


Personal recovery in psychological interventions for bipolar disorder: a systematic review

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ABSTRACT

Objective: Psychological interventions comprise a critical aspect of treatment for bipolar disorder. However, many interventions to date have focussed on clinical recovery outcomes, such as relapse prevention, rather than preferred personal recovery outcomes of hope and a meaningful life. The aim of this review was to identify, appraise and synthesise information regarding the availability, content and efficacy of recovery-oriented psychological interventions for individuals with bipolar disorder.

Methods: A systematic review was conducted using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA). Databases searched included PubMed, EMBASE, PsychINFO, CINAHL and SCOPUS. The inclusion criteria were studies that assessed a psychological intervention in participants with a diagnosis of bipolar disorder and assessed personal recovery outcomes either qualitatively or quantitatively.

Results: Five articles were included from the titles assessed (N = 507). All studies (N = 5) employed recovery-focussed interventions based on principles of Cognitive Behaviour Therapy (CBT) and were quantitative designs. Two studies used online, self-paced interventions, two studies used group psychoeducation programs, and one study used individual manualised therapy. All studies found a significant improvement in personal recovery. No studies assessed personal recovery outcomes qualitatively.

Conclusions: Whilst data is limited, initial evidence suggests that recovery-oriented interventions may be effective in improving personal recovery in people living with bipolar disorder. Limitation of this review include a focus on those studies that assessed personal recovery. Clinicians should consider personal recovery-orientated interventions in the treatment of bipolar disorder and further assess recovery outcomes as part of practice.

KEY POINTS

What is already known about this topic:

- (1) Recovery-orientated programs may be helpful for people living with a mental illness.
- (2) Benefits have been found in mixed psychiatric samples in a range of studies.
- (3) Peer led recovery programs may also assist manage symptoms and relapse in general samples.

What this topic adds:

- (1) There is growing interest in developing recovery interventions for bipolar disorder specifically.
- (2) This review noted that CBT studies assessing recovery outcomes found improvements.
- (3) Therapists should consider the use of recovery-focussed approaches in the treatment of bipolar disorder.

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Introduction

Bipolar disorders are chronic psychiatric disorder characterised by recurrent episodes of depression and mania or hypomania (Müller-Oerlinghausen et al., 2002). The lifetime prevalence of bipolar disorder is estimated around 1% globally (Merikangas et al., 2011) and is associated with significant disability and notably high suicidal behaviours, with approximately one-third of affected individuals attempting suicide at

least once across the lifetime (Müller-Oerlinghausen et al., 2002). There are two key subtypes of bipolar disorder – Bipolar I and Bipolar II disorder. Bipolar I disorder is diagnosed by the presence of a lifetime manic episode, whilst those living with Bipolar II disorder experience hypo/mania episodes (American Psychiatric Association [APA], 2013).

Ideally, treatment of bipolar disorder focusses initially on stabilisation of mood and acute symptom

reduction, followed by a maintenance phase, which includes relapse prevention and enhancement of social and occupational functioning (Geddes & Miklowitz, 2013). Pharmacological interventions are considered the first-line treatment for bipolar disorder, particularly for the initial stabilisation phase of treatment, with Lithium and antipsychotic medications the most commonly prescribed (Geddes & Miklowitz, 2013). However, as Geddes and Miklowitz (2013) discuss, more recent advances in pharmacological treatments have been hampered by a limited understanding of underlying biological and neural disease mechanisms, and consequently, a lack of specific pharmacological targets. Thus, attention has turned to adjunctive psychosocial interventions (Geddes & Miklowitz, 2013; Miklowitz et al., 2021).

According to Geddes and Miklowitz (2013), primary objectives of psychosocial interventions for bipolar disorder include increasing understanding of the illness, improving ability to identify warning signs of recurrence, providing strategies for early intervention, promoting medication adherence, and enhancing ability to develop and maintain regular healthy lifestyle habits, including managing sleep, exercise, stress, and substance use, to reduce recurrence of mood episodes. A number of studies have systematically reviewed the effectiveness of adjunctive psychosocial interventions for bipolar disorder (Beynon et al., 2008; Fountoulakis & Vieta, 2008; Miklowitz et al., 2021; Miziou et al., 2015; Oud et al., 2016). Although findings show some variability, there is consensus that adjunctive group and individual psycho-educative interventions, cognitive-behavioural therapy (CBT), interpersonal social rhythm therapy (IPSRT) and family-focussed therapy (FFT) are superior to medication alone in stabilising symptoms and reducing recurrences (Beynon et al., 2008; Fountoulakis & Vieta, 2008; Geddes & Miklowitz, 2013; Miklowitz et al., 2021; Miziou et al., 2015; Oud et al., 2016).

The outcome measures used in these reviews included frequency and duration of illness episode recurrence, symptom severity, suicide rates, hospitalisation rates, and study attrition (Beynon et al., 2008; Fountoulakis & Vieta, 2008; Geddes & Miklowitz, 2013; Miklowitz et al., 2021; Miziou et al., 2015; Oud et al., 2016). These outcomes are objective and quantifiable, and whilst empirical value comes from the objectivity of these measures, they do not capture the subjective lived experience of those individuals with bipolar disorder who engage in these interventions (Mezes et al., 2021). In this way, the evaluation of psychosocial interventions for bipolar to date has aligned predominantly with the principles of clinical recovery, rather than the

principles of personal recovery (Leitan et al., 2015; Murray et al., 2017).

Clinical recovery is a traditional, biomedical conceptualisation of outcomes of mental illness treatment, which emphasises objective symptom reduction and relapse prevention (Mezes et al., 2021). Contrastingly, personal recovery is a client-centred approach to mental illness treatment and refers to the process of individual psychological adaptation to a disorder, rather than outcomes of symptom reduction or relapse prevention, for example (Leitan et al., 2015). Personal recovery is defined as “a deeply personal, unique process of changing ones’ attitudes, values, feelings, goals, skills, and roles . . . a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness” (p.15; Anthony, 1993). The CHIME model of personal recovery has been widely adopted as a framework to conceptualise personal recovery in mental health, and includes five key components: Connectedness, Hope and optimism about the future, Identity, Meaning in life, and Empowerment (Kraiss et al., 2021; Leamy et al., 2011; Mezes et al., 2021; Shanks et al., 2013). Recently, the POETIC adaptation for bipolar disorder has been proposed. This model includes “tensions” and further, allows for the recovery process to include both negative and positive experiences in bipolar disorder (Jagfeld et al., 2021). Tensions acknowledges ambivalence around hypo/mania and also balancing acceptance with ambitions.

Mezes et al. (2021) discuss that whilst aspects of clinical recovery and personal recovery may overlap, clinical recovery may not be the only measure of the effectiveness of mental health interventions. Furthermore, consumers, including those with living with bipolar disorder, have expressed dissatisfaction with clinical targets and indicated that personal recovery outcomes are of greater value and importance to them (Jones et al., 2013; Kraiss et al., 2021; Mead & Copeland, 2000). Additionally, a recovery-focussed perspective has been suggested to improve consumer empowerment and self-efficacy, improve social and functional outcomes, reduce burden on healthcare systems and reduce economic costs (Jones et al., 2013; Todd et al., 2012). For these reasons, a personal recovery-oriented model has rapidly been adopted in mental health policies and guidelines worldwide (Murray et al., 2017), requiring services to focus on personally meaningful outcomes, as highlighted by service users, as the express goal of treatment, rather than clinical outcomes alone (Mezes et al., 2021; Murray et al., 2017).

Personal recovery has been suggested to be particularly important for those living with bipolar disorder

given the chronic and irregular nature of the illness, and its significant negative impact on personal, social and occupational functioning (Todd et al., 2012). Here, fluctuation in presenting symptoms and relapses in mood episodes can be frequent, and thus clinical outcomes of symptom reduction and relapse prevention can be less meaningful than personal recovery outcomes, for example, a fulfilling life and positive identity (Todd et al., 2012; Tse et al., 2014). In addition, research indicates that individuals with bipolar who have significant residual clinical symptoms can achieve high levels of personal functioning and recovery, and vice versa (Murray & Michalak, 2007). Thus, a focus on symptomatic recovery is likely to misrepresent treatment goals and outcomes in people living with bipolar disorder (Kraiss et al., 2021).

With an increased focus on personal recovery in mental health policy and research comes increased development of recovery-oriented interventions and treatments for mental illness, which are designed to align with theoretical frameworks of personal recovery (e.g., CHIME; Leamy et al., 2011) and achieve outcomes relevant to this framework (Winsper et al., 2020), with promising initial evidence in schizophrenia and other serious mental illnesses (Nowak et al., 2016). Previous research has found that recovery-orientated intervention may improve outcomes by providing information and skills, promoting a working alliance, role modelling recovery and increasing choice (Winsper et al., 2020). Further, recovery-orientated interventions in bipolar disorder may address issues noted in qualitative research, where participants living with bipolar disorder report that interventions address symptoms rather than areas of distress (Warwick et al., 2019).

However, despite the evident importance of personal recovery in bipolar disorder, and the crucial role of psychological intervention in bipolar treatment, it is unclear if recovery-oriented psychotherapeutic interventions for bipolar disorder specifically have been conducted, or if they are effective. Prior systematic reviews have assessed personal recovery domains and meanings qualitatively for those with psychosis (Soundy et al., 2015; Wood & Alsawy, 2018), and further assessed mental health services use of recovery (Williams et al., 2012), however, no reviews have assessed the use of recovery-orientated interventions specifically for bipolar disorder.

This paper aimed to conduct a systematic review of the literature to identify, appraise and synthesise information regarding the availability, content and efficacy of recovery-oriented psychological interventions for individuals living with bipolar disorder.

Method

This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher et al., 2009). The protocol is registered with PROSPERO and is available online (CRD42021255240).

Preliminary searches were conducted on relevant search terms to determine relevant search terms and keywords along with relevant databases. Citation tracking and reference list screening were used in the preliminary searches to assist in identifying relevant keywords and search terms. Using PICO (Population, Intervention, Comparison, Outcome) the population was participants living with bipolar disorder; the intervention was any intervention that was recovery-orientated, the comparison was any comparison group or none and the outcome considered was personal recovery. Preliminary searches did not produce any results earlier than 1980 related to personal recovery. PubMed, EMBASE, PsychINFO, CINAHL and SCOPUS were identified as key relevant databases in the preliminary searches.

Search strategy

A literature search was conducted using the following databases: PubMed, EMBASE, PsychINFO, CINAHL and SCOPUS. Relevant search terms associated with the research question were combined using Boolean operators as follows: (“bipolar disorder” OR “bipolar” OR “mental illness” OR “mental health”) AND “personal recovery”.

Inclusion and exclusion criteria

The inclusion criteria for this review were: (1) participants diagnosed with bipolar disorder (any type); (2) any type of psychological intervention conducted; (3) personal recovery assessed using quantitative or qualitative methods either via an interview or a structured instrument that assessed personal recovery (4) peer-reviewed empirical design, including any quantitative or qualitative studies, cross-sectional, longitudinal or case studies; (5) published between 1980 and April 2021; and (6) available in English. Studies were excluded if they were animal studies, review papers, discussion papers, or conference presentations, or did not meet inclusion criteria.

Study selection

Articles were assessed for inclusion at title and abstract and full-text screening. Articles were screened independently at each stage by two reviewers, JH and TP, and conflicts were resolved with discussion. Covidence systematic review software (covidence.org) was used to manage screening and data extraction. Raters were blind to the decision of the other rater when conducting the screening.

Titles and abstracts were selected for inclusion included the words bipolar OR mental illness OR mental health OR depression OR affective disorder OR mood disorder AND treatment OR intervention OR program OR group OR randomised control trial OR recovery. Abstract screening included studies that indicated that the article was an empirical study, written in English, with a human, adult sample, that referred to a psychological intervention and personal recovery.

Full-text screening included selected for data extraction which indicated participants with a diagnosis of bipolar disorder, a recovery-oriented psychological intervention conducted, and personal recovery was formally assessed as an outcome through either a structured instrument assessing personal recovery or a specified personal recovery domain, or through a qualitative interview designed to assess recovery. Articles that were excluded included those that had participants of mixed diagnoses, and did not report outcomes separately by diagnosis, a psychological intervention was not conducted, or the full text English article was not available. Recovery-oriented interventions were defined as those that made reference to personal recovery specifically in their description, content, or aims.

Data extraction

The data extracted from the full text included: authors and study location, publication year, mean age of sample, total sample size, gender of sample, BD type, type of study, measures used to confirm BD diagnoses, medication status of participants, participant recruitment source, comorbid psychological conditions in the sample, primary and additional outcome measures, type and duration of intervention, components and content of intervention, delivery method of intervention, intervention completion rates and feasibility, and baseline, post-treatment and follow-up scores on primary and additional outcome measures. Data extraction was undertaken by JH and checked by TP. Data was tabulated in Microsoft Word.

Quality assessment

Johanna Briggs Institute (JBI; Aromataris & Munn, 2020) critical appraisal tools were used to assess the quality of included studies. These were chosen as the tools cover a range of potential study types to be assessed. Quality assessment was performed by two reviewers independently with the second rater blinded to the first raters assessment and discrepancies resolved through discussion. Studies were assessed according to their selection and comparison of study groups, outcome measurement and analysis, and methodological and theoretical rigour.

The JBI Critical Appraisal Checklist for Quasi-Experimental Studies was used for three studies (Enrique et al., 2020; Jones et al., 2018; Richardson & White, 2019), and the JBI Critical Appraisal Checklist for Randomised Controlled Trials was used for the remaining two studies (Jones et al., 2015; Todd et al., 2014). Adherence to checklist items ranged between 77% and 89% for all studies, indicating sufficient quality across all measures of quality and a low risk of bias. Interrater reliability was $\kappa = .839$.

Data analysis

A narrative (descriptive) synthesis of the findings from the included studies was tabulated in excel. Reference was made to type and duration of intervention, components and content of intervention, delivery method of intervention and intervention completion rates. Data was assessed in aggregate form to determine if it was appropriate to conduct a quantitative meta-analysis. Due to the small number of articles identified a meta-analysis was not to be conducted.

Results

The initial search yielded 1926 studies from all databases combined. After 1419 duplicates were removed, 507 articles remained. At the title and abstract screening stage, 477 studies were removed as they did not meet inclusion criteria, leaving 30 studies for full-text screening. At the full-text screening stage, 25 articles were removed as they did not meet inclusion criteria. The most common reason for exclusion was a mixed-diagnosis sample of participants that included individuals with bipolar disorder but did not report outcome data separately by diagnosis ($N = 21$). Other reasons for exclusion included non-empirical studies or study protocols, non-psychological intervention, or full text unavailable. Five articles were included for data extraction. See [Figure 1](#) for a flow diagram of the study selection process, as recommended by PRISMA guidelines

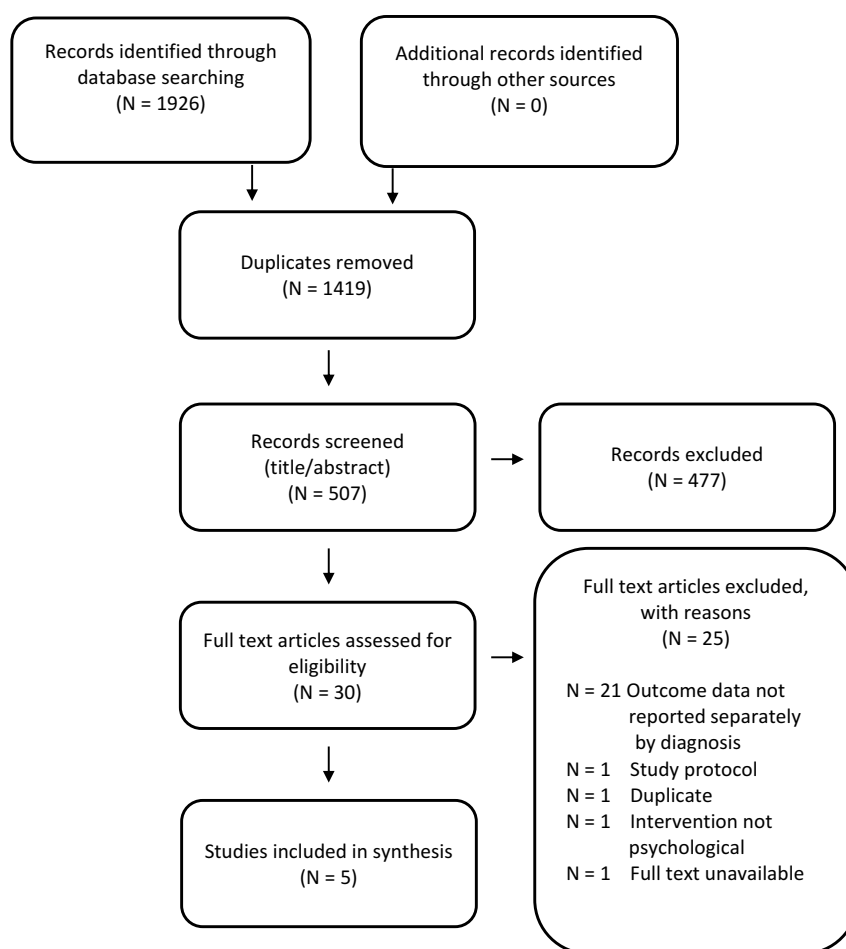


Figure 1. PRISMA flowchart.

(Moher et al., 2009). No qualitative studies were identified.

Two studies utilised a randomised-controlled trial (RCT) design. The remaining three studies utilised a non-randomised within-groups pre/post-treatment design. Characteristics of the studies are presented in Table 1. All studies recruited participants who had already received a bipolar disorder diagnosis (inpatient or outpatient), with only one study recruiting more broadly online (Todd et al., 2014). One study used a self-reported screening measure, the Mood Disorders Questionnaire (MDQ), to confirm bipolar diagnosis (Todd et al., 2014), one used a semi-structured interview (Jones et al., 2015), whilst others used psychiatric records (Enrique et al., 2020), clinical interview (Jones et al., 2018), or relied on participant self-report (Richardson & White, 2019). All studies reported personal recovery as their primary outcome except Todd et al. (2014), which reported quality of life as primary. Outcome measures, including secondary outcomes, utilised in each study are presented in Table 1.

Two interventions were delivered as online self-paced interventions (Enrique et al., 2020; Todd et al., 2014), two were delivered in face-to-face weekly groups (Jones et al., 2018; Richardson & White, 2019), and one was delivered via individual face-to-face therapy sessions (Jones et al., 2015). The format, content and completion rates of interventions in each of the included studies are described below.

Online interventions

Two studies explored online interventions delivered using a webpage interface. One study conducted was an RCT study comparing participants to a waitlist control (Todd et al., 2014), and the other was a pilot study (Enrique et al., 2020). For the pilot study, only recovery scores reduced (Enrique et al., 2020). For the RCT study, improvements were noted in several areas, such as recovery, quality of life, wellbeing, mood and social functioning (Todd et al., 2014).

Both online interventions (Enrique et al., 2020; Todd et al., 2014) had limited acceptability overall, with poor

Table 1. Characteristics of included studies.

Study No.	Author, Year, Country	Age (years)	Sample Size (Male)	BD Type (I/II)	Study Design	Outcome measures	Intervention Summary
1	Enrique et al. (2020); Ireland	Mean 40.23 (SD 12.02)	15 (67%)	4/4 7 NR	Non-randomised pre-post	Semi-structured qualitative interview for clinicians and participants; SAT; BRQ; QoLBD; BIPQ; ISS; service use data	10-week self-paced online psychoeducation program.
2	Jones et al. (2018); UK	18–25 (6%) 26–35 (32%) 36–64 (59%) 65+ (3%)	258 (32.6%)	NR	Non-randomised pre-post	BRQ; QoLBD; ISS; GAD-7; PHQ-9; WASAS; service use data; patient experience questionnaire	10-week weekly face-to-face closed-group combining psychoeducation, skills training and activities, and discussion.
3	Jones et al. (2015); UK	Mean 38.3 (SD 12.8)	67 (30%)	53/14	RCT: active treatment compared to medication and routine medical care (TAU)	SCID-LIFE; HRSD; MAS; BRQ; QoLBD; PSP; BDI-II; ISS; MEDAD; WAI-S; Recovery Fidelity Scale	Manualised treatment delivered face-to-face in one-on-one individualised sessions. Up to 18 hours across 6 months.
4	Richardson and White (2019); UK	Mean 43 (range 20–62)	23 (26%)	NR	Non-randomised pre-post	Views on Manic Depression Questionnaire; BIPQ; BRQ; author-constructed questionnaire	12-week weekly 2-hour face-to-face closed-group. Program combined psychoeducation, activities and discussion.
5	Todd et al. (2014); UK	Mean 43.44 (SD 11.25)	122 (28%)	86/36	RCT: active treatment compared to waitlist control	QoLBD-Brief; WHOQoL-BRIEF; BRQ; ISS; SASS; MEDAD; service use data	6-month self-paced online psychoeducation program.

NR = not reported

Bech-Rafaelson Mania Scale (MAS); Bipolar Recovery Questionnaire (BRQ); Beck Depression Inventory (BDI-II); ; Brief Illness Perception Questionnaire (BIPQ)
Cognitive Therapy Scale Revised (CTS-R); Hamilton Rating Scale for Depression (HRSD); Internal States Scale (ISS); Personal and Social Functioning Scale (PSP);
Quality of Life in Bipolar Scale (QoLBD-Brief); Satisfaction with Treatment Scale (SAT); Social Adaptation Self-Evaluation Scale (SASS)
Stephenson Medication Adherence Questionnaire (MEDAD); Structured Clinical Interview for DSM-IV Longitudinal Interval Follow-up Evaluation (SCID-LIFE);
Working Alliance Inventory (WAI-S); World Health Organisation Quality of Life Assessment tool (WHOQoL-BRIEF)

content engagement overall from pre to post treatment. For the Todd et al. (2014), study participants in the treatment group ($n = 61$) completed an average of 60% of the program, with 34% of allocated participants completing 100% of the program. For the other pilot study, 60% ($n = 9$) completed the post-treatment measures (Enrique et al., 2020) with completers ($n = 9$) completing an average of 60.27% of program content (range 6.06–100%). Despite this, satisfaction ratings and qualitative interview data indicated good feasibility and acceptability of the intervention in this study; however, formal analysis of the qualitative data was not conducted.

Group therapy programs

Two studies were conducted as face-to-face weekly groups (Jones et al., 2018; Richardson & White, 2019). One study was a 10-week and the other, a 12-week intervention. Both were face-to-face closed-group interventions and were non-randomised pre-post designs (See Table 1). Both studies reported improvements in recovery (Jones et al., 2018; Richardson & White, 2019) and one reported improvements in mood and functioning (Jones et al., 2018). See Table 2. Both interventions were feasibility and acceptable for participants when assessing drop out and adherence rates. For the Jones et al. (2018) study, of 258 participants recruited, 78% commenced treatment ($n = 202$). Of those who commenced treatment, 83% ($n = 167$) completed at least six sessions, and 17% dropped out. The median number of sessions completed was nine (range 6–10). The patient experience questionnaire, completed by those who completed eight sessions or more, indicated high participant satisfaction with the intervention, with 93% reporting that the intervention helped to address their difficulties all or most of the time.

The other study (Richardson & White, 2019) 87% ($n = 20$) completed the intervention, and 13% ($n = 3$) dropped out, defined as attending less than six sessions, or actively terminating involvement in the study. For those who completed the intervention, the mean number of sessions attended was 10.7 (range 7–12).

Individual face to face interventions

One study reported on outcomes of an individual, manualised intervention delivered to individuals one-on-one face-to-face basis using an RCT design (Jones et al., 2015). Personal recovery was reported to be significantly higher in treatment group at 12 month follow-up, with less recurrence of mood episodes in

15-month follow-up (see Table 2). Acceptability was also reported to be high, with 33 participants allocated to the intervention group, 97% ($n = 32$) attending at least six sessions, with a mean of 14.15 h of intervention. Of the 67 participants randomised, 78% ($n = 52$) were retained to end of therapy follow-up at six months, 76% ($n = 51$) to 9-month follow-up and 67% ($n = 45$) to 12-month follow-up.

Discussion

Although few studies have explored the use of recovery-focussed psychological interventions for bipolar disorder, there is preliminary evidence of their acceptability and efficacy in improving personal recovery. Face-to-face interventions appeared more acceptable than online interventions, with greater participant attendance being reported in these formats.

Of the studies included in this review, all five found significant improvements in personal recovery, as measured by the BRQ (Enrique et al., 2020; Jones et al., 2013, 2015, 2018; Richardson & White, 2019; Todd et al., 2014), suggesting that these types of interventions hold promise in improving recovery outcomes for people living with BD.

Two programs were run in a group format (Jones et al., 2018; Richardson & White, 2019), two as online self-paced interventions (Enrique et al., 2020; Todd et al., 2014), and one in an individual format (Jones et al., 2015). Completion rates were similar in both online interventions, approximately 60% (Enrique et al., 2020; Todd et al., 2014), and were higher, but consistent with each other, in the two-group interventions, between 83% and 87% (Jones et al., 2018; Richardson & White, 2019). The individual intervention had the highest completion rate at 97% (Jones et al., 2015). This may be a result of greater accountability, follow-up or personalised support as the ratio of participants to facilitators decreased (Jones et al., 2015). However, the financial cost and time investment also increased, meaning that one-on-one interventions may be less feasible or accessible in some contexts (Jones et al., 2015).

Despite these differences in format and delivery, results indicate that all interventions were effective and significantly improved personal recovery. However, only two studies included longitudinal follow-up (Jones et al., 2018; Todd et al., 2014), so it is difficult to ascertain if improvements in personal recovery are maintained over time. Despite this, data from these studies appear promising, with gains maintained at 6- and 12-month follow-up (Jones et al., 2018) and 3- and 6-month follow-up (Todd et al., 2014). One

Table 2. Outcomes of included studies.

Study No.	Author, Year, Country	Baseline BRQ Scores		Post-treatment BRQ Scores		p value; effect size	Other outcomes
		Mean (SD)	Median	Mean (SD)	Median		
1	Enrique et al. (2020); Ireland	2249	(Median)	2525*	(Median)	$p = 0.017$; NR	No significant differences found on other outcomes.
2	Jones et al. (2018); UK	1998.3	(387.2)	2221.0	(419.4)**	$p < 0.001$; 0.52	Significantly improved functional outcomes and mood with small effect sizes. ($d = 0.20-0.39$)
3	Jones et al. (2015); UK	Control 1934.57 (543.85)		Control 6-month: 2082.57 (518.58) 12-month: 2193.4 (357.74)			Less recurrence of mood episodes in 15-month follow up in treatment group. Significantly greater time of episode recurrence in treatment group (for both mania & depression). No significant differences in other outcomes.
4	Richardson and White (2019); UK	Treatment 1797.39 (454.80)		Treatment 6-month: 2378.92 (578.8)+ 12-month: 2351.41 (462.02)+ 2272.1*		$p = 0.01$; 0.62	Improved understanding and sense of control over bipolar disorder. No significant effects on stigma or self-esteem.
5	Todd et al. (2014); UK	Control 2115.96 (470.22)		Control 3-month: 2094.77 (426.93) 6-month: 2111.33 (396.89)		$p < 0.05$; 0.21	Significant improvement quality of life ($d = 0.40$), wellbeing ($d = 0.01-0.06$), mood ($d = 0.2-0.4$), and social functioning ($d = 0.5$) in treatment group compared to control, maintained at follow-up.
		Treatment 2055.55 (466.18)		Treatment 3-month: 2311.92 (492.55)+ 6-month: 2446.88 (465.70)+		$p < 0.01$; 0.70	

NR = not reported; d = effect size.

format that was absent in the current review is an online group therapy. Given the current evidence suggesting that online interventions and group interventions are both effective in this area, and with the COVID-19 pandemic and rapid advent of telehealth services, this is a modality that warrants further attention in future research (Zhou et al., 2020).

Additionally, only one study reported qualitative data (Enrique et al., 2020), and only extracted comments were reported, without structured formal qualitative analysis. Given that the principles of personal recovery emphasise participant subjective experience over objective data, this is a notable omission and represents an important avenue for future research. A further limitation of the review is that only studies that used both a recovery-orientated intervention and a form of assessment of recovery were included. This may have excluded some studies that assess outcomes of recovery-orientated interventions using non-recovery measures or only assessed other qualitative outcomes unrelated to personal recovery. However, the consistent use of the BRQ (Jones et al., 2013) as the measure of personal recovery across all studies represents a strength of the research in this area. Given the complexity of the construct of personal recovery, and various theoretical frameworks that have been proposed in the literature, the consistent use of one measure allows valid comparison between studies (Jones et al., 2013).

Strengths and limitations

This is one of the first studies to explore the impact of psychological treatment on personal recovery for people living with bipolar disorder which is a strength of this review. However, the number of studies analysed was small, and the sample size was small in each study, which reflects a paucity of research in this area. As such, a meta-analysis was not conducted which may be considered a limitation of the present review along with an absence of the calculation of inter-rater reliability in the screening stage, which was an omission in the method. Additionally, only two randomised controlled trials were included, both pilot studies with small sample sizes, making inferences about the findings difficult. Comorbid mental health difficulties, bipolar diagnosis type, and medication status were not assessed consistently across included studies and this is a limitation of the review. All studies were conducted in the United Kingdom which decreases generalisability of results to other geographic or demographic populations and some did not use

a diagnostic instrument to confirm diagnostic status with studies reporting a variety of methods to confirm participant diagnosis. It is clear that this is an emerging area of research in its early stages, and each of these limitations represents an avenue for future research.

Clinical implications and future research

More randomised controlled trials are required to provide more conclusive information about the efficacy of the current interventions in improving personal recovery for individuals with bipolar disorder. Future trials may consider further research into the meaning of recovery for individuals with bipolar is and how this may differ from established research on other serious mental illnesses in theory and in applications to treatment. New treatment studies published since this review have highlighted aspects of recovery that overlap with positive psychology concepts, and these may also be important to explore in larger scale studies (Celano et al., 2020). Protocols have also been published showing future planned recovery-orientated group program research in this area (Beck et al., 2018).

However, as personal recovery is highly individualised and subjective, there is a risk that relying solely on quantitative measures will not sufficiently capture recovery experiences within an intervention. Thus, future research may benefit from a greater focus on qualitative outcomes assessing personal recovery and the meaning of this for individuals taking part in these interventions. A structured interview consisting of questions aligned to the CHIME framework (Kraiss et al., 2021; Leamy et al., 2011; Mezes et al., 2021; Shanks et al., 2013) and the POETIC framework (Jagfeld et al., 2021) may be a feasible approach, and represents an avenue for future research.

At this stage, clinicians are advised that personal recovery is a meaningful outcome for people living with bipolar disorder, and that CBT-informed interventions using psychoeducation may enhance recovery outcomes in this population.

Conclusions

Generally, the findings of this review are consistent with existing research that supports the efficacy of psychological interventions, including CBT, for bipolar disorder (Miklowitz et al., 2021), and research that supports the efficacy of recovery-focussed psychological interventions in other serious mental illnesses (Morin & Franck, 2017; Winsper et al., 2020). The findings of this review align with increasing focus on the

personal recovery approach to mental health treatment and provide exciting initial support for the efficacy of CBT-based recovery-focussed interventions for the improvement of personal recovery in bipolar disorder, across a range of delivery modalities.

Although few recovery-oriented psychological interventions for bipolar disorder have been conducted, those that have been assessed in the literature to date show highly consistent and promising positive effects on personal recovery outcomes. Given the importance of personal recovery in bipolar disorder, both for consumers and healthcare providers, this is an area of research that certainly warrants further attention in the future, and many pathways for future research are open for exploration.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Data availability statement

Data available on request.

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