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Review

Towards recovery-oriented psychosocial interventions for bipolar disorder: Quality of life outcomes, stage-sensitive treatments, and mindfulness mechanisms☆

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HIGHLIGHTS

- The recovery paradigm encourages new approaches to psychological therapies for bipolar disorder.
- Subjective quality of life can be reliably quantified, and is a key person-centric outcome measure in bipolar disorder.
- Response to psychological treatment appears to be moderated by stage of disorder, and new therapies should consider stage-tailoring.
- Mindfulness-based interventions target vulnerabilities that are important across stages of bipolar disorder, and warrant further research.

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ABSTRACT

Current adjunctive psychosocial interventions for bipolar disorder (BD) aim to impact illness course via information sharing/skill development. This focus on clinical outcomes contrasts with the emergent recovery paradigm, which prioritises adaptation to serious mental illness and movement towards personally meaningful goals. The aim of this review is to encourage innovation in the psychological management of BD by considering three recovery-oriented trends in the literature. First, the importance of quality of life as a target of recovery-oriented clinical work is considered. Second, the recent staging approach to BD is described, and we outline implications for psychosocial interventions tailored to stage. Finally, we review evidence suggesting that mindfulness-based psychosocial interventions have potential across early, middle and late stages of BD. It is concluded that the humanistic emphasis of the recovery paradigm provides a timely stimulus for development of a next generation of psychosocial treatments for people with BD.

Contents

☆ G.M. and N.L. developed the study concept and drafted the paper. All authors contributed to subsequent drafts and approved the final version of the paper for submission.

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Over the past decade, psychosocial interventions have been shown to be effective adjuncts to pharmacotherapy for bipolar disorder (BD). However, effect sizes are not large, mechanisms are poorly understood, and more research is urgently required to improve outcomes for people with BD (Oud et al., 2016). The overarching aim here is to encourage innovation in this domain by reviewing three streams of research with potential to inform the next generation of psychosocial interventions for BD. The streams are linked by an emphasis on *recovery*, which is commonly defined as, "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles … a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness" (Anthony, 1993, p.15).

The paper includes five sections. First, we outline the emergent recovery framework in mental health and note that existing psychosocial interventions prioritise 'clinical and functional' recovery over 'personal recovery'. Second, the *aims of psychosocial treatments* are reconsidered in the light of growing literature on subjective quality of life (QoL) in BD. Third, we consider data suggesting that *stage of disorder* is a meaningful framework in BD and may be an important moderator of treatment response. Fourth, growing evidence for the impact of *mindfulness-based therapies* on BD and BD-related outcomes is reviewed. Findings of these overlapping reviews are critically weighed in an integrative Discussion which outlines next steps for research and practice in recovery-oriented psychosocial interventions for BD.

1. The recovery paradigm and existing psychosocial interventions for BD

Initially driven by the mental health consumer movement, the recovery perspective has been adopted in mental health policies and guidelines worldwide (Commonwealth of Australia, 2009; Department of Health, 2011; New Freedom Commission on Mental Health, 2003). The recovery perspective has rapidly become the expressed goal of treatment for persons with persistent mental disorders (Song & Hsu, 2011). Indeed, recovery has so rapidly become instantiated in mental health guidelines throughout the western world that practice has arguably outpaced research (Tse et al., 2014).

Personal recovery (contrasted with *clinical* and *functional* recovery) is commonly defined as the process of individual psychological adaptation to a disorder, contrasted with the reduction of psychiatric symptoms, relapse prevention or addressing functional difficulties (Cavelti, Kvrgic, Beck, Kossowsky, & Vauth, 2012). There is a clear focus on social justice in the recovery movement, and its implications for stigma, social inclusion and traditional health power structures are commonly discussed (Commonwealth of Australia, 2013; Manove, Price, & Levy, 2012). "Personal recovery" is often abbreviated to "recovery", and the shorter term is used here.

This focus on recovery has been described as a humanistic paradigm shift in mental health (Wand, 2015), but the details of how recovery principles might operate in different mental health contexts have not been thoroughly considered to date (Murray, 2015b). Research into recovery in BD is in its early stages (see, e.g., Jones, Mulligan, Higginson, Dunn, & Morrison, 2013; S. Jones et al., 2012; Tse et al., 2014), and to our knowledge this is the first review to consider the implications of the recovery paradigm for psychosocial interventions for BD.

Current evidence-based psychosocial interventions for BD include Cognitive Behavioural Therapy (CBT), Psychoeducation, Family-Focused Therapy (FFT) and Interpersonal and Social Rhythm Therapy (IPSRT) (Geddes & Miklowitz, 2013). Adjunctive psychosocial treatments are broadly effective for BD maintenance therapy, and there is consensus that optimal management of BD involves integrated pharmacotherapy and psychotherapy (Goodwin, 2009; Yatham et al., 2013). On the other hand, data in the acute phase is limited, effect sizes for psychosocial interventions are not large, therapeutic mechanisms are poorly understood and more research is required to maximise their beneficial impact (Geddes & Miklowitz, 2013). Indeed, it is not clear that current research has targeted and measured critical outcomes, in taking a proto pharmacological stance rather than exploring what matters to service users. As there is no strong evidence of differential efficacy, treatment guidelines usually recommend offering any of the evidence-supported structured psychological interventions (e.g., Malhi et al., 2015; National Institute for Health and Clinical Excellence, 2014).

Existing interventions for BD generally share a biopsychosocial diathesis-stress model, and a focus on development of knowledge and skills (Malhi et al., 2015). Evidence-based interventions also have overlapping content: increased knowledge about BD, monitoring sleep and mood, enhanced ability to recognise and respond to mood changes, re-engaging with social, familial and occupational roles, stress management, improved communication, medication adherence, enhanced sleep and activity rhythms and minimising substance use (Beynon, Soares-Weiser, Woolacott, Duffy, & Geddes, 2008). Critically for the present paper, then, the primary impetus of existing psychosocial interventions is to decrease symptoms and relapse: with some recent exceptions (e.g., S. H. Jones et al., 2015, see below), personal recovery has received little attention in the BD intervention literature.

2. Measuring outcomes of psychosocial interventions for bipolar disorder

Commonly recognised elements of recovery are connectedness, hope and optimism, identity, meaning in life and empowerment (giving the acronym CHIME, (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011), and there are consumer calls for the *aims of psychosocial interventions* to be more congruent with these humanistic values (Jones et al., 2013). Growing interest in recovery-congruent aims has, in turn, encouraged focus on outcome measures that capture broader subjective experiences of the individual. To date, QoL has received the most research attention (Murray & Michalak, 2012).