. Following the transcription of an interview and prior to conducting the next interview, I noted first impressions of concepts emerging from an interview. This allowed me to assess when similar responses or concepts began to repeat across the interviews.

Next, illumination and explication evolved through constant comparative analysis. This analytic technique allowed comparison of interview responses across participants to identify similarities and differences (Patton, 2002). Using constant comparison enabled inductive analysis of the multiple dimensions and patterns of discussion emerging across the interviews. I reviewed the case record of all the interview documentation (i.e., notes, transcripts, journal entries, initial concepts). Following my initial data review, I entered into open coding, an analytic process for examining the data to identify concepts (Strauss & Corbin, 1998).

The analytic process for arriving at the emergent themes began with open coding the transcript following each interview. This manner of open coding allowed for identification of terms and categories in meaning units within transcripts, for assessment of the adequacy of the interview questions, and to determine the need to continue interviewing further individuals (Ryan & Bernard, 2000). The process of open coding was informed by the first impression of concepts noted following each interview.

Open coding began with the separation of transcript text into meaning units of varying lengths representing relevant concepts. Next, meaning units were labeled with descriptive words or phrases to characterize the concepts. After completing this process with each interview transcript, the labeled meaning units were entered into a matrix format in a Microsoft Excel workbook. Use of a matrix format allowed ease of organizing and sorting the participants' meaning units and associated information. In addition, the matrix format allowed me to create a chronology of my coding decisions across worksheets within one workbook. This chronology of worksheets created an archive for verifying the evolution of my coding decisions over time. The matrix

consisted of rows displaying participant's case and columns displaying for each case the question number, item number (i.e., participant identifier and transcript line—for example, 1.34), post-interview concept, open coding, open coding cluster, and comments associated with each meaning unit.

Axial coding facilitated the clustering of categories through contrast and comparison. Axial coding allowed the categorized meaning unit to serve as an axis from which to identify the properties and dimensions subcategories of meaning (Strauss & Corbin, 1998). Subcategorization included differentiating categories by relevance to prompts for learning, describing learning experiences, and self-management strategies. This coding process occurred until no further categories surfaced. At the start of the opening coding process, there were 248 emergent codes. Throughout my coding process, I maintained recognition of the origin (i.e., a participant) and intent (i.e., what a participant expressed) of each meaning unit as a way to prevent my personally lived experience with bipolar disorder from overwriting a participant's expressed experience. However, my lived experience with bipolar disorder created a natural attentiveness, insight, and empathy when examining the meaning units and associated coding. Through contrast and comparison in the axial coding process, 14 emergent themes were distilled: (a) three relevant to prompts for learning, (b) four relevant to descriptions of learning experiences, and (c) seven relevant to self-management strategies.

The culminating phase, selective coding, involved the synthesis and integration of the emergent themes into a descriptive portrait (Strauss & Corbin, 1998). In this research, participants' experiences converged to portray how they learned to stay well with bipolar

disorder. This portrait brought together the shared and divergent meanings about the learning process as described by the participants.

Trustworthiness

Several strategies were employed as a means of ensuring the trustworthiness of the study. Trustworthiness was a product of adherence to the basic principles of design (Creswell, 2003). These basic principles included standards of dependability, credibility, transferability, and confirmability of the research. To strengthen the dependability of findings, I used a semi-structured interview to ensure all participants were asked the same core interview questions while allowing for probing questions where appropriate (Patton, 2002). In addition, the continuity of the coding across data ensured dependability of the analysis.

Confirming the creditability or accuracy of the data analysis process occurred through a validity check, which involved several methods. First, establishing the researcher's trustworthiness transpired with the recruitment of participants through 67 licensed mental health professionals (e.g., psychologists and psychiatrists), use of a consent form with extensive information about the research and participant protections, and the researcher's disclosure about researcher's having a diagnosis of bipolar disorder. Second, the researcher corroborated the findings through peer checks with the chairperson of the dissertation research and member checks with the research participants. Through member checks, participants had to opportunity to provide feedback about the emergent themes identified in the research findings.

When interviewed, all participants except one expressed interest to take part in the member check. Seven participants received an invitation by email or telephone to review

the summary of finding. Three participants did not respond. Four participants responded. Among them, two participants agreed with all the emergent themes. The remaining two participants agreed with all the emergent themes except one, which was revised with their feedback.

With the goal of transferring practical and valuable information gained from my research, I identified implications for practice relevant to persons with bipolar disorder, licensed mental health professionals, and others seeking to locate the information and to learn of practices to facilitate attaining and maintaining wellness in managing bipolar disorder. Achievement of confirmability occurred by examination of the transcripts, initial impression concepts, research journal entries, categories derived from the axial process of comparison and contrast, and the final emergent themes.

Finally, research documentation provided a detailed record of the research process and the audit trail. This documentation included interview notes, transcripts, signed consent forms, audiotapes, research journal, and analysis matrix. Audiotapes, transcripts, and consent forms all remain secured in a locked box.

CHAPTER IV

FINDINGS OF STUDY

The purpose of the research was to explore how individuals with bipolar disorder experienced learning in self-managing their mental illness. The intent was to find out how these learning experiences contributed to individuals' development of personal strategies for staying well with bipolar disorder and to discern the nature of the learning processes used. There were three main questions guiding this study:

1. What experiences prompt learning among individuals with bipolar disorder?
2. How do individuals with bipolar disorder describe their learning to self-manage their health?
3. How do personal learning experiences contribute to strategies for staying well?

Chapter Four consists of four sections. Section one provides the demographic profile of the participants. Section two presents brief personal profiles of each participant. Section three presents the themes emerging through the research analysis. Section four presents a summary of the findings.

Demographic Profile of Participants

The gender split among the participants was four females and four males, as displayed in Table 1. Their ages ranged from 25-67 with a median age of 48. Seven participants were Non-Hispanic White and one participant was Hispanic. Regarding

education level, six participants had college degrees; two of these participants had earned graduate-level degrees. Four participants were retired. Three participants worked full-time, and one participant worked part-time.

Table 1

Demographic Characteristics of Participants

Participant	Age	Gender	Education	Employment Status
Jacob	46	Male	H.S. Diploma	Full-time
Joe	25	Male	Some college	Part-time
Kevin	46	Female	B.A.	Retired
Lillie	42	Female	M.P.A. & J.D.	Full-time
Maria	51	Female	B.A.	Retired
Walter	67	Male	M.A.	Retired
Willow	52	Female	M.A. & M.S.	Full-time
Zoe	65	Female	B.S.	Retired

Bachelor of Arts – B.A.

Bachelor of Science – B.S.

High School Diploma – H.S. Diploma

Juris Doctor – J.D.

Master of Arts – M.A.

Master of Science – M.S.

Master of Public Affairs – MPA

Personal Profiles of Participants

During the interviews, the participants talked about living with and self-managing their bipolar disorder to stay well. Though each participant began their journey of learning about their diagnoses of bipolar disorder at different points in their lives, a commonality among them was experiencing challenges, setbacks, victories, and epiphanies in learning to manage their bipolar disorder. Interviews with each participant provided an understanding of how learning occurred and what it involved.

Jacob

The first interviewee was Jacob. Initially, he was tense and reserved as he began answering the interview questions. Entering into a discussion about his experiences with bipolar disorder was uncomfortable for him; he made little eye contact.

His discomfort appeared to emerge from his revisiting the terror of his first major episode of mania at age 21. This manic episode sent him to a psychiatric hospital in South America. Jacob said, "I had no question that in my mind that I should try to prevent such an episode." During his hospitalization, he received a diagnosis of bipolar disorder. His expansive thinking and erratic behaviors during his first manic episode nearly got him killed; he had reached out to touch rapidly passing buses. He believed the trigger of this manic episode was a head injury a year earlier. This injury resulted from a serious bicycle accident. He recalled his manic experience:

I noticed that colors were just beautiful. And women were beautiful. At first, I thought it was the lighting. First I thought these are pretty nurses everywhere and the lighting in the hospital. Because I woke up out of a coma what I saw were pretty nurses and beautiful colors. Then when I was released I didn't have any way of getting home. My bicycle had been turned into a pretzel. . . .

Jacob's epiphany about the necessity of firmly self-managing his bipolar disorder occurred after his hospitalization in South America:

Even if I had not had a daughter or a wife that was expecting, I was trying to touch moving buses. You know that was an incredibly dangerous experience. I am saying it helped probably that I had children. That was like burning yourself with a flame. You just don't want to go touch that again to see if that really happens.

As the interview progressed, Jacob became increasingly comfortable discussing the experiences that informed his thoughts, approaches, and strategies for self-managing to stay well. Contacts with women and lack of sleep triggered mania. He shared his primary strategy:

I tend to keep my life simple. When I am going to add something to my life, a new girlfriend or take a cooking class or whatever, it may be I am very careful to see if I am capable of juggling everything else that I do and that at the same time.

Kevin

Kevin was the opposite of Jacob; he loved mania. Mania was more exciting and productive than frightening and counterproductive. He said, “Oh yeah. You can get a lot done (while experiencing mania). It’s also when I feel the craziest inside. If I get really wound up.”

He began experiencing mania and depression in his mid-twenties. His limited success with psychiatrists led him to educate himself about bipolar disorder. He read books and searched for a better psychiatrist. His manic energy drove him to create a successful business. His energy served as a catalyst to drive his employees to peak performance. He recalled, “It (manic behavior) was contagious so I brought others into the circle with me. And they would start working beyond their limits too. I didn’t push them. It was just contagious.” However, the cost of his business success was losing his family. Too many long hours further feeding his mania and paranoia created a divide between he and his wife. His mania and paranoia frightened his family members and resulted in divorce and limited visits with his children. Kevin had an epiphany about self-managing his bipolar disorder:

Oh, just realizing that if I didn't manage myself then my life would just be totally out of control, and I'm going to be at the end of my life looking backwards going per everyone around me I've lived this lonely life that I thought was a great life but in actuality it's killed my family, my friends, and everybody around me.

Destroyed them.

Through consistency in taking his psychotropic medications, attending weekly psychotherapy sessions, building social connections, and engaging in volunteer and philanthropic activities, Kevin has maintained a happy, healthy, and productive life.

Joe

Joe inaugurated his interview with a passionate and lengthy reading of a personally written story *America*. Throughout his interview, Joe presented himself as a spiritually inspired force moving through everyday life with a heightened level of energy. Joe explained that by 19 he had experienced three manic episodes. Each resulted in psychiatric hospitalizations. He recounted his memory of the first hospitalization:

Evidently, they took me to the hospital, a hospital, the emergency room hospital, and had me in a straight jacket to treat me while I was, like I was still going. I don't remember any of this. My family was around me at that time and then they brought me back to Shoal Creek (Hospital). It was pretty severe. Like they said they've rarely seen somebody going that strong. The energy was so potent in me.

Joe expressed his struggle with understanding what the condition of being bipolar disorder meant:

So that was kind of where the bipolar diagnosis maybe sank in. I was in denial of it for a long time. You have to understand that I'd never had the depression. In my

mind, I was, I had experienced these spiritual highs and then medicating it away from me. And I have an aversion to medications period, anyway. Chemicals.

Somebody else telling, regulating (me) who really doesn't know me.

As the result of his fearing re-hospitalization, Joe regularly took his psychotropic medications. He admitted, "And so I was terrorized about going into the mental hospital. That was my sense of why I took the medication. I never, never didn't take the medication. . . ."

Joe recognized the need for learning about self-management of his bipolar disorder: "But yah, I, over time, it was like clear. Ok I'm bipolar. I would say that. You know or I would say I have the diagnosis bipolar, and I would want to learn." Overall, he was very curious, introspective, and flexible about how self-managing his mental health:

I do like that my values have shifted, have become deeper and broader. Where it's like what do I deeply want out of my life? Not like, how do I want to fix this problem? It's been less, problem oriented and more working on what I'm wanting.

Walter

When he was a young adult, Walter said he struggled with his mental health. He received treatment for major depression in his 20s. He had a hospitalization after attempting suicide in his late 20s. In his late 40s, he received the diagnosis of bipolar disorder. After his diagnosis, Walter recognized he always sensed his mental health struggles were more than mere depression:

My initial experiences were when I found out that I did have bipolar, and I got diagnosed, and then I got several drugs to take for it. I figured that was it. Ok, I

take those drugs and everything will be fine. And I didn't have any idea about managing it other than managing the drugs. So I was, I just thought it was that easy. And it turned out not to be.

At age 67, Walter now was working to establish a new career as a psychotherapist; he recently had earned a master's degree in counseling. He viewed himself as a means to teach others about bipolar disorder through his life experiences:

And to educate people whether they want it or not sometimes about mental illness. When I hear jokes about people that are mentally ill. When I hear people put down because they're mentally ill . . . I'll intervene on that stuff. Sometimes it, sometime it'll be helpful. Sometime it won't. But I'll put an effort in sometime. . . . It's worth my while to talk to other people, to be an ambassador from the bipolar world.

Zoe

Zoe was diagnosed with bipolar disorder in her 40s. She was retired from teaching and stayed busy volunteering at a local church, keeping up with her four adult children, eight grandchildren, playing tennis, and gardening. Zoe's responses to the interview questions created an image of her as the anchor of her family. She was a strong supporter of her children's management of bipolar disorder as well as for maintaining her own self-management of bipolar disorder. Years prior to her own diagnosis, Zoe had learned about managing bipolar disorder following her children's diagnoses with bipolar disorder.

When diagnosed in her 40s,

Acceptance of her diagnosis was difficult. At first, she viewed herself as primarily depressed because of some very stressful experiences while teaching high school.

However, following a vacation to the Caribbean islands, Zoe experienced the extended adrenaline stimulation of mania over four days. After this manic experience, she called her psychiatrist to ask for a mood-stabilizing drug. Since then, she has remained on a mood stabilizing medication.

In addition to taking her medication, Zoe relied on physical activity to maintain her mood: “Don’t ever give up your regular exercise. I played tennis two-three times a week ever since I was about 45. Twenty years now. . . .” She liked gardening at her and her father-in-law’s homes to stay active. Vacations, including camping and cruises, also helped balance her moods.

Zoe stressed self-management required personal strength and awareness. When she was young, she learned this from her mother:

It has to do a lot with your self-esteem. Has to do with. And you know it has a lot to do with what my mother told me when I was a kid. She said . . . don’t believe everything a doctor says, because you know what’s best for you. And, if you see that a certain drug is making you feel ill, don’t continue to take it. You just tell the doctor I need a new one. . . .

Lillie

Lillie appeared excited and pensive at the start of her interview. As with each participant, Lillie received the interview questions from me prior to her interview. Though she wanted to share her story about learning to self-manage her bipolar disorder, Lillie held concerns about divulging details about some of the most challenging circumstances on her journey of learning to self-manage bipolar disorder.

Starting in high school, Lillie had sought psychotherapy. Later in college, Lillie received a diagnosis of depression for which she took psychotropic medication and continued psychotherapy. After graduate school, Lillie sought treatment from a psychiatrist. At this point, she was unemployed and going through a lot in her personal life. She gained a new diagnosis during her visit:

Anyway, went to this new psychiatrist, and I guess it was on intake there, and I got the diagnosis of Bipolar II and Generalized Anxiety Disorder. If I hadn't already heard the Generalized Anxiety Disorder first. I got the 296.89, and anxiety was 300.00. So when I, I knew I was in trouble because I was dealing with depression. The other stuff was a surprise to me.

This new diagnosis frightened her after witnessing a close friend's struggles with Bipolar I. Lillie said, "So I was afraid to tell people. Fear was definitely a part of my initial experience. And I was afraid that my life as I knew it was ending."

While struggling initially with the symptoms of bipolar disorder, Lillie began reading *This Alien Shore*, which a friend from college recommended reading. She described a portion of the book through which she had an epiphany about the beauty of having bipolar disorder:

But it's the people on that planet who apparently have. They don't call it this but from the description it's the people with depression or bipolar that are real specific. But those are the ones, the artistic ones, who have this capacity for real darkness that can take them down. They're the ones that, they're the only ones who can pilot these space ships through the deep space part where the dragons are. And without them and those ways to go through space, everybody would be

like century, light years apart, and they couldn't be connected. But those people kept everybody connected and together. They were heroes. . . .

Lillie faithfully worked through her steps to maintain balance in her life and moods. However, daily challenges continuously tested her commitment to self-managing her bipolar disorder. She continually fought to maintain or recover her balance. She explained, "Taking the driver's seat instead of just taking responsibility for that which feels like a duty and a burden. But taking the driver's seat feels like let's go for a ride. Like we want to exceed the speed limit."

Willow

Throughout her interview, Willow presented as a person with limitless interest and motivation for self-managing her bipolar disorder. As the result of an autoimmune diagnosis, Willow had gained an awareness of the need for careful management of her health at a young age. By the time she received the diagnosis at 45, Willow had become very comfortable and skilled at searching for health information about her autoimmune condition. She employed her research skills also to learn about self-managing her bipolar disorder. She said, "I think one of the things that I've observed is that I am very much more aware of how my environment, my response to my environment contributes to my mood shifts. Whether it's hypomania or that I'm feeling depressed. . . ."

She had received her diagnosis while visiting with her primary care physician to inquire about her persistent feeling of hyperactivity. Her state of hyperness left her with the physical sensation of having drunk a pot of coffee. She described the conversation with her physician:

And so, I went to the doctor, and he said to me I think you have something called cyclothymia. And I'd been going to this physician probably for nearly 10 years, and I was kind of astounded that it only came up when I brought it up, and he had never mentioned it to me before.

Willow expressed her epiphany about this diagnoses: "I would say my initial experiences were I think a little bit like. It was. I was a little bit unnerved that I didn't just have some type of anxiety disorder or attention deficit disorder. It was something more serious." Even though her diagnosis was unnerving, she felt relieved to understand her heightened level of activity that allowed her to accomplish two to three times as much at work, home, and school. Over time, Willow described her journey to staying well:

You don't have to constantly think about being bipolar, but there's a level of awareness that you build about staying healthy. Just think of keeping yourself healthy. Because when I look after my mental health—the way I'm eating—I'm looking out after my physical health. And I exercise, so that keeps me healthy. And I meditate, which keeps me healthy. And go to church. You have a spiritual side. That keeps me healthy.

Willow also shared her philosophy about living with bipolar disorder:

You could say people who have bipolar may be uncomfortable with it, but for the most part, I don't feel, I'm not ashamed of it. I think being aware of it has just made me more comfortable with the diagnosis. And it's just a diagnosis. And you manage it just like any other health condition.

Maria

Unable to travel to the primary interview location, Maria opened her home to me for the interview. The interview had a homey, relaxed feel. Maria was cooking dinner during the interview. Her beloved cats wandered past the kitchen table, stopping at times for attention. Early in the interview, Maria described the circumstance leading to her diagnosis of bipolar disorder:

The first time I was diagnosed was when I had graduated from college, and I didn't know what to do with myself. And I had sublet an apartment, and none of the people that I knew, knew where I was. And I ended up spending four days in a third floor apartment full of the previous tenant's stuff without eating and without sleeping because it was such a beautiful place. I was just like wow! So I climbed around the fire escape. I did a summersault through one guy's window. I got taken to the hospital via the police and fire department.

Throughout the years following her diagnosis, Maria experienced the devastation of her manic binges. She accumulated thousands of dollars in debt because of impulsive decisions:

After '98, when I turned 40 and that was a bumper crop of mania. I bought two horses. I bought a car. I spent all of my life savings. I charged credit cards up into the \$40,000 range. And then had to climb back out of that. Which I did. I didn't declare bankruptcy and walk away like all the banks do. I paid it off.

Despite this personal devastation, Maria remained continuously employed by the federal government for over 20 years. However, the absence of her employer's flexibility

in allowing sufficient time for recovery from manic or depressive episodes was detrimental to her health. Days prior to her interview, Maria had retired.

Maria attributed her resilience and survival to taking charge: “Well, it has contributed to my knowledge of my illness and what it takes to get through the day to survive in this world.”

Emergent Themes

Question 1

The focus of the first research question was on exploring the initiation of learning about bipolar disorder among participants: What experiences prompt learning among individuals with bipolar disorder? Participants’ descriptions of prompts to learning clustered in three emergent themes:

- Now I know what is wrong with me
- I accept my diagnosis
- Proactive behavior prompts self-directed learning about bipolar disorder

Now I know what is wrong with me. Receiving a diagnosis of bipolar disorder from a doctor prompted most participants to begin learning about this mental illness. To understand their illness participants interpreted what the diagnosis meant to them. Their trying to gain an understanding of bipolar disorder corresponded to what Candy (1991) described as seeking familiarity with a subject through self-directed learning. In addition, they experienced their diagnoses as a reframing or reinterpretation of mental illness symptoms (Mezirow, 1991). Participants experienced their diagnosis in different ways: disorientation, relief, and indifference.

Lillie, Zoe, and Joe felt disoriented. During appointments with psychiatrists to discuss recent mental health issues, both Lillie and Zoe received a diagnosis of bipolar disorder. Lillie said, “So when I first found out, it was like my stomach and insides just turned into a huge block of ice. I was just cold and heavy.” Zoe experienced disbelief about her diagnosis because she never recalled experiencing mania. She said, “Remember, I was undergoing depression off and on from Round Rock until this point I was depressed. And Dr. B. said I warn you I think you’re bipolar and if you’re on a medicine like Paxil you will be manic.”

Joe learned about having bipolar disorder after a psychotic episode. He found his diagnosis puzzling:

When I got out of the hospital, they said you have to be on medication the rest of your life. And I was like okay well does that mean that I’m doomed to be bipolar like in your understanding? What does that mean? So I don’t know how static this diagnosis is and who, what and all that. Where does bipolar stop and sanity begin? Whatever. A normalcy. I question the heck out of that.

Jacob, Willow, and Walter expressed relief at receiving a diagnosis of bipolar disorder. Jacob said, “I was very fortunate that my first manic episode was a completely full blown manic episode. And there was no denying that I had it, . . .” Willow said, “I was glad to have a diagnosis, and at the same time rather disturbed to think that this had never been mentioned to me before.” Walter transformed his frame of reference from the unknown to the known:

And finally, I knew what was the matter with me. I knew there was something the matter with me ever since I was in my mid-20s. And so finally, I had a light bulb.

A lot of people are really weird about labels. I was so happy to have something to call it. . . . The first one (transforming experience) was getting a diagnosis and knowing that there was some kind of treatment—having a name for it. And knowing that there was some kind of treatment.

Kevin and Maria experienced indifference following the diagnosis. Kevin, who received his diagnosis during a visit to a psychiatrist, explained, “I really didn’t have an interest in my diagnosis. . . .” Maria received her diagnosis during a psychiatric hospitalization following days of mania. She said, “So then I went home and decided I didn’t need it (Lithium), and stopped taking it. . . .”

I accept my diagnosis. All participants came to recognize acceptance of their bipolar disorder diagnoses as a critical prompt toward initiating learning about this mental health condition. However, accepting the diagnosis was a simple decision for some participants and more difficult for others. For Jacob, Walter, Willow, and Lillie, acceptance came easily. Due to his experiencing a frightening episode of mania with subsequent psychiatric hospitalization, Jacob explained, “I was very fortunate that my first manic episode was a completely full blown manic episode. And there was no denying that I had it. I was hungry to learn everything I could to prevent it from happening again.” His acceptance triggered transformational learning by literally shaking his reality about what he had experienced and what he needed to learn. For years, Walter, Willow, and Lillie struggled for years with the symptoms of undiagnosed bipolar disorder. Acceptance of the diagnosis opened the way for learning how to manage their symptoms. Walter explained, “And so finally, I had a light bulb. A lot of people are really weird about labels. I was so happy to have something to call it. . . .” While Willow

explained, “But that’s when I decided to look for information, after that diagnosis. And I went to see a psychiatrist, . . .” Lillie said, “Getting a diagnosis just means there’s now a prism through which to understand the experiences that one has already been having.’

Maria, Joe, Zoe, and Kevin discussed their delayed acceptance of the diagnosis of bipolar disorder. They experienced shifts into self-determination or autonomy. Initially, Maria’s lack of health insurance and enjoyment of mania delayed her acceptance of her diagnosis. She explained, “I was winging it. I knew I was (bipolar). I would have periods of time where I wouldn’t sleep. And I’d stay up for days. And I’d start 50 projects. . . .” After the disastrous consequences of her mania (e.g., credit card debt, verbal fights with friends and family members, automobile accidents), she decided, “Well, it felt like I was taking charge of my own life. . . .” Joe explained his circumstance:

There was a point though that it became clear that I wasn’t in denial of that you know, and I didn’t romanticize it. But it was gradual. You have to understand it was over a year and a half or two years and then it gradually became ok. I’m owning it. . . . But at one point, I did call it bipolar, and I did say you know I have to have help. But it was a gradual thing.

Due to Zoe recalling only experiences with depression across her adult life, she doubted her diagnosis of bipolar disorder. However, she explained what prompted her acceptance:

So we went on a trip to the Virgin Islands because we travel a lot, my husband and I. And I was feeling better, but when I came back I was high as a kite. I still couldn’t sleep. I hadn’t slept for the last four days. I called her and said Dr. B you’re right. I haven’t slept for the last four days. What can you prescribe for me to get me off of this non-sleeping mode I’m in? And she said I told you so. I said I

know. . . . And I went back to her office and said ok give me a stabilizer drug. I believe you now. And at first, I was very stubborn. . . .

Kevin relished being manic. As a natural catalyst, he pushed himself and his employees to perform and act at extreme levels (e.g., going without sleep, overextended work hours). Recognizing the wreckage in his professional and personal life, Kevin said, “I voluntarily turned myself in to Menninger’s (Clinic) in Houston. It’s a treatment center. That’s the biggest step that I took in wanting to know and wanting to learn and wanting to get out of this. . . .”

Each participant reached a point where they were “willing and able to exert a degree of control over aspects of his or her learning situation, and likewise that the acceptance and exercise of such responsibility would be taken to indicate high level of personal autonomy” (Candy, 1991, pp. 20-21). Experiencing autonomy allowed them to act in their own best interests by self-directing their learning.

Proactive behavior prompts self-directed learning about bipolar disorder.

Several participants described how proactive behavior prompted self-directed learning about bipolar disorder. Through the means of self-directed learning, their independent methods promoted personal independence to become familiar with and gain knowledge about bipolar disorder (Candy, 1991). Willow described her initiation of proactive behavior to understand bipolar disorder:

In the beginning, I read a lot, and I just thought about the bipolar disorder an awful lot. . . . I think in the beginning, I was just always looking for an answer. Like what was the root cause? How much was genetic? What was the suicide rate? What kind of medicines were out there and then what triggered it?”

Kevin described his proactive approach toward learning about the risks of suicide and bipolar disorder:

I just turned myself in (to a mental health clinic) and wanted to know how could a human being want to commit suicide? What would bring me to that point? Now I read statistics that one out of every nine bipolar persons ends up committing suicide. You start reading these statistics. And now I can understand because I was at that point. . . .

According to Candy (1991), self-directed learning need not occur alone; it may be stimulated when working with others. Zoe described how a conversation with her psychiatrist stimulated her proactive behavior: “She said this illness is genetic to me. I said really? Nobody in my house has ever told me anything about anybody in our house every having an illness of this sort. Right. Then I started thinking.” Willow said, “So my initial experience of (what) prompted me was by the suggestion of both my psychiatrist and my psychologist, or psychotherapist, to go out and look for further information.”

Kevin described how his wife and a friend stimulated his proactively learning about bipolar disorder. He said, “She bought some books on her own, and we started reading them together. Sharing information back and forth.” In addition, Kevin’s friend stimulated his proactivity:

I shared that I was bipolar with what ended up to be one of my best friend even until today. And he bought a book and it so impressed me that wow if this guy was going to buy a book on it how much he must care for me. I need to go buy a book myself. His interest in me made me have an interest in myself.

Question 2

Exploring how participants learned to self-manage their bipolar disorder was the focus of the second research question: How do individuals with bipolar disorder describe their experience of learning to self-manage their bipolar disorder? Descriptions about learning self-management clustered under four emergent themes:

- Barriers block learning to self-manage bipolar disorder
- Choosing available resources to learn about living with bipolar disorder
- Personal motivation drives learning
- Personal experiences drive learning

Barriers block learning about self-managing bipolar disorder. Whether self-imposed or imposed by external circumstances, participants experienced barriers towards learning how to self-manage bipolar disorder. Barriers delayed the emergence of a self-directed learner who could begin to construct a path to making sense of the world and a personal system of meaning (Candy, 1991). These barriers included denying bipolar disorder, receiving treatment from medical professionals, and experiencing stigma of the bipolar disorder diagnosis.

Denial is a barrier to learning. Denial of bipolar disorder acted as a barrier to learning. Acceptance of bipolar disorder was not a necessary condition for a participant to engage in medical or mental health treatment. However, acceptance of bipolar disorder was a necessary condition for a participant to engage actively in learning how to self-manage bipolar disorder.

Several participants struggled with the diagnosis of bipolar disorder. Kevin explained, “I really didn’t have an interest in my diagnosis. I was in denial a lot about it. .

. .” Zoe had recognized depressive episodes as an adult; however, a diagnosis of bipolar disorder did not make sense to her:

And she (psychiatrist) said I warn you I think you’re bipolar and if you’re on a medicine like Paxil you will be manic. You will go manic, unless you have a stabilizer drug like Depakote or. She named a couple other ones. I said well I don’t think so. I think I’m just depressed.

Joe said, “I was just in denial of it for a long time. . . .” He explained, “In my mind, I was, I had experienced these spiritual highs”

Medical professionals as barriers to learning. Several participants discussed how the treatment decisions or incompetence of medical professionals impeded their learning how to self-manage bipolar disorder. Kevin said, “I basically relied on my psychiatrist in the beginning for information and which he turned out not so great for information. I learned a lot on my own.”

Walter said,

First of all I saw therapists from when I was mid-20s until I was late 40s, and did not get a bipolar diagnosis from those people. And I spent thousands of dollars and got mostly cognitive therapy from them which didn’t do anything for me. . . .

Stigma as a barrier to learning. Some participants reported experiencing the stigma from their diagnoses as a barrier to learning. Willow said, “So the challenging thing is just that it has such stigma to it. So, there’s an element of quietness about it.” Joe explained,

You know stuff like that but that gets into my head and that creates this sort of like stigmatized ghost of mania, you know, which is ridiculous because it doesn’t

have to be there. You know the challenges are shame. I really think that shame is such a big problem. I think if there's anything that we need to be wary of more than anything else is shame. I just don't see much function of shame. I see guilt. I see everything else. Shame is deadly. It can do harmful things. And I think that that's probably the biggest challenge. Being ashamed of going to Dr. V and telling her what, how I felt. Even though I never really. The medication never really. Being ashamed of feeling like I could not talk about things to my friends. I never really had a girlfriend until recently. Being ashamed of my own psychology. These are all like barriers to living a healthy life when you're diagnosed with bipolar disorder. . . shadowy shame that's . . . the big challenge.

Choosing resources to learn how to live with bipolar disorder. Participants identified resources for gaining knowledge about and skills for self-managing bipolar disorder. Choice of resources involved participants actively self-directing the selection and use of these resources, both non-human and human (Candy, 1991).

Literature. Participants read a variety of literature to learn about bipolar disorder and how to manage it. Reading literature (e.g., books, magazines, brochures) allowed participants to discover useful information about bipolar disorder. Participants approached searching for books in a similar manner. Kevin said, "I went to the library and bought books on bipolar and started reading them." Walter said,

So I went to the bookshelves and started reading about stuff and found out. So I guess self-manage came to me out of desperation when I finally went to the bookshelves and started reading books that had bipolar in the title.

Jacob and Maria spoke of the value of reading literature about managing bipolar disorder. Jacob explained, “I just picked up good habits from the books.” Maria said, “And I came across an article about how foods influence your moods. . . . And I have been reading up on it and reading about vitamins and reading about supplements. What can I do to keep myself level?”

Several participants spoke of specific books being of great value for learning about bipolar disorder and care of self and for providing inspiration. Joe explained, “Well my mother was reading a lot of books. . . . I remember when I got out of the hospital the last time and I was living at her house and couldn’t function. We would be reading out of Diane something or others book, *An Excitable Mind* or something about something like that and she would read to me. . . .

Willow said,

I then went and read a couple books. One was on meditation. Was a, trying to think of the name. It was like *Meditation and Staying Well*. And it was a kind of a Middle-Eastern approach basically. I can’t remember if it was like Hindu or what the kind of religious background was. But this is a doctor who is out of the University of Arizona or Arizona State who kind of blends Western medicine with meditative practices of the eastern philosophy, is how I should say it, should describe it. So, I had that. And then I had a book on use of omega 3. I think I’d gotten that suggestion from my psychiatrist. . . .

Lillie found a book recommended by a friend inspirational:

So in that, at that point, one of the books that I’d picked up was something a friend had sent me, college friend. It looked like a science fiction book, big thick

paperback with the, you know, funky looking cover on it. She had said I thought you might enjoy this. I mean there was no explanation or anything. And it's no exaggeration to say it changed my life reading that. Which in a way I was able to internalize it. It was called *This Alien Shore*.

Internet resources. For most participants, another useful external resource was the Internet. Jacob explained, "I tend to use the Internet more for going to journals of psychiatry or something like that. I don't just look for some images or videos." Zoe and Willow found medically focused websites of value. Zoe explained, "I use it (the Internet) anytime there's some new drug mentioned. I research it. Either go to MD, WebMD." Willow said,

When it comes to looking up information about medicines or supplements, the Web, reputable websites have been good. Like WebMD and like recently I've learned about NAMI, National Alliance on Mental Illness. There are things that I'm starting finally (to become) open (to), become aware of. Organizations on the Web other than WebMD and Mayo Clinic that are purely medically related.

Formal mental health resources. Formal mental health resources providing education about living with bipolar disorder included psychiatric hospitals, mental health clinics, speaker's series, and support groups. Engaging these mental health resources introduced collaboration into participants' self-directed learning (Candy, 1991). Only Jacob found his hospitalization beneficial to him in learning about bipolar disorder:

I was diagnosed during an episode in South America, and fortunately they don't keep a person for a couple of days there. They keep a person for a month. Until

he's fully aware of what happened before they release him. And I took classes there and doctors instructed me what was happening. Psychologists visited me. Kevin admitted himself to mental health clinics to discover how to make his life work while living with bipolar disorder:

I voluntarily turned myself in to Menninger's (Clinic) in Houston. It's a treatment center. That's the biggest step that I took in wanting to know and wanting to learn and wanting to get out of this. These cycles I would fall into. So I turned myself into Menninger's for nine weeks. . . . Yeah (I attended) dialectical behavior classes, cognitive classes. They put you in that and they stretch your mind and they put so much information in that you start learning about yourself. Why you behave the way you behave. What triggers you to behave that way. It was the biggest step that I took to want to know about myself and learn about myself. . . . (And then went to Cottonwood de Tucson), it's just a step down from Menninger's. They recommend that you do a step-down program afterwards. So you kind of go to less intense environment. You just step down. I took their advice and did that and decided I wanted to kind of go through the whole process. So I attended this support group there, a voluntary support group. . . .

Participants attended forums such as support groups and speaker series to learn about bipolar disorder. Zoe and Willow went to forums sponsored the National Alliance on Mental Illness (NAMI). Both found the NAMI forums informative. Zoe said, "I went to a couple of NAMI meetings and they had brochures that I picked up and read." In addition, Willow occasionally attended a support group affiliated with the Central Texas Bipolar Disorder Support Association, at which individuals shared their experience, ideas

about managing, and local mental health resources. Lillie attended support groups, including a 12-step program, through which she gained information from other people in similar circumstances:

I scrambled for information. Like I said. You know people. They say the best way to learn something is to teach somebody else. And so I would get something like an understanding and feel like okay I understand this. And then people would ask these questions, and I'd try to explain it. And I'd run up against these things that I didn't know. So I'd have to go find out.

Finally, Kevin attended speaker series to learn about managing bipolar disorder:

And that was early on when I started going to the speakers' series. I forget what it was called. I guess it was Shoal Creek (psychiatric hospital). And I went to several lectures at Shoal Creek to hear people talk. And I went and heard that girl talk about *An Unquiet Mind*.

Personal narratives. Lillie and Willow discussed how the personal narratives of other persons living with bipolar disorder served as learning resources. Learning through personal narratives exemplified that innate and powerful drive for individuals to relate to others and continually attempt to make sense of their experiences (Candy, 1991). Lillie participated in a 12-step program through which she heard other persons' experiences with addiction. Lillie explained,

What have you witnessed about your self-directed learning overtime? I witnessed, seen especially now answering these questions. It becomes more clear. I learn through narrative. I learn through first person narrative. That's where some of the strongest learning experiences have come from.

Willow said,

So, I started buying more books on bipolar disorder. . . . I'm not remembering the names but they were different like personal biography. What do they call it? Not personal biography, but personal essays about their experiences with bipolar disorder. There's one called *Electroboy* by Andy Behrman, about his experiences. And Dr. Jamison's experience with her being bipolar, which was (called) *An Unquiet Mind*. I believe she's Bipolar Type I.

Lillie also found the personal essay by Jamison informative:

Yes, *Unquiet Mind* is by Dr. Jamison. So again this is somebody with Bipolar I, but it was tremendously helpful for me to read somebody's story. So it showed that here is this person who has this and who has had some pretty funky experiences, but manages to have this amazing career. Because guess what? She's really smart. And I was learning that those two things are connected. That being really smart usually goes with this (bipolar disorder). And that was really good information.

Personal motivation drives learning. Though a variety of external resources provided valuable tools for promoting learning, personal motivation provided an internal resource for promoting for learning about managing bipolar disorder. Personal motivation catalyzed actions that suggested self-directed and transformational learning experiences. As with self-directed learning, increased control of learning led to increased satisfaction with the learning outcomes (Candy, 1991). Zoe said, "You have to be like proactive. I guess you have to say not reactive. You have to find what works best for your body, and

tell the doctor about it, and insist on it.” Joe explained his self-directed learning and transformational learning experiences:

How I describe my self-directed learning experience? It’s been learning about myself. I mean it’s not been learning about bipolar disorder. It’s been learning about what my, what got me here, what needs. It’s been a whole sort of like whole introspective long journey into understanding and being able to articulate and identify parts of myself that have been, had caused that emotional and being able to articulate and communicate and identify parts of myself that have been that have caused the emotional imbalances that have dammed up things so that they overflowed or what you ever want to say. . . . So I guess what I’ve learned, witnessed is better, about my self-directed learning over time. It’s a great question because over time things have become clear about kind of uncoiling and debunking and maybe really bringing into awareness what mania is. Which is bipolar for me. You have to understand, I’ve never had the depression. For me it’s been kind of like looking at cause and effect, and looking at. Time’s a good test for things.”

Willow said,

So the self-directed (learning) was a very empowering experience. For the most part it gave me a sigh of relief. At times through reading about individuals’ experiences (was) kind of scary. I know even in my self-directing, if something felt too close to what I had experienced personally, some problems earlier in my life, it might leave me feeling agitated or sad or depressed. But for the most part, I recall my (feeling) very empowering, strong.

Personal experiences drive learning. Some participants described transformational learning experiences that led to questioning and revising their perspectives on self-managing their bipolar disorder (Cranton, 2006). However, transformational learning did not take place until participants acted on the learning experience (Cranton 2006; Mezirow, 1991). Joe's reactions to his diagnosis and mental hospital have been to stay healthy to avoid symptoms of bipolar disorder: "For most of it, I've been reactive to the diagnosis, to the fear of going back to the mental hospital." Reflecting on her past experiences in psychiatric hospitals motivated Maria to stay well:

Me being the object of that mistreatment at the hands of the people at the state hospital and Shoal Creek (psychiatric hospital) made me very determined to keep myself well so that I didn't have to be at their mercy.

Jacob's initial manic episode of bipolar disorder resulted in hospitalization. He made an admission about this episode:

I have a hunger for knowledge, and once this was a problem I considered it a big problem. I wanted to control myself and tow the line. Had fear of wanting to experience manic episode again. . . . I don't see that I had that option. . . . And I went through a full-blown manic episode. The ones that if you put it into a book or magazine could pull in even more people to whom it happened. I didn't have this oh your bipolar maybe I am maybe I am not. I had the full-blown episode right off the bat. That was my transformation until that point in time for from now on. Mine wasn't a gradual acceptance of the illness. You're putting your children at risk, your pregnant wife at risk. Giving away tons of money. Dancing in the streets with no clothes on. Pretty much you know you can't do that. . . .

Mania was an enjoyable state of being for Kevin. However, recognizing the negative consequences of mania transformed his perspective of his manic experiences:

Oh, it's the hardest thing in the world to give up that (mania). . . . I think in 1993 I had had multiple affairs and that behavior led me to go into counseling and therapy. And there was a major transformation that took place there. A huge transformation took place; that was a big one. Really that action and that behavior led me this way. . . . Because that was all manic driven. That was all manic. And so there was a major transformation at that process of understanding how all that happened. And realizing wow that behavior that drove to this.

Question 3

Questions one and two focused on learning prompts and resources for self-managing bipolar disorder. Question three focused on learning strategies to stay well:

“How do personal learning experiences contribute to strategies for staying well?”

Participants' discussions about coping strategies question clustered within these emergent themes:

- Overcoming challenges to staying well
- I take greater ownership in my staying well
- Being proactive
- Learning what strategies work for me
- Maintaining balance
- Staying off suicidal thoughts and actions
- Closing insights about learning to stay well

Overcoming challenges to staying well. Participants experienced challenges that impeded maintaining wellness. Each challenge highlighted the difficulties of self-managing bipolar disorder and the impetus for developing coping strategies. These challenges included poor personal choices, the complexities of bipolar disorder, and taking psychotropic medications.

Poor personal choices. The challenges of Joe and Maria were their poor personal choices. Reflections on past poor choices informed future actions (Mezirow, 1991). Joe said, “Well, my own tendencies to want to be in denial of bipolar disorder have been challenging.” Maria said, “Just making stupid choices and having to live with the repercussions of those choices because ultimately I am responsible. I can’t say well I was sick. . . .”

Complexities of self-managing bipolar disorder. Complexities associated with bipolar disorder presented challenges. Walter found the illness itself daunting. Kevin found managing bipolar disorder a chore. Walter described innate difficulty of bipolar disorder:

The, the illness itself is difficult. The illness itself is. God, I had the word. The illness itself is really strong. It, it, it is unyielding, forceful. And you have to stay with it, and exert, exert energy the whole time to deal with it to keep yourself in that that strip of level.

Kevin explained how the daily management of bipolar disorder was a chore:

You know sometimes it’s the drudgery of doing it. I mean you just have to have it. Or I just have to have it (therapy) and the medication. I mean managing those things is just hard. I don’t want to wake up every day and think that I have to take

medicine to be ok. I hate that. I hate separating my medications. Go ok need this many because I'll lay mine out for two weeks and I just put them all in a bowl and just pick out the ones that I need for that day. I hate it. Go on vacation and you have to count out (medications). Oh, this sucks. . . .

Use of psychotropic medications a necessity not a choice. None of the participants expressed enthusiasm about taking psychotropic drugs to manage their bipolar disorder. They viewed taking them as a necessity rather than a personal choice. The side effects of the psychotropic drugs presented challenges. Walter said, "I learned that it wasn't that easy because the drugs didn't work very well, and there were pretty horrendous side effects to the drugs." Willow said,

So the initial experiences were good and bad. The good was when the medicine, when I initially tried it, it was wonderful, but the bad was that I was allergic to it all. And so that complicated matters for me. I knew what I had, but I didn't have a simple way manage it through medicine. . . . Challenging has been managing it without meds. You know, on the one side, my liver is being saved. But managing it without meds is a little trickier because you have to be conscientious about diet and supplements and such. . . .

Zoe said,

And the reason I took Depakote is because I'm a tennis player. And Lithium after a half hour, my legs were gone. I could not run. And I was so super thirsty, it causes dry mouth. And your teeth get really bad after years taking it. Your teeth rot out. There's no salt to kill the germs. She switched me to Depakote, and I've been on it ever since. . . .

I take greater ownership in my staying well. The act of owning the diagnosis and responsibility for self-management strengthened participants' abilities to learn strategies to stay well with bipolar disorder. To own their wellness, participants reflected to critically assess their circumstances and move forward with personal actions. "Reflection is the process of critically assessing the content, process, or premises of our efforts to interpret and give meaning to an experience" (Mezirow, 1991, p. 104).

Joe explained, "The other thing is like for me at least my bipolar—I think even depression—is predicated on this sort of like responsibility to try to own stuff. I don't know, it's like ego or sense of self." Jacob said, "If you have rules to protect you, it's obvious that there's got to be a problem. It's like I don't have to go tell myself not to smoke cigarettes." Zoe explained,

Somewhere you have to set a boundary. You say yes I can to this and I'll be fine.

Or you can say no I can't do it because it's bad for my health, basically. I've gotten to that point where I can say that.

Accepting responsibility for personal choices equaled taking personal ownership for Lillie and Willow. Lillie said,

I have a clue. I can make choices instead of going with the flow. And I'm taking the driver's seat, not just taking responsibility, which is not exactly inspiring.

Taking on this burden, and then taking the driver's seat because of these things that I've learned.

Willow said,

I've taken greater ownership in my staying well. . . . I've had some behaviors that were like things that over stimulated me. Like attractions to others, sexually.

Taking risky behaviors that way. That for me now, I am clued into that there are other ways enjoy life. And that was just a way of diverting, really diverting myself from my depression and jacking up my mood. But there's better ways to do that. . . .

For Maria ownership equaled to taking charge of her life:

Well, it felt like I was taking charge of my own life. Like I was. So much of what I grew up with was my mother saying it was always somebody else's fault that poor little me. I couldn't do anything, and I did not want to be like that. I was taking charge, and it was a very selfish extension of pride. Pride go 'ith before a fall.

Being proactive. Experience taught participants to actively not passively engage in self-managing to stay well. By actively engaging, participants acted proactively and empowered their self-management of bipolar disorder. From a constructivist perspective “learning is an active process of constructing meaning and transforming understanding” (Candy, 1991, p. 251). The emergence of being proactive grew through different contexts and was socially constructed. “In order both to learn something and to verify that it has been learned, the learner must engage in dialogue and interaction with others in the community of knowledge users” (Candy, 1991, p. 302).

Zoe and Willow described their experiences with proactively engaging to learn to stay well. Zoe recommended,

Find out the most you can about your illness, especially the history of your illness. Because then it's easier to understand how you came by it. Then once you find out about the history then you can study the illness in books. You can read about

it on the Internet. And then discuss it with your doctor, but always be vigilant of what your doctor wants to do with your therapy. You have to make the decision of what you will and will not take. The doctor can't force the medicine down your throat, basically.

Willow's recommendation was the following:

And then you did need to go out and educate yourself. You need to empower yourself with that information. And then talk to your doctors, your psychiatrists, psychologists. And even if you have a primary care physician who's their primary person from whom they get their meds, go talk about it. Ask questions. And initially when you're learning to manage it, do follow the guidance that's in the books about tracking your moods, watching what you eat, being aware of the effects of the medicines, and kind of keeping track of what you see as triggers. So really in the beginning, kind of doing the bipolar 101 learning.

Like Willow and Zoe, the process of searching for knowledge via various resources, Jacob's and Walter's self-directed learning experiences yielded proactive behaviors. Walter said, "I still believe that being proactive about your care, your own care, is the best way to go with bipolar." Jacob said, "And then it was very important in the long run to learn how to weed out bad doctors and keep the good ones."

Learning what strategies work for me. Participants identified a variety of personal strategies for learning to stay well with bipolar disorder in their daily lives. Some personal strategies, such as managing sleep patterns, were common across participants. Other personal strategies, such as limiting stimulation from music, were unique to some participants. Whether common or unique, learning and using personal

strategies were essential to stay well with bipolar disorder. Participants' discussions about gaining knowledge and mastery of their strategies resonated with self-concept of themselves as independent, self-directing persons (Knowles, 1975). Learning personal strategies resulted from continuously revisiting and reinterpreting their learning experiences (Mezirow, 1991).

Knowledge and mastery of coping strategies occurred as Jacob and Willow talked about the value of learning coping strategies. Jacob said, "What I mainly observed about my learning is that we tend to make it too complex. There's just probably a hand full of solid coping skills that a person needs to hang on to." Willow said,

What I've observed about staying well over time that I've gotten better at it. . . .

I've noticed that over time my management has become very refined, very acute, very on target. I am very observant when perhaps things are shifting in the wrong direction and how to make a correction.

Attending to personal warning signs and triggers. Participants talked about how their ability to self-manage bipolar disorder depended on developing awareness of the personal warning signs or triggers changing their moods. Awareness of personal warning signs and triggers informed self-management strategies to stay well. During their interviews, participants did not differentiate between warning signs and triggers, which they similarly described as certain circumstances preceding mood shifts into depression or mania. Examples of prompts to depressive and manic episodes included eating certain food, changing sleep patterns, and interacting with people. Walter, Willow, and Maria said sugar triggered moods shifts. Walter expressed his experience with sugar: "I still have a problem with sugar. Sugar will set me off."

Disruption of sleep patterns was a common trigger of mood shifts among most participants. Depression, mania, or irritability usually resulted from disrupted sleep patterns. Zoe, Jacob, and Willow spoke about the negative effects of lost sleep. Zoe said,

Lack of sleep is number one. I know that's crucial. If I'm not sleeping my regular eight hours. I can go anywhere from 8-10. I require a lot of sleep because I'm so active. If I drop down to four, three (hours of sleep), there's a problem. . . .

Jacob explained,

Early warning signs are when I'm going into mania this happens. Or when I am going into depression this happens. First of all, if I don't sleep an entire night call the doctor or don't let it happen a second night. If it happens a second night immediately call the doctor.

Willow said,

Going to bed early is important but I'm not overly strict about it. I'm generally in bed by mid-night and up by 7 o'clock or so. But it has made me aware if I am having difficulties. Say my moods off. I'm grumpy. Or, I'm not sleeping well. I'm able to look back and think about what are likely, what could be triggering, you know, the problems I'm having. . . .

Jacob and Kevin talked about some unique circumstances catalyzing a mood shift.

Jacob said, "So you got certain things. For me colors become enhanced. So sometimes I can notice that things are wrong because colors are little too bright. The colors being bright wouldn't happen to everybody. You learn to notice your warning signs." He also noted another sign of things being wrong. "However, when I am going into a manic

episode the same thing starts happening. Women become beautiful and even women I would never ordinarily notice.” Kevin said:

I was reading about it and understanding more about my own behavior and why I behaved that way and what were some of the triggers that I would experience that could set it off. Like music was a big one. Music would set off into a manic phase.

Avoiding the seduction of mania. For some participants, mania was seductive.

The sensations accompanying mania were extremely energizing and powerful. Avoiding manic sensations made some participants uncomfortable or sad while made others feel healthier. They relished experiencing manic exponential creativity, and a sense of indestructibility. Kevin, Joe, Lillie, and Maria spoke about their experiences with the seductive power of mania.

Kevin really hated psychotropic drugs making him calm and removing his manic experiences:

Wanting to stay manic that’s been my biggest challenge. Wanting to stay manic.

The risky behavior. The fun. The highs. That’s been biggest challenge for me.

Hating myself when I’m normal. Yeah, I mean that’s a big challenge. I shame myself for being normal. I’ve always prided myself on not being normal. Not

being like everybody else. Then all of a sudden you find yourself like I’m Mr.

Calm. You go I don’t want to be Mr. Calm. I want to be Mr. Off-the-Wall.

Joe also missed experiencing mania, which he experienced as just a naturally heightened mood:

(With) mania your senses are so heightened and everything thing is going on so fast. But at the same time, my experience with mania was, I was wanting to grab

everything because I didn't trust it would be there later. It was like maybe it's still not there. But it seemed like if I. If my, myself did not do something about the situation that was already beautiful, if I didn't own it and grab it, it would go away. . . .

The dangers of manic seduction were discussed by Lillie, Maria, and Kevin. Lillie explained,

Yeah, so what I've learned is to see hypomania as a drug for me. And I'm good with the idea that crystal meth is off limits. That I was very lucky that I didn't get addicted to that because it's very addictive for some people. It really set off my cycles. And who knows how many brain cells I killed, but I survived that. But I've learned to see hypomania as that.

Maria said,

I have to understand that even though mania is great fun, it scares people. It pisses people off. Friends back away. Strangers come and take your possessions and your money, and you smile and hand it over. It's foolish to let myself be that far out there because it's too hard to climb out of the hole. If you dig too big of a hole when you're manic, then you have to climb out of it when you get depressed.

Life's too short.

Though Kevin missed being seduced by mania, he also experienced its destructiveness:

And this is the results and it's kind of like the boat going down and you have this wake behind the boat. Like my boat would be traveling at 100 miles per hour and there was just a wake of destruction behind me. I mean I've left family, friends,

everybody just churned up in the wake of the boat. My manic activity was driven it. . . .

Analyzing the benefits of psychotropic medications. Taking psychotropic medications was a tool for managing with bipolar disorder. Participants took prescribed medication to stabilize their moods. However, participants held different perspectives regarding the role of medication in managing their moods. For some it was essential, while for others it was an option. Kevin viewed regularly taking medications as a definite part of self-managing his bipolar disorder:

Well my experience was that the books pointed out to me that medications and taking my meds on a regular basis, daily basis, and following the regimen that the doctor gave me was the most important piece. And that therapy along with that would produce best results. But I didn't seek out the therapy. I started taking my medications on a timely basis.

On the other hand, Jacob did not view medications as the ultimate mood management tool:

There's one thing that I left out that may kick in here. People tend to think you take your medicine and that is it. And by learning how to behave. Sounds like a dog learning tricks. Learning how to deal with you illness you can actually end up taking a lot less medicine and having a lot less problems. So it is more . . . A lot of people say well they took their medication. . . . There's more that can be reached within yourself by learning the proper (coping) skills.

Willow viewed taking medications to manage moods as an option when and if the need arise:

For example, I have an anxiety medicine that I don't take on a regular, very regular basis. I used to have to take it on a regular basis. But, I've learned to observe in my daily life what are those things that make me anxious. Making sure I get enough sleep. Or, eating enough protein. What I would say are some terribly simple things. That for the most part, I don't have to take the anxiety medicine a couple times a day. But, it's (there). I tell myself if I need to take it, take it. I don't make it some kind of a competition to see when you don't have to take it. But, I'm not as dependent on it. It's a nice feeling because I feel very empowered about keeping myself on track.

Seeking help from mental health professionals. Working with licensed mental health professionals was a strategy to stay well. All participants worked with psychiatrists who managed and monitored their treatment with psychotropic medications. In addition, half of the participants engaged in psychotherapy that provided a treatment method of face-to-face communication for an extended period of time about managing the bipolar disorder. Lillie and Kevin provided lengthy input about their work with licensed mental health professionals. Lillie always prepared for their discussions:

I ask questions all the time, and I don't stop until I understand, and I'm all out of questions. This really matters when they're (mental health professionals) making a suggestion that I don't like. Because I can ask questions to find out more about the suggestion. I'll be open minded about it, and say, "Now what do you mean? Does this mean that such and such? Are you saying that because you heard me

say this?” Usually we talk about it, and one of two things happen. I come to understand better what it is that’s being suggested and why because maybe I hadn’t seen something as a problem. And once it’s pointed out to me, I do. Or, they come to understand better what my situation is. And it turns out that the suggestion they’re making isn’t appropriate. Which is why I didn’t like it, and that’s not even the problem I’m trying to get solved. And so, one way or another, my asking questions is (necessary). My understanding what is being suggested and what’s being said is huge. So that’s my thing about doctors as consultants.

Kevin said of his work with mental health professionals,

I go three times a week—Monday, Tuesday, Wednesday—to psychoanalysis. And that therapy combined with the management of medications. I’m able to manage my whole bipolar diagnosis or whatever you want to call it. I’m able to management that. . . .Yeah therapy is a good safety net.

Making informed choices about nutrition and exercise. Several participants talked the importance of making informed decisions about nutrition and exercise in self-managing their bipolar disorder. Willow explained,

When they (my moods) get off, I’m very aware of looking at what I’ve been eating. What I’ve been drinking. Maybe I’ve had a little bit of caffeine. Most likely, it’s because I’ve had too much sugar. You know, maybe a candy bar here, some hard candy, or just a lot of carbs during the day, and that will shift my mood maybe. And just have been eating like junk food versus have a solid meal with balanced proteins, fats, and carbs.

Exercise for Zoe was a necessity:

I still kept my tennis constant because that's natural serotonin. And I believe in that 100 percent. . . . We'd all fill up the junior high tennis courts, and they had lights, and Saturday too. We'd played for two hours . . . depending on how hot it was. If they hadn't cooled off enough, we'd make it later because we had lights, and it didn't matter. And I am also a very avid gardener. So when I'm not playing tennis, I'm gardening.

Maria explained,

Well, I think making sure that I get the right vitamins. And I found out about omega 3 through my reading, and went out to Whole Foods and bought omega 3. And I even put my name in the hat to be in an omega 3 study but it was in Houston. But I understand that it worked (for managing moods), and I started taking it.

Maintaining balance. Some participants described staying well with bipolar disorder as an act of maintaining balance. Joe described use of trust to maintain balance or calmness: "I guess I've kind of learned to be calmer. And that through being calmer it's kind of like you can trust and abide in sort of that which persists." Zoe said,

You never know what's going to happen. And what's going to add extra stress to your life. I haven't mentioned the half of the stress in my life. You're only seeing the tip of the iceberg. You never know what's underneath that iceberg. And so, you have to be able to stay balanced. You have to maintain balance between what you need to do to keep yourself healthy and feeling obliged to overboard helping these other people, who are putting stress on your life.

Walter explained,

So I can, I can often bring myself back to level. Ran into that level time. It's a time when you're ok. Level time. I can bring myself back toward level time by remembering that these are just chemicals that are going on and it will leave me after awhile. Just wait. And sometimes when I'm doing that I'll take myself out of whatever situations that I'm in that's even to the point of just saying excuse me I have to go now. . . .

Willow said,

If I'm feeling hyper, I learn to down shift, and that's a description that I like to use that I down shift into a lower gear. And you find those things over time that work for you. Those mnemonics. For me I have an acronym which is I think FLO, which stands for focus, listen, observe. When I'm in a meeting, (I use FLO) to keep me focused and listening and observing. And you find different catch phrases, for me down shifting. I've heard other people call it leveling. Or, whatever it means being in balance. But, go out and search, and dive into it. Get support. Find out what works for you. And stay the course. . . .

Staving off suicidal thoughts and actions. Several participants talked about learning to stave off suicidal ideation or suicidal actions and how they dealt with feeling suicidal. Lillie explained,

It's like if my moods every day were a graph, you know, going up and down like an EEG, EKG something on a screen. It's going up and down. You know, it might dip down below the threshold of this is worse than death. You know. And I don't seem to fear death as most people do then a lot of my life is there. But I also seem

to have the sense that it's not always there all the time. And it does get better if I can just get through it then it will get better. There weren't just many times when, that I really wanted to die for long periods of time where I'd start thinking about how. I could always talk myself out by saying no it's not fair to the train engineer to go get drunk and lie down on the tracks because that would really just be awful for that person. . . .

Willow said,

I think like one transforming experience, learning experience, was going through a short period of where I felt very suicidal. Whenever I talk about my family of origin; it had some definitely dysfunctional dynamics and not healthy. Too much discussion on that in the past has led me to feeling overwhelmed and nauseous, and it made me feel suicidal. I actually went and read a book what do I do basically if I feel like I'm going to kill myself. And so I had different things in place. Like a backup network to my husband. And identified how to be aware of my behavior, things that I was saying, to catch before I spiraled into feeling suicidal or even feeling depressed. . . .

Closing insights about learning to stay well. A prompt related to the third search question asked: What would you tell others who have bipolar about the journey to learning to stay well? Through their messages, participants conveyed empowerment to others in self-directing their lives and owning their self-management to stay well.

Thoughtful responses were shared by Maria, Kevin, Willow Jacob, Joe, and Walter.

Maria said, "Trust yourself, and keep your balance." Kevin suggested, "Get some type of weekly therapy if not more."

Willow shared,

I would say that learning it's big; it's multi-dimensional. You get it from books. You get it from doctors. Managing your bipolar is bigger than just taking your meds. It's how you engage in life. It's being a part of life. It's being happy about life. And don't ever forget that other people have come before you and had these conditions. And that you can get your life back on course. I won't say normal, but you can manage it so you feel good.

Jacob recommended,

Learn your early warning signs and coping skills. And those probably should be tied. Everybody has different warning signs and coping skills. You know, some people go shopping. I never, that's never been a problem that I've seen in me. You need to learn your individual (coping skills).

Joe said, "So if I could tell them I would say you're not alone. If I could hold them, I would hold them in a way that says something like, it's ok to let go. It's ok not to be in control."

Walter shared,

I wouldn't, I would not trade the experience of being bipolar. I definitely would not do that. And part of that is because what I've learned about me. I've been poking around in there about the bipolar and a lot of other stuff about me.

Summary

Exploring how individuals with bipolar disorder experienced learning in self-managing their mental illness was the focus of this research. The intent of this exploration was to discover how these learning experiences contributed to participants'

learning to stay well with bipolar disorder and how self-directed learning and transformational learning experiences contributed to their learning. Participants included females and males between 25-67 years of age. All participants had attended some college and most participants were employed.

The focus of question one was on learning prompts. Participants' experiences prompted learning about bipolar disorder. Some of their experiences served as examples of self-directed learning and transformational learning. Participants sought knowledge to gain familiarity with the diagnosis and management of bipolar disorder. Becoming familiar with bipolar disorder included a chance to reframe or reinterpret the symptoms of mental illness that had complicated their lives for years. Their experiences (a) allowed them to learn the name for the mental illness that they had endured for years, (b) led to their accepting the diagnosis of bipolar disorder, and (c) resulted in actions prompting learning about bipolar disorder.

The focus of question two was on how participants learned to self-manage their bipolar disorder. Participants described a variety of experiences contributing to their learning to self-manage bipolar disorder. They discussed how barriers blocked or delayed their entrance into self-directed learning. They also discussed how choice of various resources, such as literature, the Internet and other people, supported their self-directed learning activities. Finally, they discussed how personal motivation drove their self-directed learning, which led to increased control of learning and satisfaction with learning outcomes.

The focus of question three was on how participants learned personal strategies to stay well. Seven emergent themes highlighted these strategies. Acquiring personal

strategies occurred through a variety of experiences. Critical reflection about the challenges of self-managing bipolar disorder provided a method through which to assess past experiences in order to take responsibility and ownership for future actions. Participants described how poor personal choices, the complexities of bipolar disorder, and psychotropic medications presented challenges to staying well. Taking greater ownership and being personally proactive were necessities for staying well. Discovering coping strategies enabled participants to gain control of self-managing bipolar disorder to stay well. Self-trust, personal balance, and disengaging suicidal thinking or actions enabled participants to cope to stay well. Obtaining help from mental health professionals facilitated stay welling. Finally, participants shared their thoughts about their journeys for learning to stay well.

CHAPTER V

INTRODUCTION, DISCUSSION, AND CONCLUSIONS

Introduction

How do persons with chronic illnesses stay healthy? A review of literature identified actions supporting positive health outcomes. Acceptance of day-to-day responsibility for self-management supported positive health outcomes (Lorig and Holman, 2003). Use of self-management practices also supported positive health outcomes (Bodenheimer et al., 2002; Frank et al., 2006; Grumbach, 2002; Lorig & Holman, 2003; Stevens & Sin, 2005).

Discussions in previously reviewed literatures also identified self-management practices as supportive of staying well with bipolar disorder (Colom, Vieta, Martínez-Arán, et al., 2003; Colom et al., 2004; Michalak et al., 2005; Perry et al., 1999; Pollack, 1995; Russell & Browne, 2005; Weiss et al., 2000). However, a review of literature did not identify the nature of the learning experiences through which individuals with bipolar disorder learned actions to self-manage their bipolar disorder to stay. This raised the question of how persons with bipolar disorder go about learning how to self-manage their health to stay well.

Exploring the nature of self-directed learning and transformational learning experiences among individuals self-managing bipolar disorder to stay well was the purpose of this research. Through this exploration, the nature of self-directed learning and

transformational learning in learning to self-manage bipolar disorder could be examined at a deeper level. Eight individuals volunteered to participate in this research and discussed how they went about learning to self-manage bipolar disorder to stay well.

In Chapter 5 examination of the research findings occurs in five sections. Section one presents the discussion of the key findings. Section two presents the conclusions. Section three presents the recommendations for practice. Section four presents the recommendations for future research. Section five presents reflection on the research.

Discussion of Key Findings

The focus of this research was on adults with bipolar disorder who identified themselves as engaged in activities for learning how to stay well. During their interviews, adult participants described experiences through which they learned how to self-manage bipolar disorder to stay well. Years prior to being diagnosed with bipolar disorder, some participants described experiencing personal challenges, such as depression, physical illness, substance abuse, and risky behaviors, without an identified cause. During those years, they sought help from physicians and psychiatrists whose prescribed treatments were inadequate to remedy participants' challenges. For the remaining participants, the challenges of mental illness appeared acutely with episodes of mania, psychosis, depression, or paranoia resulting in emergency admittances to psychiatric hospitals. However, at some point in their searches or encounters with mental illness treatment,

every participant received a diagnosis of and treatment for bipolar disorder. For this study, the interview questions were focused on understanding:

1. What experiences prompt learning among individuals with bipolar disorder?
2. How do individuals with bipolar disorder describe their experiences of learning to self-manage their health?
3. How do personal learning experiences contribute to strategies for staying well?

Experiences of Learning to Self-Manage Bipolar Disorder

Participants in this research described movement through key personal experiences in learning to self-manage bipolar disorder and to maintain wellness. Though their experiences were variable, they did share common key events in learning to self-manage bipolar disorder to stay well. Figure 1 illustrates these events and experiences.

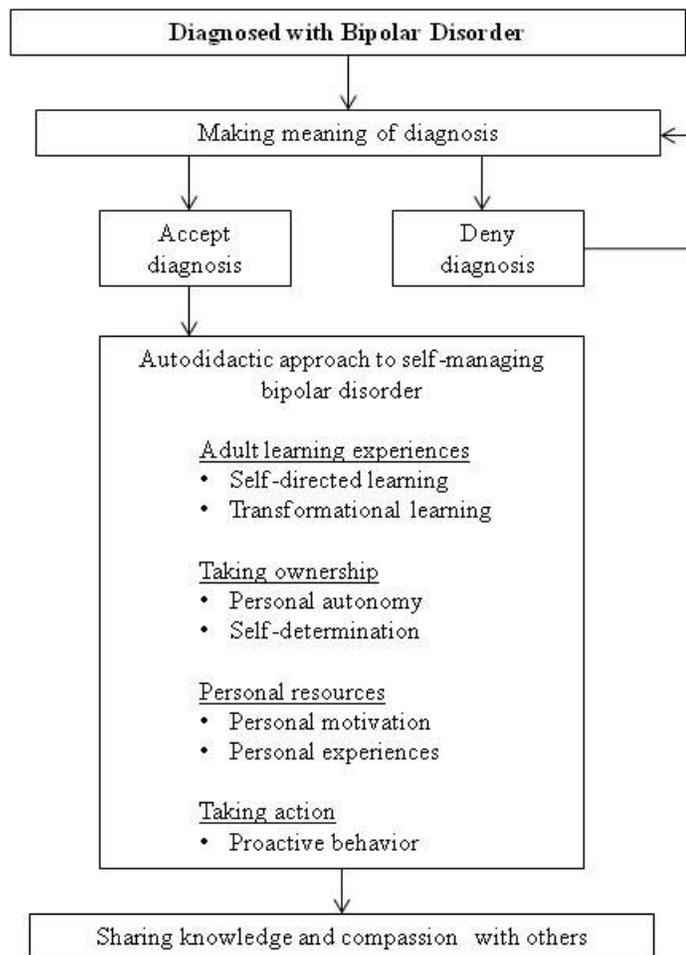


Figure 1. Experiential diagram of participants' learning to self-manage bipolar disorder to stay well.

Making Meaning of Bipolar Disorder Diagnosis

In order to move forward with learning to self-manage bipolar disorder, participants described experiences of trying to make meaning for themselves within the context of having a diagnosis of bipolar disorder. They had to answer the question of what this diagnosis meant to each of them personally. For some participants, now I know what is wrong with me meant relief for finally having a name for the symptoms with which they had experienced life-long struggles. For others knowing meant discomfort and disbelief.

Meaning making. Following their diagnoses, a common question expressed by participants was, “What does it mean?” Their descriptions illustrated how meaning making transpired through reinterpreting their experiences of being diagnosed and becoming aware of the symptoms of bipolar disorder. In the context of receiving a diagnosis of bipolar disorder, transformational learning involved reinterpreting old experiences from a new perspective (Mezirow, 1991). Also, transformational learning enabled making use of meaning to question previous assumptions (Cranton, 2006).

Participants began to construct meaning about what having bipolar disorder meant to each of them. They initiated learning to construct knowledge for themselves. They described engaging in learning activities, such as reading books, attending mental health education courses, and talking with mental health professionals, to gain an understanding of bipolar disorder and how to approach managing it. From a constructivist perspective, learners are not passive beings who respond to ‘stimuli,’ and learning is not merely the appropriation of previously devised labels and categories. “Instead learning is an active process of constructing meaning and transforming understandings” (Candy, 1991, p.

251). As participants recounted their personal experiences of constructing meaning about having bipolar disorder, they described experiences emblematic of transformational learning and self-directed learning.

Participants' experiences were similar to those described in previous research about meaning making through transformational learning for persons diagnosed as HIV-positives. Courtenay et al. (1998) reported that individuals' immediate reactions to being diagnosed as HIV-positive were cognitive responses of shock or mental numbness. In that research, expressions included went blank, felt dazed, and the future came slamming shut. However, the immediate reaction of two individuals was not being surprised and being in a state of anticipation; these individuals were living with partners previously diagnosed as HIV-positive. "The subtle differences in the immediate reaction . . . suggest that the context might be a contributing factor to the response to the disorienting dilemma" (Courtenay et al, 1998, p. 4). The context within which individuals received the diagnosis of HIV-positive affected their immediate reactions. A primary theme emerged among persons learning how to live with MRSA: "Learning – "I guess everything changes when it happens to you" (Rhode & Ross-Gordon, 2012). Participants experienced meaning about living with and managing a MRSA infection plus faced understanding the stigma of this infectious disease.

Accepting the diagnosis. Making meaning of the diagnosis of bipolar disorder involved coming to terms with accepting the diagnosis. Among the participants, active engagement in learning to stay well depended on acceptance of a diagnosis of bipolar disorder. However, acceptance of a diagnosis of bipolar disorder proved difficult for most participants. Acceptance signified acknowledging the symptoms (e.g., mania, depression)

and the risks (e.g., substance abuse, suicide) of bipolar disorder within themselves. In addition, acceptance of the diagnosis meant experiencing the pain and shame of stigma associated with bipolar disorder. Prior to acceptance, participants described experiencing resistance toward engaging in learning about bipolar disorder.

Denial signified disbelief of the diagnosis and avoidance of dealing with the symptoms, risks and stigma of bipolar disorder. Joe's explanation for initially denying his symptoms of mental illness was, "In my mind, I was, I had experienced these spiritual highs . . ." Kevin explained, "I really didn't have an interest in my diagnosis. . . ." Zoe struggled with the diagnosis because at the time she said to her psychiatrist, "I think I'm just depressed. . . ."

Whether gradual or immediate, acceptance removed denial or doubt about a diagnosis. Joe said, "But at one point, I did call it bipolar and I did say you know and I have to have help. But it was a gradual thing. . . ." Jacob said, "And there was no denying that I had it. I was hungry to learn everything I could to prevent it from happening again." Zoe described her point of acceptance coming after she experienced symptoms of bipolar disorder of which her psychiatrist had forewarned her. But she had to experience, acknowledge, and determine for herself the need to seek treatment for bipolar disorder:

I hadn't slept for the last four days. I called her and said Dr. B you're right. I haven't slept for the last four days. . . . And I went back to her office and said ok give me a stabilizer drug. I believe you now. And at first, I was very stubborn. . . .

Acceptance of a diagnosis prompted learning about bipolar disorder. Participants' descriptions of acceptance resonated as transformational learning experiences. Participants' acceptance of their diagnosis served as a trigger of transformational

learning, through which they reframed their personal paradigms about experiencing the symptoms of bipolar disorder (Mezirow, 1991). Transformational learning experiences occurred with the examining, assessing, validating, and revising of participants' perspectives of experiencing the symptoms of bipolar disorder (Cranton, 1996).

In previous research, acceptance also was critical for moving forward with managing chronic illnesses. Russell and Browne (2005) researched how individuals stayed well with bipolar disorder. Among those interviewed, a first step in the evolution of learning was accepting the diagnosis. Moving into acceptance following diagnosis emerged as a step preceding immersion into learning about MRSA (Rhode & Ross-Gordon, 2012). Similarly Courtenay et al. (1998) found acceptance of being HIV-positive was immediate for some individuals and delayed for others. Accepting the diagnosis helped individuals get unstuck and move into making meaning, gathering information, and learning about being HIV-positive.

Acceptance empowered participants to become responsible for learning to stay well, similar to what Courtenay et al. (1998) reported. The concept of "empowerment" can convey accepting personal responsibility for and proactively seeking information about self-managing an illness (Bodenheimer et al., 2006). From the theoretical perspective of Candy (1991), proactive behavior allowed the expression and expansion of personal autonomy toward self-directing activities to learn. However, acceptance of bipolar disorder was a necessary but not sufficient condition for prompting engagement in self-directed learning.

Autodidactic Approach to Self-Managing Bipolar Disorder

Within an informal learning setting such as the context of daily life, an autodidactic individual sets goals, locates and uses appropriate resources, experiments with different ways to approach the subject under study, attends to feedback, assesses progress in learning, and engages in next steps (Candy, 1991). Simultaneous role occupancy as both competent teacher and proficient learner occurs in autodidactic experiences (Candy). Descriptions of participants learning experiences portrayed this dual role of the autodidactic. In practicing autodidaxy, they engaged in autonomous approaches to learn about bipolar disorder and how best to self-manage it. As defined in the Stanford Encyclopedia of Philosophy (September 12, 2008),

To be autonomous is to be a law to oneself; autonomous agents are self-governing agents. Most of us want to be autonomous because we want to be accountable for what we do, and because it seems that if we are not the ones calling the shots, then we cannot be accountable. More importantly, perhaps, the value of autonomy is tied to the value of self-integration (p. 1).

Participants' autonomous approaches to learning included exercising personal autonomy, taking ownership, employing self-determination, harnessing personal motivation, examining personal experiences, and implementing proactive behavior.

Personal autonomy. Participants exercised personal autonomy by taking responsibility for understanding and owning the diagnosis and experiences of bipolar disorder. Participants described the actions they took in taking responsibility such as reading a lot, seeking therapy at a mental health clinic, and thinking about what to gain

knowledge about having bipolar disorder. As Candy (1991) has discussed, personal autonomy situates an individual favorably toward self-directed learning.

Common across participants' descriptions was the expression of personal autonomy in making decisions about learning how to self-manage their bipolar disorder. Personal autonomy prompted learning about self-management and facilitated gaining self-management strategies. According to Candy (1991) "That is, one does not 'become' autonomous in any final or absolute sense; rather one is able to think and act autonomously in certain circumstances" (p. 114).

Participants' descriptions portrayed them as autonomous adults. In discussing the development of personal autonomy, Candy (1991) points out that ". . . adults are not passive or inert, nor are they sitting around waiting to be 'made more autonomous' by the actions of adult educators" (p. 122). The self-constructing individual tends to be autonomous (Candy). "He or she would be presumed to have both the ability and the willingness to be introspective and self-aware, as well as having an inclination towards self-improvement" (Candy, p. 259). Cranton (1994) proposes, "The more autonomous a learner is, the more likely he or she would be to engage in transformative learning. Likewise, participation in the process of transformative learning further increases autonomy" (p. 60).

Participants identified taking greater ownership as a means of strengthening their self-management skills to stay well. They described taking greater ownership as recognizing a problem and taking the driver's seat or taking charge to solve the problem. Participants' acts of ownership strengthened their abilities to gain strategies to stay well. In owning their well being, they critically assessed current and past events in order to

move forward with personal actions to self-manage to stay well. Their critical assessments led to transformation of perspectives in understanding their experiences with bipolar disorder and in self-directing their learning to self-manage and live healthfully with this mental illness (Candy 1991; Mezirow, 1991).

Participants explained the interdependence of taking ownership and taking responsibility or making personal choices. Joe explained, “The other thing is like for me at least my bipolar—I think even depression—is predicated on this sort of like responsibility to try to own stuff. . . .” Lillie said, “I can make choices instead of going with the flow. And I’m taking the driver’s seat, not just taking responsibility Taking on this burden, and then taking the driver’s seat because of these things that I’ve learned.” Willow said, “I’ve taken greater ownership in my staying well. . . . I’ve had some behaviors that were like things that over stimulated me. . . . And that was just a way of diverting, really diverting myself from my depression and jacking up my mood. But there’s better ways to do that. . . .” Maria explained, “So much of what I grew up with was my mother saying it was always somebody else’s fault that poor little me. I couldn’t do anything, and I did not want to be like that. I was taking charge”

Similarly, previous research found participants discussed taking ownership for the management of their chronic illnesses (Baumgartner, 2002; Courtenay et al., 2000; Rager, 2006; Russell & Browne, 2005). Courtenay et al. and Baumgartner found individuals who were HIV-positive adopted a meaning scheme of needing to care for their selves. Individuals became more focused on wanting to fix up my body” (Courtenay) and to care for self (Baumgartner). In a similar vein, Rager reported men with prostate cancer possessed a sense of responsibility or ownership in their self-directed

learning about treatment options. Likewise, Russell and Browne discovered the importance of individuals with bipolar disorder developing personal stay well plans for preventing acute episodes. Whether informally written or verbally communicated with family, partners, friends, and health professionals, all participants with bipolar disorder took ownership in their stay well plans.

Self-determination. Throughout their interviews, every participant demonstrated self-determination in wanting to figure out what worked best for personally self-managing bipolar disorder. Through their interview responses, descriptions of their personal experiences demonstrated the practices of self-directed learning and transformational learning. Individuals exercised self-determination in adopting a critical perspective toward their diagnostic circumstances (Cranton, 2006). “When self-direction is used in the sense of personal autonomy, it may have one of two meanings: either a broad disposition toward thinking and acting autonomously in all situations (self-determination) or, more narrowly, an inclination to exert control over one’s learning endeavors (self-management)” (Candy, 1991, p. 101). Engaging in self-directed learning involves the dimensions of personal autonomy, self-management, learner-control, and autodidaxy (Candy).

Candy (1991) defines self-determination as being self-directing within the power of controlling one’s destiny. Adults are self-determining. “The fact that they are self-determining, however, does not preclude the possibility of increasing their personal autonomy in learning, but it emphatically does preclude the possibility of ‘making’ them autonomous (Candy, p. 123).

In the context of managing bipolar disorder to stay well, participants made decisions to engage in learning. They began to construct their approaches to self-management. Each participant defined what self-management meant to them. Within this context, moving forward with learning depended on the decision to deny or accept the diagnosis of bipolar disorder. When in a state of denial, participants received information but did not actively use or seek further information. With acceptance, transformation occurred. They self-determined the need to learn in order to self-manage. Acting autonomously equates to being self-determining (Candy, 1991). As Candy states, “However, a person can vary markedly in the degree of independence he or she exhibits from one situation to another” (p. 139). Learning is context-bound.

Participants self-determined how to move forward with learning for themselves how to self-manage their bipolar disorder. Jacob said, “My first manic episode was a completely full blown manic episode. And there was no denying that I had it. I was hungry to learn everything I could to prevent it from happening again.” Zoe explained, “That I’m the best decision maker about my body. Because, I told you. I have the best picture. . . .” Similarly Lillie explained, “Yah, you are your own best physician. And what that means is that I get to own the decisions. I’m the one who gets to live with this stuff, and I get to own these decisions. So, I listen to what they say, but it’s my decision ultimately. . . .”

Participants’ self-direction of learning facilitated their self-determining which resources were of most interest and use to them in learning to self-manage bipolar disorder. They described experiences of self-directed learning to find information about treating and managing bipolar disorder by making use of available resources such as the

Internet, books, mental health clinics, psychotherapists, and psychiatrists. Through self-determining their choices of resources, participants gained insights about treatment options and self-management strategies.

In a previous study by Rager (2006), men diagnosed with prostate cancer similarly expressed strong motivation to self-direct their learning to make informed treatment choices or to validate the recommendations of their doctors. For example one man said, “I better find out what these choices are and how that’s going to affect me” (Rager, p. 453). Another explained, “I think first of all, it was to make a treatment choice and to make sure that I made that decision base on my own analysis—not just the doctor’s” (Rager, p. 453).

Personal motivation. In the current research, personal motivation provided a personal resource promoting for learning about managing bipolar disorder. Descriptions of personal motivation acting as a catalyst to action suggested both self-directed and transformational learning experiences. As with self-directed learning, increased control of learning led to increased satisfaction with the learning outcomes (Candy, 1991). Participants described self-directed learning experiences as empowering.

Even after accepting a diagnosis, participants described only engaging in self-directed learning after being motivated to make conscious decisions to proactively engage in personal quests to learn about self-management strategies with their personal interests in mind. As self-directed learners, they described circumstances demonstrating what Candy (1991) identified as a self-directed learner’s characteristics: self-sufficiency, confidence, curiosity, openness, and motivation for independent learning. In addition, reflection on personal experiences inspired participants to make choices about the best

resources, information, and strategies for learning to self-manage bipolar disorder. Participants' reflective actions resulted from what Mezirow (1991) identifies as both reflecting on and critiquing perceptions, judgments, feelings, and acts. Mezirow states, "Reflective action is making decisions or taking other actions predicated upon the insights resulting from reflection" (p. 108).

Several participants described their harnessing of personal motivation. Zoe explained, "You have to find what works best for your body, and tell the doctor about it, and insist on it." Willow said, "So the self-directed (learning) was a very empowering experience. . . . I know even in my self-directing, if something felt too close to what I had experienced personally, some problems earlier in my life, it might leave me feeling agitated or sad or depressed. But for the most part, I recall my (feeling) very empowering, strong." Joe described his transformational and self-directed learning experiences:

It's been learning about what my, what got me here, what needs. It's been a whole sort of like whole introspective long journey into understanding and being able to articulate and identify parts of myself So I guess what I've learned, witnessed is better, about my self-directed learning over time. It's a great question because over time things have become clear about kind of uncoiling and debunking and maybe really bringing into awareness what mania is. Which is bipolar for me. . . ."

In a previous study by (Rager, 2003) women with breast cancer reported three common motivations for self-directing their learning about breast cancer. Their motivations were the desire to overcome fear related to breast cancer, the desire to understand the impact of breast cancer on themselves, and the need to learn how to make

informed choices about treatment options. Motivation to learn was expressed as wanting to have answers, desiring to feel at peace with the diagnosis, and gathering sufficient information to arm one's self to informed treatment decisions.

Similarly, men with prostate cancer expressed a strong motivation to self-direct their learning to make informed choices about treatment choices (Rager, 2006). Choice of treatment options directly impact the presence of treatment outcomes, such as impotence and incontinence. One man explained, "And so I thought, . . . I better find out what these choices are and how that's going to affect me" (p. 153).

Personal experiences. Participants' descriptions of learning experiences highlighted the importance of learning through the personal experiences of self and of others, which served as personal resources. Through descriptions of their personal experiences participants shared their personal narratives of learning about the bipolar disorder as a mental illness and bipolar disorder as an experience to be self-managed in daily life.

Reflecting on personal experiences allowed participants to reexamine judgments based on past and current assumptions about what self-management involved. According to Mezirow (1991), "These judgments are based on assumptions, and these assumptions are open to question. Reflection upon assumptions thus becomes crucially important in learning to understand meaning" (p. 15). For example, participants' reexaminations provided the opportunity for reframing their perspectives on personal experiences with symptomatic behaviors (e.g., risky behaviors, impulsive actions) preceding past psychiatric hospitalizations or destructive actions (e.g., attempt of suicide, use of illicit drugs) as warning signs for the future. Transformational learning experiences can lead to the

questioning and revising of perspectives, such how best to self-manage one's bipolar disorder (Cranton, 2006). Reframing allowed participants to reinterpret personal experiences and acting upon what was learned (Cranton; Mezirow).

Reflecting and reframing helped to shape participants narratives. As Rossiter and Clark (2007) explain, "Perhaps most relevant in relation to adult learning is the empowering realization that to critically reflect on one life story is to claim the authority to rewrite it" (p. 25). The reflecting and reframing also helped participants create meaning through personal narratives. "If we make sense of our experience through storying it, it follows that we construct our understanding narratively" (p. 4).

Participants described experiences leading to transformational learning. For example, Joe's and Maria's revisiting of being mistreated at psychiatric hospitals motivated them to stay well. They both told their stories in graphic detail regarding how they had arrived at fearing re-admittance to a psychiatric hospital. Joe explained, "And so I was terrorized about going into the mental hospital. That was my sense of why I took the medication" Maria explained she was "very determined to keep myself well so that I didn't have to be at their mercy."

Jacob and Kevin provided a narrative journey of events leading to full blown, manic episodes. However, their experiences and interpretations of mania differed. Jacob said, "I considered it a big problem. I wanted to control myself and toe the line. Had fear of wanting to experience manic episode again. . . . I don't see that I had that option. . . ."

However, Kevin always recalled mania as an enjoyable state of being with negative consequences:

Oh, it's the hardest thing in the world to give up that (mania). . . . I think in 1993 I had had multiple affairs and that behavior led me to go into counseling and therapy. And there was a major transformation that took place there. A huge transformation took place; that was a big one. Really that action and that behavior led me this way. . . . Because that was all manic driven. . . .

Lillie and Willow identified the value of experiencing others' personal narratives about living with bipolar disorder. Learning through personal narratives serves as an example how individuals attempt to identify with others' experiences in effort to attempt to make sense of their experiences (Candy, 1991). Lillie discussed the meaningfulness of hearing personal narratives of others in a 12-step program and also reading the personal essay, *An Unquiet Mind*. She said, "It becomes more clear. I learn through narrative. I learn through first person narrative. That's where some of the strongest learning experiences have come from." In addition, she said, Yes, *Unquiet Mind* is by Dr. Jamison. So again this is somebody with Bipolar I, but it was tremendously helpful for me to read somebody's story. . . ."

Willow shared, "So, I started buying more books on bipolar disorder. . . . but they were different like personal biography. What do they call it? Not personal biography, but personal essays about their experiences with bipolar disorder. There's one called *Electro Boy* by Andy Behrman, about his experiences. And Dr. Jamison's experience with her being bipolar, which was (called) *An Unquiet Mind*. . . ."

Kevin engaged in a variety of learning activities through which he had heard other's talk about their experiences with bipolar disorder. He said, "Just individuals talking to. Going to, I started going to lectures and speakers forums. An *Unquiet Mind* the lady that wrote that I went to hear her speak."

In previous studies focused on self-directed learning and transformational learning experiences among individuals diagnosed as HIV positive or with prostate cancer, learning through personal narratives was not discussed in the findings (Baumgartner, 2002; Courtenay et al., 1998; Courtenay et al., 2000). However, when talking about their learning experiences, women with breast cancer used personal stories to convey how self-directed learning experiences facilitated their connecting to other people as a means for reducing the loneliness and isolation often accompanying a diagnosis of breast cancer (Rager 2003; 2004).

Participants learned through their personal narratives about living with bipolar disorder and also the narratives of others. Their self-directed learning allowed them to gain new perspectives and to make meaning about staying well by examining their own experiences and those of others. By sharing personal stories or narratives and learning from other's personal narratives, self-directed learning becomes collaborative (Candy, 1991).

In relation to adult learning, the role of narrative empowers critical reflection and the authority to rewrite one's life story (Rossiter & Clark, 2001). "The 'storied life' suggests not only that people make meaning of events across the life span narratively, but that the very nature of identity—the self—is an unfolding story" (Rossiter & Clark, p.

44). An individual comes to understand the meaning of an event in relation to the story context within which it occurs.

Proactive behavior. In the current research, proactive behavior also simulated self-directed learning about bipolar disorder. Proactive behavior catalyzed self-directed learning alone or in collaboration with others. Proactive behaviors exhibited by participants included reading various publications, enrolling in a mental health clinic, and engaging in discussions to understand the root cause, genetics, symptoms, risks, and management of bipolar disorder. Descriptions of their proactive behaviors suggested an autodidactic approach to a single-minded commitment toward learning and to the achievement of high levels of expertise about self-managing their bipolar disorder to stay well (Candy, 1991).

Participants' proactive behaviors illustrated the personal autonomy through which they conceived of goals and plans, exercised freedom of choice, applied rational reflection, exercised personal determination, invoked self-discipline, and viewed themselves as autonomous (Candy, 1991). Knowles (1975) explained that proactive learners "enter into learning more purposefully and with greater motivation. They also tend to retain and make use of what they learn better and longer than do reactive learners" (p. 14).

Engaging in self-directed learning, participants exercised independence in educating themselves about bipolar disorder. Zoe advised, "Find out the most you can about your illness, especially the history of your illness. . . ." Willow recommended the next step following being diagnosed with bipolar disorder: "And then you did need to go out and educate yourself. You need to empower yourself with that information. . . ."

Walter believed in “being proactive about your care, your own care, is the best way to go with bipolar.”

In addition, being proactive became a means of sustaining learning about self-managing bipolar disorder. Being proactive enabled participants to obtain the resources they needed to stay well. They did not passively accept knowledge from others, but actively engaged to construct the knowledge they needed to stay well. In essence they self-directed their learning. Engaging in learning was an active process to construct meaning and transform their understanding (Candy, 1991, p. 251).

Similarly, findings from previous research highlighted the presence of proactive behaviors in learning about an illness. Being proactive proved valuable in learning how to handle the impact of MRSA on individuals in adapting to the infection (Rhode & Ross-Gordon, 2012). “Don’t be afraid to ask questions ” and “life is precious and we need to do everything we can right now” were expressions of being proactive (Rhode & Ross-Gordon). Courtenay et al. (1998) found the catalytic experiences of HIV-positive individuals prompted proactive steps to gather information and to work with a doctor who was HIV educated and friendly (Courtenay et al., 1998). In another study, women with breast cancer described being empowered was experienced as being more aggressive, assertive, and willing to fight about decisions for treatment (Rager, 2004). One woman explained, “That I can help myself, that I can have an effect on my health, that I’m not at the mercy of fate” (p. 100). In a similar vein, Russell and Browne (2005) discovered proactive behaviors to stay well were prompted by mindfulness, an awareness of self and knowledge about how to respond to their physical, mental, and social environment. For example, one individual explained, “I moved swiftly to interrupt a

mood swing” (p. 190). Like participants in Courtenay et al.’s (1998) study, Russell and Browne (2005) reported being proactive in making changes in their lives was essential for individuals with bipolar disorder to stay well.

Sharing Knowledge and Compassion with Others

Most participants with bipolar disorder felt compelled to reach out to educate others about bipolar disorder and support those with bipolar disorder. Having messages to share with others was a byproduct of their constructing meaning to make sense of having bipolar disorder. A central tenet of constructivism is giving meaning to perplexing collections of events and ideas in which individuals find themselves (Candy, 1991). What transpired among these participants was the recognition that the discomforts or disorienting dilemmas they experienced were shared or common to others. “Relating one’s discontent to similar experiences of others or to public issues—recognizing that one’s problems is share not exclusively private matter” (Cranton, 1994, p. 20). Though each person is unique, commonalities exist with others.

Maria, Kevin, Willow Jacob, Joe, and Walter all conveyed a sense of duty or responsibility to enlighten others about what they experienced and learned about living with bipolar disorder. Maria shared a reminder to trust yourself and keep your balance. Willow offered a number of recommendations to others with bipolar disorder including “managing your bipolar is bigger than just taking your meds. It’s how you engage in life. . . .” Jacob recommended, “Learn your early warning signs and coping skills. And those probably should be tied. Everybody has different warning signs and coping skills. . . .” Joe said, “So if I could tell them I say you’re not alone.” Walter viewed himself as a

vehicle for teaching others about bipolar disorder: “It’s worth my while to talk to other people, to be an ambassador from the bipolar world.”

Likewise, adults with HIV in previous research had transformational experiences leading to the desire to be of service to others and making meaningful contributions (Baumgartner, 2002; Courtenay et al., 1998; Courtenay et al., 2000). Everyone concluded the meaning of living with HIV involved helping other people (Courtenay et al., 1998; Courtenay et al., 2000). For example, helping was like lighting the way with a candle where “maybe somebody two steps behind me can make it to that point and then perhaps go a couple steps more” (Courtenay et al., 1998, p. 7), or like affirming one’s self because when “you begin to give things away, it comes back and if you stop that, then you become stagnant” (Courtenay et al., 2000, p. 7). Baumgartner reported adults saw having HIV or AIDS as an opportunity to make a meaningful contribution instead of viewing it as a curse.

Similarly, Rager’s (2003) study of women diagnosed with breast cancer, a common outcome of self-directed learning was increased confidence, which for most women resulted in their reaching out to help other women who diagnosed breast cancer (Rager). For example one woman realized the importance of supporting other women in return for others having supported her. For example, one woman explained, “When you get diagnosed with something like this you’re learning lots of things, you realize how important it is that other people share with you. You realize that you in turn have a responsibility to do that at the other end” (p. 288).

Conclusions

Learning to stay well with bipolar disorder is possible according to the findings from the current research. Participants' descriptions of personal experiences serve as examples of what learning to stay well requires. First, staying well requires a commitment to learn how to self-manage bipolar disorder. Second, staying well requires a proactive approach toward learning to stay well. Third, staying well requires engaging others in conversations about our experiences of living with and managing bipolar disorder.

Making a commitment to learning how to self-manage bipolar disorder involved participants' making meaning of the diagnosis, accepting the diagnosis and taking ownership for learning to stay well. Across their interviews, participants expressed a common purpose for wanting to make meaning of the presence of bipolar disorder in their lives. As Joe explained, "And I was like okay well does that mean that I'm doomed to be bipolar like in your understanding? What does that mean?" Participants' meaning making occurred through an autodidactic approach to learning via transformational and self-directed learning experiences.

Transformational learning transpired with their acceptance of bipolar disorder. Participants described assessing the circumstances and events around their diagnoses and emerging at new perspectives about the meaning of having bipolar disorder. Participants' acceptance served as a critical stimulus for learning about managing bipolar disorder. Prior to acceptance, some participants lingered in a state of denial. Acceptance came slowly to Joe and Zoe. Joe said, "There was a point though it became clear that I wasn't in denial . . . But this was a gradual thing." After experiencing continuous days of mania,

Zoe acknowledged experiencing bipolar disorder in a conversation with her psychiatrist: “What can you prescribe me to get me off of this non-sleeping mode I’m in? . . . I believe you now.”

Participants were awakened to the acknowledgment of what accepting bipolar disorder meant to them. They no longer were on the outside looking in at their diagnosis. They were now inside engaged in making meaning of their diagnosis in the context of their lives. Personal experiences transpiring through transformational learning and self-directed learning helped participants to know thyself within the context of having bipolar disorder.

Inscribed by the Seven Sages of Greece in the courtyard of the Delphic oracle a few generations before Socrates, the statement of know thyself challenged all subsequent philosophers to acquire self-knowledge before gaining knowledge of anything else (Braverman, 2011). From Socrates’ perspective, “one could not know anything without knowing one’s self” (Braverman, p. 1). Participants’ self-management of bipolar disorder relied on knowing thyself and ownership of learning to stay well.

Participants committed to owning their learning actions. Ownership of learning strengthened their confidence to self-manage bipolar disorder. Through a sense of personal autonomy, they experienced ownership personal well being. They embraced responsibility for learning how to stay well. Their descriptions of experiences to learn about bipolar disorder highlighted an interconnection between transformational and self-directed learning experiences. In addition, their descriptions showed how different events or experiences prompted their self-direction to learn about some aspect of managing bipolar disorder which in turn would lead to a reinterpretation of an event or experience

resulting in a change of perspective. This interconnection demonstrated how the presence of one learning experience triggers another learning experience. As Candy (1991) and Cranton (2006) explained a triggering event or experience may bring about entry into self-directed learning. In the process of engaging in self-directed learning, personal interpretation of the experience may ensue through transformational learning (Candy; Mezirow, 1991). Through their learning experiences, they took control and set the direction for self-managing their bipolar disorder. They became proactive.

Daily existence and long-term survival relied on participants' being proactive toward learning what was required for them to stay well with bipolar disorder. Proactive approaches to know one's self within the context of bipolar disorder transpired through participants' self-directed learning and transformational learning experiences. Lillie explained her approach to faithfully working the steps to learn to manage her bipolar disorder and stay in balance: "Taking the driver's seat instead of just taking responsibility feels like a duty and a burden. . . ." Maria attributed her personal strength and survival to being proactive in recovering and learning from past destructive, manic episodes: "Well, it has contributed to my knowledge of my illness and what it takes to get through the day and survive in this world."

Engagement in self-directed learning and transformational learning experiences appeared to have been empowered by participants' self-determination for self-managing bipolar disorder to stay well. Participants expressed a sense of personal autonomy while engaged in learning experiences for mastering how to stay well. "Clearly, autodidactics, in common with other learners, do not enter into a learning engagement without some good or purpose in mind" (Candy, 1991, p. 177).

Their autodidactic learning occurred alone or in collaboration with others. Whether alone or in concert with others, participants made meaning of their experiences through transformational and self-directed learning experiences. Engaging others in conversations about experiences of living with and managing bipolar disorder was essential for learning how to staying well. Candy (1991) points to engaging in dialogue and interactions with others in a community of knowledge as a means to learn and to verify what is learned. Participants' interactions with mental health professionals provided means of gaining and validating what was learned. In addition, other interactions were of value for learning how to stay well.

The sharing of personal experiences with others engaged participants in self-directed learning and transformational learning experiences. For example, Lillie witnessed the value of a 12-step program which allowed for sharing her personal narrative and for listening to others' personal narratives. Among the participants, sharing and listening often transpired into transformational learning experiences, which presented new perspectives about personal experiences with bipolar disorder, and into self-directed learning experiences, which led to further exploration of how best to self-manage bipolar disorder. As Willow explained, "I would say the learning it's big; it's multi-dimensional. . . . It's how you engage in life. It's being part of life." Being part of life included participants engaging others, whether mental health professionals or other persons with or without bipolar disorder, to be keep the conversation going about how to self-manage bipolar disorder and their lives to stay well.

Recommendations for Practice

Emerging from the research findings, the recommendations for practice serve as practical guidance for learning to self-manage bipolar disorder. This practical guidance was informed by the voices of the research participants who shared their personal experiences and journeys in learning how to self-manage bipolar disorder to stay well. The recommendations are relevant to individuals with bipolar disorder, mental health professionals, educators, and others seeking to locate the information and identify the practices that facilitate attaining and maintaining wellness in managing bipolar disorder.

First, recognize acceptance of a diagnosis of bipolar disorder presents a major hurdle. As my research findings highlighted, some participants readily accepted the diagnosis of bipolar disorder while most others struggled to invite the diagnosis into their lives. However, coming to a point of acceptance required a personal investment in constructing the meaning for bipolar in their lives. Most participants struggled through many tragic and uncomfortable circumstances while trying to make meaning of their personal experiences with bipolar disorder.

To arrive at a place of acceptance, mental health professionals and educators can guide individuals with bipolar disorder in sifting through and reflecting on their personal experiences with and the meaning of bipolar in their lives. Mental health professionals and educators should provide positive and constructive support to individuals as they construct meaning for themselves. Meaning emerges from different places, as participants in my research pointed out. The societal or cultural meaning of having bipolar disorder carried stigma and shame for them. The clinical meaning of having bipolar disorder presented medical managements and behavioral control issues. The personal meaning of

having bipolar disorder determined how an individual would approach learning how to self-manage this illness. In the midst of these meanings, personal acceptance opens a gateway to self-instruction or autodidaxy for discovering how best to self-manage bipolar disorder. In addition, support the work of individuals as they try to find their gateway to acceptance.

Second, personal autonomy toward self-determining what to learn is largely situation specific (Candy, 1991). The participants in this research experienced personal autonomy toward self-instruction in learning how to self-manage bipolar disorder. In the context of having to manage bipolar disorder, they expressed self-confidence in autodidactic practices in self-determining what they needed to know within the context of understanding how to live and stay well. However, other individuals may not experience confidence toward self-instruction in the context of managing bipolar disorder. An absence of self-confidence in self-instruction may arise from an absence of interest or denial in their diagnosis or from an interest or comfort in solely receiving information about managing bipolar disorder through formal avenues, such as psychotherapist, psychiatrist, or psychoeducation programs. Candy (1991) points out “although such learning may be characteristic of adulthood, it is also manifestly clear that certain people are more competent, more dedicated, more experienced, and indeed more successful at this pursuit than others” (p. 128). Yet, learner competence may be enhanced.

Numerous approaches exist to enhance competence of individuals to self-direct their learning. In a review of research, Kirschenbaum and Perri (1982) examined the efficacy of programs to improve academic competency. Key strategies for enhancing self-instruction included contract-based learning, experiential learning, and various forms

of learning–controlled instruction (Candy, 1991; Kirschenbaum & Perri). In addition, the level of personal competence toward self-directing learning was impacted by personal factors such as perceived personal control, study skills, reading efficiency, and note taking (Kirschenbaum & Perri). Mental health professionals and educators could use strategies identified by Candy (1991) to encourage the development of competence in self-directed learning. These strategies included:

- Creating a supportive environment for learning
- Making use of learners’ existing knowledge
- Improving reading skills
- Encouraging deep-level learning
- Developing critical thinking
- Building confidence in self-directing learning
- Monitoring comprehension of subject matter

In addition, results from the current research indicate struggle with or denial of the diagnosis of bipolar disorder acted as a barrier to initiating self-directed learning. However, once participants in this research owned or came to own a sense of personal responsibility, self-confidence, and pride in discovering how best to stay well with bipolar disorder. Through their autodidactic practices they experienced transformational learning and self-directed learning transpired through participants personal learning experiences. Within the context of having a diagnosis of bipolar disorder, they engaged in self-directing their learning.

Third, results of the current research highlight how personal experiences with self-directed learning and transformational learning resulted in the enhancement of their

capacities to self-manage their health. As asserted in previous research, individuals can learn to self-manage chronic illnesses to achieve positive health outcomes (Bodenheimer et al., 2006). Learning experiences can empower individuals to “accept responsibility to manage their own conditions and . . . solve their own problems . . .” (Bodenheimer et al., p. 2470). Similarly, Baumgartner (2002), Courtenay et al. (2000), Russell and Browne (2005), and Rager (2006) found individuals with chronic illnesses engaged in self-control and direction of their learning by exercising personal autonomy to own and empower self-managing their illness. Mental health professionals and educators should create opportunities to promote personal autonomy and empowerment in learning to self-manage bipolar disorder to stay well. Help individuals locate and employ resources to achieve wellness.

Fourth, personal stories or narratives served as a valuable means for participants in this research to reflect on and share their personal experiences of living with bipolar disorder and learn from other’s experiences. All of the participants said having their voices heard was a primary reason they volunteered to participate in this research. They wanted everyone with or without a diagnosis of bipolar disorder to understand their challenges and triumphs in learning how to self-manage themselves to stay well. As Walter said, “It’s worth my while to talk to other people, to be an ambassador from the bipolar world.” Mental health professionals and educators should create an environment in which individuals feel safe in sharing their narratives and learn to reflect on the meaning within their narratives.

Finally, remember learning to self-manage bipolar disorder requires a lifelong commitment for the participants in the research. Candy (1991) pointed out, “On the one

hand, self-directed learning is one of the most common ways in which adults pursue learning throughout their life span, as well as being a way in which people supplement (and at times substitute for) learning received in formal settings” (p. 15). Mental health professionals and educators could promote the use of stay well plans, which were identified a valuable mental health management tools in the study by Russell and Browne (2005), to facilitate wellness goals and strategies among persons with bipolar disorder.

Participants echoed his point. Willow said, “What I’ve observed about staying well over time that I’ve gotten better at it. . . . I’ve noticed that over time my management has become very refined, very acute, very on target. . .” Maria explained her taking charge learning how to self-manage her bipolar disorder is “what it takes to get through the day to survive in this world.”

Recommendations for Research

The exploratory nature of the current research provides an opportunity to expand upon what was explored and how it was explored. The intention of the research recommendations is to improve and enhance the methodological approach of the current research. These suggestions include changing the recruitment approach, altering the selection criteria for participants, employing narrative analysis, and exploring other aspects of self-directing and transformational learning experiences.

First, the recruitment approach in the current research was designed to include only individuals with bipolar disorder who were receiving treatment from a licensed psychologist or psychiatrist. However, during consultations with several psychologists and a psychiatrist about ways to maximize the research recruitment method, recommendations were made to recruit potential participants through licensed medical

doctors. These licensed mental health professionals explained many individuals received treatment for bipolar disorder through their primary care physician. By limiting my recruitment of potential participants through coordination with licensed psychologists and psychiatrists, a large pool of potential participants was lost. Expansion of recruitment through primary care physicians could be a helpful strategy in recruiting more participants.

Second, future research might expand the recruitment the criteria to invite individuals with a diagnosis of bipolar disorder to participate in the research whether or not they engage in activities to learn how to stay well with bipolar disorder. Recruitment criteria from the current research limited those actively engaged in learning to stay well. Interviewing individuals not engaged in learning activities may provide further understanding about how individuals' personal choices or approaches for informing treatment and management of bipolar disorder. Perhaps they have experienced barriers or challenges to self-direct their learning about self-managing bipolar disorder to stay well. Perhaps they have not experienced similar prompts to self-directed and transformational learning.

Third, it would be useful to employ a life history or biographical method to explore how individuals approach learning to self-manage bipolar disorder. As stated by Watson and Watson-Franke, "the life history approach is any retrospective account by the individual of his life in whole or part, in written or oral form, that has been elicited or prompted by another person" (as cited in Denzin and Lincoln, 2000, p. 539). Though the interview questions from the current research only focused on asking about personal learning experiences, participants always described their learning experiences within the

larger contexts of their lives. Their responses to the interviews questions prompted reflection past events in their personal histories or stories. Employing a biographical method would allow the research greater depth of discovery about their personal learning experiences. In tandem, the use of narrative analysis would facilitate discovering how an individual has constructed meaning through life events framing events around learning to live with and manage bipolar disorder. Rossiter and Clark (2007) state, “Perhaps most relevant to adult learning is the empowering realization that to critically reflect on one’s life story is to claim the authority to rewrite it” (p. 25). Participants in the current research expressed that telling their stories whether through the research interview or in conversations with others allowed them to listen and to learn from their own experiences.

Researcher’s Reflection

A look back at my research highlights several primary accomplishments. First, my research opened new territory in exploring the nature of self-directed learning and transformational learning experiences among individuals learning to stay well with bipolar disorder. Previously reviewed research focused on examining how persons diagnosed as HIV-positive or with cancer experienced transformational learning and self-directed learning in discovering how best to manage and live with the illnesses (Baumgartner, 2002; Courtenay et al, 1998; Courtenay et al; 2000; Rager, 2003; Rager, 2004; Rager, 2006). In addition, although Russell and Browne (2005) highlighted the importance of self-education among individuals with bipolar disorder for developing stay well plans, the focus of their research was not the nature of adult education in developing stay well plans.

Second, my research provided a means for the participants with bipolar disorder to share with others their stories of learning to self-manage bipolar disorder. Each participant expressly stated the importance of informing others about their challenges and triumphs in self-managing their bipolar disorder to stay well. They were very proud of their journeys in learning to negotiate the varied terrain of bipolar disorder. Their personal narratives provided extensive depth to the interviews which was not anticipated and greatly appreciated.

Third, my conducting of the research raised strong personal feelings including vulnerability, sadness, joy, fear, and kinship with the participants. These feelings were part of the experience of being both the researcher and someone with bipolar disorder. In addition, as an individual who lives with self-managing bipolar disorder on a day-to-day basis, the participants' narratives often sounded like my own.

Fourth, immersion in the personal narratives allowed me as the researcher both to learn about others' experiences of living with bipolar disorder and to explore the nature of their transformational and self-directed learning experiences. The details of their personal experiences displayed the tragedies and triumphs in self-managing bipolar disorder. The details of their personal experiences also showed the power of autodidactic learning. Through their self-instruction, they empowered themselves to create personal paths to wellness.

Finally, the findings from this research have created a path with which to further explore how adults inform their choices about and approaches to managing their bipolar disorder. Generating further research findings may generate a greater understanding of how adult education facilitates individuals' learning to manage bipolar disorder to stay

well. A greater understanding hopefully will further inform individuals, mental health professionals, and educators about the value of adult education in learning to manage bipolar disorder.

In addition, a greater understanding of the value of adult education may provide individuals with a greater sense of power or control in self-managing their bipolar disorder to stay well and may ultimately reduce their daily frustrations of living with bipolar disorder. As described in *Electroboy*, Andy Berhman's (2002) sense of frustration with bipolar disorder captures the frustration voiced by my research participants, including me: "It frustrates me that I can't just grab the manic depression in my hands and smash it into pieces or burn it or bury it" (p. 257). Although it may never be destroyed, perhaps bipolar disorder can be disarmed with education.

APPENDIX A

RECRUITMENT LETTER

Texas State University Letter

DATE

NAME

ADDRESS

Dear NAME:

Outside observers may view individuals with bipolar disorder as being in a constant state of mental illness or unwellness. However, to an insider like me, I view having bipolar disorder as a state of health that I manage for wellness. How do adults with bipolar disorder learn to stay well?

As a doctoral student in the College of Education at Texas State University in San Marcos, I will explore this question through my dissertation research, which has Texas State University Institutional Review Board approval (IRB #210103). I plan to interview individuals with bipolar disorder who actively engage in activities to learn how to stay well while living with bipolar disorder. However, I need the assistance of licensed mental health professionals, such as you, to facilitate my connecting with individuals who:

- are age 18 or older;
- have a diagnosis of bipolar disorder;
- have not been hospitalized in the past 12 months for treatment of bipolar disorder;
- coping successful with bipolar disorder; and
- engage in activities to learn how to stay well with bipolar disorder.

I would greatly appreciate your sharing the attached flyer about my dissertation research with individuals, whom you treat, meeting the above criteria. My research is treatment oriented. If you want further information, I gladly will meet with you at your

convenience, talk to you by telephone, or communicate by email. In addition, you may contact Dr. Jovita Ross-Gordon, my dissertation chair, at xxx-xxx-xxxx or jross-gordon@xxxxx.xxx.

Sincerely,

Wendy Francik, M.A., M.S.H.P.
Doctoral student
College of Education
Texas State University, San Marcos
xxx-xxx-xxxx
wfrancik@xxxxx.xxx

Attachment

APPENDIX B

RECRUITMENT FLYER

Opportunity to Share Your Successes in Learning to Cope with Bipolar Disorder

Outside observers may view individuals with bipolar disorder as being in a constant state of mental illness or unwellness. However, to an insider like me, I view having bipolar disorder as a state of health that I manage for wellness. How do adults with bipolar disorder learn to stay well?

As a doctoral student in the College of Education at Texas State University in San Marcos, I will explore this question through my dissertation research, which has Texas State University Institutional Review Board approval (IRB #210103). I plan to interview individuals with bipolar disorder who actively engage in activities to learn how to stay well while living with bipolar disorder. Your licensed mental health professional has been asked to share this flyer with clients who:

- are age 18 or older;
- have a diagnosis of bipolar disorder;
- receive treatment of bipolar disorder from a licensed medical professional;
- have not been hospitalized for the treatment of bipolar disorder in the past 12 months; and
- engage in activities for learning to stay well with bipolar disorder.

If you think this list of characteristics describes you, please consider participating in my study.

My dissertation research will provide insight into why individuals seek to educate themselves about bipolar disorder, the nature and evolution of their learning, and the effect of their learning on staying well. My research is treatment oriented.

To inquire further about participating in my dissertation research, please contact me, Wendy Francik, at xxx-xxx-xxxx or wfrancik@xxxxxx.xxx. In addition, you may contact Dr. Jovita Ross-Gordon, my dissertation chair, at xxx-xxx-xxxx or jross-gordon@xxxxxx.xxx.

APPENDIX C

CONSENT FORM

Consent Form #2008-52133 for Participating in Dissertation Research about Adults with Bipolar Disorder Learning to Stay Well through Self-Directed Learning

You have responded to a flyer announcing my dissertation research exploring how adults with bipolar disorder actively engage in activities to learn how to stay well. I, Wendy Francik, am conducting this research as a doctoral student in the College of Education at Texas State University, San Marcos. I am working under the academic guidance of my Dissertation Chairperson, Dr. Jovita Ross-Gordon, who is a professor in the Department of Educational Administration and Psychological Services, College of Education, at Texas State University. Please feel free to contact me at xxx-xxx-xxxx or wfrancik@xxxxx.xxx or Dr. Ross-Gordon at xxx-xxx-xxxx or jross-gordon@xxxxx.xxx with your questions or concerns about my dissertation research.

You expressed an interest in voluntarily participating in an interview. I will need to collect a signed copy of this consent form, when we meet for the interview. Please read the consent information below in order to understand fully the research purpose, criteria for selection, and other critical information about this dissertation research. Prior to or during the interview, please ask any questions about this research to be certain you understand the purpose of this study and your role as a participant.

Background Information

The purpose of this qualitative study is to interview individuals with bipolar disorder to explore how they engage in self-directed learning to gain information about how to stay well. My interviews will provide insight into why individuals seek to educate themselves about bipolar disorder, the nature and evolution of their learning, and the effect of their learning on staying well.

Agreement to Participate

A participant in this study must:

- be age 18 or older;
- have a diagnosis of bipolar disorder;
- receive treatment for bipolar disorder from a licensed medical professional;

- have not been hospitalized for the treatment of bipolar disorder in the past 12 months; and
- engage in activities for learning to stay well with bipolar disorder.

Participant Rights

As a research participant, you may contact Institutional Review Board Chair Dr. Jon Lasser, and Office of Sponsored Programs Administrator, Ms. Becky Northcut, with questions about my dissertation research (IRB #210103) and your right as a research participant.

Research Procedure

If you agree to participate in this study, I will ask you to agree to the following statements:

- you acknowledge your participation is voluntary
- you acknowledge you are free to discontinue your research participation at any time without any negative consequences to you with the researcher or with Texas State University
- you agree to participate in an initial interview lasting approximately one hour at a meeting space providing privacy, such as a conference room at a state agency or a church
- you agree to participate in a brief follow-up interview, as necessary, to gather further information about some of your initial responses and/or to receive your feedback to check the accuracy of my interpretation of the interview data
- you agree to respond to questions, as you desire, about your self-directed learning experiences as a means to staying well with bipolar disorder
- you agree to permit my tape recording of your interview
- you agree to permit my taking of notes during your interview

Risks and Benefits of Participating in the Study

This study carry minimal risk. Though not likely, it is possible that some of your interview responses may leave you feeling uncomfortable. Should you feel it would be helpful to talk to a professional counselor, please contact the licensed mental health professional through which you received the flyer about this study. In addition, I have listed several Austin-area mental health resources that provide services with income-based, sliding-fee scales. You will be responsible for covering any expenses incurred in the event that you require mental health services from these or any other mental health providers:

- Austin Family Institute, xxx-xxx-xxxx, 3201 Bee Caves Rd, Austin, TX 78746
- Capital Area Mental Health Center, xxx-xxx-xxxx, 1106 Clayton Lane, Austin, TX 78723
- The Listening Tree Counseling Services, xxx-xxx-xxxx, 3906 N. Lamar Blvd., Austin TX 78756

There are a number of possible benefits from my dissertation research. As a participant, you may gain insight about how you have learned to cope successfully with bipolar disorder. In addition, your responses may help inform the development of future education programs designed to help adults with bipolar disorder better understand the benefits and challenges in self-directing their learning about how to cope with bipolar disorder.

Confidentiality

As the researcher I personally will transcribe your interview responses in a manner that assures protection of your anonymity to everyone except me. Your real name will not appear on the interview transcripts; you may tell me a preferred pseudonym to use when I interview you. All interview data, tape recordings, and other related research materials will be kept in a locked file box at my personal residence for no more than three years following the completion of my dissertation research for further analysis and publication. In addition, I will keep the consent forms stored in a locked file box separate from the transcripts. After three years, I will destroy the tape recordings. In any future publications or conference presentations based on my research, your identity in no case will be revealed.

Terms of Participation

Your decision to participate is voluntary. If you agree to participate in this study, you will be given a copy of your signed consent form to keep for your personal records. You are free to discontinue your participation at any time without any negative consequences to you with the researcher or with Texas State University. In addition, you will receive a summary of the research findings upon my completion of this study, if you desire.

Statement of Consent

I have read the above research consent information. I have asked questions and have received answers about the study. I consent to participate in the study.

Signature _____ Date _____

Signature of Investigator Obtaining Consent _____ Date _____

APPENDIX D

INTERVIEW GUIDE

1. Let's talk about your experiences in learning about bipolar disorder after you were diagnosed.
 - a. What experiences prompted or motivated you to learn about your bipolar disorder diagnosis?
 - b. How would you describe your initial experiences in learning about bipolar disorder?
 - c. How would you describe your initial experiences in learning to self-manage your bipolar disorder?
2. I am interested in hearing about your experiences with self-directing your learning about bipolar disorder.
 - a. What experiences prompted you to search for information about bipolar disorder rather than solely relying on others for information, such as doctors or therapists?
 - b. How would you describe your self-directed learning experiences?
 - c. What resources have been useful to self-directing your learning?
 - d. How have your self-directed learning experiences shaped your self-management of bipolar disorder?
 - e. What have you witnessed about your self-directed learning over time?
3. Let's talk about experiences that you believe changed or transformed your thinking and approach toward self-managing your bipolar disorder.
 - a. What have been transforming experiences?
 - b. How have these transforming experiences changed your thinking and approach toward self-managing bipolar disorder?

- c. What have you observed about your thinking and approach toward self-managing your bipolar disorder over time?
4. Finally, I am interested in learning your self-directed learning or transformational learning experiences have helped you stay well.
- a. What have you observed about your approach to staying well over time as the result of your learning experiences?
 - b. What has been challenging about the process of learning to stay well?
 - c. What would you tell others who have bipolar disorder about the journey of learning to stay well?

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