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Adaptive Lifestyle Strategies Used by Young Adults Living With Bipolar II Disorder

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ABSTRACT

This study aimed to explore the adaptive lifestyle strategies employed by young adults living with Bipolar II Disorder (BD-II) to manage emotional regulation, daily functioning, and mental well-being. A qualitative research design was employed, utilizing semi-structured, in-depth interviews with 18 participants aged 21 to 34, all formally diagnosed with BD-II and residing in Tehran. Participants were recruited using purposive sampling, and interviews continued until theoretical saturation was reached. Data were transcribed verbatim and analyzed using thematic analysis with the assistance of NVivo software. The analytic process followed Braun and Clarke's six-phase framework, allowing for inductive identification of themes grounded in the participants' lived experiences. Three overarching themes emerged from the analysis: Self-Regulation and Emotional Management, Lifestyle Structure and Daily Stability, and Social Connection and Support Systems. Participants employed a variety of personalized strategies, including emotional tracking, mood journaling, sleep regulation, structured routines, physical activity, and selective social engagement. Many participants relied on self-monitoring tools, created crisis response plans, and developed medication adherence routines. Social support was sought through trusted relationships, peer communities, and therapeutic alliances, while selective disclosure was used to navigate stigma. These findings underscore the agency and intentionality of young adults in managing BD-II beyond clinical interventions. Young adults with BD-II actively engage in diverse, context-specific lifestyle strategies to stabilize mood and maintain functional well-being. These strategies reflect a proactive, integrative approach to selfmanagement that complements clinical treatment. Recognizing and supporting these behaviors within therapeutic settings can enhance recovery-oriented care and promote long-term stability for individuals living with BD-II.

Keywords: Bipolar II Disorder; lifestyle strategies; young adults; self-regulation.

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Introduction

Bipolar II Disorder (BD-II) is a chronic psychiatric condition marked by recurrent episodes of depression and hypomania that profoundly affect an individual's emotional regulation, functional capacity, and quality of life (1). While it is often considered less severe than Bipolar I Disorder due to the absence of full-blown manic episodes, BD-II is frequently underdiagnosed and mismanaged, contributing to heightened risks of suicidality, occupational impairment, and interpersonal difficulties (2, 3). Compared to the general



population, individuals with BD-II experience disproportionately high rates of comorbidities, fluctuating mood states, and challenges in self-regulation, all of which necessitate sustained, adaptive coping strategies beyond pharmacological treatment (4, 5).

Emerging research emphasizes that lifestyle-related factors play a critical role in the onset, course, and management of bipolar disorders, particularly in BD-II, where residual symptoms often persist despite medication adherence (6, 7). A growing body of evidence suggests that self-directed lifestyle strategies—such as structured routines, sleep regulation, physical activity, and dietary control—can significantly improve mood stability and functioning (3, 7). These lifestyle interventions are especially crucial for young adults, who face unique psychosocial stressors related to education, employment, and identity formation. During this developmental phase, BD-II can disrupt critical milestones, rendering lifestyle self-management a key component of holistic care (8).

Clinically, BD-II poses diagnostic and therapeutic challenges. The fluctuating course of hypomanic episodes, which are often perceived as periods of productivity and enhanced functioning, leads to delayed help-seeking and inaccurate assessments (9, 10). Furthermore, depressive episodes in BD-II are typically more persistent and disabling than in Bipolar I, yet they may be misclassified as unipolar depression (11, 12). This diagnostic ambiguity often results in treatment regimens that inadequately address the cyclical nature of the disorder. Therefore, individuals are frequently left to develop their own compensatory strategies to navigate the demands of daily life.

Recent scholarship has begun to delineate the biological and psychosocial underpinnings of BD-II, pointing to complex gene-environment interactions, neuroinflammatory processes, and disruptions in circadian regulation (13-15). These findings have laid the groundwork for an integrated biopsychosocial framework in which lifestyle strategies can be conceptualized not merely as adjunctive care but as essential therapeutic modalities. For instance, circadian rhythm disruption has been consistently implicated in the pathophysiology of BD-II, and lifestyle patterns such as erratic sleep, dietary inconsistency, and lack of physical activity can exacerbate this dysregulation (6, 16). Consequently, individuals often adopt self-initiated behavioral strategies to counteract internal instability—strategies that warrant systematic investigation.

Despite this theoretical advancement, relatively few qualitative studies have focused specifically on how young adults with BD-II adaptively manage their condition in real-life contexts. Quantitative designs dominate the literature, often overlooking the nuanced, experiential knowledge individuals use to maintain daily stability. Where lifestyle interventions are addressed, they tend to emphasize clinician-led programs rather than patient-initiated adaptations (3, 7). This gap is particularly salient considering the limitations of traditional treatment frameworks, which can leave patients feeling passive or disempowered in their recovery process (17).

An additional layer of complexity is introduced by the sociocultural context. Cultural beliefs, stigma, and access to mental health resources all shape how individuals perceive and manage BD-II. In non-Western societies, where mental health discourse may still carry significant stigma, young adults may rely more heavily on personal coping mechanisms and less on formal support systems (8). Thus, understanding how lifestyle strategies are culturally constructed and applied in diverse contexts, such as among urban youth in Tehran, offers vital insight for tailoring interventions that resonate with lived experience.

Among the most commonly cited adaptive strategies are emotion regulation practices such as journaling, mindfulness, and creative expression. These methods serve as cognitive-affective tools for managing the intensity and unpredictability of mood states (3, 18). Additionally, structured daily routines—encompassing consistent wake times, meal schedules, and task organization—have been associated with improved sleep patterns and reduced symptom severity (6, 10). Physical exercise, particularly low-to-moderate intensity activity such as walking or yoga, has shown benefits for energy modulation and stress reduction, both critical for maintaining equilibrium in BD-II (6, 7).

Dietary regulation also emerges as a significant theme, with studies reporting that individuals often engage in personalized nutritional strategies to stabilize mood, manage energy, and reduce inflammation (15, 19). While formal dietary protocols have not yet been standardized in BD-II treatment, patient-reported data suggest that low-sugar, anti-inflammatory, or plant-based diets may offer subjective benefits. These insights call attention to the need for individualized care models that integrate such experiential knowledge into clinical practice.

Medication adherence, another cornerstone of BD-II management, is frequently compromised by side effects, lack of insight, or ambivalence toward diagnosis (12, 20). In response, individuals often create personal systems to ensure consistency, such as using alarms, organizing pill boxes, or enlisting family support. These micro-strategies represent a form of self-governance that underscores the agency of young adults in their recovery journey. They also reflect an important counter-narrative to the prevalent assumption that psychiatric recovery is solely contingent on clinician-directed care (8, 9).

Additionally, social support plays a mediating role in how lifestyle strategies are sustained. Supportive relationships with family, peers, and therapists can buffer the psychological burden of BD-II and reinforce positive behavioral patterns (11, 17). However, social environments can also pose risks, especially when individuals are exposed to stigma, invalidation, or interpersonal instability. Therefore, many young adults with BD-II practice selective social engagement, choosing to limit contact with unsupportive individuals and seek connection with those who validate their experiences (3, 5).

The present study builds on this body of knowledge by exploring the adaptive lifestyle strategies employed by young adults with BD-II in Tehran.

Methods and Materials

Study Design and Participants

This study employed a qualitative research design to explore adaptive lifestyle strategies used by young adults living with Bipolar II Disorder. A purposive sampling method was used to recruit participants who could provide rich, first-hand insights into their lived experiences. The inclusion criteria required participants to be between the ages of 20 and 35, have a formal diagnosis of Bipolar II Disorder by a licensed psychiatrist, and reside in Tehran. Individuals experiencing acute manic or depressive episodes at the time of recruitment were excluded to ensure their ability to participate in extended interviews.

A total of 18 participants (10 females and 8 males) took part in the study. Recruitment continued until theoretical saturation was achieved—that is, the point at which no new themes or insights were emerging from subsequent interviews.

Data Collection

Data were collected through in-depth, semi-structured interviews, allowing participants the flexibility to elaborate on their experiences while ensuring consistency in the exploration of key topics. An interview guide was developed based on existing literature and expert consultation, focusing on areas such as daily routines, emotional regulation, social engagement, physical health practices, and strategies for managing symptoms and mood fluctuations.

All interviews were conducted in person in a private setting, ensuring participant confidentiality and comfort. Interviews lasted between 45 to 75 minutes and were audio-recorded with participant consent. Transcriptions were completed verbatim in Persian and subsequently reviewed for accuracy.

Data analysis

Data were analyzed using thematic analysis, guided by Braun and Clarke's six-phase framework. Transcribed interviews were imported into NVivo software (version 12) for coding and thematic organization. Initial codes were generated inductively from the data, and patterns across interviews were examined to identify recurrent themes. A constant comparative approach was used to refine categories and establish the relationships between emerging concepts.

Findings and Results

The study sample consisted of 18 young adults diagnosed with Bipolar II Disorder, ranging in age from 21 to 34 years (M = 27.1). Of the participants, 10 identified as female and 8 as male. All participants were residents of Tehran and had been living with the diagnosis for at least one year at the time of the interview. The duration since diagnosis ranged from 1 to 9 years. Thirteen participants were either employed or self-employed, while five were unemployed at the time of data collection. Regarding educational background, 5 participants held a bachelor's degree, 8 had completed or were pursuing postgraduate education, and 5 had a high school diploma or vocational training. All participants reported being under psychiatric care and were taking mood-stabilizing medications, though five had experienced at least one period of treatment discontinuation in the past.

Category (Theme)	Subcategory (Subtheme)	Concepts (Open Codes)
1. Self-Regulation and Emotional Management	Establishing Emotional Awareness	Recognizing mood shifts, Naming emotions, Identifying triggers, Journaling
	Use of Coping Rituals	Listening to music, Art therapy, Deep breathing, Meditation, Candle lighting
	Managing Sleep-Wake Rhythms	Fixed bedtime, No screen time before bed, Morning sunlight exposure, Limiting caffeine
	Medication Adherence Strategies	Setting reminders, Pill organizers, Doctor follow-up, Family supervision
	Self-Monitoring Techniques	Mood tracking apps, Daily mood journals, Symptom scales, Reviewing past episodes
	Crisis Response Planning	Having an emergency contact, Written crisis plan, Temporary medication adjustment
	Reducing Emotional Triggers	Avoiding news, Conflict avoidance, Reducing alcohol, Limiting overwhelming social events
2. Lifestyle Structure and Daily Stability	Creating Routine and Structure	Scheduled meals, Time-blocking, Habit tracking, Consistent wake time
	Physical Activity Habits	Regular walking, Yoga, Home workouts, Fitness groups

Гable 1. Themes, Subthemes	, and Concepts from	Qualitative Analysis
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	Diet and Nutritional Choices	Avoiding sugar, Regular meals, Plant-based meals, Hydration reminders
	Digital Media Boundaries	Screen time limits, No phone in bedroom, Unfollowing stressful accounts
	Productive Use of Time	Creative projects, Volunteering, Reading, Learning new skills
	Financial Self-Regulation	Budget planning, Avoiding impulsive spending, Tracking expenses, Seeking financial advice
3. Social Connection and Support Systems	Selective Social Engagement	Limiting contact with toxic people, Choosing empathetic friends, Social media boundaries
	Peer Support and Shared Experience	Support groups, Talking to others with bipolar disorder, Online forums
	Family Involvement	Family education, Emotional support, Monitoring for signs, Shared routines
	Disclosure and Identity Management	Selective disclosure, Rehearsing how to tell others, Anticipating reactions
	Therapist-Patient Relationship	Trust in therapist, Regular sessions, Feeling understood, Collaborative goal setting

The analysis of interview data with 18 young adults living with Bipolar II Disorder yielded three overarching themes: (1) Self-Regulation and Emotional Management, (2) Lifestyle Structure and Daily Stability, and (3) Social Connection and Support Systems. Each theme comprised several subcategories that reflect the participants' adaptive strategies for navigating daily life with the condition.

1. Self-Regulation and Emotional Management

Establishing Emotional Awareness was described as a foundational strategy. Participants emphasized the importance of recognizing early emotional changes and understanding their internal states. Common practices included identifying emotional triggers, labeling feelings, and reflective journaling. One participant shared, *"I try to catch it early—when I feel that tightness in my chest or sudden irritation, I stop and think: What's going on here?"* This awareness often served as a preventive measure against mood escalation.

In **Use of Coping Rituals**, individuals relied on personalized sensory or calming activities to regain emotional balance. These rituals included listening to soothing music, lighting candles, engaging in meditation, and drawing or painting. A participant reflected, *"When I feel I'm spiraling, I put on instrumental music and light a candle—it slows me down."* Such rituals were seen not only as soothing but also as symbolic acts of self-care.

Managing Sleep-Wake Rhythms emerged as a critical pillar in participants' self-management. Most reported maintaining strict sleep schedules, avoiding digital screens before bedtime, and exposing themselves to natural light in the morning. Disrupted sleep was consistently linked with symptom flare-ups. As one respondent noted, *"If I stay up past midnight for a few nights, I can already feel my moods start to shift—it's dangerous."*

Participants demonstrated various **Medication Adherence Strategies** to ensure consistency. Techniques included using mobile reminders, pill organizers, and involving family members in medication supervision. Some framed this adherence as non-negotiable: *"I don't argue with my meds anymore—it's like brushing my teeth. It has to happen every day."*

In **Self-Monitoring Techniques**, many used apps and journals to track mood fluctuations, energy levels, and behaviors. These tools allowed them to detect patterns and intervene early. One participant explained, *"I use a color-coded mood tracker. If I see too many red days, I know I need to adjust something."* Such practices helped individuals externalize and make sense of their inner experiences.

Crisis Response Planning involved developing proactive systems for moments of acute distress. Strategies included creating written crisis plans, identifying emergency contacts, and discussing potential medication adjustments with healthcare providers in advance. One interviewee shared, "*My therapist and I made a crisis plan that's taped inside my closet. It reminds me I'm not helpless.*"

Lastly, **Reducing Emotional Triggers** entailed deliberate lifestyle choices, such as avoiding conflict, reducing alcohol consumption, and minimizing exposure to distressing media. As one participant articulated, *"I don't watch the news anymore. It makes my anxiety worse, and it's not worth it."*

2. Lifestyle Structure and Daily Stability

Creating Routine and Structure was widely described as a stabilizing force. Participants adhered to structured daily plans, including consistent meal times, wake-up routines, and scheduled rest periods. A participant shared, *"If I let go of my routine, everything else falls apart. Structure keeps me grounded."*

Physical Activity Habits such as walking, yoga, and home-based workouts were noted as effective for mood stabilization and energy regulation. These activities were often chosen for their accessibility and calming effects. One individual noted, *"I walk every evening—it helps my body relax and my mind slow down."*

Regarding **Diet and Nutritional Choices**, many participants reported avoiding sugar and processed foods, maintaining hydration, and opting for plant-based or balanced diets. These choices were linked with improved mood stability. One person commented, *"I've noticed when I eat clean, I feel cleaner inside—less fog, more control."*

Digital Media Boundaries were also key. Participants limited screen time, especially before bed, and avoided emotionally provocative content online. They also unfollowed accounts that triggered comparison or anxiety. One participant explained, *"Social media used to make me feel like I was falling behind. Now I just mute most people."*

In terms of **Productive Use of Time**, many engaged in creative or meaningful activities such as writing, painting, volunteering, or learning new skills. These pursuits served as both distraction and empowerment. A participant shared, *"When I'm focused on learning something new, I feel like I have a purpose—it keeps my mind from racing."*

Financial Self-Regulation was a less commonly discussed but significant strategy. Some participants mentioned setting budgets, avoiding impulsive spending, and seeking financial advice when necessary. One participant admitted, *"I used to spend a lot during hypomanic phases. Now I freeze my cards when I feel the urge coming."*

3. Social Connection and Support Systems

Selective Social Engagement was practiced to preserve emotional energy. Participants described intentionally distancing themselves from toxic or energy-draining individuals and choosing friends who were empathetic and understanding. As one participant shared, *"I don't go out just to socialize anymore. I choose people who make me feel safe."*

Peer Support and Shared Experience played an important role. Many sought out others with lived experience through support groups or online communities. This peer validation helped reduce feelings of isolation. One participant said, *"Talking to someone who gets it—that's priceless. They don't try to fix you."*

Family Involvement varied, but those with supportive families reported positive impacts. Family members helped monitor symptoms, supported routines, and provided emotional grounding. As one noted, *"My sister knows my signs better than I do. She's my checkpoint."*

Disclosure and Identity Management involved complex decisions about when and how to disclose their diagnosis. Participants carefully navigated these disclosures based on trust and perceived safety. One participant said, *"I don't tell everyone. I test the waters first—it's part of protecting myself."*

Lastly, **Therapist-Patient Relationship** was repeatedly described as essential. A trusting, consistent relationship with a therapist allowed for emotional processing, goal setting, and long-term strategy development. One participant noted, *"My therapist helps me connect the dots—I don't just vent, I grow."*

Discussion and Conclusion

The current study explored the adaptive lifestyle strategies employed by young adults living with Bipolar II Disorder (BD-II) in Tehran. Through thematic analysis of semi-structured interviews with 18 participants, three overarching themes emerged: *Self-Regulation and Emotional Management, Lifestyle Structure and Daily Stability*, and *Social Connection and Support Systems*. These findings offer rich insight into how individuals manage the complexities of BD-II beyond clinical treatment, emphasizing personalized, intentional strategies to achieve emotional stability, functional independence, and overall well-being.

A core finding of the study was the widespread use of *self-regulation and emotional awareness techniques* among participants. Practices such as journaling, mood tracking, and naming emotional states were identified as foundational tools for early detection of mood shifts. These strategies align with previous research highlighting the importance of insight and emotional literacy in managing BD-II (20). Similar to Sylvia et al.'s findings on lifestyle intervention feasibility, participants in this study emphasized how proactive emotional monitoring enabled timely behavioral adjustments and reduced the likelihood of relapse (3). Moreover, the regular use of personalized coping rituals—such as listening to calming music or engaging in creative expression—underscored how non-pharmacological techniques function as supplementary mechanisms to reduce emotional intensity. This is consistent with cognitive-behavioral approaches that emphasize the utility of emotion regulation tools during depressive episodes in BD-II (18).

Another significant theme was the role of *structured routines in maintaining daily stability*. Participants repeatedly emphasized the value of sleep hygiene, consistent wake times, and time-blocked schedules to counteract internal chaos. These findings are strongly supported by the literature, as disruptions in circadian rhythm and irregular daily patterns are widely associated with mood destabilization in bipolar disorders (6, 16). Several participants reported that erratic sleep or inconsistent routines triggered hypomanic or depressive episodes—echoing research by Gao, which identified behavioral rhythm disruptions as a modifiable risk factor in BD-II (9). Moreover, these findings reinforce the biological foundation of BD-II, where circadian misalignment and neural dysregulation play central roles in symptom expression (13, 14). Thus, lifestyle structure acts not merely as a behavioral preference but as a protective regulatory mechanism grounded in neurobiological evidence.

Consistent with broader lifestyle psychiatry findings, this study revealed that *diet and physical activity* were actively managed by participants as self-directed mood stabilizers. Most avoided sugar, processed foods, and alcohol while promoting hydration and plant-based diets, echoing the epigenetic links between

metabolic regulation and mood disorders proposed by Kesebir (15). In line with Arora's findings on lifestyle and biochemical health, dietary patterns were often chosen not only for physical benefits but also as a way to reduce inflammation and cognitive fog associated with BD-II (19). Physical activity, particularly lowintensity movement like walking and yoga, was used to manage restlessness, regulate energy, and mitigate emotional dysregulation. These strategies mirror previous reports by Lopresti and Drummond, who found that structured exercise contributes to neuroprogression moderation in bipolar spectrum disorders (6). Collectively, these patterns highlight the biopsychosocial interface through which daily behavior mediates symptom expression and emotional functioning.

A prominent and nuanced area of self-management was *medication adherence strategies*. Although all participants were under pharmacological treatment, many developed customized adherence systems involving pill organizers, phone alarms, and family oversight. This finding aligns with previous studies demonstrating that personal systems of medication adherence can significantly reduce relapse and hospitalization rates (5, 12). Yet, participants also expressed ambivalence about long-term medication use due to side effects and stigma, underscoring the importance of psychological ownership in treatment adherence (1). These attitudes highlight the essential role of psychoeducation and patient-provider collaboration, both of which are strongly supported by Sylvia's findings on intervention acceptability (3).

Participants also emphasized *crisis planning and trigger reduction*, revealing a proactive approach to relapse prevention. These included written crisis plans, emergency contact lists, and lifestyle modifications to avoid emotional triggers such as media exposure or toxic relationships. Such strategies illustrate a shift toward anticipatory care and echo the work of Parker et al. in advocating for more refined diagnostic and management criteria that account for patient-led stabilization efforts (12). Moreover, these findings mirror insights from the AREDOC project, which advocates for broader, more integrative definitions of bipolar disorders that encompass self-management behaviors and lived experience (10).

Importantly, the theme of *social connection and support systems* revealed that participants engaged in strategic social filtering to maintain psychological balance. Many described limiting contact with emotionally draining individuals and instead investing in relationships marked by empathy and understanding. This selective social engagement parallels findings by Suhaff, who identified that social dynamics can either buffer or intensify bipolar symptoms depending on quality and trust (4). Participants who had access to peer support or therapeutic alliances reported higher levels of emotional containment and a greater sense of agency in managing their illness. These observations are supported by Spelber's analysis of COVID-19's impact on mental health, which highlighted the pivotal role of supportive networks during periods of increased stress and isolation (17).

Interestingly, some participants practiced *selective disclosure* of their diagnosis, navigating identity and stigma in careful, deliberate ways. This theme has received relatively little attention in BD-II literature but is consistent with Youssef's recommendations for managing bipolar depression in primary care contexts, where trust and patient comfort play crucial roles in disclosure and diagnosis continuity (11). In a sociocultural context such as Tehran—where stigma around psychiatric conditions remains strong—selective disclosure becomes both a safety strategy and a means of maintaining autonomy.

Therapeutic relationships emerged as a critical source of support, validation, and continuity. Participants who maintained long-term relationships with therapists described these alliances as emotionally stabilizing

and directive. This finding supports earlier calls by Mahini and colleagues for a broader focus on psychosocial interventions in BD-II care that promote individualized understanding and emotional scaffolding (8). Therapeutic consistency not only helped manage symptoms but also allowed participants to develop personal goals and insights into behavioral patterns, echoing the emphasis on recovery-oriented models in contemporary psychiatric practice (2).

Taken together, the findings from this study reflect a multi-dimensional approach to lifestyle management in BD-II. Participants did not rely on any single intervention but instead combined emotional, behavioral, relational, and physical strategies into a dynamic self-care system. This integrative approach aligns with emerging views in bipolar disorder management that advocate for personalized, holistic care models blending medication, psychotherapy, and everyday behavior modification (3, 7). The results strongly reinforce the idea that young adults with BD-II are not passive recipients of care but active agents in their stabilization and recovery, often compensating for gaps in formal support systems through personalized strategies that are both practical and emotionally resonant.

This study, while rich in detail, is limited by its sample size and demographic scope. All participants were from Tehran, which may constrain the transferability of findings to other cultural or socioeconomic contexts. Additionally, the reliance on self-reported data introduces the possibility of recall bias or social desirability effects. The study also did not include participants during acute manic or depressive episodes, meaning the insights represent the perspectives of relatively stable individuals and may not capture the full spectrum of coping during crisis phases.

Future studies should investigate how adaptive lifestyle strategies evolve over time, particularly during periods of relapse or acute symptomatology. Longitudinal qualitative or mixed-methods research could provide valuable insight into the dynamic nature of self-management across the illness trajectory. It would also be beneficial to explore differences across gender, socioeconomic status, and cultural backgrounds to understand how intersectional factors influence lifestyle adaptation. Further investigation into the role of digital tools, such as mobile health apps for mood tracking or routine scheduling, could offer practical advancements in BD-II care.

Mental health practitioners should integrate lifestyle assessment and support into standard care protocols for BD-II, particularly for young adults. Clinicians can enhance treatment outcomes by validating patientinitiated coping strategies and co-developing personalized behavioral plans that align with individuals' lived experiences. Psychoeducation programs should emphasize the importance of sleep hygiene, diet, physical activity, and emotional monitoring, while also addressing stigma and disclosure. Lastly, fostering strong therapeutic relationships and encouraging peer support can serve as protective factors that enhance engagement and resilience throughout the recovery process.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants. Written consent was obtained from all participants in the study.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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References

1. Dunner DL. Personal Recollections About the Development of Bipolar II Disorder. Taiwanese Journal of Psychiatry. 2023;37(1):8-13. doi: 10.4103/tpsy.tpsy_1_23.

2. Brancati GE, Nunes A, Scott K, O'Donovan C, Cervantes P, Grof P, et al. Differential Characteristics of Bipolar I and II Disorders: A Retrospective, Cross-Sectional Evaluation of Clinical Features, Illness Course, and Response to Treatment. International Journal of Bipolar Disorders. 2023;11(1). doi: 10.1186/s40345-023-00304-9.

3. Sylvia LG, Janos J, Pegg S, Dufour S, Chang WC, Bernstein EE, et al. Feasibility and Acceptability of a Lifestyle Intervention for Individuals With Bipolar Disorder. Journal of Psychiatric Practice. 2019;25(6):451-60. doi: 10.1097/pra.00000000000426.

4. Suhaff AA. Psychiatric and Medical Comorbidities inpatients With Bipolar Disorder: A Hospital Based Study. Scholarly Journal of Psychology and Behavioral Sciences. 2019;2(3). doi: 10.32474/sjpbs.2019.02.000136.

5. Preuss UW, Hesselbrock MN, Hesselbrock V. A Prospective Comparison of Bipolar I and II Subjects With and Without Comorbid Alcohol Dependence From the COGA Dataset. Frontiers in Psychiatry. 2020;11. doi: 10.3389/fpsyt.2020.522228.

6. Lopresti AL, Drummond PD. Lifestyle and Neuroprogression: Diet, Sleep, and Exercise. 2019:207-22. doi: 10.1093/med/9780198787143.003.0013.

7. Moussa AAE, Harfush SAE, Tawfik A. Effectiveness of Lifestyle Intervention on Recovery of Patients With Bipolar Disorders. Tanta Scientific Nursing Journal. 2023;30(3):26-47. doi: 10.21608/tsnj.2023.315134.

8. Mahini EA, Hosseyni SA, Ebrahimkhani M, Mohammadi M, Shokri S. Bipolar Disorder and Its Factors. Advances in Social Sciences Research Journal. 2024;11(9):01-11. doi: 10.14738/assrj.119.17524.

9. Gao Y. Bipolar Disorder: A Comprehensive Analysis of Its Etiology, Impact, and Treatment Options. Hc. 2024;1(8). doi: 10.61173/8q7k9824.

10. Parker G, Spoelma MJ, Tavella G. The AREDOC Project and Its Implications for the Definition and Measurement of the Bipolar Disorders: A Summary Report. Australian & New Zealand Journal of Psychiatry. 2022;56(11):1389-97. doi: 10.1177/00048674221103478.

11. Youssef NA. A Primary Care Guide to Bipolar Depression Treatment. 2020;69(7). doi: 10.12788/jfp.0043.

 Parker G, Tavella G, Ricciardi T, Hadži-Pavlović D, Alda M, Hájek T, et al. Refined Diagnostic Criteria for the Bipolar Disorders: Phase Two of the AREDOC Project. Acta Psychiatrica Scandinavica. 2020;142(3):193-202. doi: 10.1111/acps.13218.
Kao C-F, Chen HW, Chen HC, Yang J-H, Huang MC, Chiu Y-H, et al. Identification of Susceptible Loci and Enriched

Pathways for Bipolar II Disorder Using Genome-Wide Association Studies. The International Journal of Neuropsychopharmacology. 2016;19(12):pyw064. doi: 10.1093/ijnp/pyw064.

14. Wang TY, Lee S-Y, Chen SL, Chung Y-L, Li CL, Chang YH, et al. The Differential Levels of Inflammatory Cytokines and BDNF Among Bipolar Spectrum Disorders. The International Journal of Neuropsychopharmacology. 2016;19(8):pyw012. doi: 10.1093/ijnp/pyw012.

15. Kesebir S. Epigenetics of Metabolic Syndrome as a Mood Disorder. Journal of Clinical Medicine Research. 2018;10(6):453-60. doi: 10.14740/jocmr3389w.

16. Faurholt-Jepsen M, Frost M, Busk J, Christensen EM, Bardram JE, Vinberg M, et al. Differences in Mood Instability in Patients With Bipolar Disorder Type I and II: A Smartphone-Based Study. International Journal of Bipolar Disorders. 2019;7(1). doi: 10.1186/s40345-019-0141-4.

17. Spelber D, Strakowski SM. Expert Opinion in Bipolar Disorder: Impact of COVID-19 on Outcomes and Treatment of Bipolar Disorder. Personalized Medicine in Psychiatry. 2021;27-28:100074. doi: 10.1016/j.pmip.2021.100074.

18. Kimura Y, Hamatani S, Matsumoto K, Shimizu E. Cognitive Behavioral Therapy for Three Patients With Bipolar II Disorder During Depressive Episodes. Case Reports in Psychiatry. 2020;2020:1-9. doi: 10.1155/2020/3892024.

19. Arora S, Katyal A. Protein Modifications and Lifestyle Disorders. 2019:87-108. doi: 10.1016/b978-0-12-811913-6.00004-7.

20. Büchmann CB, Pedersen G, Aminoff SR, Laskemoen JF, Barrett EA, Melle I, et al. Validity of the Birchwood Insight Scale in Patients With Schizophrenia Spectrum- And Bipolar Disorders. Psychiatry Research. 2019;272:715-22. doi: 10.1016/j.psychres.2018.12.072.