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Abstract

Purpose. To conduct a thematic synthesis to evaluate qualitative studies exploring individuals' experiences of psychological-based interventions for bipolar disorder (BD).

Method. A systematic search of relevant databases (Web of Science, PsycINFO, MEDLINE, CINAHL) was conducted using predefined search terms related to 'Bipolar' 'Qualitative method', 'Psychological-based interventions' and 'Adults'. Studies meeting the inclusion criteria were selected and were then evaluated using established quality appraisal criteria. A thematic synthesis was used to synthesise the findings.

Results. From the thematic synthesis, nine analytical themes were derived from the ten identified research studies. These were helpful and unhelpful aspects of the intervention, increased knowledge of BD, mood recognition, control of moods, change of perspective, mood stability, empowerment, improved relationships, and lifestyle changes.

Conclusions. Findings from the review suggest there were characteristics of psychological-based interventions that individuals with BD valued and which helped facilitate areas of positive change, such as feeling empowered and in control of their moods and other aspects of their lives. However, there were also elements that individuals did not find as helpful and therefore reflects the challenge of a one-size-fits-all model or plan of interventions, compared to a wider recognition of the individuals as being the agent of their recovery. Future qualitative research is needed to explore individual experiences across a range of psychological interventions, in order to further understand the therapeutic processes, which may facilitate recovery.

Practitioner Points

- Psychological-based interventions for BD need to consider facilitating and measuring empowerment in individuals, rather than focusing just on mood stability.
- Clinicians with expertise and knowledge in BD should provide timely information to individuals and their families to help increase their understanding of the diagnosis.

Introduction

Bipolar disorder (BD) is defined as a severe, chronic and disabling mental health disorder characterised by recurrent episodes of depression and mania or hypomania (Royal College of Psychiatrists, 2015). In addition to mood instability, BD is associated with significant psychosocial functional impairments, reduced quality of life and higher incidences of suicide (American Psychiatric Association, 2013; Novick et al., 2010; Rosa et al., 2010). The primary treatment for BD still remains the use of mood-stabilising or antipsychotic medication (Geddes & Miklowitz, 2013; Nivoli et al., 2013). However, pharmacological treatments do not always lead to absence or prevention of relapse and do not benefit the residual depression that many people experience out of the episode (Vieta et al., 2013).

There have been a number of studies that have either developed or adapted psychological interventions for use within the BD population, to be used in conjunction with pharmacological treatment. These include psychoeducation (Colom et al., 2009; Depp et al., 2015; Proudfoot et al., 2012), cognitive behavioural therapy (CBT: Castle et al., 2010; Costa et al., 2012; Jones et al., 2015), interpersonal and social rhythm therapy (ISRT: Inder et al., 2015; Swartz et al., 2012), dialectal behavioural therapy (DBT: Goldstein et al., 2014; Van Dijk et al., 2013), mindfulness-based cognitive therapy (MBCT: Perich et al., 2013; Williams et al., 2008), and family-focused therapy (Miklowitz et al., 2008, 2013, 2014).

A number of recent reviews have been conducted investigating the effectiveness of different psychological interventions on psychosocial outcomes in BD (Oud et al., 2016; Reinares, Sanchez-Moreno & Fountoulakis, 2014; Salcedo et al., 2016). Most reviews concluded that specific adjunctive psychotherapies have been shown to improve outcomes (Geddes & Miklowitz, 2013); however, outcomes varied between studies and not all randomised controlled trials (RCTs) of psychological interventions have shown positive outcomes (Gomes et al., 2011; Scott et al., 2006). All the reviews concluded that psychological interventions were effective in conjunction with pharmacological treatment for BD, but these effect sizes were small (Oud et al., 2016).

The variability in quantitative research findings on the effectiveness of psychological interventions is reflected within the National Institute for Health and Care Excellence (NICE, 2015) guidelines for treatment and management of BD, as a specific psychological intervention is not recommended. Instead, it recommends the use of any structured manualised psychological intervention – individual, group or family, which has at least one

RCT published. This is only for depression in BD, and there are no recommendations for the psychological treatment of mania in BD. The NICE recommendations are based on a large number of meta-analyses, which contained a small number of RCT studies (Jauhar, McKenna and Laws, 2016). In addition, a majority of the included studies were of low quality, had methodological concerns and statistical issues. Little is known about how people with BD experience psychological interventions and thus there is a need to understand this more.

Qualitative evaluation of the experience of interventions is encouraged by the 'Framework for Developing and Evaluating Complex Interventions' (Medical Research Council, 2008), and can provide a deeper understanding of individuals' experiences of treatment. Evaluating interventions qualitatively is important to fully understand its feasibility, acceptability and effectiveness (Harper & Thompson, 2012). There are a number of synthesis methods for qualitative studies, including meta-ethnography, narrative synthesis, thematic synthesis and meta-study (Dixon-Woods et al., 2005; Noblit & Hare, 1988). A synthesis of qualitative studies could provide insight and clarification about individuals' views and experiences of psychological-based interventions to understand what is helpful or unhelpful, and clarify what might contribute to individual recovery. This may identify whether any changes are needed to improve the effectiveness of psychological treatments. To the author's knowledge, there have been no published reviews that synthesise the findings from qualitative studies to provide insights into the individual experiences of psychological-based interventions. The review aims to address this gap within the research.

Aims of Review

The aim of this synthesis was to:

i) Systematically identify for qualitative studies exploring individual experiences of psychological-based interventions (individual, group or internet-based) for BD.
ii) Assess the quality of the research.
iii) Integrate the findings using a thematic synthesis approach to explore what individuals perceive to be the benefits and difficulties of psychological-based interventions, and the processes that might facilitate positive change.

Method

In order to improve the conduct and reporting of this qualitative synthesis, the Enhancing Transparency in Reporting the Synthesis of Qualitative Research guidelines (ENTREQ: Tong et al., 2012) was used.

Search Strategy

The CHIP tool (Shaw, 2010) was used to break down the key components of the search question into Context, How study was conducted, Issues examined, and People involved. Search terms were developed through consideration of terms used in previous literature reviews and guidelines for searching qualitative studies (Shaw, 2012; Toye et al., 2014). Search terms are presented in Table 1. A number of key databases were used to ensure a comprehensive search of all the relevant literature was conducted. The following databases were searched: Web of Science (Core Collection), PsycINFO, MEDLINE, CINAHL and Google Scholar. References were searched from the period of their inception up until May 2018. The references of all relevant studies were checked, and Google Scholar was used to examine citations of articles meeting the inclusion criteria. See Table 2 for inclusion and exclusion criteria.

Authors of the identified papers, as well as authors of RCTs for psychological interventions for BD (published since 2010), were contacted to identify whether they published or were aware of further qualitative studies exploring individual experiences of interventions.

(Table 1 here)

(Table 2 here)

Appraisal of Study Quality

Upon completion of the search process, relevant information from the identified papers was imported into an Excel spreadsheet in order to allow the study characteristics to be summarised and to prepare for the quality appraisal.

The Critical Appraisal Skills Programme for qualitative research (CASP, 2010) was used to assess the quality of the identified studies. It has been widely used in a number of qualitative syntheses (Coleman et al., 2017; Devereux-Fitzgerald et al., 2016; Katsakou & Pistrang, 2017). The tool assesses 10 key areas, including suitability and appropriateness of qualitative method, recruitment strategy, consideration of ethical issues and data analysis methods. An overall quality rating was assigned to each paper: ‘satisfactory’, ‘unable to evaluate’ due to insufficient information, or ‘fatally flawed’ and must therefore be treated with caution (Dixon-Woods et al., 2007). The quality appraisal was not used to exclude papers, but was used to provide a ‘quality context’ within which the outcome of the synthesis can be placed.

A peer researcher, blind to the author’s ratings, appraised a third of the papers chosen at random. The results from the appraisal were discussed and any areas of uncertainty or discrepancy were resolved through discussion.

Synthesis Process

A thematic synthesis based on the method described by Thomas and Harden (2008) was used to analyse the data from the primary studies and address the review questions. Thematic synthesis was developed and applied to systematic reviews that consider individuals' perspectives and experiences in order to address specific review questions about need, appropriateness, acceptability and effectiveness of interventions (Barnett-Page & Thomas, 2009). Therefore, this methodology was chosen as it was well suited to meeting the aims of this review.

The first author read and re-read the studies to fully immerse in the data. In accordance with Thomas and Harden's (2008) recommendations, all text within the 'Results' or 'Findings' of the primary studies were extracted and entered verbatim into NVivo software. Both participant quotes and author interpretations were treated equally as primary data.

The first author carried out the following three stages:

1. Line by line coding to generate descriptive codes. Each line had at least one code applied, although most were classified using several codes.
2. Development of descriptive themes by comparing and grouping codes based on similarities and differences

across papers. Data from each study was also extracted and grouped together in Excel to further identify themes.

3. Analytical themes were generated by looking at the studies as a whole in relation to the review questions. Themes emerged through an iterative process of reflection and interpretation of all of the descriptive themes within and across studies.

The first author adopted a critical realist perspective (Cook & Campbell, 1979) throughout the synthesis process. Critical realism sits between an independent, real and knowable world; however the knowledge and understanding of this is constructed and interpreted through subjective, cultural and social processes that the researcher can access (Sayer, 2000). It is a position that assumes there are multiple ways of interpreting the data (Madill et al., 2000). The first author kept a reflective diary as an audit trail recording the decisions made throughout the analysis process. The preliminary coding framework, descriptive and analytical themes were discussed and refined by all the authors during regular meetings.

Results

The search identified 1108 studies. Following the removal of duplicates, 781 titles were screened for relevance. After excluding titles that were irrelevant, 84 abstracts were screened for relevance based on the inclusion/exclusion criteria. Following this, 41 full-text papers were checked based on the inclusion/exclusion criteria. A total of ten studies were identified for the review and were assessed for their methodological quality. Two authors (Morris et al., 2016; Straughan & Buckenham, 2006) were contacted for qualitative information that was contained within the appendices of the papers.

No additional papers were identified through alternative sources. Several authors from RCT studies who were contactable shared that they either did not seek qualitative feedback from their participants, or if they did, they were in the process of analysing the data, or the results had not yet been published. The process of identification and inclusion of relevant studies in the review is also shown in Figure 1 using the 'preferred reporting items for systematic reviews and meta-analyses' (PRISMA; Moher, Liberati, Tetzlaff, Altman & The PRISMA Group, 2010).

Quality Assessment

Following the evaluation of studies using the CASP tool, there were no studies that were assessed as 'fatally flawed'; however, five papers (Evans et al., 2016; Menezes & Conceicao, 2012; Morris et al., 2016; O'Connor et al., 2008; Poole, Simpson & Smith, 2012) were reported in insufficient detail to allow for a clear rating. Therefore caution must be taken when interpreting the findings of these papers. The majority of papers failed to report author reflexivity.

(Figure 1 here)

Description of Studies

A summary of key characteristics of the ten primary studies and quality ratings is provided in Table 3. In total, there were 155 participants, with ages ranging from 20 to 76 years. Of the 155 participants in the studies, 90 were female. Menezes and Conceicao (2012) focused exclusively on all female accounts. Participant ethnicity and diagnosis clarification were often not presented within papers.

Seven studies focused on psychoeducation and relapse prevention interventions. The content of these interventions included evaluating the causes of BD, understanding early warning signs and triggers, focusing on lifestyle factors, medication and non-pharmacological treatments and developing coping strategies. Other psychological interventions included cognitive analytic therapy (CAT: Evans et al., 2016), MBCT (Chadwick et al., 2011) and a novel CBT approach (Joyce et al., 2016).

Six studies were group-based interventions, three were individual interventions and one study was internet-based (Poole, Simpson & Smith, 2012). Interventions ranged from 6 - 24 sessions, with sessions ranging from 50-minutes to 3-hours. Two studies (Chadwick et al., 2011; Evans et al., 2016) included follow-up sessions. Mental health professionals, including clinical psychologists, mental health nurses, psychiatrists and care coordinators facilitated the majority of interventions. Both the Menezes and Conceicao (2012) and Morriss et al. (2016) studies had mixed input from mental health professionals and service users. The Straughan and Buckenham (2006) study evaluated a service-user led intervention.

Nine studies used semi-structured or open-ended interviews and thematic analysis as the qualitative methodology. Evans et al. (2016) collected their qualitative data from participant feedback on post-session Helpful Aspects of Therapy forms. O’Connor et al. (2008) used interpretative phenomenological analysis (IPA) for their qualitative methodology. All but one study (Straughan & Buckenham, 2006) were published during the last decade. Nine of the studies were conducted in the United Kingdom and one study (Menezes & Conceicao, 2012) was conducted in Brazil.

(Table 3 here)

Thematic Synthesis Findings

The findings from the ten primary studies were synthesised into nine analytical themes. The first theme 'Helpful and unhelpful aspects' addresses the review question of what individuals find beneficial or difficult from the interventions. The remaining eight themes: Increased knowledge in BD; Mood recognition; Control of moods; Change of perceptive; Mood stability; Empowerment; Improved relationships; and Lifestyle changes, are grouped together to understand the processes of positive changes and what factors may contribute to individual recovery (Figure 2). A summary of the themes are presented in Table 4, along with quotations from participants' and authors' interpretations.

(Table 4 here)

Helpful and Unhelpful Aspects

There were several helpful and unhelpful elements within the psychological-based interventions identified by individuals. These were: Professional expertise; Similar experiences; Learning from others' experiences; Intervention structure; Therapist style; Opportunity to talk; and Impact of mood.

Professional expertise. Five of the ten papers reported that individuals valued and appreciated having expert knowledge from professionals. Individuals felt that they had more confidence in information about BD because they trusted professional knowledge

(Joyce et al., 2016; Menezes & Conceicao, 2012; O'Connor et al., 2008; Poole et al., 2012, 2015).

Similar experiences. Participants who attended the group interventions found that sharing their experiences with other individuals with BD was helpful and important (O'Connor et al., 2008; Menezes & Conceicao, 2012; Morriss et al., 2016; Pontin et al., 2009; Straughan & Buckenham, 2006). For some individuals it was their first time meeting other people experiencing BD (Poole et al., 2015). In Morriss et al.'s study, individuals shared that one of the reasons they participated in the RCT was to meet others with similar experiences. Many individuals found it satisfying to meet others and reported that they realised they were not alone with their experiences of BD. Individuals reported increased support and some made friendships from the interventions (Morriss et al., 2016; Poole et al. 2015; Straughan & Buckenham, 2006).

Some individuals reported that meeting others with BD was also helpful as they were able to make comparisons with others in the group in relation to the extent of their illness (Menezes & Conceicao, 2012; O'Connor et al., 2008; Poole et al., 2015). Individuals reported a sense of relief when they met others who had worse experiences than their own (Menezes & Conceicao, 2012).

The exception to this was reported in Poole et al.'s (2012) study as some individuals perceived that engaging with other people with BD would be a negative experience. Individuals stated that it would be unappealing because they did not want to identify themselves with mental illness or be reminded of the experience of being unwell. Some people also worried that this might lead to a deterioration in their own mental health.

Learning from others' experiences. Individuals reported that they had learnt from other people's experiences of BD, benefitting from their knowledge and understanding (Menezes & Conceicao, 2012; Morriss et al., 2016; Poole et al., 2015; Straughan & Buckenham, 2006). In particular, individuals stated that they learnt from others insights and coping methods, which subsequently motivated and inspired them to make changes. Learning was not regarded as a one-way process, and individuals described how sharing their own knowledge with others was also valuable (Menezes & Conceicao, 2012; Poole et al., 2015). Individuals highlighted that learning from others' experiences would be helpful for those who were newly diagnosed (Morriss et al., 2016).

In the Poole et al. (2012) study, individuals reported that they would have preferred naturalistic videos within the online modules, which should include people with BD talking about their experiences. Similarly, participants reported preferring learning with and from other people's experiences.

Intervention structure. Some individuals considered the timing, spacing, number and context of sessions to be important. Participants acknowledged spacing between sessions allowed them time to engage with content and their goals (Joyce et al., 2016; Poole et al., 2012). Individuals within the internet-based study found that accessing the modules in their own time in a private environment provided safety (Poole et al., 2012). Likewise, a group in the community setting in Poole et al.'s (2015) study was seen as a helpful aspect as it provided a neutral, social setting, compared to if the group was set within a hospital environment. The timing of the group was considered by some individuals, such as time of the day (e.g. impact on work) and time of the year (e.g. cold winter evenings) (Poole et al., 2015).

Participants within group interventions (Morriss et al., 2016; Poole et al., 2015) reported one unhelpful element was that group discussions were dominated by other people and this was not facilitated well. This led to participants dropping out of the Morriss et al.'s study.

Therapist style. Three studies reported positive experiences of the therapist within interventions (Evans et al., 2016; Joyce et al., 2016; Poole et al., 2015). Individuals felt that the therapists were responsive and facilitated engagement. Therapists were seen as kind, calming and good listeners, who provided a relaxed and comfortable space for individuals. People felt the therapist adapted their style according to the individual needs, rather than adhering to a rigid structure. This helped build therapeutic alliances and facilitated communication (Joyce et al., 2016). In the Straughan and Buckenham (2006) study, individuals found the service user led style helpful.

However, not all participants in the Poole et al. study found the facilitators helpful. Some reported that the facilitators had poor group management skills, with a disengaged approach. The facilitators were focused on the PowerPoint slides and individuals felt they could have been more flexible to the needs of the group. Similarly, individuals in the Pontin et al. (2009) study found their care coordinators to be more structured and focused within the intervention, which was seen as unhelpful.

Therapy techniques. Most studies focused on helpful or unhelpful techniques used within the different interventions.

For the psychoeducation and relapse prevention interventions (Morriss et al., 2016; Pontin et al., 2009; Poole et al., 2012, 2015), there were mixed views from participants regarding the use of the life chart exercise. Some individuals valued creating a life timeline, as it gave them the opportunity to clarify and understand their diagnosis. It helped increase their understanding of previous mood episodes and provide a link to triggers. Individuals reported that it facilitated reflection on how the diagnosis had affected them personally and enabled them to think about more helpful ways to manage their moods in the future (Morriss et al., 2016; Pontin et al., 2009; Poole et al., 2015).

However, some individuals reported feeling uncomfortable about recalling past episodes, triggers, and warning signs (Pontin et al., 2009; Poole et al., 2012, 2015). Participants in Poole et al.'s (2012) study found the online life chart exercise difficult to complete and recall mood episodes. For some, remembering past events led them to feeling upset, whilst others were reluctant to think about it as they were worried it would trigger a depressive episode. Individuals recommended that they be prepared and supported to complete the exercise, or have the option of opting out if they did not feel prepared or want to do it (Poole et al., 2015). Furthermore, a few studies (Joyce et al., 2016; Poole et al., 2015; Pontin et al., 2009) reported that individuals found creating individualised safety action plans helpful.

Additional effective techniques were unique to the type of intervention. For example, the use of mindfulness techniques and focusing on the present moment was seen as a useful way of broadening individual awareness on difficult thoughts and feelings

(Chadwick et al., 2011). In the Evans et al. (2016) study, individuals found the reformulation letter and the process of finding ‘exits’ helpful. In the novel CBT study, participants found that identifying the advantages and disadvantages of mood and ‘finding a middle ground’ helpful to try and conceptualise an ideal self-state. Reappraisal techniques to consider alternatives and using metaphors to facilitate positive perspectives were also seen as helpful techniques. However, two individuals reported unwillingness to learn therapeutic techniques, requiring only emotional support (Joyce et al., 2016).

Opportunity to talk. Being given the opportunity to talk was described as a helpful experience (Evans et al., 2016; Joyce et al., 2016; Morriss et al., 2016). It was seen as a comforting and necessary process, as individuals reported not having the opportunity to share their thoughts, emotions and experiences around BD or talk about important personal topics in their day-to-day lives. Feeling safe within the interventions was highlighted as an important element to facilitate communication (Menezes & Conceicao, 2012; Poole et al., 2015). However, in the Pontin et al. (2009) study, some individuals stated that talking about their experiences was ‘emotionally tiring and upsetting’ and for some this induced feelings of anxiety.

Individuals within the Poole et al. (2012) study highlighted that an unhelpful element to the online intervention was the lack of opportunity to engage with others.

Impact of mood. A few studies reported that individuals' moods affected engagement within interventions (Evans et al., 2016; Poole et al., 2012). Low mood seemed to impact on the concentration and motivation levels required to engage with interventions, and some individuals felt less sociable (Chadwick et al., 2011; Poole et al., 2015). The experience of high moods led to some individuals feeling angry, upset and restless (Poole et al., 2015). The impact of mood led to some individuals missing sessions or dropping out of interventions completely (Poole et al., 2012, 2015).

(Figure 2 here)

Process of Positive Change

The remaining eight themes are outlined below to help explain the process of positive changes from the psychological-based interventions. The four themes (Increased knowledge of BD, Mood recognition, Control of moods, Change of perspective) appear to be important factors within interventions for individuals with BD, which then lead directly to the following themes of positive changes within their lives: Mood stability; Empowerment; Improved relationships; and Lifestyles changes.

Increased Knowledge of BD

Several studies (Pontin et al., 2009; Poole et al., 2015; Straughan & Buckenham, 2006) highlighted the importance that individuals attributed to increased knowledge around BD. This enhanced their insight and understanding of the diagnosis, the different forms it can take, the causes, and treatment options. Some participants had experienced symptoms for years without receiving any information or an understanding of their diagnosis (Menezes & Conceicao, 2012), and one of the main reasons for being involved in the research was to access this knowledge (Morriss et al., 2016). In the Poole et al. (2012) study, individuals had experienced BD for a significant number of years, and although they reported learning little new information, the information reinforced and consolidated their existing knowledge. The participants suggested that the online intervention would be helpful for those who were newly diagnosed, as they also reported having difficulty accessing sufficient information at the time of their diagnosis.

Mood Recognition

All ten studies highlighted that following the interventions individuals reported an increased self-awareness of early warning signs of mood changes, as well as recognising triggers to mood and noticing mood changes better. Due to the increase in self-awareness and monitoring of moods, individuals were able to deal with symptoms better.

Control of Moods

All but one study (Evans et al., 2016) reported that due to the increased mood recognition, individuals consequently described responding differently to their mood changes. Some participants had developed coping strategies, such as distraction techniques, to prevent or manage mood escalations, as well as regulate their behaviour (Joyce et al., 2016; Menezes & Conceicao, 2012; Morriss et al., 2016; Poole et al., 2012, 2015). In the Chadwick et al. (2011) study, individuals adapted their mindfulness practice according to the mood state they were in to help control changes. However, some individuals within the Pontin et al. (2009) study felt that when their mood changes occurred too quickly, their strategies were ineffective.

Some studies identified that individuals had become aware of how to control their moods in order to maintain their wellbeing (Poole et al., 2015; Pontin et al., 2009; Straughan & Buckenham, 2006). Individuals reported feeling less overwhelmed by moods, and experienced an increased tolerance to mood swings (Chadwick et al. 2011; Joyce et al., 2016). In Joyce et al.'s study, some participants reported no impact of the therapy on their mood management.

Change of Perspective

The subthemes related to individuals with BD change of perspective following completion of psychological-based interventions were: Attitudes towards medication; Taking responsibility; Acceptance; and Thinking differently.

Attitude towards medication. Following a number of psychoeducation interventions, some individuals described a change in their attitude towards medication, and acknowledged its role in relapse prevention (O'Connor, 2008; Poole et al., 2015; Pontin et al., 2009). Some participants also reported feeling more confident and willing to try medication (Poole et al., 2012).

Taking responsibility. Half of the papers described how individuals were feeling more determined to take personal responsibility in managing their BD (Joyce et al., 2016; Pontin et al., 2009; Poole et al., 2015). Individuals reported awareness in the need to engage in active in the treatment process and in taking responsibility for their actions in order to change behaviour (Menezes & Conceicao, 2012; Straughan & Buckenham, 2006).

Acceptance. Following interventions there was a reported increase in acceptance of the mood changes, diagnosis and the self (Chadwick et al., 2011; O'Connor et al., 2008; Poole et al., 2012, 2015; Pontin et al., 2009). For some individuals this meant coming to terms with the disorder, and learning to live a ‘normal’ and ‘happy’ life despite the BD (Menezes & Conceicao, 2012). The process of normalising and understanding that everyone can experience mood changes helped with the acceptance of moods (Joyce et al., 2016).

Thinking differently. Three papers reported that individuals responded differently to their thoughts and had changed their way of thinking (Chadwick et al., 2011; Joyce et al., 2016; Straughan & Buckenham, 2006). From the interventions, individuals learnt to reappraise situations to consider alternatives and respond to negative thoughts differently, such as challenging thoughts and beliefs or letting go of the thoughts. This led to individuals feeling less overwhelmed by their thoughts and changed their patterns of behaviour. Participants described an increase in meta-cognitive awareness into their thoughts (Chadwick et al., 2011; Joyce et al., 2016). However, three individuals in the Joyce et al. study reported no changes in their thinking.

Mood Stability

Five papers highlighted individual experiences of mood stability following interventions (Chadwick et al., 2011; Pontin et al., 2009; Poole et al., 2015). Individuals reported a reduction in negative affect and increased mood stability. Individuals felt they were maintaining their wellness for longer periods (Straughan & Buckenham, 2006) and had experienced a reduction in the number of hospitalisations (Menezes & Conceicao, 2012).

Empowerment

Individuals reported a sense of empowerment, as well as increased confidence and self-esteem following interventions (O'Connor et al., 2008; Menezes & Conceicao, 2012; Pontin et al., 2009; Straughan & Buckenham, 2006). Some individuals described an increase in assertiveness, enabling them to cope better in situations they originally found challenging (Joyce et al., 2016; Poole et al., 2015).

Improved Relationships

Individuals reported improved relationships with partners, family and mental health professionals due to an increase in their understanding and support (Pontin et al., 2009; Straughan & Buckenham, 2006). Family and partners were more accepting of an individual's diagnosis and supported their involvement within interventions (Poole et al., 2015). Giving or sharing of information with others helped to facilitate this process, in particular information on diagnosis and aetiology (Poole et al., 2012). Individuals in Poole et al.'s (2015) study gave information to family members so that they could also identify and be aware of mood changes. Due to their increased knowledge and understanding about their diagnosis, individuals were able to communicate their experiences of BD to others in a concise way that helped reduce experience of stigma.

For some, the intervention did not impact on individuals' personal relationships (Poole et al., 2015). For example, some family and friends were not interested or considerate to the individual's mental health needs, and individuals reported cutting out these particular people from their lives.

Lifestyle Changes

Individuals made healthier lifestyle changes as a consequence of the interventions, and also experienced increased levels of functioning and quality of life (Poole et al., 2012, 2015). Participants shared that they had adopted healthier behaviours; such as reducing alcohol intake, adjusting their sleep patterns, eating more healthily and exercising, as well as creating and maintaining a structure to daily life. Individuals reported engaging with their life goals and managing their daily work and personal responsibilities better (Joyce et al., 2016; Menezes & Conceicao, 2012; Straughan & Buckenham, 2006).

Discussion

The thematic synthesis of ten primary qualitative studies provides valuable insight into what individuals with BD find helpful and unhelpful within psychological interventions, as well as summarising the processes within the interventions that facilitate positive changes. Despite there being a relatively sparse body of research exploring individual experiences of psychological-based interventions, this review highlights some common themes across studies.

The hypothetical model of processes which might facilitate positive change suggests increasing individuals' knowledge and understanding of BD, especially early on in diagnosis, can help individuals recognise their early warning signs and triggers. This meant individuals could cope better with mood fluctuations - using strategies learnt in interventions, such as reappraisal of thoughts and moods and mindfulness techniques. These enabled individuals to feel less overwhelmed by their mood changes and helped with mood stability. Overall, this led to individuals feeling more in control and empowered in their lives. The effect of feeling empowered, along with increased skills and knowledge meant that individuals dealt with situations, relationships and lifestyle choices better.

The findings of this review mirror some qualitative studies exploring experiences of individuals with BD in general. Mansell et al. (2010) investigated qualitative accounts of the process of recovery in individuals with BD. Similar helpful approaches were found, including understanding and acceptance of BD. These were important processes for personal growth, which also helped change individual thought processes about behaviours, and take more responsibility. Individuals found information on BD a helpful resource, as they gained insight into their thoughts, feelings and behaviours, and learnt how to manage these. Similarly, lifestyle factors and social support were also seen as important in increasing mood stability.

The themes 'Control of moods' and 'Change of perspective' seem consistent with the integrative cognitive model (Mansell et al., 2007). This model proposes that individuals with BD have conflicting beliefs about their internal mood states and how to control them. Re-appraisal techniques may help individuals disconfirm these beliefs, which are linked to control, and therefore enhance mood states.

Another study by Barker (2002) identified coping techniques commonly used by members of Mood Swings Network. Seventy-five percent of individuals reported using non-medical strategies such as support from family and friends, positive thinking, healthy lifestyle management, understanding the diagnosis and talking to others.

Finally, the themes in the review are also supported by Billsborough et al.'s (2014) findings about what individuals with BD want from support. These included being listened to, empowerment through self-coping strategies, and an understanding of early warning signs in order to respond quicker and maintain wellbeing.

Limitations and Future Research

This review used a systematic and rigorous method to ensure a broad range of all relevant studies were included. However, the inclusion of only peer-reviewed English papers may have narrowed the results and be subject to bias. Excluding 'grey' area research may have distorted the findings, as theses, service evaluations, or case reports may have added value. All but one study was conducted in the UK, and the findings from the review may not be generalisable to other countries or cultures, which may have alternative views.

The majority of the included papers focused on psychoeducation interventions. Only one of these studies was based on a service user led intervention. This limited the findings of the review to those specific types of interventions. However, it is important to highlight that the majority of themes were represented across all interventions. There is a need for further qualitative studies obtaining the perspectives of individuals diagnosed with BD on CBT, CAT, and mindfulness, but also on other interventions such as DBT and family therapy, which might expand further on understanding of intervention processes. Future qualitative research should focus on a range of psychological interventions other than CBT and psychoeducation, looking at facilitators and barriers which may add to the inconsistent quantitative research on effectiveness of psychological interventions for BD. There are authors who are due to publish separate qualitative aspects embedded within the RCTs in due course (Evans et al., 2016; Morriss et al., 2016). Future RCTs should consider the use of qualitative methods in order to address the gap in individual perspectives on interventions and strengthen the evaluative research.

Similarly, there is an absence within the review findings about the importance of addressing anxiety and past trauma within psychological-based interventions, despite the reported high levels of comorbidity within BD and individual accounts of trauma histories (Maniglio, 2013; McIntyre et al., 2006; Palmier-Claus, Berry, Bucci, Mansell & Varese, 2016). Future qualitative research should explore whether this is something individuals would like to address within psychological-based interventions.

The findings of the thematic synthesis were limited due to the quality and depth of some of the included studies. Some studies provided a ‘thin’ description of participant experiences, which contributed less to the final analysis when compared to studies that were more detailed in their Results/ Findings. The insufficient detail presented in some papers may be due word limit issues within journal publications, which are more appropriate for quantitative studies. These studies were included in the review due to the small number of studies available investigating qualitative experiences of psychological interventions for BD.

In addition, the majority of studies did not highlight the impact of researcher and participant relationship in their methodological information. Future qualitative research needs to remain attentive to conducting rigorous analyses, including researcher reflexivity, and provide rich descriptions of individual experiences of psychological-based interventions.

Implications for Clinical Practice

The present review brings together helpful and unhelpful aspects of psychological interventions for people with BD and highlights intervention characteristics which might facilitate positive change. This links to areas for future development of research and clinical practice of existing treatment approaches for BD.

Jauhar, McKenna and Laws (2016) reported that the majority of intervention studies focus measure outcomes relating to mood stability across time and social functioning. This review highlights that these are important measures of positive change; however, there is also a need for interventions to use outcomes of empowerment and improved relationships to measure positive change. Furthermore, it seems there is a need for psychological interventions to facilitate these active processes more directly. If individuals with BD feel empowered, they may experience more engagement in, and control over, their lives.

As a helpful starting point to empower individuals, clinicians should consider providing a choice of options within interventions. For example, providing the option for either individual, group, online, or a combination of these approaches. In addition, negotiating the timing, number of sessions, and the involvement of significant others may be useful. Clinicians should be flexible and adapt approaches where necessary, and create a safe and supportive environment to provide an opportunity for the individual to talk about what is most important to them. Clinicians need to be highly attuned in order to work with individuals across the diverse mood states and interpersonal styles. The interventions and information provided to individuals should be delivered by those with knowledge and expertise, and that this should be provided as early as possible to, increase individuals understanding and knowledge of BD. The role of peer support within interventions should also be considered to reduce feelings of isolation.

Given the effects of psychological-based interventions for BD are modest, it is important that researchers and clinicians discover what clients would want from therapy, rather than only focusing on what clients felt worked in those therapies, in order to improve the effectiveness of treatment.

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