

See discussions, stats, and author profiles for this publication at: <https://www.researchgate.net/publication/335697587>

The impact of a CBT-based bipolar disorder psychoeducation group on views about diagnosis, perceived recovery, self-esteem and stigma

Article in *The Cognitive Behaviour Therapist* · January 2019

DOI: 10.1017/S1754470X19000308

CITATIONS

0

2 authors:



Thomas Richardson

Solent NHS Trust

110 PUBLICATIONS 1,655 CITATIONS

[SEE PROFILE](#)

READS

17



Lucy White

Solent NHS Trust

7 PUBLICATIONS 0 CITATIONS

[SEE PROFILE](#)

Some of the authors of this publication are also working on these related projects:



Finances in Bipolar [View project](#)



Test of a Cognitive Model of Cannabis related Paranoia [View project](#)

This article has been accepted for publication in the Cognitive Behaviour Therapist and will appear in a revised form, subsequent to peer review and/or editorial input by Cambridge University Press, published by Cambridge University Press.

Copyright for the article belongs to Cambridge University Press

DOI: [10.1017/S1754470X19000308](https://doi.org/10.1017/S1754470X19000308)

<https://www.cambridge.org/core/journals/the-cognitive-behaviour-therapist/article/impact-of-a-cbtbased-bipolar-disorder-psychoeducation-group-on-views-about-diagnosis-perceived-recovery-selfesteem-and-stigma/6C452C37BB0B9C46F7FBF9FAF0082060>

**The Impact of a CBT-Based Bipolar Disorder
Psychoeducation Group on Views about Diagnosis,
Perceived Recovery, Self-Esteem and Stigma.**

Journal:	<i>The Cognitive Behaviour Therapist</i>
Manuscript ID	CBT-00484-19.R1
Manuscript Type:	Original Research
Keywords:	group psychotherapy, CBT, stigma, self esteem

SCHOLARONE™
Manuscripts

BIPOLAR GROUP AND RECOVERY

Original Research

The Impact of a CBT-Based Bipolar Disorder Psychoeducation Group on Views about Diagnosis, Perceived Recovery, Self-Esteem and Stigma.**Abstract**

Background: Previous research has shown psychoeducation for Bipolar Disorder improves symptoms and reduces relapse risk, but there is little research on how this impacts stigma, perceived recovery and views about diagnosis.

Aims: To explore whether a CBT-Based 12 week Bipolar Disorder Psychoeducation Group conducted in a community mental health team for adults impacted perceived stigma, diagnosis related self-esteem, recovery and views about diagnosis.

Method: Case series pre and post group with 23 participants across 3 groups. The brief illness perception questionnaire, views on manic depression questionnaire, bipolar recovery questionnaire and author constructed questions were completed pre and post.

Results: Twenty participants completed the group. An Intent-To-Treat repeated measures MANOVA showed significantly improved perceived recovery and improvements in sense of control and understanding around their diagnosis. Other specific questions such as understanding of triggers and impact of thinking patterns also improved. However there was no change in the perceived stigma or self-esteem associated with living with Bipolar Disorder.

Conclusions: CBT-based Psychoeducation Groups may help improve perceived recovery and factors such as sense of control in Bipolar Disorder. However there appears to be no impact on stigma and self-esteem, and the role of non-specific factors needs to be examined further.

BIPOLAR GROUP AND RECOVERY

Keywords: Bipolar Disorder; Psychoeducation; Group; Recovery; CBT; Stigma, Self-Esteem.

Key Learning Aims

- To raise awareness of the impact of stigma and self-esteem in Bipolar Disorder.
- To understand the content and structure of CBT based psychoeducation groups.
- To consider the potential benefits of CBT based psychoeducation groups beyond symptoms and relapse reduction on factors such as perceived recovery

BIPOLAR GROUP AND RECOVERY

**The Impact of a CBT-Based Bipolar Disorder Psychoeducation Group on Views about
Diagnosis, Perceived Recovery, Self-Esteem and Stigma.****Introduction**

Bipolar Disorder is characterised by episodes of mania or hypomania and usually episodes of depression (American Psychiatric Association, 2013; World Health Organisation, 2018). Manic episodes include symptoms such as inflated self-esteem and an increase in goal-directed activity. A major depressive episode is characterised by symptoms such as reduced pleasure in activities and feelings of worthlessness (APA, 2013; WHO, 2018). The lifetime prevalence is around 1% (Merikangas et al., 2011), and the diagnosis is associated with considerable impact on functioning even outside of acute mood episodes (Sanchez-Moreno et al., 2009).

A number of studies have found that psychological interventions may be beneficial in Bipolar Disorder. A meta-analysis (Oud et al., 2016) found reduced relapse rates and hospital admissions, with group interventions linked to fewer symptoms of depression. Individual studies of group based psychoeducation and Cognitive Behavioural Therapy (CBT) have also found an impact on functioning (Castle et al. 2007; Patelis-Siotis et al., 2001).

A smaller body of research has focused on changes outside of symptom improvements and relapse rates. Recovery focused CBT has also been shown to improve perceived personal recovery (Jones et al., 2015). Camardese et al. (2018) found that a psychoeducational and psychological programme improved self-reported insight and resilience. Etain et al. (2018) demonstrated improvements in knowledge about Bipolar Disorder and illness perception following from psychoeducation. Crowe & Inder (2018) interviewed young people with Bipolar Disorder 5 years after therapy had ended finding qualitative themes of understanding and self-awareness around Bipolar as well as learning to

BIPOLAR GROUP AND RECOVERY

live well with it. An online intervention has also been shown to improve recovery, wellbeing and quality of life (Todd, Jones, Hart, & Lobban, 2014).

Studies have shown that those with Bipolar Disorder often feel stigmatised: Warick, Mansell, Porter & Tai (2019) reviewed qualitative research about factors leading to distress in BD and found a theme of stigma. Nilsson, Kugathasan, & Straarup (2016) found perceived stigmatisation on a numbers of factors such as friendships and trustworthiness, with more than half reporting feeling stigmatised around hospitalisation and perceived ability to work. A study in multiple European countries found around one fifth had moderate or high levels of self-stigma, and this was predicted by factors such as education, employment and social contact (Brohan, Gauci, Sartorius, Thornicroft, & Group, 2011). Studies suggest that such self-stigma correlates with symptoms of depression, mania and anxiety (Howland, Levin, Blixen, Tatsuoka, & Sajatovic, 2016, Gilkes, Perich, & Meade, 2018), poorer social adjustment (Perlick et al., 2001) and poorer quality of life (Post et al., 2018). Karidi et al. (2015) however found that such stigmatisation was less intense than seen in those with a diagnosis of schizophrenia, and did not impact functioning. There has been little research on whether psychological therapy helps reduce stigma: though Nilsson et al. (2016) found such an effect following psychoeducation.

Bipolar disorder is also associated with low self-esteem: a meta-analysis of 19 studies found overall lower self-esteem in BD compared to controls, though higher than those with depression alone (Nilsson et al., 2010). Such low self-esteem occurs outside of mood episodes (Blairy et al., 2004). Other research has shown that outside of episodes self-esteem is not lower in BD but it is more variable (Knowles et al., 2007), and those with BD show more self-esteem changes in response to successes and failures (Pavlova, Uher, Dennington, Wright, & Donaldson, 2011). There is also some evidence of a relationship between self-esteem and feelings of stigma in BD (Hayward, Wong, Bright, & Lam, 2002). There is

BIPOLAR GROUP AND RECOVERY

however little research on psychological interventions around self-esteem in BD specifically, though Etaine et al (2018) found improved self-esteem following psychoeducation.

This study therefore aimed to add to the limited literature on whether psychoeducational groups for Bipolar disorder improve factors outside of mood symptoms specifically perceived recovery, diagnosis perception and Bipolar Disorder specific self-esteem and perceived stigma.

Method

Design

A case series was used evaluating changes in standardised measures pre and post group. This was conducted as a service evaluation: measures were used as part of standard care so ethics approval was not needed. Approval was given as a service evaluation by the hosting NHS trust research and audit service. Participants gave written consent for their data to be used for this evaluation.

Service and Group Content

The service is a National Health Service (NHS) secondary care community mental health service for working age adults with severe and enduring mental health problems. The group ran for 12 weeks and was facilitated by a Clinical Psychologist or Cognitive Behavioural Therapist supported by a Nurse/Care Coordinator or Assistant Psychologist. The session content was based on a number of previous papers, in particular the book by Colom and Vieta (2006), with more direct use of CBT thought-challenging techniques and mindfulness incorporated.

The data used is from 3 groups run separately over a two year period. Referrals were made to the group from staff in the community mental health teams. Each participant had an

BIPOLAR GROUP AND RECOVERY

individual appointment or phone call with the group facilitator to orient them to the group and discuss expectations. The group met weekly at the team base and ran for 2 hours with a break in the middle. A powerpoint presentation was used to convey the session content and these were made available as handouts. The group contained some didactic delivery of information but also emphasised the sharing of experiences, learning from and supporting one another. Questions and discussion was encouraged. A Psychiatrist or Pharmacist delivered the session on medication. Table 1 displays the content of each of the 12 sessions.

In terms of the content of the group from table 1 and how this focused on the specific variables measured here:

- **Recovery:** Awareness of early warning signs and triggers, behavioural strategies to cope with these, the role of thoughts in relapse, mood monitoring, issues around medication, the role of sleep and behaviours in mood, a relapse prevention plan to summarise, using mindfulness to prevent relapse, coping strategies for anxiety.
- **Diagnosis perception:** Education about symptoms, types of Bipolar disorder, continuum with normality, prevalence, genetic and brain factors, psychological factors such as early bereavement and households of high expressed emotion, lifetime course of Bipolar disorder, impact of life events and relation to stress-vulnerability model, relationship with substance use.

Self-Esteem and Stigma in relation to Bipolar Disorder: Discussing similar issues with fellow service users, self-disclosure of lived experience from staff running group if relevant and helpful, discussion of celebrities with a diagnosis of BD. Discussion of prevalence of BD, impact of genetics and early bereavements to normalise and validate. Discussion of BD not defining who you are, connecting with important parts of your identity outside of BD diagnosis, using CBT thought-challenging techniques to tackle self-critical

BIPOLAR GROUP AND RECOVERY

thoughts, discussion of how to tell friends family and employers, ways to challenge misconceptions or stigmatising attitudes towards BD, ***Insert Table 1 here***

Measures

The following questionnaires were given out before the group started and in the final session of the group:

Author Constructed Questions: Participants had to mark on a visual analogue scale ‘Not at all’ to ‘A lot’ for ‘To what extent do you feel you...’ for a number of questions such as:

- Understand what can trigger mood changes for you.
- Can recognise the early warning signs of becoming unwell.
- Are aware of your thinking patterns and how these relate to mood episodes.
- Can take action to prevent relapse.

Higher scores on these questions represented greater understanding/awareness.

Views on Manic Depression Questionnaire (Haywood, Cited in Lam, Jones, & Hayward, 2010) A 14 item measure of self-esteem and perceived stigma around Bipolar Disorder (For example ‘*I am able to do things as well as most other people*’ and ‘*Most people believe that a Bipolar Disorder sufferer is just as trustworthy as the average person*’.) α in current sample $\alpha = .77$. The term ‘Manic Depression’ was changed to ‘Bipolar Disorder’ for this measure. Lower scores represent greater stigma.

The Brief Illness Perception Questionnaire (Broadbent, Petrie, Main, & Weinman, 2006) is a 9 item questionnaire designed to assess the cognitive and emotional representations of illness (For example ‘*How well do you feel you understand your illness?*’ and ‘*How much control do you feel you have over your illness?*’). This was completed for Bipolar Disorder

BIPOLAR GROUP AND RECOVERY

diagnosis specifically. There are no totals for this measure each questions response is analysed individually.

Bipolar Recovery Questionnaire (Jones, Mulligan, Higginson, Dunn, & Morrison, 2013): A 36 item questionnaire measuring recovery experiences in Bipolar Disorder (For example *'I can have mood experiences and still get on with my life'* and *'I am unsure about the reasons behind some of the experiences I have had'*). α in current sample pre=.82. Higher scores represent greater perceived recovery.

Participant Characteristics

All participants had a diagnosis of Bipolar Disorder (Type 1 or Type 2). 43.5% ($n=10$) also had a secondary diagnosis such as Emotionally Unstable Personality Disorder, Anorexia, Alcohol Dependence or an Anxiety Disorder. Gender was 73.9% ($n=17$ female) and all participants reported their ethnicity as White European. Ages ranged from 20 to 62 with a mean of 43 years.

Statistical Analysis

For individual missing items on standardized measures, mean substitution was used. The scales of Views of Bipolar Disorder and Bipolar Recovery were normally distributed: Shapiro-Wilk=.93, $p>.05$ and .91, $p>.05$. A repeated measures Multiple Analysis of Variance was used to analyze changes from pre to post using an Intent to Treat (ITT) analysis with pre data being used as post data for those who did not complete the group.

Results

Out of the 23 participants who started the group, 87% ($n=20$) completed and 13% ($n=3$) dropped out (defined as attending less than half the sessions and/or actively saying they

BIPOLAR GROUP AND RECOVERY

no longer wished to attend). For those who dropped-out the number of sessions attended range from 1 to 4 out of 12 with a mean of 2.7, for completers the number of sessions attended range from 7 to 12 out of 12 with a mean of 10.7. Reasons given for drop out where one person reported feeling too low or oversleeping at times and finding it hard to attend, another was looking for work so could not commit to weekly sessions, and the final participant who dropped out stopped attending with no reason given and could not be contacted.

Table 2 displays the univariate results for pre and post group changes in all of the measures for the intent-to-treat analysis. This showed a number of statistically significant improvements on all of the author constructed questionnaires around factors such as understanding life events, understanding their triggers and impact of thinking patterns. All of these significant changes were for higher scores post-group representing greater understanding and awareness.

There were significant changes on the Brief Illness Perception questionnaire post-group with a greater sense of control over Bipolar disorder and more understanding about it, as well as non-significant trends for feeling more that treatment can help. There was also a trend for reporting that individuals experienced more symptoms post-group.

The overall total on the Views on Bipolar Disorder questionnaire did not change significantly. There was a significant change in scores on the Bipolar Recovery Questionnaire with higher overall scores representing greater perceived recovery: Mean total 2109.9 pre and 2272.1 post.

Insert Table 2 here

Discussion

BIPOLAR GROUP AND RECOVERY

The study aimed to examine the effects of a CBT-based Bipolar Disorder Psychoeducation Group on views about diagnosis, perceived recovery, and diagnosis specific self-esteem and stigma. The results show overall higher perceived recovery in relation to Bipolar Disorder following the group, in line with Jones et al (2015). This demonstrates the positive impact of psychoeducational interventions on factors outside of relapse rates and mood symptoms, and is in line with the recovery model of mental health which emphasises the importance of factors such as identity, hope and optimism about the future and empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). It is also important to note the relatively low dropout rates for the group; this demonstrates its acceptability and feasibility within this population.

Changes on diagnosis perception and suggest improved understanding of Bipolar Disorder and a greater sense of control of symptoms. Clients reporting a better understanding of the role of thinking patterns and behaviour in relapse further demonstrate improved recovery. They also show an increase in perceived ability to keep mood stable, take action to prevent relapse and greater awareness of early warning signs and triggers, in line with the work of de Andrés et al. (2006), who found that group therapy increase perceived ability to cope with relapse. Similarly Etain et al (2018) showed that improvements in functioning following psychoeducation were mediated by change in diagnosis perception. Experiencing symptoms was in the opposite direction to expected with individuals reporting more symptoms: this might represent becoming more aware of their early warning signs as is one of the group aims.

However other factors such as how much it affects life and how concerned participants were about diagnosis did not change. In particular there were no improvements on the Views on Manic Depression Scale which measures self-esteem and stigma in relation to Bipolar Disorder. This is surprising given that stigma has been shown to be less likely in those who

BIPOLAR GROUP AND RECOVERY

have received psychoeducation (Nilsson et al., 2016), and psychological and psychoeducational programmes have also been shown to improve self-esteem in Bipolar Disorder (Etain et al., 2018). The measure used has not been validated and though in this sample it had a high cronbach's alpha level it might not be a valid measure of Bipolar Disorder specific stigma. Another measure of broader self-esteem such as the Rosenberg Self-Esteem scale may have shown results (Rosenberg, 1989). It may be that the group content did not address stigma and self-esteem directly, or that other approaches such as multi-family group psychoeducation (Madigan et al., 2012), might have been more effective. It might have also been that changes in perceived stigma or self-esteem linked to the diagnosis had not yet emerged as the group had only just finished and a longer follow-up was needed to detect changes.

This study is limited by a number of factors: there was a short follow-up: the current study tried to assess changes at three and six month follow-up but only received five completed questionnaire for each so could not use this data. There was also no comparison control group which would be needed to control for input from the wider mental health team and non-specific factors may have impacted perceived recovery: unstructured peer support may prove a useful active control condition for future research. The small sample size also prevents any definitive conclusions and it may be that stigma and self-esteem are shown to improve with a larger sample size. All participants were white European which prevents generalizability of the findings to other ethnic groups. Public surveys in the UK have shown less knowledge and less positive attitudes and intended behaviour towards those with mental illness in minority ethnic groups (Evans-Lacko, Henderson & Thornicroft, 2013), thus challenging self-stigma and self-esteem in relation to Bipolar Disorder may be especially difficult within populations.

BIPOLAR GROUP AND RECOVERY

However the results suggest that psychoeducation groups may help perceived recovery in Bipolar Disorder; future research should help confirm this and determine effective ways of tackling stigma and improving self-esteem within this population.

Main Points

- A CBT-based psychoeducation group improved perceived recovery in those with Bipolar Disorder.
- There were also improvements in views about the diagnosis and perceived ability to cope.
- Drop-out rates were low suggesting acceptability.
- There is no benefit on Bipolar disorder related self-esteem and stigma, further work is needed to see how to improve self-esteem and self-stigma within this population.

BIPOLAR GROUP AND RECOVERY

Further Reading

- Lam, D. H., Jones, S. H., & Hayward, P.** (2010). *Cognitive Therapy for Bipolar Disorder: A Therapist's Guide to Concepts, Methods and Practice, Second Edition*. Chichester: Wiley, 71-122.
- Jones, S.H., Smith, G., Mulligan, L., Lobban, F. Law, H. & Morrison, A.P.** (2015). Recovery-focused cognitive-behavioural therapy for recent-onset bipolar disorder: randomised controlled pilot trial. *British Journal of Psychiatry*, **206**(1), 58-66.
- Oud, M., Mayo-Wilson, E., Braidwood, R., Schulte, P., Jones, S. H., Morriss, R., . . . Kendall, T.** (2016). Psychological interventions for adults with bipolar disorder: systematic review and meta-analysis. *The British Journal of Psychiatry*, **208**(3), 213-222. doi:10.1192/bjp.bp.114.157123

BIPOLAR GROUP AND RECOVERY

References

- American Psychiatric Association** (2013). *Diagnostic and statistical manual of mental disorders (DSM-5)*: Arlington VA: American Psychiatric Publishing.
- Blairy, S., Linotte, S., Souery, D., Papadimitriou, G., Dikeos, D., Lerer, B., . . . Macciardi, F.** (2004). Social adjustment and self-esteem of bipolar patients: a multicentric study. *Journal of affective disorders*, **79**(1-3), 97-103.
- Broadbent, E., Petrie, K. J., Main, J., & Weinman, J.** (2006). The brief illness perception questionnaire. *Journal of psychosomatic research*, **60**(6), 631-637.
- Brohan, E., Gauci, D., Sartorius, N., Thornicroft, G., & Group, G. E. S.** (2011). Self-stigma, empowerment and perceived discrimination among people with bipolar disorder or depression in 13 European countries: The GAMIAN–Europe study. *Journal of affective disorders*, **129**(1-3), 56-63.
- Castle, D., Berk, M., Berk, L., Lauder, S., Chamberlain, J., & Gilbert, M.** (2007). Pilot of group intervention for bipolar disorder. *International Journal of Psychiatry in Clinical Practice*, **11**(4), 279-284.
- Colom, F., & Vieta, E.** (2006). *Psychoeducation manual for bipolar disorder*: Cambridge: Cambridge University Press.
- Camardese, G., Vasale, M., D'Alessandris, L., Mazza, M., Serrani, R., Travagliati, F., . . . Janiri, L.** (2018). A Mixed Program of Psychoeducational and Psychological Rehabilitation for Patients With Bipolar Disorder in a Day Hospital Setting. *The Journal of Nervous and Mental Disease*, **206**(4), 290-295.
- Crowe, M., & Inder, M.** (2018). Staying well with bipolar disorder: A qualitative analysis of five-year follow-up interviews with young people. *Journal of Psychiatric and Mental Health Nursing*, **25**(4), 236-244.

BIPOLAR GROUP AND RECOVERY

de Andrés, R. D., Aillon, N., Bardiot, M.-C., Bourgeois, P., Mertel, S., Nerfin, F., . . .

Aubry, J.-M. (2006). Impact of the life goals group therapy program for bipolar patients: an open study. *Journal of Affective Disorders*, 93(1), 253-257.

Etain, B., Scott, J., Cochet, B., Bellivier, F., Boudebessé, C., Drancourt, N., . . . Fouques,

D. (2018). A study of the real-world effectiveness of group psychoeducation for bipolar disorders: Is change in illness perception a key mediator of benefit? *Journal of Affective Disorders*, 227, 713-720.

Evans-Lacko, S., Henderson C., & Thornicroft, G. (2013). Public knowledge, attitudes and behaviour regarding people with mental illness in England 2009–2012. *The British Journal of Psychiatry*, 202, 51–57.

Gilkes, M., Perich, T., & Meade, T. (2018). Predictors of self-stigma in bipolar disorder: Depression, mania, and perceived cognitive function. *Stigma and Health*, Epub ahead of print.

Hayward, P. (2010) “The Views on Manic Depression Questionnaire” Cited in **Lam, D. H., Jones, S. H., & Hayward, P.** (2010). Pre-Therapy Assessment. *Cognitive Therapy for Bipolar Disorder: A Therapist's Guide to Concepts, Methods and Practice, Second Edition*. Chichester: Wiley, 71-122.

Hayward, P., Wong, G., Bright, J. A., & Lam, D. (2002). Stigma and self-esteem in manic depression: an exploratory study. *Journal of affective disorders*, 69(1-3), 61-67.

Howland, M., Levin, J., Blixen, C., Tatsuoka, C., & Sajatovic, M. (2016). Mixed-methods analysis of internalized stigma correlates in poorly adherent individuals with bipolar disorder. *Comprehensive Psychiatry*, 70, 174-180.

Jones, S.H., Smith, G., Mulligan, L., Lobban, F. Law, H. & Morrison, A.P. (2015). Recovery-focused cognitive-behavioural therapy for recent-onset bipolar disorder: randomised controlled pilot trial. *British Journal of Psychiatry*, 206(1), 58-66.

BIPOLAR GROUP AND RECOVERY

- Jones, S., Mulligan, L. D., Higginson, S., Dunn, G., & Morrison, A. P.** (2013). The bipolar recovery questionnaire: psychometric properties of a quantitative measure of recovery experiences in bipolar disorder. *Journal of Affective Disorders*, **147**(1), 34-43.
- Karidi, M. V., Vassilopoulou, D., Savvidou, E., Vitoratou, S., Maillis, A., Rabavilas, A., & Stefanis, C. N.** (2015). Bipolar disorder and self-stigma: A comparison with schizophrenia. *Journal of Affective Disorders*, **184**, 209-215.
- Knowles, R., Tai, S., Jones, S. H., Highfield, J., Morriss, R., & Bentall, R. P.** (2007). Stability of self-esteem in bipolar disorder: comparisons among remitted bipolar patients, remitted unipolar patients and healthy controls 1. *Bipolar Disorders*, **9**(5), 490-495.
- Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M.** (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry*, **199**(6), 445-452.
- Merikangas, K. R., Jin, R., He, J.-P., Kessler, R. C., Lee, S., Sampson, N. A., . . . Karam, E. G.** (2011). Prevalence and correlates of bipolar spectrum disorder in the world mental health survey initiative. *Archives of General Psychiatry*, **68**(3), 241-251.
- Nilsson, K. K., Kugathasan, P., & Straarup, K. N.** (2016). Characteristics, correlates and outcomes of perceived stigmatization in bipolar disorder patients. *Journal of Affective Disorders*, **194**, 196-201.
- Nilsson, K. K., Jørgensen, C. R., Craig, T. K. J., Staarup, K. N. & Licht, R.M.** (2010). Self-esteem in remitted bipolar disorder patients: a meta-analysis. *Bipolar Disorders*, **12**(6), 585-592.
- Oud, M., Mayo-Wilson, E., Braidwood, R., Schulte, P., Jones, S. H., Morriss, R., . . . Kendall, T.** (2016). Psychological interventions for adults with bipolar disorder:

BIPOLAR GROUP AND RECOVERY

- systematic review and meta-analysis. *The British Journal of Psychiatry*, **208**(3), 213-222.
- Patelis-Siotis, I., Young, L. T., Robb, J. C., Marriott, M., Bieling, P. J., Cox, L. C., & Joffe, R. T.** (2001). Group cognitive behavioral therapy for bipolar disorder: a feasibility and effectiveness study. *Journal of Affective Disorders*, **65**(2), 145-153.
- Pavlova, B., Uher, R., Dennington, L., Wright, K., & Donaldson, C.** (2011). Reactivity of affect and self-esteem during remission in bipolar affective disorder: An experimental investigation. *Journal of affective disorders*, **134**(1-3), 102-111.
- Perlick, D. A., Rosenheck, R. A., Clarkin, J. F., Sirey, J. A., Salahi, J., Struening, E. L., & Link, B. G.** (2001). Stigma as a barrier to recovery: adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatric Services*, **52**(12), 1627-1632.
- Post, F., Pardeller, S., Frajo-Apor, B., Kemmler, G., Sondermann, C., Hausmann, A., . . . Hofer, A.** (2018). Quality of life in stabilized outpatients with bipolar I disorder: Associations with resilience, internalized stigma, and residual symptoms. *Journal of Affective Disorders*, **238**, 399-404.
- Sanchez-Moreno, J., Martinez-Aran, A., Tabares-Seisdedos, R., Torrent, C., Vieta, E., & Ayuso-Mateos, J.** (2009). Functioning and disability in bipolar disorder: an extensive review. *Psychotherapy and Psychosomatics*, **78**(5), 285-297.
- Todd, N. J., Jones, S. H., Hart, A., & Lobban, F. A.** (2014). A web-based self-management intervention for bipolar disorder 'living with bipolar': a feasibility randomised controlled trial. *Journal of Affective Disorders*, **169**, 21-29.
- Warwick, H., Mansell, W., Porter, C. & Tai, S.** (2019). 'What people diagnosed with bipolar disorder experience as distressing': A meta-synthesis of qualitative research. *Journal of Affective Disorders*, **248**(1), 108-130.

BIPOLAR GROUP AND RECOVERY

World Health Organisation (2018). *World Health Organization. Classification of diseases Eleven (ICD-11)*. Geneva: World Health Organisation.

For Peer Review

Table 1

Group session content

Session number	Session Content
1	Introductions and group rules: What is bipolar disorder - psychological and biological aspects.
2	Mood Monitoring: The potential value of diaries and apps. Introducing the Stress vulnerability model and lifetime course of Bipolar Disorder. Introducing the idea of life charts (each participant was then encouraged to complete their own life chart and share with the group during the course of the 12 sessions).
3	Identifying symptoms, triggers and early warnings signs
4	Medication: What's available, pros and cons, managing expectations, side effects and an open forum for questions.
5	Introduction to CBT model: making links between thoughts, behaviours and mood. Highlighting the role of thoughts in relapse

-
- 6 Unhelpful thinking patterns: how to notice them and how to challenge them
-
- 7 Introduction to Mindfulness and its potential value in living with Bipolar Disorder. Overview and brief practices.
-
- 8 Stress and Anxiety Management: theory and techniques to manage differently
-
- 9 Linking behaviour, habits and mood. Introducing problem solving and prioritising.
-
- 10 The impact of alcohol and drugs on living with Bipolar Disorder.
-
- 11 Interpersonal issues: how and why to tell people, involving others in supporting the noticing of early warning signs and how best they can support you.
-
- 12 Putting it all together: creating your own Staying Well Plan. (this idea was introduced in session 3 and all content was delivered with explicit links to
-

how it could be incorporated into an individualised staying well plan.

For Peer Review

Table 2:

Univariate results of MANOVA: Changes pre and post group in all measures for Intent-To-Treat Analysis

Measure	F	Partial η^2
ACQ Measure		
Understand what bipolar disorder is	14.7**	.40
Understand causes	17.3**	.44
Understand triggers	22.5***	.51
Recognise the early warning signs	27.1***	.55
Have control over mood changes	4.7*	.18
Understand impact of life events	38.9***	.64
Impact of thinking patterns	19.0***	.46
Impact of behaviour	9.8**	.31
Manage stress	15.3**	.41
Understand medications	65.9*	.21
Keep mood stable	19.5***	.47
Action to Prevent Relapse	20.2***	.48
Brief Illness Perception Questionnaire		
How much affect your life	2.5	.12
How long will continue	.67	.01
How much control have	8.3**	.27
How much can treatment help	3.3+	.13
How much experience symptoms	3.1+	.12
How concerned about illness	.96	.04
How well understand illness	18.7***	.46

How much affect emotionally	1.2	.05
Views on Bipolar Disorder Questionnaire:		
Total	1.9	.08
Bipolar Recovery Questionnaire: Total		
	5.9*	.21

* $p<.05$

** $p<.01$

*** $p<.001$

+ = NS trend $p<.10$

For Peer Review

BIPOLAR GROUP AND RECOVERY

Original Research

The Impact of a CBT-Based Bipolar Disorder Psychoeducation Group on Views about Diagnosis, Perceived Recovery, Self-Esteem and Stigma.**Abstract**

Background: Previous research has shown psychoeducation for Bipolar Disorder improves symptoms and reduces relapse risk, but there is little research on how this impacts stigma, perceived recovery and views about diagnosis.

Aims: To explore whether a CBT-Based 12 week Bipolar Disorder Psychoeducation Group conducted in a community mental health team for adults impacted perceived stigma, diagnosis related self-esteem, recovery and views about diagnosis.

Method: Case series pre and post group with 23 participants across 3 groups. The brief illness perception questionnaire, views on manic depression questionnaire, bipolar recovery questionnaire and author constructed questions were completed pre and post.

Results: Twenty participants completed the group. An Intent-To-Treat repeated measures MANOVA showed significantly improved perceived recovery and improvements in sense of control and understanding around their diagnosis. Other specific questions such as understanding of triggers and impact of thinking patterns also improved. However there was no change in the perceived stigma or self-esteem associated with living with Bipolar Disorder.

Conclusions: CBT-based Psychoeducation Groups may help improve perceived recovery and factors such as sense of control in Bipolar Disorder. However there appears to be no impact on stigma and self-esteem, and the role of non-specific factors needs to be examined further.

BIPOLAR GROUP AND RECOVERY

Keywords: Bipolar Disorder; Psychoeducation; Group; Recovery; CBT; Stigma, Self-Esteem.

Key Learning Objectives/Aims

- To ~~be~~raise awareness of the impact of stigma and self-esteem in Bipolar Disorder.
- To understand the ~~role~~content and structure of CBT based psychoeducation groups.
- To c~~o~~nsider the potential benefits of CBT based psychoeducation groups beyond symptoms and relapse reduction on factors such as perceived recovery.

BIPOLAR GROUP AND RECOVERY

**The Impact of a CBT-Based Bipolar Disorder Psychoeducation Group on Views about
Diagnosis, Perceived Recovery, Self-Esteem and Stigma.****Introduction**

Bipolar Disorder is characterised by episodes of mania or hypomania and usually episodes of depression (American Psychiatric Association, 2013; World Health Organisation, 2018). Manic episodes include symptoms such as inflated self-esteem and an increase in goal-directed activity. A major depressive episode is characterised by symptoms such as reduced pleasure in activities and feelings of worthlessness (APA, 2013; WHO, 2018). The lifetime prevalence is around 1% (Merikangas et al., 2011), and the diagnosis is associated with considerable impact on functioning even outside of acute mood episodes (Sanchez-Moreno et al., 2009).

A number of studies have found that psychological interventions may be beneficial in Bipolar Disorder. A meta-analysis (Oud et al., 2016) found reduced relapse rates and hospital admissions, with group interventions linked to fewer symptoms of depression. Individual studies of group based psychoeducation and Cognitive Behavioural Therapy (CBT) have also found an impact on functioning (Castle et al. 2007; Patelis-Siotis et al., 2001).

A smaller body of research has focused on changes outside of symptom improvements and relapse rates. Recovery-focused CBT has also been shown to improve perceived personal recovery (Jones et al., 2015). Camardese et al. (2018) found that a psychoeducational and psychological programme improved self-reported insight and resilience. Etain et al. (2018) demonstrated improvements in knowledge about Bipolar Disorder and illness perception following from psychoeducation. Crowe & Inder (2018) interviewed young people with Bipolar Disorder 5 years after therapy had ended finding qualitative themes of understanding and self-awareness around Bipolar as well as learning to

BIPOLAR GROUP AND RECOVERY

live well with it. An online intervention has also been shown to improve recovery, wellbeing and quality of life (Todd, Jones, Hart, & Lobban, 2014).

Studies have shown that those with Bipolar Disorder often feel stigmatised: Warick, Mansell, Porter & Tai (2019) reviewed qualitative research about factors leading to distress in BD and found a theme of stigma. ~~(Nilsson, Kugathasan, & Straarup, (2016); found perceived stigmatisation on a numbers of factors such as friendships and trustworthiness, with more than half reporting feeling stigmatised around hospitalisation and perceived ability to work~~ Karidi et al., 2015), and such A study in multiple European countries found around one fifth had moderate or high levels of self-stigma, and this was predicted by factors such as education, employment and social contact (Brohan, Gauci, Sartorius, Thornicroft, & Group, 2011). Studies suggest that such self-stigma correlates with symptoms of depression, mania and anxiety (Howland, Levin, Blixen, Tatsuoka, & Sajatovic, 2016₂); ~~(Gilkes, Perich, & Meade, 2018), poorer social adjustment (Perlick et al., 2001) and poorer quality of life (Post et al., 2018).~~ Karidi et al. (2015) however found that such stigmatisation was less intense than seen in those with a diagnosis of schizophrenia, and did not impact functioning. There has been little research on whether psychological therapy helps reduce stigma: though Nilsson et al. (2016) found such an effect following psychoeducation.

Bipolar disorder is also associated with low self-esteem: a meta-analysis of 19 studies found overall lower self-esteem in BD compared to controls, though higher than those with depression alone (Nilsson et al., 2010); Such low self-esteem occurs outside of mood episodes (Blairy et al., 2004). Other research has shown that outside of episodes self-esteem is not lower in BD but it is more variable (Knowles et al., 2007), and those with BD show more self-esteem changes in response to successes and failures (Pavlova, Uher, Dennington, Wright, & Donaldson, 2011). There is also some evidence of a relationship between self-esteem and feelings of stigma in BD (Hayward, Wong, Bright, & Lam, 2002). There is

BIPOLAR GROUP AND RECOVERY

however little research on psychological interventions around self-esteem in BD specifically,
though Etaine et al (2018) found improved self-esteem following psychoeducation, ~~but there~~
~~is little research on this variable specifically.~~

This study therefore aimed to add to the limited literature on whether psychoeducational groups for Bipolar disorder improve factors outside of mood symptoms specifically perceived recovery, diagnosis perception and Bipolar Disorder specific self-esteem and perceived stigma.

Method

Design

A case series was used evaluating changes in standardised measures pre and post group ~~was used~~. This was conducted as a service evaluation: measures were used as part of standard care so ethics approval was not needed. Approval was given as a service evaluation by the hosting NHS trust research and audit service. Participants gave written consent for their data to be used for this evaluation.

Service and Group Content

The service is a National Health Service (NHS) secondary care community mental health service for working age adults with severe and enduring mental health problems. The group ran for 12 weeks and was facilitated by a Clinical Psychologist or Cognitive Behavioural Therapist supported by a Nurse/Care Coordinator or Assistant Psychologist. The session content was based on a number of previous papers, in particular the book by Colom and Vieta (2006), with more direct use of CBT thought-challenging techniques and mindfulness incorporated.

BIPOLAR GROUP AND RECOVERY

The data used is from 3 groups run separately over a two year period. Referrals were made to the group from staff in the community mental health teams. Each participant had an individual appointment or phone call with the group facilitator to orient them to the group and discuss expectations. The group met weekly at the team base and ran for 2 hours with a break in the middle. A powerpoint presentation was used to convey the session content and these were made available as handouts. The group contained some didactic delivery of information but also emphasised the sharing of experiences, learning from and supporting one another. Questions and discussion was encouraged. A Psychiatrist or Pharmacist delivered the session on medication. Table 1 displays the content of each of the 12 sessions.

In terms of the content of the group from table 1 and how this focused on the specific variables measured here:

- **Recovery:** Awareness of early warning signs and triggers, behavioural strategies to cope with these, the role of thoughts in relapse, mood monitoring, issues around medication, the role of sleep and behaviours in mood, a relapse prevention plan to summarise, using mindfulness to prevent relapse, coping strategies for anxiety.
- **Diagnosis perception:** Education about symptoms, types of Bipolar disorder, continuum with normality, prevalence, genetic and brain factors, psychological factors such as early bereavement and households of high expressed emotion, lifetime course of Bipolar disorder, impact of life events and relation to stress-vulnerability model, relationship with substance use.
- **Self-Esteem and Stigma in relation to Bipolar Disorder:** Discussing similar issues with fellow service users, self-disclosure of lived experience from staff running group if relevant and helpful, discussion of celebrities with a diagnosis of BD. Discussion of prevalence of BD, impact of genetics and early

BIPOLAR GROUP AND RECOVERY

bereavements to normalise and validate. Discussion of BD not defining who you are, connecting with important parts of your identity outside of BD diagnosis, using CBT thought-challenging techniques to tackle self-critical thoughts, discussion of how to tell friends family and employers, ways to challenge misconceptions or stigmatising attitudes towards BD,

****Insert Table 1 here****

Measures

The following questionnaires were given out before the group started and in the final session of the group:

Author Constructed Questions: Participants had to mark on a visual analogue scale ‘Not at all’ to ‘A lot’ for ‘To what extent do you feel you...’ for a number of questions such as:

- Understand what can trigger mood changes for you.
- Can recognise the early warning signs of becoming unwell.
- Are aware of your thinking patterns and how these relate to mood episodes.
- Can take action to prevent relapse.

Higher scores on these questions represented greater understanding/awareness.

Views on Manic Depression Questionnaire (Haywood, Cited in Lam, Jones, & Hayward, 2010) A 14 item measure of self-esteem and perceived stigma around Bipolar Disorder (For example ‘*I am able to do things as well as most other people*’ and ‘*Most people believe that a Bipolar Disorder sufferer is just as trustworthy as the average person*’.) α in current sample $\alpha = .77$. The term ‘Manic Depression’ was changed to ‘Bipolar Disorder’ for this measure. Lower scores represent greater stigma.

BIPOLAR GROUP AND RECOVERY

The Brief Illness Perception Questionnaire (Broadbent, Petrie, Main, & Weinman, 2006) is a 9 item questionnaire designed to assess the cognitive and emotional representations of illness (For example '*How well do you feel you understand your illness?*' and '*How much control do you feel you have over your illness?*'). This was completed for Bipolar Disorder diagnosis specifically. There are no totals for this measure each questions response is analysed individually.

Bipolar Recovery Questionnaire (Jones, Mulligan, Higginson, Dunn, & Morrison, 2013): A 36 item questionnaire measuring recovery experiences in Bipolar Disorder (For example '*I can have mood experiences and still get on with my life*' and '*I am unsure about the reasons behind some of the experiences I have had*'). α in current sample pre=.82. Higher scores represent greater perceived recovery.

Participant Characteristics

All participants had a diagnosis of Bipolar Disorder (Type 1 or Type 2). 43.5% ($n=10$) also had a secondary diagnosis such as Emotionally Unstable Personality Disorder, Anorexia, Alcohol Dependence or an Anxiety Disorder. Gender was 73.9% ($n=17$ female) and all participants reported their ethnicity as White European. Ages ranged from 20 to 62 with a mean of 43 years.

Statistical Analysis

For individual missing items on standardized measures, mean substitution was used. The scales of Views of Bipolar Disorder and Bipolar Recovery were normally distributed: Shapiro-Wilk=.93, $p>.05$ and .91, $p>.05$. A repeated measures Multiple Analysis of Variance was used to analyze changes from pre to post using an Intent to Treat (ITT) analysis with pre data being used as post data for those who did not complete the group.

BIPOLAR GROUP AND RECOVERY

Results

Out of the 23 participants who started the group, 87% ($n=20$) completed and 13% ($n=3$) dropped out (defined as attending less than half the sessions and/or actively saying they no longer wished to attend). For those who dropped-out the number of sessions attended range from 1 to 4 out of 12 with a mean of 2.7, for completers the number of sessions attended range from 7 to 12 out of 12 with a mean of 10.7. Reasons given for drop out where one person reported feeling too low or oversleeping at times and finding it hard to attend, another was looking for work so could not commit to weekly sessions, and the final participant who dropped out stopped attending with no reason given and could not be contacted.

Table 2 displays the univariate results for pre and post group changes in all of the measures for the intent-to-treat analysis. This showed a number of statistically significant improvements on all of the author constructed questionnaires around factors such as understanding life events, understanding their triggers and impact of thinking patterns. All of these significant changes were for higher scores post-group representing greater understanding and awareness.

There were significant changes on the Brief Illness Perception questionnaire post-group with a greater sense of control over Bipolar disorder and more understanding about it, as well as non-significant trends for feeling more that treatment can help. There was also a trend for reporting that individuals experienced more symptoms post-group.

The overall total on the Views on Bipolar Disorder questionnaire did not change significantly. There was a significant change in scores on the Bipolar Recovery Questionnaire with higher overall scores representing greater perceived recovery: Mean total 2109.9 pre and 2272.1 post.

BIPOLAR GROUP AND RECOVERY

Insert Table 2 here

Discussion

The study aimed to examine the effects of a CBT-based Bipolar Disorder Psychoeducation Group on views about diagnosis, perceived recovery, and diagnosis specific self-esteem and stigma. The results show overall higher perceived recovery in relation to Bipolar Disorder following the group, in line with Jones et al (2015). This demonstrates the positive impact of psychoeducational interventions on factors outside of relapse rates and mood symptoms, and is in line with the recovery model of mental health which emphasises the importance of factors such as identity, hope and optimism about the future and empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). It is also important to note the relatively low dropout rates for the group; this demonstrates its acceptability and feasibility within this population.

Changes on diagnosis perception and ~~author constructed questions further demonstrates~~ suggest improvements improved on factors such as understanding of Bipolar Disorder and ~~increased feelings of a greater sense of control of symptoms~~. Clients reporting a better understanding of the role of thinking patterns and behaviour in relapse further demonstrate improved recovery. They also show an increase in perceived ability to keep mood stable, take action to prevent relapse and greater awareness of early warning signs and triggers, in line with the work of (de Andrés et al., (2006), who found that group therapy increase perceived ability to cope with relapse. Similarly Etain et al (2018) showed that improvements in functioning following psychoeducation were mediated by change in diagnosis perception. Experiencing symptoms was in the opposite direction to expected with

BIPOLAR GROUP AND RECOVERY

individuals reporting more symptoms: this might represent becoming more aware of their emerging warning signs as is one of the group aims.

However other factors such as how much it affects life and how concerned participants were about diagnosis did not change. In particular there were no improvements on the Views on Manic Depression Scale which measures self-esteem and stigma in relation to Bipolar Disorder. This is surprising given that stigma has been shown to be less likely in those who have received psychoeducation (Nilsson et al., 2016), and psychological and psychoeducational programmes have also been shown to improve self-esteem in Bipolar Disorder (Etain et al., 2018). The measure used has not been validated and though in this sample it had a high cronbach's alpha level it might not be a valid measure of Bipolar Disorder specific stigma. Another measure of broader self-esteem such as the Rosenberg Self-Esteem scale may have shown results (Rosenberg, 1989). It may be that the group content did not address stigma and self-esteem directly, or that other approaches such as multi-family group psychoeducation (Madigan et al., 2012), might have been more effective. It might have also been that changes in perceived stigma or self-esteem linked to the diagnosis had not yet emerged as the group had only just finished and a longer follow-up was needed to detect changes.

This study is limited by a number of factors: there was a short follow-up: the current study tried to assess changes at three and six month follow-up but only received five completed questionnaire for each so could not use this data and no comparison group. There was also no comparison control group which would be needed to control for input from the wider mental health team and ~~thus~~ non-specific factors may have impacted perceived recovery: unstructured peer support may prove a useful active control condition for future research. The small sample size also prevents any definitive conclusions and it may be that stigma and self-esteem are shown to improve with a larger sample size. All participants were

BIPOLAR GROUP AND RECOVERY

white European which prevents generalizability of the findings to other ethnic groups. Public surveys in the UK have shown less knowledge and less positive attitudes and intended behaviour towards those with mental illness in minority ethnic groups (Evans-Lacko, Henderson & Thornicroft, 2013), thus challenging self-stigma and self-esteem in relation to Bipolar Disorder may be especially difficult within populations.

However the results suggest that psychoeducation groups may help perceived recovery in Bipolar Disorder; future research should help confirm this and determine effective ways of tackling stigma and improving self-esteem within this population.

Main Points

- A CBT-based psychoeducation groups improved perceived recovery in those with Bipolar Disorder.
- There ~~are~~ were also improvements in views about the diagnosis and perceived ability to cope.
- Drop-out rates were low suggesting acceptability.
- There is no benefit on Bipolar disorder related self-esteem and stigma, further work is needed to see how to improve self-esteem and self-stigma within this population.

BIPOLAR GROUP AND RECOVERY

Further Reading

- ~~Hayward, P. (2010) "The Views on Manic Depression Questionnaire" Cited in Lam, D. H., Jones, S. H., & Hayward, P. (2010). *Pre-Therapy Assessment: Cognitive Therapy for Bipolar Disorder: A Therapist's Guide to Concepts, Methods and Practice, Second Edition*. Chichester: Wiley, 71-122.~~
- ~~Jones, S.H., Smith, G., Mulligan, L., Lobban, F. Law, H. & Morrison, A.P. (2015). Recovery-focused cognitive-behavioural therapy for recent-onset bipolar disorder: randomised controlled pilot trial. *British Journal of Psychiatry*, **206**(1), 58-66.~~
- ~~Oud, M., Mayo-Wilson, E., Braidwood, R., Schulte, P., Jones, S. H., Morriss, R., . . . Kendall, T. (2016). Psychological interventions for adults with bipolar disorder: systematic review and meta-analysis. *The British Journal of Psychiatry*, **208**(3), 213-222. doi:10.1192/bjp.bp.114.157123~~
- ~~Colom, F., & Vieta, E. (2006). *Psychoeducation manual for bipolar disorder*. Cambridge: Cambridge University Press.~~

References

- American Psychiatric Association** (2013). *Diagnostic and statistical manual of mental disorders (DSM-5)*: Arlington VA: American Psychiatric Publishing.
- Blairy, S., Linotte, S., Souery, D., Papadimitriou, G., Dikeos, D., Lerer, B., . . . Macciardi, F.** (2004). Social adjustment and self-esteem of bipolar patients: a multicentric study. *Journal of affective disorders*, **79**(1-3), 97-103.
- Broadbent, E., Petrie, K. J., Main, J., & Weinman, J.** (2006). The brief illness perception questionnaire. *Journal of psychosomatic research*, **60**(6), 631-637.
- Brohan, E., Gauci, D., Sartorius, N., Thornicroft, G., & Group, G. E. S.** (2011). Self-stigma, empowerment and perceived discrimination among people with bipolar disorder or depression in 13 European countries: The GAMIAN–Europe study. *Journal of affective disorders*, **129**(1-3), 56-63.
- Castle, D., Berk, M., Berk, L., Lauder, S., Chamberlain, J., & Gilbert, M.** (2007). Pilot of group intervention for bipolar disorder. *International Journal of Psychiatry in Clinical Practice*, **11**(4), 279-284.
- Colom, F., & Vieta, E.** (2006). *Psychoeducation manual for bipolar disorder*: Cambridge: Cambridge University Press.
- Camardese, G., Vasale, M., D'Alessandris, L., Mazza, M., Serrani, R., Travagliati, F., . . . Janiri, L.** (2018). A Mixed Program of Psychoeducational and Psychological Rehabilitation for Patients With Bipolar Disorder in a Day Hospital Setting. *The Journal of Nervous and Mental Disease*, **206**(4), 290-295.
- Crowe, M., & Inder, M.** (2018). Staying well with bipolar disorder: A qualitative analysis of five-year follow-up interviews with young people. *Journal of Psychiatric and Mental Health Nursing*, **25**(4), 236-244.

BIPOLAR GROUP AND RECOVERY

de Andrés, R. D., Aillon, N., Bardiot, M.-C., Bourgeois, P., Mertel, S., Nerfin, F., . . .

Aubry, J.-M. (2006). Impact of the life goals group therapy program for bipolar patients: an open study. *Journal of Affective Disorders*, 93(1), 253-257.

Etain, B., Scott, J., Cochet, B., Bellivier, F., Boudebese, C., Drancourt, N., . . . Fouques,

D. (2018). A study of the real-world effectiveness of group psychoeducation for bipolar disorders: Is change in illness perception a key mediator of benefit? *Journal of Affective Disorders*, 227, 713-720.

Evans-Lacko, S., Henderson C., & Thornicroft, G. (2013). Public knowledge, attitudes and behaviour regarding people with mental illness in England 2009–2012. *The British Journal of Psychiatry*, 202, 51–57.

Gilkes, M., Perich, T., & Meade, T. (2018). Predictors of self-stigma in bipolar disorder: Depression, mania, and perceived cognitive function. *Stigma and Health*, Epub ahead of print.

Hayward, P. (2010) “The Views on Manic Depression Questionnaire” Cited in Lam, D. H., Jones, S. H., & Hayward, P. (2010). Pre-Therapy Assessment. *Cognitive Therapy for Bipolar Disorder: A Therapist's Guide to Concepts, Methods and Practice, Second Edition*. Chichester: Wiley, 71-122.

Hayward, P., Wong, G., Bright, J. A., & Lam, D. (2002). Stigma and self-esteem in manic depression: an exploratory study. *Journal of affective disorders*, 69(1-3), 61-67.

Howland, M., Levin, J., Blixen, C., Tatsuoka, C., & Sajatovic, M. (2016). Mixed-methods analysis of internalized stigma correlates in poorly adherent individuals with bipolar disorder. *Comprehensive Psychiatry*, 70, 174-180.

Jones, S.H., Smith, G., Mulligan, L., Lobban, F. Law, H. & Morrison, A.P. (2015). Recovery-focused cognitive-behavioural therapy for recent-onset bipolar disorder: randomised controlled pilot trial. *British Journal of Psychiatry*, 206(1), 58-66.

BIPOLAR GROUP AND RECOVERY

- Jones, S., Mulligan, L. D., Higginson, S., Dunn, G., & Morrison, A. P.** (2013). The bipolar recovery questionnaire: psychometric properties of a quantitative measure of recovery experiences in bipolar disorder. *Journal of Affective Disorders*, **147**(1), 34-43.
- Karidi, M. V., Vassilopoulou, D., Savvidou, E., Vitoratou, S., Maillis, A., Rabavilas, A., & Stefanis, C. N.** (2015). Bipolar disorder and self-stigma: A comparison with schizophrenia. *Journal of Affective Disorders*, **184**, 209-215.
- Knowles, R., Tai, S., Jones, S. H., Highfield, J., Morriss, R., & Bentall, R. P.** (2007). Stability of self-esteem in bipolar disorder: comparisons among remitted bipolar patients, remitted unipolar patients and healthy controls 1. *Bipolar Disorders*, **9**(5), 490-495.
- Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M.** (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry*, **199**(6), 445-452.
- Merikangas, K. R., Jin, R., He, J.-P., Kessler, R. C., Lee, S., Sampson, N. A., . . . Karam, E. G.** (2011). Prevalence and correlates of bipolar spectrum disorder in the world mental health survey initiative. *Archives of General Psychiatry*, **68**(3), 241-251.
- Nilsson, K. K., Kugathasan, P., & Straarup, K. N.** (2016). Characteristics, correlates and outcomes of perceived stigmatization in bipolar disorder patients. *Journal of Affective Disorders*, **194**, 196-201.
- Nilsson, K. K., Jørgensen, C. R., Craig, T. K. J., Staarup, K. N. & Licht, R.M.** (2010). Self-esteem in remitted bipolar disorder patients: a meta-analysis. *Bipolar Disorders*, **12**(6), 585-592.
- Oud, M., Mayo-Wilson, E., Braidwood, R., Schulte, P., Jones, S. H., Morriss, R., . . . Kendall, T.** (2016). Psychological interventions for adults with bipolar disorder:

BIPOLAR GROUP AND RECOVERY

systematic review and meta-analysis. *The British Journal of Psychiatry*, **208**(3), 213-222.

Patelis-Siotis, I., Young, L. T., Robb, J. C., Marriott, M., Bieling, P. J., Cox, L. C., & Joffe, R. T. (2001). Group cognitive behavioral therapy for bipolar disorder: a feasibility and effectiveness study. *Journal of Affective Disorders*, **65**(2), 145-153.

Pavlova, B., Uher, R., Dennington, L., Wright, K., & Donaldson, C. (2011). Reactivity of affect and self-esteem during remission in bipolar affective disorder: An experimental investigation. *Journal of affective disorders*, **134**(1-3), 102-111.

Perlick, D. A., Rosenheck, R. A., Clarkin, J. F., Sirey, J. A., Salahi, J., Struening, E. L., & Link, B. G. (2001). Stigma as a barrier to recovery: adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatric Services*, **52**(12), 1627-1632.

Post, F., Pardeller, S., Frajo-Apor, B., Kemmler, G., Sondermann, C., Hausmann, A., . . . Hofer, A. (2018). Quality of life in stabilized outpatients with bipolar I disorder: Associations with resilience, internalized stigma, and residual symptoms. *Journal of Affective Disorders*, **238**, 399-404.

Sanchez-Moreno, J., Martinez-Aran, A., Tabares-Seisdedos, R., Torrent, C., Vieta, E., & Ayuso-Mateos, J. (2009). Functioning and disability in bipolar disorder: an extensive review. *Psychotherapy and Psychosomatics*, **78**(5), 285-297.

Todd, N. J., Jones, S. H., Hart, A., & Lobban, F. A. (2014). A web-based self-management intervention for bipolar disorder 'living with bipolar': a feasibility randomised controlled trial. *Journal of Affective Disorders*, **169**, 21-29.

Warwick, H., Mansell, W., Porter, C. & Tai, S. (2019). 'What people diagnosed with bipolar disorder experience as distressing': A meta-synthesis of qualitative research. *Journal of Affective Disorders*, **248**(1), 108-130.

BIPOLAR GROUP AND RECOVERY

World Health Organisation (2018). *World Health Organization. Classification of diseases Eleven (ICD-11)*. Geneva: World Health Organisation.

For Peer Review