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The Resilience Questionnaire for Bipolar Disorder: Development and validation

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ABSTRACT

The goal of this research project was to develop a new questionnaire to assess resilience in Bipolar Disorder (BD), the Resilience Questionnaire for Bipolar Disorder (RBD). To examine its psychometric properties, a sample of 125 patients diagnosed with BD and a comparison sample of 107 people completed the new RBD and established measures of generic resilience and health-related outcomes. Exploratory factor analysis for the RBD yielded a 23-item 5-factor solution, and confirmatory factor analysis indicated adequate fit indices. Internal consistency, stability, concurrent validation and known-groups' validity were also supported. The RBD obtained higher responsiveness (6-month follow-up) than the generic resilience scale (BD sample). The RBD is a robust measure to monitor resilience in BD.

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

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

Evidence supports the importance of resilience in overcoming the challenges associated with mental health issues, such as depression (Dowrick, Kokanovic, Hegarty, Griffiths, & Gunn, 2008), schizophrenia (Torgalsbøen, 2012), and other mental disorders (Edward, Welch, & Chater, 2009). For instance, Torgalsbøen (2012), in a 15-year follow-up study, found a robust relationship between resilience,—measured with the Connor Davidson Resilience Scale ([CD-RISC] Connor & Davidson, 2003)—well-being, and psychosocial functioning in schizophrenia. Few studies have explicitly explored resilience in patients with BD. For example, Edward et al. (2009) found resilient qualities in a sample of eight participants with various mental disorders, including BD, in remission. Choi et al. (2015) have recently studied resilience—also using the CD-RISC resilience questionnaire—in 62 euthymic outpatients with BD, and concluded that, given the inverse relationship between resilience and impulsivity, enhancing resilience may significantly contribute towards patient treatment by reducing impulsivity (a known risk factor for worse clinical outcomes in BD, (Jiménez et al., 2012).

Several scales to measure resilience have been developed. A recent systematic review of the psychometric properties of resilience measures concluded that no measure was satisfactory in psychometric terms, and most measures—such as the CD-RISC—were questionable on theoretical grounds; for example, the literature review on which the CD-RISC was based is limited and furthermore, resilience was defined as a personal quality reflecting the ability to cope with stress (Windle, Bennett, & Noyes, 2011) whereas established definition highlights that resilience is a dynamic process encompassing multidimensional factors (e.g. psychological, environmental and biological factors) that includes other attributes (e.g., self-esteem, self-efficacy, competence, hope, self-determination, and pro-social attitude) apart from coping (Windle, 2011). In addition, resilience and coping are conceptually distinct constructs, "resilience influences how an event is appraised, whereas coping refers to the strategies employed following the appraisal of a

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stressful encounter" (Fletcher & Sarkar, 2013 p. 16), and not all outcomes of coping are mirrored in resilience (Glennie, 2010). Another limitation of theoretically adequate resilience measures (i.e. questionnaires that for their development were based in a sound revision of the literature on resilience, and therefore covered appropriately the theoretical understanding of resilience)—such as the Resilience Scale for Adults ([RSA] Friborg, Hjemdal, Rosenvinge, & Martinussen, 2003)—is that, in fact, they were developed focusing on protective factors against psychopathology (Windle et al., 2011), therefore excluding the assessment of resilience in people with an ongoing psychological disorder.

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

The development of a resilience measure specific for BD patients would improve the monitoring of patient responses and evolution better than using existing generic measures of resilience. Unspecific measures of resilience may not be able to capture specific changes in resilience, given the unique fluctuating course of the disorder, since they do not contain the specific items that are considered relevant by BD patients when conceptualizing resilience. Thus, this paper reports the development and psychometric validation of a new measure, the Resilience Questionnaire for Bipolar Disorder (RBD). The development of this new measure was based on resilience experiences reported by both people living with BD and experienced clinicians during qualitative interviews (Echezarraga et al., 2014; Echezarraga et al., 2015).

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

METHODS

PARTICIPANTS AND PROCEDURE

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

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

The patient sample (N = 125, 62.10% female, mean age = 46.13 years old, SD = 10.89) was recruited from nine public mental health services distributed across the three regions of the Basque Country (Spain) and through non-governmental BD associations of several regions in Spain (i.e., the associations of BD "El Ascensor" from Murcia, "Esperanza Bipolar" from Vizcaya, "Bipolares Andalucía Oriental" from Andalucía). The therapists or coordinators of the associations of people with BD invited the patients to participate in the study, based on inclusion criteria. Patients coming from non-governmental associations participated in the study through a web based portal. Participants recruited from the public mental health services completed the questionnaire either by the web based portal, by telephone (a psychologist called the participant, read the questions and took note of responses), by paper at their homes, or in the company of a psychologist if required.

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

A control group sample (N = 107, 77.60% female, mean age = 35.42, SD = 10.61) was recruited from the general population. Inclusion criteria were identical to those for the BD sample, except that diagnosis of BD as exclusion criterion (screening negatively for bipolar pathology when they were asked about being diagnosed of any mental illness including BD). Participants in the control group sample were younger than BD patients ($t(232) = -7.56$, $p \leq 0.05$) and that the proportion of women was also higher in the control group than in the patient sample (χ^2 (1, N = 231) = 6.46, <0.05). The control sample recruitment process was online, displaying the survey's URL link in different TV panels at the University of Deusto, as well as by sending emails to colleagues and posting information in public websites and social media, like Facebook. They also completed the battery of test only via online.

The website hosting the battery of tests included information about the research's purpose and characteristics, the study's voluntary nature, inclusion criteria for participation, and stating the freedom to withdraw from the study at any time. Participants agreed to participate by simply checking a box, a prerequisite for access to the battery of tests. To facilitate a 6-month follow-up assessment (T2), all participants provided a contact address. This was saved in an independent database which only the main researcher could access using an encrypted access code. The participants' identity was safeguarded by an alphanumerical identification code. Four modes for completing the questionnaire at baseline (T1) and follow-up (T2) were offered, depending on participant preferences: via telephone interview with a clinical psychologist paper and pencil in their mental health center (a clinical psychologist interviewed participant, or the battery was self-completed with the personal help of a clinical psychologist if required) in their home (self-completed, returning the questionnaires by post using pre-stamped envelopes provided), or online (self-completed). Two reminders were sent at 1-month intervals to the participants who failed to complete the survey at both T1 and T2.

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

RBD QUESTIONNAIRE DEVELOPMENT (VERSION 1)

RBD Questionnaire development took place in three phases. The first stage of development for the RBD questionnaire involved a series of qualitative interviews and focus groups with patients with BD and experienced clinicians. Thus, semi-structured in-depth interviews were carried out, asking participants about the resilience process in BD: (1) nine patients recovered from BD participated in individual interviews, (2) another six patients recovered from BD participated in a focus group, and (3) six clinical experts who had witnessed the resilience process in their patients with BD took part in two different focus groups (n = 4 and n = 2). A qualitative

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