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The Type, Impacts, and Experiences of Peer Support for People Living With Bipolar Disorder: A Scoping Review

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ABSTRACT

Background: Internationally, mental health policy has highlighted the exchange of peer support between people with lived experience as a key component of recovery-oriented care. There is some evidence to support the benefits of peer support in mixed-diagnosis groups, major depressive disorder, and schizophrenia. However, no reviews have specifically described the types and impacts of peer support interventions for bipolar disorder (BD).

Methods and Analysis: A scoping review was conducted to explore the type, outcomes, and experience of peer support interventions in BD. Databases searched were MEDLINE, EMBASE, and PsycINFO, using terms related to peer support and BD. Extracted data included study design, participant demographics, intervention characteristics, and qualitative or quantitative data on outcomes and experiences.

Results: Thirty studies met eligibility criteria and were included in the review. A diverse array of interventions incorporating peer support were evaluated, including unstructured face-to-face group programs, peer-facilitated psychoeducation, and web-based psychoeducation with accompanying peer support. Quantitative studies largely assessed clinical outcomes, with some attention to functioning and quality of life. Qualitative data included observations of interaction patterns and subjective experiences of programs.

Discussion: Given this heterogeneous literature, the effects of peer support in BD cannot be firmly concluded. However, qualitative research and rates of engagement with peer support programs are suggestive of subjective appeal. Priorities for future research include comparative studies to parse out the effects of different types of peer support, routine reporting of the characteristics of peer support programs, assessment of recovery-oriented outcomes, and partnership with community organizations to optimize trial designs.

1 | Background

Individuals who live with bipolar disorder (BD) can be supported to live well with a combination of pharmacological and psychosocial intervention [1–3]. However, access to care for BD is suboptimal: approximately 50% of individuals in treatment receive psychosocial services [4], and treatment often does not address patient-valued goals such as quality of life (QoL) and wellbeing [5, 6]. Peer support (where individuals with shared lived experience of a mental health condition

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provide each other with informational, emotional, and social support) may help address limitations in treatment access for people with BD, and more specifically, recovery and QoL-focused care. However, applications of peer support for BD have not yet been systematically described, which may limit awareness of the potential of this form of care to complement and diversify BD treatment.

Dedicated peer support roles and programs have been embedded in healthcare settings as a result of the adoption of recovery-oriented frameworks in mental health policy [7–9]. It is important to highlight that grassroots organizations facilitating mutual support between individuals with lived experience of mental health difficulties existed long before such approaches were adopted by the mental health system, and the influence, knowledge, and expertise developed within the consumer movement are fundamental to the widespread recognition and adoption of peer support we see today [10]. To contextualize this review, we note that peer support can involve varying levels of formality, mutuality, and structure [11]. Informal peer support involves the voluntary coming together and mutual exchange of support and tends to be unstructured (i.e., activities and topics of discussion are not prescribed). Formal peer support is provided by peers within the context of a traditional mental health service and may incorporate structured activities or psychoeducation. Support in this context tends to be more unidirectional: peers share their experiences for the benefit of the individual(s) attending mental health services. However, formal peer support may at times be bidirectional and unstructured, such as one-to-one meetings between an employed peer worker and service user. To support readability, the umbrella term "peer support" will be used to describe this broad spectrum of activities, the term "peer" will describe individuals with lived experience who are involved in the receipt or provision of support, and the term "peer worker" will describe those who are involved in the provision of unidirectional support (paid or unpaid).

Despite the longstanding history of peer support for mental health difficulties, efforts to evaluate such programs in a research context are relatively recent. Existing reviews of peer support for mental health challenges have described small positive effects on recovery-oriented outcomes, such as stigma, hope, QoL, subjective recovery, self-efficacy, and empowerment [12–15]. More inconsistent effects on clinical outcomes have been reported. One meta-analysis found peer support to be non-inferior to group cognitive behavior therapy for depressive symptom reduction [16], and another found equivalent symptom outcomes and slightly lower use of crisis/emergency services for peer workers relative to mental health professionals [17]. Other meta-analyses found no significant effects of peer support on clinical outcomes such as hospitalization or symptom reduction [12–15]. However, the heterogeneity of study designs (both in terms of the methods used to assess peer support, and the design of peer support interventions) presents a challenge for meta-analyses in this area, and reliance on observational designs and use of small sample sizes limits our ability to generalize findings [18].

Peer support is also lauded for its ability to improve access and affordability of mental health care. Although the evidence base is limited and heterogeneous, there is evidence to suggest that peer support may be cost effective by reducing demands on the healthcare system, such as costly hospitalizations [19]. Staffing costs associated with peer support may also be lower: training individuals to provide peer support may be accomplished with brief interventions [20], and peer support workers may be voluntary, or if salaried, generally paid less than traditional healthcare providers [21, 22]. Peer support is thereby positioned to increase the availability of the healthcare workforce and may extend reach into areas that are underserved by traditional services, such as rural and remote areas or low- and middle-income countries [23]. It may also support access to healthcare for individuals for whom cost is a prohibitive barrier to engagement [24]. However, we note that while staffing and training costs undoubtedly contribute to the perception of peer support as a scalable and cost-effective intervention, models of compensation and training require ongoing discussion [25], as low salary and opportunities for professional advancement are barriers to peer support worker job satisfaction, personal well-being, and perceived support and recognition [21, 22]. Beyond addressing socioeconomic barriers (i.e., cost, distance, availability of services) to care, peer support is also likely to address known psychological barriers to help-seeking, such as stigma, trust in the healthcare system, and agreement with the medical model of mental health difficulties [26, 27].

Taken together, there is evidence to support some effects of peer support for recovery outcomes and potentially clinical outcomes. In addition, there is theoretical justification for peer support to bolster the availability, reach, and affordability of healthcare services. Peer support interventions may therefore be helpful in addressing issues of access and unaddressed QoL-related needs for people with BD. However, findings from previous reviews of peer support cannot be generalized to BD specifically, due to the fact that these have largely focused on diagnostically heterogenous groups [28, 29] or dyads [15]. Although reviews of diagnosis-specific peer support interventions exist, they have focused on unipolar depression [16], schizophrenia [30], or substance-use disorders [31, 32]. To date, no review has specifically considered peer support in BD. This is a limitation, given that 21%–33% of individuals with BD have turned to online or in-person peer support when information-seeking [33, 34]. Furthermore, individuals with lived experience have called for peer support to be incorporated in future interventions for BD [35, 36].

The aim of this scoping review was to describe what peer support interventions have been evaluated for people with BD and their impacts on recovery-oriented or clinical outcomes. A secondary aim, depending on the availability of relevant literature, was to describe the subjective experience of peer support interventions in BD.

2 | Methods

2.1 | Study Design

This scoping review was conducted according to the methodological framework by Levac and colleagues [37] based on the foundational work of Arksey and O'Malley [38]. Six steps are outlined: (1) identifying the research question, (2) identifying relevant studies, (3) selecting studies, (4) charting the data, (5) collating, summarizing, and reporting the results, and (6) consulting with relevant stakeholders. The scoping review protocol was developed according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses methodology Extension for Scoping Reviews (PRISMA-ScR [39]; see Data S1) and a protocol is listed as a public project on Open Science Framework [40].

2.2 | Step 1: Identifying the Research Question

Three exploratory research questions are addressed by this review:

1. "What peer support programs and interventions have been developed and evaluated for people with BD?"
2. "What are their impacts to clinical or psychosocial outcomes?"
3. "How do people with BD experience peer support interventions?"

2.3 | Step 2: Identifying Relevant Studies

2.3.1 | Search Strategy

A search strategy was developed in consultation with a medical librarian and informed by previous reviews on related topics. Databases searched were MEDLINE (via Ovid), EMBASE (via Ovid), and PsycINFO (via EBSCOhost). Search terms were identified from relevant papers and a workplace survey of peer supporters [21], centred around two concepts: peer support (e.g., self-help group, mutual support) and bipolar disorder (e.g., bipolar depression, manic depression). The search strategy was iteratively developed in MEDLINE and then translated to other databases (see Data S2 for a detailed search strategy for each database). We manually reviewed the reference lists of articles meeting inclusion criteria to identify additional relevant references.

2.4 | Step 3: Selecting Studies

2.4.1 | Eligibility Criteria

Inclusion criteria were: (a) original peer-reviewed articles published in English, (b) included only participants with BD-spectrum diagnoses (BD-I, BD-II, BD-NOS, or cyclothymic disorder), and (c) reported quantitative or qualitative data describing the outcomes or experiences of peer support. We excluded articles that did not report original data (i.e., literature reviews, study protocols, commentaries) and conference presentations/abstracts. No restrictions were placed on the geographic location or dates of studies. Both comparative (e.g., randomized controlled trials, prospective cohort studies) and non-comparative (e.g., survey, qualitative interviews and focus groups) were included.

Following other condition-specific reviews of peer support [16, 41], we sought to be as inclusive as possible regarding what constitutes peer support interventions. We considered studies as incorporating peer support if they described themselves as such (or any of the synonyms used in the search strategy), and if they met the minimally restrictive, broadly defined criteria of placing individuals with BD in regular contact with another individual with BD and facilitating the peer-to-peer exchange of advice and support. We did not place limitations on whether these interventions were structured/unstructured, mutual/unidirectional, or informal/formal. Professional involvement in peer support was permitted (e.g., facilitation or co-facilitation of peer groups, moderation of discussion boards). To err on the side of inclusivity, and because we did not plan to conduct statistical comparisons where it would be important to isolate the specific effects of peer support, we accepted studies where peer support was a component of a larger intervention (e.g., a self-help program with accompanying peer support). Accepted delivery formats were similarly broad, whether group or individual programs, and in-person or remote delivery (i.e., web or smartphone-based).

2.4.2 | Study Selection

All identified articles were uploaded to the Covidence Systematic review software for deletion of duplicates and article screening. Screening occurred over two phases: (1) initial title and abstract screening, and (2) full text review. Two reviewers (JB, EW, and SS) screened article titles and abstracts to exclude irrelevant or ineligible papers based on the described eligibility and ineligibility criteria. Subsequently, full text screening of the remaining articles was carried out independently by two reviewers; conflicts were reviewed and resolved by an independent third reviewer (EM).

2.5 | Step 4: Charting the Data

Data extraction was conducted independently by two reviewers (SS and EW) using a standardized data extraction form (see Data S3). Discrepancies were reviewed and resolved by the first author (EM). The following characteristics were extracted from each study: citation (authors, title), country in which the study was conducted, study aim, study design, format and description of peer support, participants (population characteristics, inclusion and exclusion criteria), outcomes measured, and main qualitative and quantitative findings regarding the experience and impacts of peer support. Risk of bias and quality assessment of included studies is not a necessary step of scoping reviews [39].

2.6 | Step 5: Collating, Summarizing, and Reporting the Results

The purpose of this scoping review is to map and synthesize existing evidence about the type, impacts, and experiences of peer support interventions in BD. The results of the review are presented using two strategies: first, the amount, type, and distribution of included studies are summarized numerically; second, a narrative summary is used to synthesize the extracted data. Key findings regarding peer support in BD, including intervention design and effectiveness, are collated and summarized.

2.7 | Step 6: Consulting With Relevant Stakeholders

Rather than consulting with stakeholders as a distinct sixth step, lived experience feedback was sought and integrated at various stages of the scoping review using a community-based participatory research framework (CBPR). CBPR is a collaborative approach to knowledge generation and translation: academic researchers/clinicians and those with lived experience work in partnership to identify research priorities, conduct research, and disseminate findings [42]. The Collaborative RESearch Team to study psychosocial issues in Bipolar Disorder (CREST.BD) research network developed a CBPR model for BD, informed by over a decade of research and integrated knowledge translation [43]. The present research questions were selected due to their potential to address CREST.BD research priorities of psychosocial interventions, stigma, and quality of life, which were established through earlier community consultation [43, 44]. Our study team includes knowledge users/peer researchers to support the relevance of the study to individuals with BD and to facilitate the dissemination of study results. The scoping review protocol was reviewed by CREST.BD peer researchers and knowledge users. After data extraction, the CREST.BD Community Advisory Group (comprised largely of individuals living with BD, as well as healthcare providers) was consulted regarding findings and recommendations.

3 | Results

3.1 | General Overview

Database searches were conducted June 13, 2023. The study selection process is described using a PRISMA flow diagram (Figure 1). After the removal of duplicates ($n=255$), 786 records were identified through database searching, and a further 44 were identified as a result of citation searching. Taken together, a total of 830 records were subject to title and abstract screening, and 766 records were excluded. The full text of 64 studies was assessed for eligibility. Thirty studies met eligibility criteria and were included in the review. A summary of the data extracted from included studies (country, study design, details of peer support, outcomes assessed, and key findings) is presented in Data S4.

Included studies were published between 1993 and 2021; over two-thirds of included studies ($n=21$) were published after 2010. All included studies were conducted in high or upper middle-income countries according to World Bank Classifications [45], with the majority in European Union member countries ($n=9$; of which 78% were conducted in Spain), the UK ($n=9$), Australia ($n=4$), North America ($n=2$), and China ($n=2$). Two web-based studies recruited internationally; two specified a language used (Spanish, German) but not a location.

In terms of study design, twenty-two studies presented quantitative data, either from a randomized control trial ($n=18$), uncontrolled evaluation study ($n=2$), or survey ($n=2$). Length of follow-up in intervention studies ranged from immediately post-intervention to five years. Thirteen studies presented qualitative data, drawn from either participant interviews ($n=8$) or analyses of forum/email text ($n=5$). Five studies used a mixed-methods approach and are counted in the summary of both qualitative and quantitative data.

3.2 | Intervention Characteristics

A variety of formats of peer support were described: the most prevalent was unstructured, face-to-face, group peer support (30%, $n=9$). However, all but one of these studies utilized peer support groups as the control condition for the evaluation of a psychoeducation program. The next most prevalent delivery format of peer support was an accompaniment to a web-based psychoeducation program; this could be in the form of a peer-to-peer discussion forum (20%, $n=6$), one-to-one peer coaching via web messaging/email (10%, $n=3$), or both (3%, $n=1$). Other studies analyzed face-to-face group psychoeducation programs with a peer facilitator, either alone (3%, $n=1$) or co-facilitated with healthcare providers (10%, $n=3$). Few studies reported on community-based programs: only four studies (13%) described established peer-led, web-based discussion forums . Three studies (10%) allowed for multiple kinds of peer support, including any form of online peer support groups, forums, or chats [33], various formal one-to-one and group peer support programs [46], and a variety of web-based and face-to-face knowledge translation strategies incorporating peer support [47]. It should be noted that the prevalence of different types of peer support is influenced by the fact that a number of papers described analyses or sub-analyses of the same program, specifically, the Psychoeducation, Anxiety, Relapse, Advance Directive Evaluation, and Suicidality (PARADES) program ($n=2$), the Barcelona Bipolar Disorders Program ($n=7$), the MoodSwings intervention ($n=2$), the Bipolar Education Program ($n=3$), and the Beating Bipolar intervention ($n=3$).

3.3 | Intervention Outcomes and Experiences

3.3.1 | Outcomes of Peer Support

3.3.1.1 | Clinical Outcomes. The majority of studies reported on clinical outcomes, such as symptoms (50%, $n=15$; including time to, number and duration of relapses, clinician or self-rated mood symptoms), care utilization (23%, $n=7$; including hospitalization and resource use), cost-effectiveness (6.7%, $n=2$), and medication adherence (23.3%, $n=7$). Analyses of clinical outcomes generally favored face-to-face group psychoeducation over unstructured peer support in terms of symptom reduction and relapses [48–51], with the exception of the PARADES trial, which found no differences between a peer co-facilitated psychoeducation group and unstructured peer support in terms of time to relapse or mood symptoms [52]. Program participants in a peer-led psychoeducation program reported improved symptoms compared to controls [53], however, it should be noted that the sample size was small. Some studies reported sensitivity analyses, suggesting that differences in clinical outcomes between psychoeducation and unstructured peer support were specific to those with fewer episodes [52, 54].

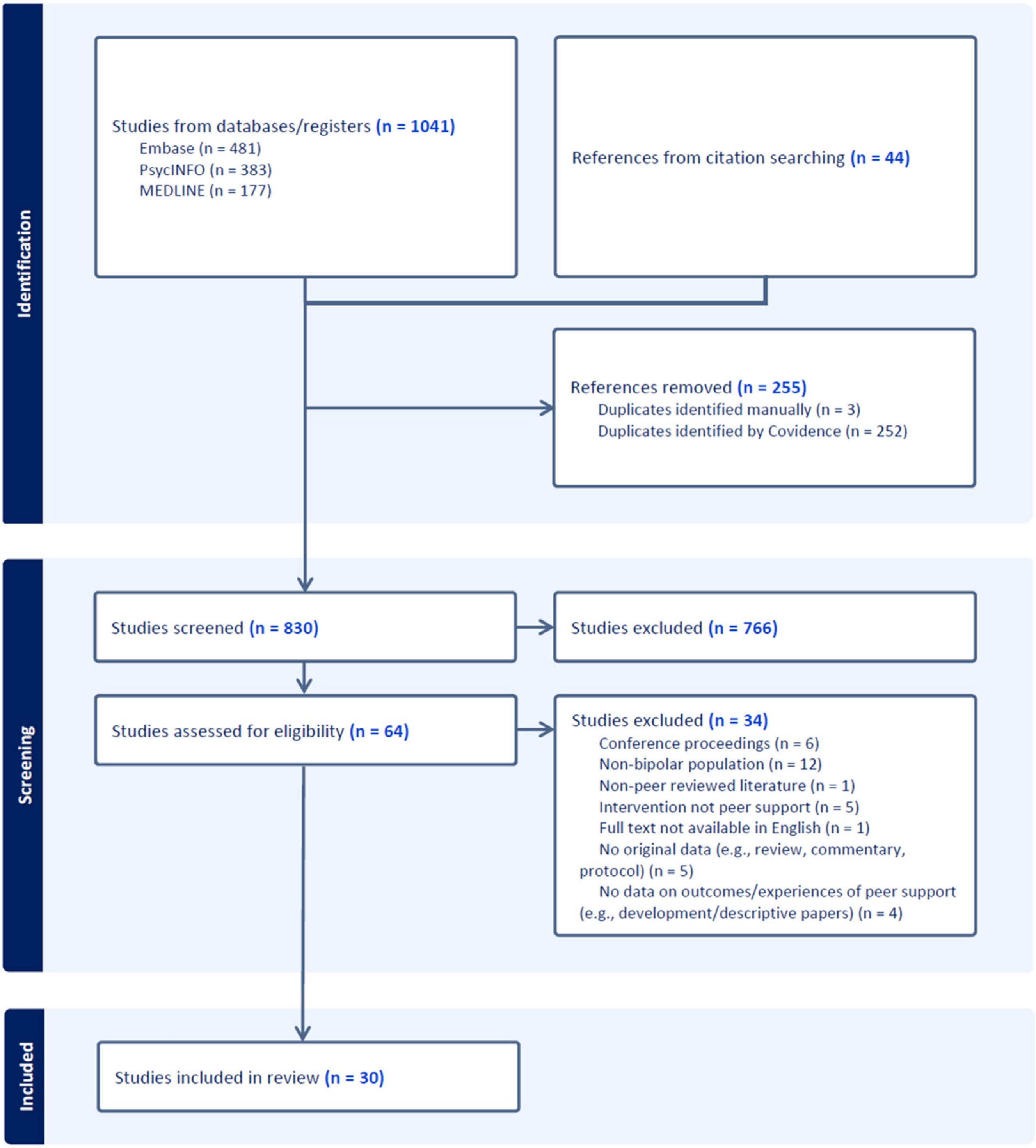

FIGURE 1 | PRISMA flow diagram.

In terms of medication adherence, psychoeducation was reported to be superior to peer support in a two-year follow-up of the Barcelona Bipolar Disorders Program [49, 55], these differences were not observed at 5 years [48]. Wang et al. [56] found that unstructured peer support resulted in better medication adherence than a peer group discussing non-illness related topics. Face-to-face peer support had less direct costs than psychoeducation [57, 58]; however, unstructured peer support had more costs associated with relapses (i.e., emergency visits and hospitalisations).

Controlled comparisons of web-based psychoeducation programs paired with peer support reported varied findings with regard to clinical outcomes, with some studies reporting no significant between-group differences [59], and others favoring the intervention [60]. An uncontrolled comparison trial showed improvement in symptoms for both iterations of a web-based program with peer discussion forums [61]. When intervention elements were parsed out, the addition of a peer discussion forum to a web-based psychoeducation program did not improve clinical outcomes, nor did either group outperform an attention control [62]. The addition of a web-based psychoeducation program relative to a peer discussion forum alone improved depressive symptoms, but not mania, time to relapse, or medication adherence [63].

3.3.1.2 | Psychosocial Outcomes.

Psychosocial outcomes commonly reported included functioning ($n = 8$) and QoL ($n = 9$; including satisfaction with life and wellbeing). Outcomes for face-to-face interventions were varied: one trial of psychoeducation reported improved functioning compared to unstructured peer support [50], whereas the comparable PARADES trial reported no group differences in QoL or functioning [52]. A small, controlled trial of peer-led psychoeducation reported improved QoL [53], and an unstructured peer support group improved QoL compared to a group discussing non-mental health topics [56].

Outcomes for web-based programs were similarly varied: both iterations of the MoodSwings web-based program paired with a peer discussion forum were associated with improvements to functioning and QoL [61]. Similarly, the web-based Living with Bipolar program and discussion forum reported improved QoL, well-being, and social functioning compared to controls [60]. Conversely, use of the Beating Bipolar program and discussion forum was not associated with improved QoL or functioning compared to controls [59]. As was observed with clinical outcomes, when the peer support and psychoeducation elements of such programs were analyzed separately, the addition of peer coaching to the Bipolar Education Program did not result in improved satisfaction with life or functioning [62]. However, both versions of the MoodSwings program plus discussion forum performed similarly to peer discussion alone in terms of QoL and functional outcomes [63].

Other psychosocial outcomes studied included subjective recovery, self-efficacy, perceived control, illness knowledge, attitudes towards BD, insight, self-esteem, social cognition, social support, coping, empowerment, perceived conflict, and perceived stigma. Of these, positive impacts of peer support were seen for subjective recovery and perceived conflict [60], coping and empowerment [53], illness knowledge and attitudes towards BD [64], social cognition [56], social support [61], and self-efficacy [47].

3.3.2 | Experiences of Peer Support

3.3.2.1 | Acceptability and Feasibility.

Quantitative measures on the acceptability and feasibility of peer support were reported by six papers (20%), which variously described satisfaction, program completion or adherence, and rates of uptake of peer support within the community. 12.8% ($n = 157$) of respondents in a paper-based survey reported using online peer support groups; the likelihood of participation was elevated for those who had participated in face-to-face support groups, searched online monthly for information on BD, or had a particular website as a favorite information source. Participants reported high levels of satisfaction with a psychoeducation program co-facilitated by a peer worker [65]. Both iterations of the MoodSwings web-based psychoeducation program paired with discussion forums were reported to have completion rates comparable to other online interventions [61]. The majority (86%) of MoodSwings users accessed the peer discussion forum, as did the discussion-only control [63]. The addition of peer coaching was found to improve engagement as compared to a standalone web-based psychoeducation program [66], and a web-based psychoeducation program with a peer discussion forum [67].

3.3.2.2 | Qualitative Findings.

Qualitative studies investigating the experience of peer support in BD ranged from observational reports on topics discussed and social interactions within the context of peer support (16.6%, $n = 5$). Topics discussed in peer forums or interactions with peer workers included aspects of the illness (symptoms, medications, diagnosis, and interactions with healthcare providers) as well as its impacts on social relationships and employment [68–72]. Social interactions in such contexts were characterized by the exchange of information (including self-disclosure) and emotional support (including empathy, encouragement, and the normalization of shared experiences). Some infrequent negative interactions were observed, involving 'trolls' or critical group members [69], as well as a mismatch between the type of support requested and provided [72].

Qualitative interview-based studies on perceptions of the impact and experience of programs incorporating peer support (23.3%, $n = 7$) highlighted that participants valued and learned from the experience of meeting others with BD [52, 53, 65], and that hearing how others with BD managed their condition brought a sense of normalization, hope and self-efficacy [45, 47, 73]. Some individuals thought that meeting others with BD could be confronting if those peers were better able to manage their condition [47]. Conversely, participants who thought themselves to be managing well felt that peer contact could serve as an unwanted reminder that they could experience similar destabilization [74]. The expertise of peer support workers was viewed as unique, although some individuals placed a higher value on the clinical training of healthcare providers [46]. Minimal facilitation of peer support groups could detract from their reception, with some participants commenting negatively on a lack of structure in a face-to-face group [52], or lack of input from moderators and peers on a forum [74].

4 | Discussion

4.1 | Key Findings

Peer support has been increasingly encouraged in mental health policy and has the potential to address unmet treatment needs for individuals with BD, including access to care and support for patient-valued outcomes. To our knowledge, this scoping review was the first to characterize the type, impacts, and experiences of interventions incorporating peer support for individuals with BD. The included studies described a diverse range of programs incorporating peer support, with varying degrees of formality, mutuality, and structure [11], from unstructured mutual support groups (online and in-person) to peer-led or co-facilitated psychoeducation programs within the context of healthcare settings.

Unstructured peer support generally did not result in improvements to clinical outcomes compared to psychoeducation, although peer support was less costly to deliver. Mixed findings were reported for face-to-face or web-based psychoeducation programs incorporating peer support in regards to clinical and psychosocial outcomes (e.g., QoL, functioning), with some beneficial impacts reported. Trends in the included studies are echoed by findings from the broader mental health peer support literature, which have largely reported no significant impacts of peer support on symptoms and hospitalization [12–15], nor functional outcomes [15, 75]. Similar to the present review, mixed evidence has been found for QoL improvements as a result of peer support in the broader mental health literature [12, 15]. A striking finding in the present review was that few studies reported on other key patient-oriented outcomes such as self-stigma, self-efficacy, hope, subjective recovery, and empowerment. This is a limitation of the work done in BD to date, given evidence from the broader mental health literature that peer support may demonstrate its most conclusive benefits for such outcomes [12–15, 76]. Indeed, qualitative findings identified in this review provided some support for the benefits of peer support in BD for these outcomes: similar to the broader literature, participants with BD described the positive impacts of social support, gaining a sense of hope by seeing peers flourish, reduced self-stigma through the normalization of their experiences, and self-efficacy by learning about the condition and its management from others. Given that the ethos of recovery-oriented intervention is to support individuals in living a satisfying, meaningful life, despite the experience of symptoms [77], it may be that clinical outcomes are not the most appropriate indices by which to identify change. The alignment between clinical outcome assessment and the goals of peer support interventions has been questioned both in the context of mental health [76] and chronic health conditions more broadly [18].

Positively, the present review found evidence that peer support contributed to the feasibility of web-based psychoeducation, with the addition of peer coaching boosting engagement in two interventions [65, 67]. Although the number of studies specifically examining the impact of peer contact on engagement was small, this finding is supported by the broader literature: a review of engagement with mental health smartphone apps similarly reported that adherence was increased when apps contained some peer support elements [78]. Related findings have also been shown in an evaluation of face-to-face peer support: initially disengaged clients showed increasing contacts when randomized to case management from a peer support worker, while those randomized to a non-peer case manager showed declining contacts [79]. Taken together, these positive impacts of peer support on engagement further emphasize the likelihood of subjective benefits not fully described by clinical measures, and the need to identify outcomes and instruments that can be used to more fully demonstrate the impacts of such programs.

It should be emphasized that due to the heterogeneity of interventions and research designs across studies included in the present review, we cannot draw firm conclusions regarding the efficacy of peer support in BD. This challenge has been similarly noted in other systematic reviews and meta-analyses of peer support interventions, which have also recorded a great deal of heterogeneity in intervention design [14]. Different forms of peer support may differentially impact outcomes: a meta-analysis identified that in cases where peer support has been found to be equivalent to clinical care, peer support workers received training and regular supervision, and delivered either manualized recovery-focused or self-management interventions, or intensive case management in dyads [75]. In the present review of BD-specific interventions, only two studies compared types of peer support directly: the PARADES trial compared a peer co-facilitated psychoeducation program to unstructured peer support and observed no significant differences between groups [52]; while the evaluation of MyRecoveryPlan compared a web-based psychoeducation program (including a peer discussion forum) alone and with additional peer coaching [67]. Given the limited number of such comparisons, it is difficult to conclude what types of peer support may be most beneficial for which outcomes.

Further complicating the interpretation of findings in this review, numerous studies incorporated elements of peer support as part of an overarching intervention. It is therefore difficult to determine whether the observed effects (or lack thereof) were driven by peer support specifically. Even trials which utilized unstructured peer support reported that these groups were facilitated or co-facilitated by health professionals; as treatment is a common subject of discussion between peers with BD [68–70]. It is possible that the presence of professionals could impact both the content and dynamics of interactions between peers. Two head-to-head comparisons of programs with and without peer support elements reported mixed findings, with one finding few differences in clinical or psychosocial outcomes between a standalone peer forum alone and paired with psychoeducation [63], and another finding that the addition of peer coaching to a psychoeducation program did not improve outcomes [62].

Additional comparative research may help parse out the effects of different types of peer support for BD and potential additive benefits of incorporating elements of peer support in overarching interventions. However, given that peer support programs differ not just in delivery format and content, but also in the degree of formality, mutuality, and structure, synthesis of findings across evaluation of such diverse interventions is likely to remain challenging [80]. Variation exists even within similar forms of peer support: the impacts and experience of a peer support group can be expected to differ based on the history and treatment goals of group members, the characteristics and training of facilitators, and the setting in which programs are embedded, among a myriad of other factors. Taking guidance from recommendations for complex intervention research (i.e., interventions with multiple components, diverse treatment targets, and flexible delivery), evaluations of peer support in BD should consider research questions with a broader focus alongside efficacy studies, such as exploration of how and under what circumstances such interventions result in changes to diverse clinical and psychosocial outcomes [81]. In order to facilitate this, detailed reporting of the characteristics and qualities of peer support is required. Recommended attributes to report in the evaluation of peer support interventions include fidelity to core peer support principles and aims [82], process outcomes of peer support (e.g., working alliance, participant satisfaction), peer work model used, characteristics of peer support workers (experience, mental health and recovery status), training and supervision, and the degree of peer leadership in program development and delivery [76]. Although we did not systematically record this information in the present review, we observed that few of the included studies described peer support interventions in such detail. Reviews of peer support in schizophrenia, youth mental health, and chronic health conditions have similarly highlighted limited reporting of the orientation and characteristics of peer support programs [18, 41, 83]. Without such information, it is difficult to conclude whether findings will generalize beyond a single given trial. Replication of the impacts of interventions found to be beneficial in other research or in real-world contexts is also hampered by sparse detail, as it is unclear what factors may underpin positive effects.

Qualitative research can help elaborate on the key components, change mechanisms, and contextual factors underpinning the successful implementation of complex interventions such as peer support [18, 81]. As an example, findings reported across several of the studies included in this scoping review flagged social comparisons as a potential change mechanism warranting further exploration. Participants reflected on their own experiences relative to peer workers or others in their peer group, which could inspire both hope and normalization [46, 47, 73], or alternatively, distress if the health status of peers was interpreted as unachievable or personally unwanted [47, 74]. Social comparison theory suggests that individuals use their knowledge of others to make sense of information related to the self [84]; in the context of peer support, upward social comparisons with flourishing peers may be inspiring, encourage self-improvement efforts, and facilitate more effective coping strategies through social learning [85]. Social comparisons may also explain the rare occurrence of negative reactions to peer support in identified studies: downward social comparisons with peers who seem worse off may induce negative emotional reactions if the person fears their own condition may similarly decline, as seen in a study of a group intervention for breast cancer survivors [86]. Individuals who identify less with a given peer group report less positive reactions to upward social comparisons [87, 88]; the finding in one study that some individuals with BD felt unable to relate to well-off peers was similarly expressed in a qualitative evaluation of lived experience videos for people with schizophrenia [89]. As BD is highly heterogeneous in terms of present polarity and severity of symptoms, overall course, and comorbidities, whether social comparisons result in beneficial or unwanted impacts may depend on the precise composition of peers involved. Some degree of matching between group participants may therefore be necessary to support beneficial social comparisons. Relatedly, a focus group exploring preferences for a lifestyle program for people with BD reported consensus on the idea that the group should be fairly homogeneous, with participants desiring similar levels of insight and symptom stabilization [90]. Further qualitative investigation of factors that encourage helpful social comparisons within BD peer dyads and groups is required to optimize the delivery of peer support.

A final limitation to note in the identified literature is that few studies evaluated existing BD peer support interventions, despite the fact that a number of regional and national organizations exist to coordinate peer support initiatives for this population. As described below, the exclusion of some such papers may have occurred due to our focus on diagnostically homogenous groups, as some prominent community-based peer support interventions may be inclusive of mood disorders or serious mental illnesses more generally. Similarly, we excluded gray literature, which may have included service evaluations or organizational reports. The lack of representation of community-based peer support in the peer-reviewed literature means that beneficial impacts may be underrepresented, given the high level of appetite for such services among the BD population. For instance, individuals with BD type I are overrepresented in Depression and Bipolar Support Alliance peer support meetings relative to a community sample [91]. Evaluations of community-based programs may help characterize the effects of peer support on people who may not access clinical services due to stigma or unwillingness to engage with the medical model, and thereby create a more well-rounded impression of real-world effectiveness. CBPR may offer a framework through which to partner with people with lived experience to advance the literature on peer support for BD [42]. Community organizations hold critical experiential knowledge about the key characteristics and qualities of effective peer support in BD [10]; collaboration during trial design may help researchers to ensure that the delivery of peer support is optimized, and that the outcome measures selected in clinical trials are best suited for evaluating its impacts. From an ethical perspective, CBPR can demonstrate respect for the rich history of community-based peer support and provides an avenue for researchers to give back to the organizations which initiated and refined peer support before it reached its current popularized status [92]. Partnering with community organizations on research projects may grow capacity for groups to evaluate and report on their own programs, which can help them advocate for funding and further strengthen access to peer support within the community.

4.2 | Strengths and Limitations

Our scoping review has some limitations. To support feasibility, we limited our search and analysis to published, peer-reviewed articles. We acknowledge that the inclusion of gray literature may have contributed unpublished evaluations of programs by grassroots, community, or healthcare organizations. Similarly, for reasons of feasibility, only articles available in English were included; this may limit our ability to comment on peer support interventions for BD globally, as well as programs for minority populations. Indeed, all studies included in our review were conducted in high-or upper-middle-income countries. However, we note that only one study was excluded in the present systematic search for not having a full text available in English. This article was an evaluation of a subset of posts to a German-language forums [93]; the full sample was later reported on in English and was included in our review [68]. While peer support interventions are of increasing interest in resource-limited settings, a systematic review of peer support interventions in low- and middle-income countries was only able to identify 14 papers, the majority of which focused on depressive symptoms in mothers [23]. All included studies were published post-2000, suggesting this literature is quite nascent. Such findings lend confidence that our decision to exclude papers not reported in

English did not substantially alter our findings. The absence of papers describing peer support for BD in low- and middle-income countries does highlight an important avenue for future research, especially given that cultural values and norms may influence comfort with the sharing of experiences characteristic of peer support [94].

While we argue that a specific emphasis on peer support interventions for BD is warranted given the focus of reviews to date, we acknowledge that diagnostically heterogeneous peer support interventions are common. Indeed, some of the largest grassroots organizations are inclusive of all mood disorders (e.g., DBSA [91]) and studies describing these organizations were not captured in this review. Future reviews of diagnostically heterogeneous groups with broader inclusion criteria, such as affective disorders (e.g., BD, major depressive disorder) and serious mental illnesses (e.g., BD, schizophrenia spectrum disorders), may provide useful, complementary findings and may also help answer the question of whether the needs of people with BD are best served by diagnostically heterogeneous or homogeneous groups. Such investigations will be particularly pertinent in light of social comparison theory, discussed above, which suggests that some degree of matching may be necessary for individuals to identify with and benefit from peer comparisons.

A strength of this review is the use of CBPR. Although consultation with stakeholders is a recommended step in scoping review frameworks [38], in practice, this step is implemented less than 50% of the time [95]. This is despite potential benefits for the relevance of scoping review questions, the identification of key themes and gaps in identified literature, and the uptake of research findings [96]. Here, consultation with individuals with lived experience and knowledge users occurred during study design, data collection, and interpretation of results. Among the gaps highlighted in the scoping review discussion, two in particular were emphasized in discussion with CREST.BD Community Advisory Group members and peer researchers. First, the lack of attention to recovery-oriented outcomes came as a surprise, given participants' personal experiences with peer support. It was noted that peer support programs are not positioned as a replacement for clinical services but are often sought out to address other unmet needs (e.g., social support, personal recovery). Qualitative findings, in particular, resonated during discussions with CREST.BD Community Advisory Group members; peer group composition and moderation strategies were emphasized as key areas for further research. Individuals with experience in facilitating peer support groups highlighted the role of matching on diagnosis and recovery status, as well as groups for specific ages, genders, LGBTQIA+ identified individuals, and ethnic/cultural backgrounds. Moderators and program workbooks were highlighted for their potential to add structure to peer support groups and to manage the risk of misinformation or affective symptoms impacting group dynamics.

5 | Conclusion

The present scoping review identified a diverse range of interventions for people with BD incorporating peer support. While quantitative findings were mixed in regard to whether these programs may effectively support clinical outcomes, functioning, or quality of life, qualitative findings and the impact of peer support on program engagement suggest some benefits and subjective appeal. Qualitative research also identified some potential cautions in need of additional study, such as the impacts of social comparisons. Efforts to draw conclusions are limited by a highly heterogeneous literature. Furthermore, outcomes assessed in the included studies may not align with the goals of peer support, and studies may therefore not fully represent the impacts of such programs. To advance understanding of peer support for BD, further comparative studies, routine reporting of the characteristics of peer support programs, assessment of recovery-oriented outcomes, and use of CBPR frameworks are recommended.

Author Contributions

E.M. conceptualized and designed the study, led the conduct of the systematic search and data analysis, and drafted the manuscript. E.W. contributed to the systematic search. J.B. contributed to the systematic search and overall study design. A.K. contributed to the overall study design. E.E.M. contributed to the overall study design. All authors provided critical revisions of the manuscript for important intellectual content. All authors read and approved the final manuscript.

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Conflicts of Interest

E.W., J.B., and A.K. declare no conflicts of interest. E.M. has received honorarium for advising on the development of educational materials for Neurotorium, an online educational platform supported by the Lundbeck Foundation. E.E.M. has received funding to support patient education initiatives from Otsuka–Lundbeck.

Data Availability Statement

The authors have nothing to report.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.