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Diverse Mindfulness Practices for Bipolar Recovery: Qualitative Study Results

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This study investigated the lived experience of Buddhist-informed mindfulness practice and its utilization in recovery from bipolar disorder (BD) in 9 adult participants. Established mindfulness based interventions (MBIs) decontextualize mindfulness practice from a Buddhist theory base, omitting conceptual frameworks that may have adaptive value in recovery from BD. In interviews, participants reported blending techniques learned from various Buddhist lineages throughout the course of their recovery, as well as a variety of other contemplative practices such as techniques to cultivate adaptive emotions, devotional practices, visualization practices, embodiment practices, investigative practices, and informal daily practice. Mindfulness practice for recovery from BD is perhaps best viewed as a personalized craft of recovery, rather than a one-size-fits-all approach. Seeking ongoing optimization and expert guidance helped participants adapt their meditation practice to different mood states and the unfolding stages of their recovery. While evidence for the efficacy of MBIs for BD is equivocal, these results illustrate the idiosyncratic nature of recovery pathways and how mindfulness may improve self-management and integrate with other wellness practices in recovery from BD.

Keywords: *bipolar disorder, recovery, mindfulness, compassion, Buddhism, thematic analysis*

Bipolar disorder (BD) is a mental health concern characterized by intense fluctuations in mood, fluctuating between depression and mania or hypomania, and is sometimes accompanied by psychotic features (American Psychiatric Association, 2013). In the general population, BD has a lifetime prevalence of about 1% for bipolar disorder, and 5% for bipolar spectrum disorders (Jauhar & Cavanagh, 2013, pp. 303–305). Drug treatment is the primary intervention for BD, yet the neurobiological causes of BD remain unclear (Macritchie & Blackwood, 2013). Several BD-specific adjunctive psychotherapies have been evaluated in randomized controlled trials (RCTs), and although adjunctive psychotherapy with drug treatment far outperforms drug treatment alone (Salcedo et al., 2016), residual depressive symptoms, reduced functioning, and low quality of life impair many with BD, and new interventions are needed

to address these issues (Bonnín et al., 2019). This study suggests that Buddhist-informed mindfulness practices could inform new interventions to promote recovery in BD.

Mainstream psychiatry defines recovery as symptom reduction and disease remission, and although these are worthy BD treatment goals, such outcomes are not within reach for everyone with a BD diagnosis. Recovery in BD may be better framed as an ongoing journey, in which one's wellness practices contribute to overall quality of life (Michalak et al., 2012). Qualitative studies have identified numerous self-management strategies used by those with BD (Michalak et al., 2016; Murray et al., 2011; Russell & Browne, 2005; Todd et al., 2012). Reducing stress, enhancing awareness, recognizing warning signs, and identifying triggers are important wellness practices in BD (Russell

& Browne, 2005), and mindfulness practice may support the development and implementation of these skills. Mindfulness meditation and other contemplative practices have been helpful self-managements strategies for some individuals (Suto et al., 2010), and mindfulness may improve quality of life in BD (Murray et al., 2017).

Mindfulness has been defined as a particular kind of present-moment, non-judgmental attention (Kabat-Zinn, 1994) that can be trained through practice. Mindfulness has its roots in Buddhist meditation, and can be considered both a quality of consciousness and a method for stabilizing and refining attention in order to observe mind and behavior directly (Brown et al., 2015). A broader category of contemplative practices refers to practices that transform consciousness, cultivate prosocial traits, and provoke spiritual insight. Such practices exist in all the major world spiritual traditions (Barbezat & Bush, 2014).

Western psychology and medicine have decontextualized Buddhist mindfulness practices and other contemplative practices from their philosophical, religious, and cultural frameworks and reconstituted them within secularized mindfulness-based interventions (MBIs), leading to controversy and ethical conflicts (Walsh, 2016). Mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1982) and mindfulness-based cognitive therapy (MBCT; Teasdale et al., 2000) were early successes in blending Western therapies with contemplative practices and gaining empirical support. MBCT and MBSR have both been studied in terms of their benefits for BD, but meta-analyses of randomized controlled trials (RCTs) for these MBIs have concluded that results are equivocal (Chu et al., 2018; Lovas & Schuman-Olivier, 2018), at least in terms of symptom reduction and time to relapse. Although MBI treatments for BD show promise, higher-quality studies with larger samples are needed.

Despite the ambiguous quantitative results, in qualitative studies, individuals with BD have reported beneficial effects from MBCT mindfulness practice (Chadwick et al., 2011; Weber et al., 2017). These findings suggest that mindfulness in BD can improve quality of life and help people feel more agency in working with their condition. Future research on BD

treatments could benefit from including recovery frameworks such as improved quality of life and better functional outcomes (Bonnín et al., 2019; Murray et al., 2017), and mindfulness practice may have particular benefits for those types of recovery. A drawback to the MBIs that have been evaluated for BD is that they were originally formulated for depression (MBCT) and chronic pain (MBSR), and subsequent applications to BD have been adaptations rather than formulations designed specifically to address the experience of BD. Future treatments developed with BD in mind from the start may have improved efficacy compared with past MBIs.

The experience of BD sometimes includes psychotic or anomalous experiences, rapid shifts in state, cyclical suffering, and patterns of thought, emotion, and behavior that fuel mood episodes. The philosophical and psychological frameworks of Buddhism may have special benefit in working with these features of BD, but secularized MBIs have largely discarded those supportive ideas. Although it is ethically necessary to be forthcoming with clients about the religious and spiritual contexts of Buddhist-informed MBIs (Shonin et al., 2013), including Buddhist frameworks to support mindfulness practice within MBIs specifically developed for BD may enrich treatment options and include the spiritual and philosophical experiences that are common in BD within a supportive, non-pathologizing approach to recovery. A needful step in establishing the utility of such an approach is to explore the experiences of those who have used such practices and frameworks in their own recovery from BD, which is the approach I took in this study. During the literature search for this paper, no studies were found that investigated Buddhist-informed mindfulness practice for BD.

In this study, I interviewed nine lived experience experts about how they used Buddhist-inspired mindfulness practice in recovery from BD, to learn more about what might work for others. This report focuses on the different practices participants used and the different Buddhist traditions they practiced in. As I argue below, these findings provide a rich basis for understanding how participants integrated contemplative practice into their personalized approaches to recovery, and

suggest that sitting meditation is only one practice in a suite of contemplative approaches to wellness and health in BD. To contextualize these findings, I also briefly summarize the study's findings on Buddhist ideas, effects of mindfulness practice, and other wellness practices that participants reported.

Method

I developed themes from qualitative interview data using thematic analysis, a flexible method that can be used with any interpretive frame (Braun & Clarke, 2006). With the aim of developing a future approach to recovery from BD, I used a pragmatic phenomenological frame to elicit data about lived experience during the interviews and generate useful findings during analysis. Ethical review and approval were provided by the Human Research Review Committee of the California Institute of Integral Studies. All participants gave written informed consent prior to conducting the interview. All participants also gave written consent for their anonymized data to be used in research and publication.

Recruitment and Screening

Participants were recruited using professional and academic networks, and by posting flyers for the study at a university and in medical and psychotherapy offices. Potential participants completed an online encrypted form that captured contact information, demographics, and screening

criteria. Inclusion criteria were being at least 18 years old, practicing mindfulness at least 45 minutes a week during a six-month period in the two years prior to the study, using Buddhist ideas as taught by a contemporary lineage, and having been diagnosed with BD in the past. Participants also needed to have experienced at least one of five dimensions of recovery: disease remission, symptom reduction, improved quality of life, psychosocial adjustment, and social empowerment. These dimensions of recovery were selected based on a literature review and to build a recovery perspective into the study design. In order to reduce the risk of harm, exclusion criteria were experiencing a major depressive episode, manic episode, or psychotic features in the 6 months prior to the study.

After candidates completed the online screening, I conducted a brief phone screening to establish personal contact, answer their questions about the study, and assess their ability to participate in an interview. Next, participants submitted an attestation from a psychiatrist stating that they met diagnostic criteria for BD in the past and were stable enough to participate in the study.

Participant Demographics

Nine participants completed the study (a tenth dropped out before the verification interview). At the time of the online screening, participant ages ranged from 24 to 73, with a mean of 40 years.

There was one non-binary person, one woman, and seven men. One participant reported experiencing two dimensions of recovery, and eight participants reported experiencing four or more dimensions of recovery. Participant demographic information is summarized in Table 1. During interviews, participants reported a mix of past diagnoses, including Bipolar I, Bipolar II, and Bipolar NOS.

Interviews and Transcription

Participants were interviewed face-to-face (6), via

Table 1. Participant demographics

P#	Age	Gender	Employment	Types of Recovery				
				SR	DR	IQoL	PA	SE
1	24	M	Student	Y	?	Y	Y	Y
2	33	M	Student & part-time	Y	?	Y	Y	Y
3	28	M	Full-time	Y	-	Y	Y	Y
4	47	M	Full-time	Y	?	Y	Y	Y
5	53	F	Full-time	Y	Y	Y	Y	Y
6	45	M	Part-time	Y	-	Y	Y	Y
7	73	M	Retired	Y	-	Y	Y	Y
8	27	M	Full-time	Y	Y	Y	Y	Y
9	28	X	Unemployed	Y	?	Y	Y	Y

Note: P#: Participant number. Gender: F = female, M = male, X = non-binary. Types of recovery: SR - symptom reduction, DR = disease remission, IQoL = improved quality of life, PA = psychosocial adjustment, SE = social empowerment. Y = yes, ? = not sure, - = no

videoconference (2), or via telephone (1). (The telephone meeting began via video-conference, but we soon switched to phone due to connection problems.) Interviews lasted between 62 and 111 minutes (93 minutes on average) and were digitally recorded. A semi-structured open-ended interview guide (Patton, 1990) provided for a blend of structure and spontaneous exploration during interviews. The interview questions were:

“Please tell me about your experience of bipolar disorder.”

“Please describe your current mindfulness meditation practice, how often you use it, and what specific instruction or technique you use.”

“Have mindfulness meditation and/or Buddhist psychology and philosophy had an impact on your recovery from bipolar disorder, and if so, how?”

“What effects have you noticed from using mindfulness meditation and/or Buddhist psychology and philosophy in your recovery?”

“Do you still experience mood episodes, and if so, how do you use mindfulness meditation when you sense that a mood episode might be coming on?”

“Do you use other meditation practices? Which ones? How often? How do they help you?”

“What other wellness practices or strategies do you use regularly?”

“If you still experience mood episodes, what other wellness practices or strategies do you use when you sense that a mood episode might be coming on?”

“Are spirituality or spiritual experiences an important part of your recovery, and if so, how?”

“What recommendations do you have for others who might choose to use mindfulness meditation and Buddhist ideas to work with bipolar disorder?”

“What does recovery mean to you?”

During interviews, I refrained from asking leading questions so as to elicit participants’ lived experience without imposing my own meanings. In a few instances, I felt that I inadvertently did so, and so I omitted those brief segments from coding. Recordings were transcribed using f5transkript software (Dresing et al., 2018) and a USB foot pedal. Transcripts were then anonymized (such as by substituting “Portland, OR” with “West Coast City A”) and sent to participants for review. I conducted a follow-up phone interview with each participant to verify transcript accuracy. I took notes of these calls, anonymized them, and included them in the dataset.

Coding and Analysis

After verifying the accuracy of each transcript against the recordings, I used f4analyse qualitative data analysis software (Dresing et al., 2017) to read transcripts line by line and create sentence-level codes. I sorted codes into themes using Scapple visual mind mapping software (Blount et al., 2019), generated a hierarchy of top-level and subordinate themes, and made changes in the f4analyse document to reflect the developing hierarchy in a spiral of analysis (Creswell, 2013). My theme development strategy used the study’s pragmatic phenomenological frame to generate themes that reflected participants’ experiences and could help craft an approach to recovery from BD. To bracket my biases, I emphasized bottom-up development of codes and themes from surface-level semantic data in the transcripts. While my sensitization to the topic through my lived experience may have helped me elicit and interpret data better than a less familiar researcher, I wanted to ensure that my findings were grounded in the data.

Data Repository

After completing the verification interview, participants were given the option to include their materials in a data repository (Strong & Hartelius, 2020). Nine anonymized transcripts and eight audio files are available to users with institutional authorization who would like to use the data for future research and education purposes. General study materials are also in the repository. The Databrary repository was chosen based on its strong protections of participant data and its authorization

process that allows only qualified researchers to access sensitive data.

Standpoint

My interest in this topic stems from my own recovery from BD in my twenties, when I used Buddhist mindfulness practice and other wellness strategies to stabilize and ultimately recovery completely from BD. This report is informed by that experience, as well as my training in Buddhist-inspired psychotherapy and doctoral studies integrating psychology and spirituality. Although my own relationship to Buddhism and mindfulness practice has changed significantly in the last 15 years, I still feel they could benefit those in recovery from BD. I have sought to prevent my biases from interfering in the study, as I explain at various points in this report.

Findings

Findings are presented in three sections. The first section provides context by describing in brief the effects of mindfulness, other wellness practices, and the Buddhist frameworks participants used to support their recovery from BD. The second section reports on the diverse Buddhist traditions participants took part in. In the third section, the mindfulness practices participants used in their recovery are reported in four themes: sitting meditation, other contemplative practices, informal practice in daily life, and implementing practice. In keeping with thematic analysis (Braun & Clarke, 2006), each theme and sub-theme has convergence in the accounts of at least three different participants. Themes and sub-themes are displayed in text as headings and subheadings. Participant quotes exemplify the themes and have been lightly edited for readability. Pulses of laughter are indicated by the @ sign.

Providing Context: Other Findings

Before presenting the main findings of this report, it seems fitting to provide some context in terms of other findings of this study, which I summarize below. These include the effects of mindfulness practice, other wellness practices participants used in their recovery, and the Buddhist ideas they used as supports. Due to limitations of space, a full exposition is not possible here.

Effects of Mindfulness Practice

Participants reported a variety of effects of mindfulness practice, most of them beneficial. These findings illustrate the value of mindfulness and contemplative practice in recovery from BD for these participants. These findings have been submitted for publication (Strong, 2020) and are summarized below.

Participants reported effects of mindfulness practice that in four major themes. In **building capacity for health**, participants built a foundation of resilience and stability that helped them end problematic patterns that contributed to BD, and enhanced their health and life outcomes. Mark reported feeling empowered to work with his experience: “And so the recovery, in a lot of ways for me, has just been the ability to confront things that used to bother me... I feel empowered to work with my reality.”

Participants gained capacities for **emotion regulation**, including increased awareness of emotions, trust of emotions, and a better relationship with their emotions. Adam reported using mindfulness in daily life to recognize early signs of hypomania and slow down:

Now, pretty quickly, when somebody else is getting agitated, my first thought is ... ‘Oh, I’m stepping over some boundary here.’ And then I realize, ‘Oh, my heart rate’s up, @@ I’m getting obsessed with being right again’... I’m not sitting on a cushion, but I’m noticing what’s going on around me, and I’m using those [meditative] techniques, to just kind of slow time down and become more aware of the present moment. And I realize, in the present moment, I’m allowing myself to tip into this kind of hypomanic activity, where I’ve become obsessed with being right, or proving a point, or whatever it is.

Based on his experience and skills gained in sitting meditation, Adam noticed the early signs of hypomania and adjusted his conduct to self-regulate and slow down, thus avoiding mood episodes.

In **shifts in experiential perspective**, participants found their experiences of self and the world changed through mindfulness practice. This

included cognitive clarity, greater embodiment, changes in the sense of self, opening to vastness, and developing a sense of unconditional confidence. Gabriel discussed how he integrated body and mind through walking meditation, which he incorporated casually in daily life:

I would call it synchronizing body and mind? To me that feels tremendously grounding ... to just feel the movement of my body in coordination with my breath, and with my attention. ... In all the ways that I might be prone to dissociation or distraction, it's like the opposite. I feel more embodied, and my concentration is more steady, when I do things like that.

The capacity to stabilize one's state of mind through a deliberate practice such as walking meditation could have profound benefits for BD, and build a cycle of stability, increased self-trust, willingness to experience emotions, and engagement with life. Participants reported a variety of such beneficial shifts.

Participants also reported a few **adverse effects** of mindfulness practice, including hyper-ventilation, panic attacks, and physical pain. They either modified their meditation technique or simply continued to practice meditation, and eventually the experience subsided. Mindfulness is not a cure-all, and helping clients identify skillful strategies to engage with different emotions is important. Additionally, including resources on trauma-informed mindfulness practice (Treleaven, 2018; Turow, 2017) may be indicated for BD. Again, this is just a brief discussion, and these results will be reported in detail in a forthcoming publication (Strong, 2020).

Other Wellness Practices

Study participants implemented mindfulness practice alongside other wellness practices that formed their personalized approach to recovery. These other practices included **caring for the body, therapy and healing, social support, spiritual practice, skillful conduct, supportive ideas, and creating emotional balance**. Along with **mindfulness**, these practices contributed to an overall process of **integrating self and experience**, which included greater openness to the world,

friendliness towards oneself, and willingness to engage with experience. The wellness practices participants used seemed to be interconnected in a weblike matrix, in which each element informed and supported the others. Due to the copious data generated by this qualitative study, only this brief summary is possible here.

Buddhist Ideas

In the web-like matrix of wellness practices described above, Buddhism was organized among the supportive ideas participants used to interpret and contextualize their experience of contemplative practice and recovery from BD, although it was connected with many of the other wellness practices. Buddhist views included the existential givens of the three marks of existence: suffering, impermanence, and selflessness. Participants benefited from maps of contemplative practice that Buddhist provided, such as the four foundations of mindfulness, the noble eightfold path, and teachings on stages of meditation. Participants discussed the value of Buddhist psychological and philosophical models, such as the three poisons of passion, aggression, and ignorance; the five *skandhas* (Sanskrit: heaps) which constitute the dualistic sense of self; the eight consciousnesses map of sensory-phenomenological experience; the three *kayas* (Sanskrit: bodies) or dimensions of spaciousness, energy, and physical manifestation; and the doctrine of ultimate and relative truth, i.e., awareness-emptiness and the interdependence of causes and conditions. Participants also felt that Buddhism's recognition of transcendent potentials, such as non-duality, universal love, and basic goodness, were important reference points for them during their recovery from BD.

Participants discussed integrating Buddhist frameworks with Western psychological models, positive psychology, trauma recovery frameworks, and other spiritual and psychological views. These integrative frameworks amounted to personally crafted worldviews that supported participants' recoveries. Buddhist views appeared to contextualize and enhance participants' contemplative practice, and may have contributed to the effects of mindfulness and other benefits that participants reported in the study. Due to limitations of space, a

more complete discussion of how participants used Buddhist views awaits future publication.

Mindfulness Teachers and Buddhist Traditions

Respondents learned about Buddhism and mindfulness meditation from a contemporary Buddhist lineage, whether in person or through books, recordings, or another medium. Rather than seeking convergence in multiple accounts, these findings on teachers and traditions indicate the diversity of Buddhist lineages reported by participants, and if one participant named a given tradition, it is listed below. Most of the participants' teachers were Westerners who had studied and practiced Buddhism for many years. Names of specific teachers are omitted or anonymized to protect participant privacy. The major doctrinal Buddhist traditions and respective lineages reported by participants are listed in Table 2.

This organization of lineages into traditions is both somewhat canonical and somewhat arbitrary (cf. Ray, 2000, pp. 238–240). There is considerable overlap in some of the Buddhist practices and teachings, and yet each lineage emphasizes its own distinct set of practices and frameworks. Participants commonly drew from multiple different teaching streams, or progressed from one tradition and set of practices to another during their meditation careers. For example, James described his journey among different Buddhist traditions over the past 40 years:

So my practice is @ kind of an amalgam—I started out with Nichiren Shoshu, *nam myo-ho rengye kyo* [a chanting practice] ... Then, I practiced at Tibetan Buddhist Center A here in Midsize City 4, with—I never practiced directly with Buddhist Teacher A, but I practiced with his students. And then moved into Zen from there. (Actually, I did yoga before that, with a yoga teacher here in town.) ... With Buddhist Teacher F, who was at the City Zen Center A many years ago. Now I'm back into Zen. So, so I've got Tibetan, I've got Zen, I do a little Pure Land. It's kind of an amalgam of all those different [traditions]. One of my first meditation instructors at University H, the first session, was Buddhist Teacher G [who is now associated with a Theravada Buddhist tradition].

In the course of their recovery from BD, participants engaged in a rich tapestry of teachings and practices from different Buddhist traditions, sometimes cycling among techniques and teachings to work with a particular mental or emotional state. Because participants described eclectic encounters with Buddhist teachers and traditions, it seems needless to identify specific lineages as being of primary importance. Rather, the diversity of Buddhist lineages participants engaged with may point to the value of engaging with multiple teachings and practices—a point to which I return in the discussion.

Mindfulness Practices

Before presenting the main findings of this paper, it seems helpful to articulate the confusion in the field around what exactly is meant by “mindfulness.” Mindfulness as popularized in the West over the last 20 years has become a slippery signifier, and now refers broadly to sitting meditation, other contemplative practices, a measurable trait, an attitude, psychotherapeutic approaches, and a variety of different adaptations on the cultural marketplace, such as mindful eating, mindful movement, mindful birthing, and so on. While such approaches and meanings may have their value, it has led to a situation in which it is increasingly difficult to say with clarity what precisely mindfulness means. Rather than imposing

Table 2. *Buddhist Traditions and Lineages that Participants Learned from*

Buddhist Tradition	Lineage
Theravada	Insight Meditation Society Pragmatic Dharma
Mahayana	Nichiren Soto Zen Rinzai Zen
Vajrayana	Shingon Tibetan Buddhism (Kagyu and Nyingma) Shambhala
Non-Dual	Dzogchen

a definition of mindfulness practice on participants during recruitment, I chose to cast a wide net.

Due to this difficulty in definitions, in the report, I use the words “mindfulness practice” and “contemplative practice” interchangeably. Mindfulness as a capacity for stable attention and open acceptance probably plays a part in all contemplative practices, and contemplative practices such as mindfulness meditation are powerful ways to cultivate the capacity for mindfulness. At the same time, attending to any activity with openness, interest, and acceptance may both exercise the capacity for mindfulness and integrate it with daily life. In the face of these difficulties, in the section on mindfulness practices, I have tried to describe different practices clearly enough to distinguish them.

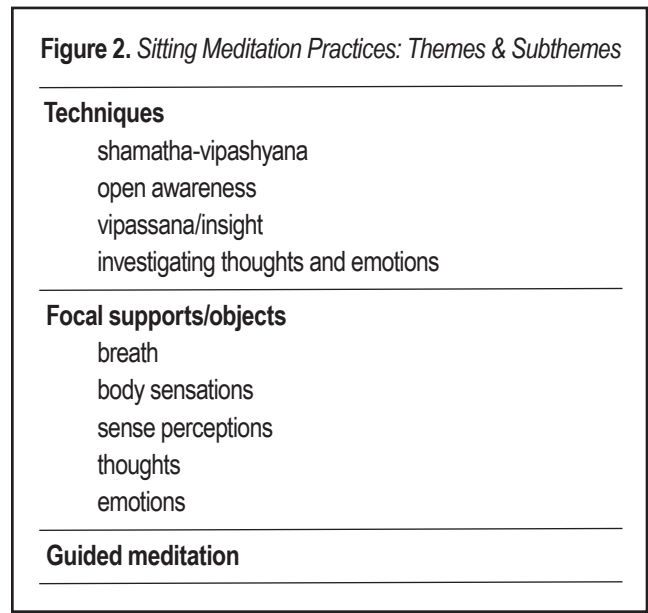
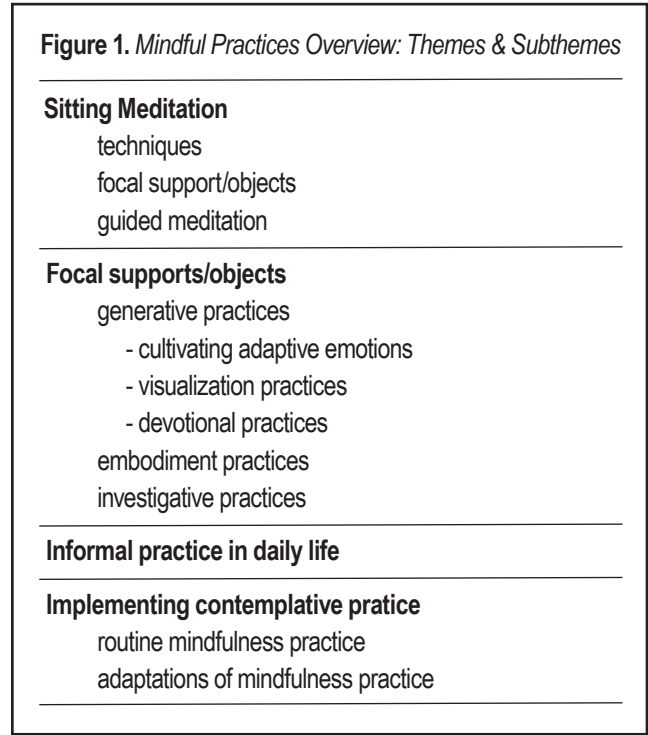
Participants used a variety of mindfulness practices to work with BD. These included sitting meditation (a.k.a. shamatha-vipashyana, mindfulness-awareness, or insight meditation), other contemplative practices, and informal practice in daily life. Respondents also reported ways they implemented contemplative practice. For practices and effects, all themes and sub-themes were reported by at least three participants. These themes and their major sub-themes are summarized in Figure 1, and the following sections expand on these themes. The findings in this section are interwoven with some interpretation to provide a narrative arc for this paper, and some sections conclude with a brief discussion of their implications.

Sitting Meditation

Sitting meditation is the most common form of Buddhist mindfulness practice, at least in the West. Participants used a variety of different sitting meditation techniques and focal objects of awareness in their recovery from BD. Some participants reported using guided meditation recordings as well. These themes and subthemes are summarized in Figure 2. At least three participants used guided meditation, but there was no convergence among subthemes.

Sitting Meditation Techniques. Participants used a variety of different sitting meditation techniques, as shown in Figure 2. Antonio used *shamatha* (Sanskrit: calm abiding) and *vipashyana*

(Sanskrit: insight) to explore his embodied experience during sitting meditation with an open, observational stance: “It’s like shamatha-vipashyana, you know... there’s shamatha, and then things open.... So I’m exploring my body, but I’m exploring it mostly through placing my mind and watching.” James discussed his sitting meditation practice of cultivating openness, awareness, and acceptance toward mind states: “My kind of go-to of mindfulness has always



been *metta* [Pali: loving-kindness]. So it's like, letting mind states arise and just becoming cognizant of them, and accepting of them." The sitting meditation practices that participants discussed all involved orienting to present-moment experience with an attitude of acceptance and openness. The techniques listed in Figure 2 all had further techniques that different participants reported, although these items did not reach convergence among 3 participants. For example, participants named a dozen different techniques they used during shamatha-vipashyana practice.

Participants selected different sitting meditation techniques for particular circumstances, emotions, and psychological states. Gabriel reported using a labeling technique as part of his mindfulness practice to help work with distraction and come back to the present moment, adjusting the technique based on his state of mind:

I ... practice labeling thoughts ... If my mind feels busy, I'll just use [the label] 'thinking,' and come back, so 'thinking' to kind of acknowledge the thought, and then come back to the breath and the body, ... but if it's a particular content that's coming up, I'll label the content. So I might it might be an emotion, like sadness. Something like that.

Gabriel's account illustrates a refined approach to meditation in which he adapts the techniques to prevailing conditions. If his mind feels busy, he just labels mental or emotional processes as 'thinking' and then gently returns his attention to the breath, but if particular content recurs, he labels the specific content, e.g. 'sadness.' The process that Gabriel uses combines several attentional skills in a way that works for him.

Respondents also reported using different techniques at different points in their meditation careers. Antonio related: "I've been practicing for about ten years... at one point it was a very diligent hours a day... and then there were a lot years of experimenting with... different practices— more open awareness practices, more investigative practices... ecstatic practices...". Thus, participants drew from different approaches at different times, and reported adapting their meditation practice

to help them work with different aspects of their experience.

Seeking out and adopting new mindfulness practices may be a developmental process, or clients may be seeking an optimal fit for their particular tendencies. It seems reasonable to anticipate that clients with BD may continue to branch out to find meditation teachings and practices that work for them, and psychotherapists and meditation instructors could help facilitate this process. It seems ethical for therapists and meditation instructors only to teach techniques with which they are themselves familiar, and to refer out for contemplative practice instruction that is beyond their scope.

Focal Supports/Objects for Sitting Meditation. As shown in Figure 2, participants used different supports for their meditation practice, including the breath, body sensations, sense perceptions, thoughts, and emotions. A support for meditation practice is an object of awareness: it is what one attends to as a reference point during meditation. Mark recounted: "my first introduction was mindfulness meditation in a book by the Dalai Lama. And it was just sitting in my basement, following my breath."

The breath is a common first object for meditation practice. It helps meditation practitioners establish stability of mind by returning attention again and again to a subtle yet ubiquitous phenomenon that is usually unconscious. Training in paying attention to a boring, commonplace experience helps clarify and settle the fickleness of the untrained mind, and provides a neutral backdrop against which mental and emotional activity can be observed.

Based on developing stability of attention, meditators learn to extend mindful awareness to other, less neutral aspects of their experience, including sensations, emotions, and thoughts. Choosing different objects can be a way of extending mindfulness into different areas of experience, and it can also be part of a self-directed BD intervention. Joanne practiced with body sensations that accompany strong emotions, which helped her reduce trauma reactions: "It's about feeling... It's just staying present to the actual sensation... and... not listening to my brainstem anymore." Antonio used

a “touch and go” mindfulness technique (Trungpa, 1991/2005) and sensation, the breath, and thoughts as reference points, so as not to get tangled up in thoughts of reference:

When my mind would escalate, it would put associations into the world that weren't necessarily there... So shamatha has been a very good ally in, like, 'oh yeah, mind is making associations, mind is making thoughts—' This idea of touch and go, touching, and coming down, and coming back to just raw sensation, breath, even thought as well, but having that soft touch?

For many participants, once they gained strength and stability in their meditation practice, the mere act of bringing awareness to emotions, sensations, or thoughts shifted the experience in a beneficial way. As one of his practices, Mark looked directly at his mind within a non-dual frame, which reduced emotional reactivity and mood episodes:

I feel less propelled, and more in tune, when I look directly at... my mind.... Knowing that my mind and the world are not two totally separate entities. But knowing 'Ok, this is the play of my mind,'... and I can be aware of that, without needing to do much more than that, 'cause it'll shift. The problem is when I really react to it, really follow it in one way, or reject it in another... Then [it's] good fuel for a manic... or depressive episode.

Choosing appropriate supports for awareness and applying appropriate techniques helped participants use mindfulness to modulate their experience and work with BD.

Guided Meditation. Some participants reported listening to guided meditation recordings, which provide mindfulness instructions in real time and implicitly include the voice and words of the presenter as objects of awareness. Sky described a time they used a guided meditation to help shift their state:

As I was driving into the city, I was like 'Okay, you've just been in your head all day, you haven't eaten anything, you actually shouldn't go to

your class with this kind of [speedy] energy!... So I put Tara Brach on in my car, I set a timer, I was like 'You're just gonna sit here and you're gonna eat this food, you're gonna listen to Tara, and just do a lot of really serious breathing... And I really changed the energy that I had in my body, and my readiness to be in that room full of people. By the time I arrived there, I was so much more grounded.

James discussed how guided meditation is different from self-directed practice: “In my meditation practices, I'm listening to myself, and there is no sound, and everything is pointed inward. Whereas for the guided meditations, you have to listen to outside sources... and figure out what you're gonna do.” Using guided meditations may reduce cognitive load, stimulate the social engagement system, and provide an experiential reference point other than clients' inner monologues. Participants reported using guided meditations in different contexts in their lives, including in the car, in the bathtub after a stressful day, and as part of a bedtime routine. One person used a smartphone app to discover guided meditations. Helping clients discover new practices and find ways to practice mindfulness that work for them seems an important component of creating a personalized recovery approach. Recordings and other technological supports may be beneficial for some people during their recovery.

Implications of Sitting Meditation. Sitting meditation is not a single, unitary practice, but encompasses multiple different techniques and contemplative skills. Furthermore, these techniques can be used with a variety of different objects of awareness, leading to an expansion of skills for self-awareness, emotion regulation, and neurobiological integration. Important applications of sitting meditation to BD recovery may be to learn and apply techniques that are suitable for different mood states, investigate the lived experience of emotions, and observe, experiment with, and reshape the personal patterns that aggravate and perpetuate BD.

Because the experience of BD includes fluctuating mood, cognitive, and behavioral states,

it is important for individuals to find ways to adapt their recovery practices to these different states. By using multiple different supports for their sitting meditation practice, participants may have expanded the variety of stabilizing and integrating habits and cues available to them. The cultivation of different sitting meditation techniques and supports, and learning when to use them in different states of mind, may help clients optimize meditation practice and other recovery practices to their personal experience of BD. Other authors have acknowledged the value of adapting mindfulness techniques to different states (Chadwick et al., 2011) and stages (Murray et al., 2017) of BD.

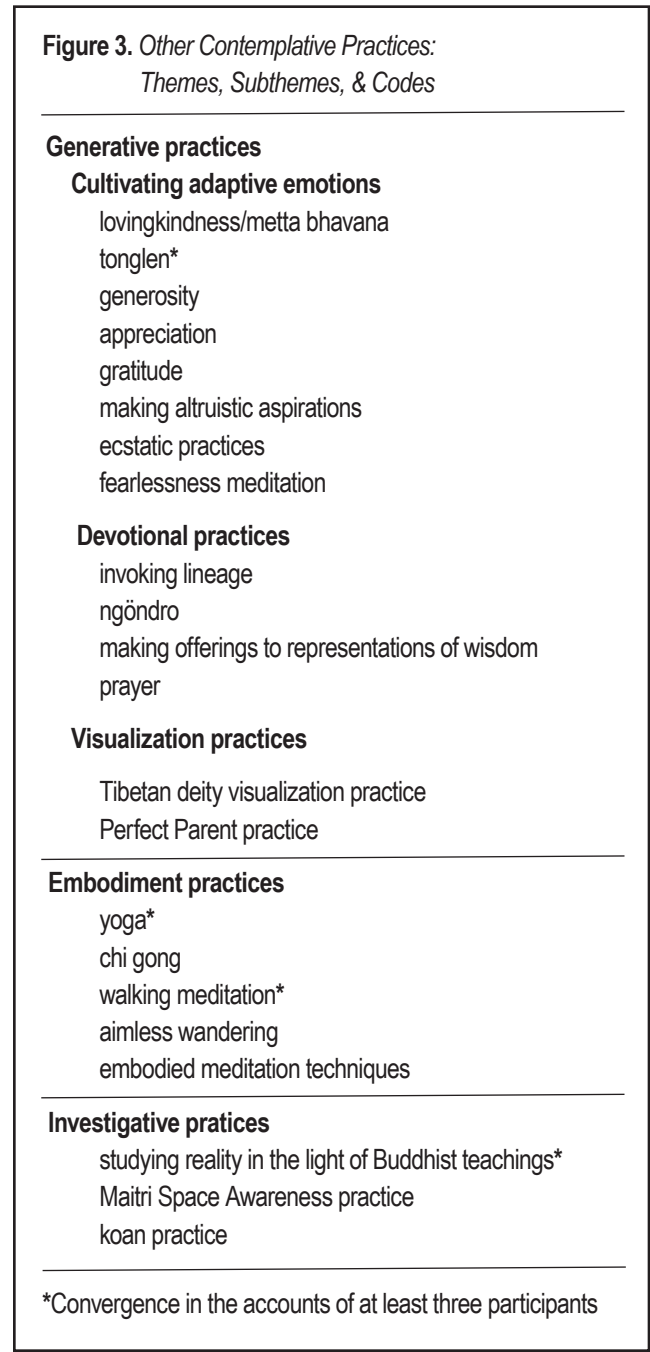
Selecting different focal supports and applying appropriate techniques can help clients gain familiarity with their experience and achieve insight into its nature. For example, participants reported learning to recognize thoughts as temporary phenomena, rather than getting caught up in the thought process or elaborating habitual ways of thinking that lead to suffering. Participants reported that mindfulness practice led to new perspectives on self and experience, and reduced behaviors, thoughts, and emotions that maintained their experience of BD. Using Buddhist perspectives such as impermanence, the non-solidity of self and experience, and interdependence to guide meditation practice may promote effective change in pathogenetic habits more effectively than secularized approaches for some people. More research is needed to investigate this question.

The Buddhist meditation literature includes recommendations on working with the mental experiences of excitement and torpor (cf. Traleg, 2003, pp. 158–161), and these techniques may provide clues to working with speed and lethargy as possible prodromes of hypomania and depression. Enhancing awareness of one’s state of mind, emotions, and body sensations through sitting meditation may contribute to enhanced self-monitoring in BD and the ability to deploy appropriate interventions to reduce or prevent mood episodes.

Other Contemplative Practices

Respondents used a variety of other contemplative practices, including generative, embodiment, and investigative practices,

summarized in Figure 3. Some of these category names are inspired by the Tree of Contemplative Practices (Duerr & Bergman, 2013). Participants used some of these practices alongside sitting meditation, and they integrated others with sitting practice. Although each of the bold headers in Figure 3 were endorsed by at least three participants, many of the individual practices were reported by only one or two respondents, indicating the diversity of individual practices they used.



Generative Practices. Sitting meditation in the Buddhist tradition cultivates the even placement of attention, openness to present-moment experience, and insight into the mind and experience. Generative practices, on the other hand, give rise to specific feelings, attitudes, or experiences. Practices to cultivate adaptive emotions, such as loving-kindness (metta), often use an imaginal procedure to induce a specific prosocial feeling state, with the aim of creating easier access to that emotion in the future and reducing fixation on a limited sense of self. Some of the other practices discussed below, such as the Tibetan *ngöndro* preliminary practices and deity yoga, can involve elaborate sets of interlinking practices, including generating devotion, giving rise to compassionate resolve, complex visualizations, mantra recitation, and a meditation liturgy. As with sitting meditation, there are various different techniques even within a specific set of practices, and meditators gain fluency, technical competency, and stability with repeated practice. This section includes generative practices for cultivating adaptive emotions, visualization practices, and devotional practices.

Cultivating Adaptive Emotions. Participants used meditation practices to cultivate generosity, compassion, gratitude, joy, and fearlessness. These practices generated emotional states which could relieve present-moment suffering, and they also helped participants cultivate prosocial and adaptive attitudes. These prosocial emotions may have become an embodied habit that had a positive influence on their experience of life and BD.

For example, Antonio practiced *tonglen* (Tibetan: “taking and sending”) to cultivate compassion and get unstuck: “Now when I’m struggling the most... I’ll practice tonglen... It’s like... moving towards your pain, but... another way.” Tonglen is a practice for cultivating compassion and reducing fixation on the self, in which one visualizes inhaling others’ pain and suffering as clouds of dark smoke, and exhaling one’s own happiness and health back to them in the form of light (Chödrön, 2001). Antonio reported that using tonglen transformed his experience of suffering, and had a major impact on his recovery from BD.

Another common generative practice is *metta* or loving-kindness meditation, in which one

cultivates benevolent well-wishes and gives rise to an experience of friendliness. James explained the practice, and how he used it to work with BD: “You start with yourself, and then [cultivate happiness and well-being] towards [someone] you’re having a good relationship with... and then with everybody. That meditation is pretty good for being depressed.” James used loving-kindness practice as an antidote to depression, and he appeared to extend an attitude of friendliness towards his thoughts and emotions, and he explained in his excerpt in the section on sitting meditation.

Participants felt that such practices helped them cultivate altruism, generosity, appreciation, fearlessness, feelings of connectedness, and gratitude. Practices for generating adaptive emotions seemed to help participants give rise to prosocial states and shift their focus away from their own pain. Compassion training has been shown to change brain activity and protect from empathic distress (Singer & Klimecki, 2014). Meditations that give rise to prosocial emotions may entrain and potentiate behavior patterns that lead to experiences of benevolence and connectedness. Mindful self-compassion has been developed to enhance self-directed loving-kindness (Germer, 2009; Neff & Germer, 2013), and mindfulness practiced with curiosity, openness, acceptance, and love may promote a secure internal attachment style and promote emotion regulation and a positive sense of self (Siegel, 2020). Such positive mood states and social experiences may serve as immediate and long-term antidotes to painful moods in BD.

Devotional Practices. Participants discussed using devotional practices such as invoking lineage figures, visualizations, prostrations, and prayer. Two participants discussed the Tibetan Buddhist *ngöndro* preliminary practices, in which the meditator establishes devotion, cultivates altruism and generosity, and purifies bad habits through visualization and confession of faults to different visualized enlightened Buddhist figures (Khyentse, 2012). Typically, meditators accumulate many thousands of repetitions of such practices as preparation for being introduced to a new practice. Other respondents used devotional practices such as prayer and invoking lineage as other parts of their meditation practice.

Mark remarked that taking on a daily routine including this long-term practice provided a metaphor for recovery: “ngöndro in a way is synonymous with my recovery from bipolar, in that it’s this beautiful, kind of distant goal. It’s such a huge task, and yet it’s like the monotony of day-by-day.” The ngöndro practices also serve as a template for the deity yoga practices, and those visualization practices typically include devotional elements. Thus, there are implicit aspects of devotional practice in multiple participant reports.

Visualization Practices. Some respondents used visualization practices such as Tibetan Buddhist deity yoga. These practices use active imagery as a meditative technique, with the aim of helping the practitioner identify with aspects of the awakened state and misidentify from habitual self-conceptions through the medium of mythological Indo-Tibetan Buddhist deities, which are themselves anthropomorphized depictions of different aspects of the enlightened mind (Berzin, 2020; Kongtrül & Thrangu, 2002). Two respondents discussed engaging in Medicine Buddha practice, and one of those also mentioned receiving a Vajrayogini empowerment. Medicine Buddha and Vajrayogini are Tibetan meditational deities, each of which have their own sets of practices and teachings. Respondents did not discuss these practices in detail. More information on the theory and practice of Tibetan Buddhist deity yoga is available elsewhere (e.g., Thrangu, 2004).

A third participant discussed practicing an adaptation of deity yoga practice for the West, called the Perfect Parent technique. Brendan felt this helped him heal from attachment difficulties, feel more connected to the natural world, and repair distorted beliefs about himself:

This loving deity across from you is attending to you [with] the perfect type of care for you, so if you just spend a lot a lot of time, just visualizing that, feeling it in your body, relating to it in a complete and harmonious and loved and loving way... being held and protected, totally receiving love, you start to internalize that as your metacognition to yourself after awhile.

Deity yoga, discussed here as a visualization practice, and ngöndro, discussed above as a

devotional practice, typically involve the cultivation of devotion to one’s teacher and meditation lineage, as well as an intersubjective relationship and/or identification with the various visualized deities. In this regard, these practices may engage the social nervous system and aspects of identity and relationship differently than either sitting meditation or the cultivation of adaptive emotions. Wolf (2017) discussed the intersubjective aspects of these practices, particularly in the guru yoga or mentor bond aspects of relationship with the guru as the deity figure, and integrated them with intersubjective psychotherapy theory.

In the Buddhist view, all sentient beings possess an enlightened basic nature, but this is covered over by temporary stains which create confusion and suffering. Ngöndro and deity yoga involve the visualized transformation of ordinary reality into a pure realm, which serves as a commentary on the subjective and habitual nature of suffering, and our potential to shift suffering based on sacred outlook (Thrangu, 2004, pp. 27–28). Participant reports suggest that such practices may be beneficial in recovery from BD for those who are drawn to them. Such devotional and visualization practices have so far received scant attention in the research on mindfulness. While they were not a main focus of this study, they merit attention in future research.

Embodiment Practices. Several respondents used embodied mindfulness practices, such as chi gong, yoga, walking meditation, and body-focused meditation. Adam used walking meditation to enhance conscious connection with himself and the world: “If I am walking to or from someplace, I try to turn it into a walking meditation... fully paying attention to the feeling of [walking, and] trying to... take in all the sights [and] sounds around me.” Participants used these practices to extend their mindfulness into movement and daily life. Some respondents used specific embodied mindfulness techniques that helped them to work with fear, pain, and disorientation. Joanne reported years of engagement with embodied mindfulness practice, and discussed one such technique:

So even today, if I get a little overwhelmed as something arises, I’ll go down and feel it as

a sensation. And not get so caught up in the whatever [i.e., the reactive storyline]. And then back off of the sensation. So you're staying curious? And which is, in my sense, a ventral vagal tone. If you're curious, by definition you're not in fight, flight, or freeze. It totally shifts the gear... And that has probably saved my life.

Focusing on present-moment body sensation can be a support for meditation practice, and it can be a way to deepen one's relationship with the body and integrate mindful-awareness into everyday experience. By foregrounding body sensations and bringing curiosity to them, Joanne was able to break free of emotional reactions that she felt were linked to a trauma response. Embodiment practices were powerful tools in recovery from BD.

Investigative Practices. A few participants discussed the value of investigative practices that involve examining experience, sometimes in the light of Buddhist ideas. Antonio meditated on the conflicting emotions of passion, aggression, and ignorance to orient toward rather than turn away from experience: "Meditations on the three poisons, I think that teaching has been the most helpful for me... being able to... see what I'm avoiding and turn towards it, see what I'm liking and... not get duped by [it.]" By investigating how he habitually attempted to edit his experience to suit his unconscious preferences, Antonio expanded his range of comfort and tolerance for experience.

Mark reported contemplating the impermanence of things as an antidote to difficult experiences: "Being mindful of impermanence is huge for me... When I'm stuck in a difficult time [I can use] impermanence as like, 'Okay, I can stick with whatever's happening, knowing that it's not gonna be like this forever.'" Knowing that emotions will pass away eventually and cooperating with impermanence can be a powerful antidote to mania and depression. Podvoll (1991/2003) argued that contemplating impermanence can be a helpful practice for navigating psychotic experiences. Respondents also discussed investigating the sensory fields and the phenomenology of experience, recognizing interdependence, and other ways of investigating life, experience, and the self. Participants also used specialized meditation

techniques, such as Maitri Space Awareness (Evans et al., 2008) and Zen koan practice, to investigate the nature of reality, mind, and emotions.

Implications of Other Contemplative Practices. Respondents used many practices besides sitting meditation to develop additional capacities and remedy difficulties they were unable to address with sitting meditation alone. For example, in response to the panic attacks and hyperventilation she experienced during some sitting meditation retreats, Joanne learned and practiced embodied meditation techniques that helped her find her ground and experience safety in the present moment. Several participants discussed the value of compassion practices in cultivating prosocial attitudes and developing kindness and gentleness toward themselves, which helped remedy negative self-talk and depressive rumination. To the degree that BD arises from suboptimal processes of arousal, meaning-making, emotion regulation, and reactivity to inaccurate cognitions (Dodd et al., 2019; Wright, 2013), these additional practices may provide the opportunity for clients to dismantle maladaptive patterns and train in more helpful habits of attention, self-soothing, and meaning-making. Learning an array of contemplative practices can help clients expand their repertoire of skills for recovery.

Informal Practice in Daily Life

In addition to periods of formal practice, participants used mindfulness practices informally, weaving them into daily activities. Mark discussed working with mindfulness in everyday life:

Times that I feel like I don't need to sleep as much, or I'll get kind of eccentric or wild with my behavior, I would consider little episodes, and I just become aware of that, and say, 'OK, this is what's happening to me.' And instead of following it, I try to curb it. Not necessarily judge that it's bad or good, but just notice...

Applying mindfulness, alertness, and non-judgmental curiosity to his everyday life helped Mark detect early warning signs of a mood episode and respond with skillful restraint. Instead of building up a story about things being good or bad, Mark found a way to notice what was happening and intervene

skillfully. Adam did not have a daily sitting practice at the time of the interview, but reported practicing mindful moments throughout the day, or when the need arose. He applied the mindfulness and awareness he had developed in meditation to reduce emotional reactivity: "I try to use the techniques of meditation to help me be more aware of what I'm feeling at any given moment... to sort of explore that and therefore let it not be in control of me." Sky also discussed transferring capacities they gained on the meditation cushion to the rest of their life:

Researcher: And then figuring out that there's something to do about your current state, such as 'take a few deep breaths,' itself is a mini-practice.

Sky: And... I'm only able to do that in a situation, you know, out in the world, because I've been doing that so much in the kind of calm and isolated space of my meditation practice.

For Sky, using a self-calming practice such as taking a few deep breaths depended on their having noticed they were feeling activated. Sky attributed their ability to do these things to the time they spent in regular formal practice at home. Participants integrated mindfulness practice in their daily life to enhance their recoveries.

Implications of Informal Practice in Daily Life. Participants transferred skills and capacities of formal meditation practice to informal daily practice, which made those skills and capacities available throughout life situations. This is a mark of success: meditation is having a positive effect on recovery once it becomes useful in everyday life. Informal daily practice seems important for helping people make mindfulness and other contemplative practices useful in everyday life and recovery from BD. Informal practice may also be more appropriate for different mood states or stages of BD (cf. Chadwick et al., 2011; Murray et al., 2017); this question warrants further research.

Implementing Contemplative Practice

Participants discussed how they implemented mindfulness practices. One aspect of this was building meditation practice into their daily routine, in which case meditation contributed to a sense of structure in peoples' lives. At other times, meditation

practice and techniques needed to be adapted to fit the person and their situation.

Routine Mindfulness Practice. Routine practice was important for many participants. Mark started each day by making aspirations: "For me, routine is really big. When I wake up first thing in the morning, I fill offering bowls and light a candle and make a positive aspiration." Sky discussed meditation as part of their daily ritual, and something they implemented as part of Interpersonal Social Rhythm Therapy (Frank, 2005): "I have a set morning routine that I do every day, and the second thing I do after I wake up and make tea is meditate, and sometimes I just set a timer for 15 minutes." Although not all participants had a regular practice at the time of the interview, all reported that regular meditation practice was important at some point in their recovery.

Some participants reported approaching their meditation practice schedule with flexibility. Gabriel practiced meditation 40 minutes a day, about 6 days a week: "Sometimes that's one sit, sometimes that's two sits, depending on my schedule. So I either do two 20-minutes, or one 40-minute... I probably miss one day a week... when I'm busy and tired." Gabriel's account highlights the value of flexibility in implementing routine, and not being discouraged if one doesn't meet all one's goals for regular practice.

Adaptations of Mindfulness Practice. Participants also adapted meditation practice to their situation. For example, participants chose specific techniques based on their mental or emotional state. Adam reported that when he was feeling quite depressed or anxious, he shifted his meditation technique to have a more external focus, and contemplated positive thoughts:

If I am feeling really down, or very anxious or agitated, or any kind of strong emotion, I will do essentially the kind of meditation that I normally do on Sundays, which is just focusing on my breath, but I do something so that... I will turn my focus onto positive thoughts. So I will say you know, 'In this moment, I'm breathing just fine. In this moment, I'm in a house... that's heated, that has electricity and running water.'

Adam appears to have adapted his mindfulness practice to work with specific mood states. Joanne adapted mindfulness practice to her experience of trauma and incorporated a trauma lens in her approach to meditation. Among these adaptations was an embodied meditation technique from Shinzen Young (2004) that she used to work with dissociation and the physical sensations linked with a trauma response:

I still do guided meditations. I do, yeah! It's a very powerful tape. [Shinzen Young's "Break Through Pain."] ... I listen to it and do it in the bathtub. And that does help! It kind of keeps me from floating, floating away. It's really workable. It's like, 'Oh, it's just a sensation.' It's not whatever you might think it is. If you can tolerate it until it passes, and it passes, — and there's always that, I just don't believe it's gonna pass, and then it passes! And then the system shifts, so I feel that felt shift, and I can breathe a little easier, and then I'm warmer, and I go back to the original trigger, ah! 'Well that was silly!' You know? It's not that big a deal, it's not personal— who knew? It wasn't personal. Just knowing... there is a way to slow it down and not believe your brainstem so much. Because the part of the brain that overrides that isn't really that good at it, so you have to go below it. Not trying to figure it out, go below it. It was a real epiphany.

Joanne appears to have used embodied mindfulness techniques to modulate her autonomic nervous system arousal and return to the window of tolerance (Siegel, 2010). Elsewhere in her interview, she discussed experiencing profound healing from trauma through meditation practice, leading to many positive life outcomes. Joanne's account is a good example of adapting mindfulness practice to working with psychological trauma states.

Implications of Implementing Contemplative Practice. Participants felt that establishing a daily mindfulness routine was an important part of their recovery. As regulating the sleep-wake cycle is a key component of many psychosocial treatments for BD (Swartz & Swanson, 2014), implementing regular mindfulness practice could contribute to the regularity of a daily schedule. Regularly scheduled, brief meditation periods (e.g., a set time period of 5, 10, or

15 minutes, once or twice a day) may help clients stick with starting a mindfulness practice. For those who are enthusiastic about practice, longer meditation sessions can be helpful. Participants in this study discussed the benefits of routine mindfulness practice over time. To make the most of mindfulness practice, it may be important to help clients implement regular practice and stick with it, even their follow-through is not perfectly consistent.

The ability to adapt mindfulness practice to client needs may be significant for addressing the wide range of experiences and possible subtypes of BD. Many participants described selecting specific meditative techniques to work with different emotions, experiences, and states of mind. While there were some commonalities, there was also divergence in matching techniques to different states. The capacity to recognize a wide variety of mind and mood states and apply an appropriate meditation technique for one's personal make-up may be a mark of sophisticated meditation practice in the context of recovery from BD. Different individuals may need to select different meditation tools to work with their states of mind, and keep on adapting their practice as it develops.

BD is correlated with post-traumatic stress disorder (Neria et al., 2008), and multiple studies show a strong correlation between childhood trauma and BD (Aas et al., 2016). Assessing for underlying trauma and providing evidence-based trauma interventions for BD are sorely needed components of competent treatment, yet these are not yet part of mainstream treatment (Aas et al., 2016). For these reasons, mindfulness-based approaches to recovery from BD should be trauma-informed.

Some participants in this study reported panic attacks, hyperarousal, and hyperventilation during mindfulness practice. There is overlap in the phenomenology of BD mood swings and trauma-related shifts in ANS arousal (e.g., Scaer, 2001), and it seems reasonable to speculate that participants' experiences may be linked to trauma. The dissociative features and emotional and attentional regulation difficulties that are hallmarks of unresolved trauma create obstacles in mindfulness practice. If mindfulness practice is not adjusted appropriately, clients run the risk of retraumatization through

uncontrolled flooding and traumatic recapitulation, and they may abandon mindfulness practice as a result.

The classic trauma symptom clusters are intrusion, hyperarousal, and constriction (Herman, 1997). Overwhelming intrusive affect can create obstacles to mindfulness practice, such as when clients are engulfed by disturbing experiences during mindfulness practice but do not have the skills or capacity to separate from and observe the unpleasant sensations, memories, feelings, and beliefs. Clients can also misuse mindfulness practice to isolate and avoid experience rather than learning to turn toward it and find safety in the present moment (e.g., Ogden et al., 2006). Without careful guidance and appropriate techniques, mindfulness practice can become a structured form of dissociation rather than a way to access openness, safety, warmth, and acceptance in the present moment. Trauma-informed approaches to using mindfulness with BD should include trauma recovery psychoeducation and guidance in noticing and navigating the window of tolerance (Siegel, 2020). Trauma recovery techniques such as pendulation, titration, containment (Levine, 2012), resourcing, and anchoring (Rothschild, 2000) can be taught to clients and adapted to mindfulness practice. Existing trauma-sensitive approaches to mindfulness (e.g., Treleaven, 2018; Turow, 2017) can provide guidance in adapting mindfulness practice to recovery from BD.

Discussion

This study investigated the real-world experience of people who used Buddhist-inspired mindfulness in their recovery from BD. Participants used a broad array of practices and discussed specific skillful ways they had learned to use them to work with the experience of BD. This included adopting a set of practices that were suited to their particular situation, applying practices based on specific mood states, and seeking personal guidance to optimize mindfulness practice. Participants also described an evolution in their mindfulness practice. The development of more advanced meditation skills may interact with stages of BD and stages of recovery. Although participants felt that mindfulness practice made major contributions

to their recovery, they also used many other wellness strategies in their long-term recovery process. Mindfulness practice may have facilitated integration of the different aspects of participants' recovery plans and enhanced emotional balance, healing, and growth.

Based on these findings, although sitting meditation does appear to be a useful reference point and basic practice, there does not appear to be a "silver bullet" mindfulness technique in recovery from BD. Just as different people have different styles and experiences of BD, different individuals may respond better to one practice or another. Participants reported personal learning around which practices work for them in particular situation or states of mind, and this selection process seemed important for adapting mindfulness practice to the course of recovery. Such a personalized approach suggests that using mindfulness in recovery from BD is a craft rather than a one-size-fits-all approach. Meditation practice is a developmentally iterative craft that combines subtle observation with learned skills of shifting focus and modulating attention. Different Buddhist traditions and teachers emphasize different techniques and teach them to meditation students based on developmental considerations and the particular obstacles that students are facing in their meditation practice. Past research on mindfulness in BD has paid scant attention to these subtleties of mindfulness practice. Future research could investigate the subtleties of mindfulness practice development as applied to BD.

Explaining to clients that there are many mindfulness practices that work differently for different people can help clients find practices that work for them, establish reasonable expectations, and encourage them to keep trying things out till they find something that fits. Models such as the Tree of Contemplative Practices (Duerr & Bergman, 2013) can provide an overview of these diverse options, and each practice may have further developments and intersections with other practices.

In the case of BD, this also calls for selecting mindfulness practices based on mood states. Study participants reported used different techniques based on their moods, informed by

their past experience of what worked for them and their ongoing experimentation with applying mindfulness practice in their lives. Encouraging service users to develop a personal understanding of how and when to apply different practices may help optimize mindfulness in recovery. Developing such an understanding of mood states and their markers promotes self-monitoring and lends itself to the application of self-managements skills more generally.

Mindfulness practice benefits from expert guidance. Several participants discussed encountering specific challenges in their moods and in meditation practice. To work with their experiences, they sought out advice from books and meditation teachers, and tried different techniques and interpretive frameworks. Participants also reported benefiting from personalized instruction to fine-tune their meditative technique, overcome obstacles, and select appropriate practices. As with learning other skills such as piano, chess, or tennis, expert mindfulness instruction can enhance performance and learning. Successful development of mindfulness skills probably benefits from both individual practice and periodical consultations with an expert instructor. Group instruction and guided meditation recordings may also contribute to developing and deepening mindfulness skills. For this context, an ideal instructor might have deep domain-specific knowledge, including training and experience as a mindfulness instructor, clinical training and background, and lived experience using mindfulness to recover from BD. Even so, clients may benefit from combining clinical support and mindfulness instruction in whatever way works for them.

Participants engaged in different kinds of practices at different stages in their recovery. Several participants worked with a rigorous formal practice early in their recovery, and later transitioned to less frequent formal practice and ongoing informal practice. Because different stages of BD present different challenges and opportunities for treatment, tailoring mindfulness practices to a stage conceptualization of recovery may optimize treatment (Murray et al., 2017). Additionally, the Buddhist tradition recognizes stages of development

in meditation practice, and clients may benefit from further study, meditation retreats, and learning new techniques depending on the development of their meditation practice. It remains to be seen how BD stages and developmental stages of meditation practice interact.

As reported above under Other Wellness Practices, participants integrated a variety of other practices in their recovery. Developing a personal recovery approach takes time, energy, and money. Participants reported fine-tuning their recovery practices to get it right, and it took many hours per week over years to reap the benefits. As Sky put it, "I'm thrilled! I love my life! I'm really proud of it. It's really fulfilling and challenging and, [that] respects the fact that I still do have a lot of limitations. I just worked so hard." Mindfulness is not a quick fix, but for participants, it was a core recovery practice that they felt made major contributions to their wellness. Participants described practicing mindfulness and reaping its benefits over months and years. It seems important to emphasize the value of long-term practice and the need for ongoing optimization and guidance. Future studies could investigate how clients are successful in implementing mindfulness in recovery from BD in the long term, and how they seek further development in their practice to support their recovery.

Participants felt that Buddhist-informed mindfulness practices, when implemented alongside other wellness practices, had a healing or beneficial effect on the cluster of lived experience called BD. The specific mechanisms of mindfulness practice are unknown, just like many mechanisms of action in psychotherapy, psychology, and medicine. Although the value of these therapeutic disciplines is undeniable, much of life remains a mystery to science. With this in mind, mindfulness practice might be best viewed as one component in a treatment approach that can help promote healthy balance in a complex life system. Human neuropsychology, socialization, and development are complex processes, and mindfulness may help by improving neural integration and reducing both rigidity and chaos (Siegel, 2010). Such benefits may be universal, or at least transdiagnostic; even so, specific guidelines for implementing mindfulness in recovery from BD are helpful. Hopefully the present

results will contribute to the development of best practices for implementing mindfulness in recovery from BD.

Limitations and Delimitations

Qualitative studies investigate a specific group of people, and these findings are not meant to be statistically generalizable. This study's findings may be easier to translate to populations similar to this sample, which was predominantly white, North American, and middle-class. Future research could test a treatment protocol using quantitative or mixed methods and investigate its usefulness for culturally diverse groups.

I tried to bracket my assumptions during interviews, coding, and analysis, and I wrote the interview guide to learn more about the various strategies participants used in their recoveries, not just mindfulness practice. My position from the outset of this study was that people can use mindfulness in their recovery from BD, and that presumption was confirmed—in fact, recruitment criteria selected only for those who were able to support this assumption. This study did not gather disconfirming evidence, such as by interviewing people who have not used mindfulness in their recovery, or who attempted to do so, but found it unhelpful. Future research could help clarify for whom such practices are suited. Then again, in real-world settings, service users would hopefully be offered an array of options, and those for whom mindfulness practice is effective could continue to pursue it.

I was surprised to learn about all the intricacies of people's lives, and how they used mindfulness in new ways that were intelligible to me, but also quite different from my experience. Although there is much overlap in participants' accounts, there is also significant divergence. One possible interpretation is that the study did not achieve data saturation. However, the research design did not set out to achieve saturation, and saturation per se is not a sufficient quality marker for all qualitative methods (O'Reilly & Parker, 2013). Rather, I think the divergence among accounts represents the idiosyncratic, personal, and contextualized differences among specific individual

experiences of using mindfulness in recovery from BD. Human lives have universal commonalities such as birth, aging, and death; frequent commonalities such as parenthood and marriage; and uncountable differences; each life is a singular combination of experiences. I hope that these findings indicate both the rich diversity and meaningful commonalities among those who shared about their experience with me.

Future Directions

Future research could investigate best practices in teaching mindfulness to individuals in recovery from BD. A future treatment approach could entail an approach to teaching mindfulness practices, contextualizing them with supportive conceptual frameworks (such as contemplative psychotherapy, Strong, 2019), and integrating mindfulness with other wellness practices. Although not all individuals with BD might respond to such an approach, given the prevalence and severe impacts of BD, a treatment that could promote recovery for only a small percentage of individuals would be of profound benefit. After creating such an approach to recovery, manualizing, empirically evaluating, and optimizing it would be a reasonable program for future research. Finally, multimedia delivery methods (such as books, audio and video recordings, and web-based learning) could expand the reach of a recovery approach. Even so, personalized instruction and social engagement will likely be important to optimize skill implementation and promote program adherence (Murray, 2019). Future research could contribute to the emerging conversation on Buddhist-influenced second-generation MBIs (Van Gordon & Shonin, 2020).

Summary

Nine participants reported using a variety of different mindfulness practices in their recovery from BD. This included sitting meditation, several other contemplative practice, and informal practice in daily life. Participants also discussed ways they implemented practice. Other study results were summarized to contextualize these findings, including the effects of mindfulness practice that participants reported, the other wellness practices

participants used in their recovery, and the Buddhist ideas that helped them apply mindfulness in recovery from BD. Implications of these findings include ways to help clients implement mindfulness practices for recovery from BD and future directions for research.

The diverse practices participants used imply the need for individualized approaches to mindfulness in recovery from BD. Clients need to know that it takes time to find and gain fluency with the different practices that work for them in different states of mind to obtain full benefit. While mindfulness practice can be very beneficial, it is not a panacea, and it needs to be contextualized as one of many wellness strategies for successful recovery. Recovery means different things to different people, and the diverse styles of recovery that participants reported suggest that mindfulness practice can be beneficial across different functional outcomes, stages of BD, and BD subtypes.

To benefit from these approaches, clients need patience, ongoing personalized mindfulness instruction, and clinical support. Future research may serve to expand these findings into a workable treatment approach. This study could inform a second-generation Buddhist-informed MBI that could address the existential and phenomenological aspects of BD recovery, emotion regulation, neurobiological integration, life optimization, trauma recovery, and stress management. I hope these findings will prove fruitful in future lines of research, and that they will support those who wish to recover from BD.

Ethics Approval

Approval was obtained from the Human Research Review Committee of the California Institute of Integral Studies. The procedures used in this study adhere to the tenets of the Declaration of Helsinki.

Conflict of Interest

The author declares that they have no conflict of interest.

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