# Psychosocial Interventions for Bipolar II Disorder

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**Objective:** Bipolar II disorder is a challenging psychiatric condition that causes significant suffering. Some of this suffering may be reduced by the receipt of psychotherapy, either as a monotherapy or adjunctive to pharmacotherapy. There have been only four reports from trials of psychosocial interventions that focus exclusively on individuals with bipolar II disorder. Because of this dearth of information, clinicians must rely on information garnered from trials that include subsets of individuals with bipolar II, in addition to those diagnosed with bipolar I or related bipolar disorders.

**Methods:** The authors conducted a systematic literature review and identified 35 reports on 27 trials where ≥10% of the sample and at least ten participants met criteria for bipolar II disorder.

**Results:** Preliminary evidence supports the use of interpersonal and social rhythm psychotherapy, cognitive-behavioral therapy, psychoeducation, and, to a lesser extent, functional remediation and family-focused therapy in the management of bipolar II disorder.

**Conclusions:** There is a strong rationale for using psychotherapy to manage bipolar II disorder, either as a monotherapy or adjunctive to pharmacotherapy. Salience of psychotherapies may improve if modified to meet the needs of those with this disorder.

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Bipolar II disorder is a challenging psychiatric condition with unmet somatic and psychosocial treatment needs. By conservative estimates, the disorder affects approximately 0.4% of the population (1) and causes significant suffering. Associated with morbidity comparable to that of bipolar I disorder (2), bipolar II disorder causes marked impairment in psychosocial functioning (3), a chronic course of illness (4), and high rates of suicide (5). Cognitive impairment is common (6) and multiple comorbidities are the rule rather than the exception (1).

Compared with bipolar I disorder, far less is known about bipolar II disorder or how to treat it. Clinicians often do not recognize the illness, and many do not know how to manage it. Consequently, thousands are unaware they have the disorder and receive no treatment or inappropriate treatment (7). Although many individuals seeking treatment for bipolar II disorder turn to medication first, evidence-based pharmacotherapy options for this illness are limited (8, 9). Evidenced-based psychotherapies may have an important role in the management of this disorder.

In this review, we present the rationale for offering psychotherapy to adults with bipolar II disorder, either alone or in combination with pharmacotherapy. Next, we discuss the results of a systematic literature review focused on identifying randomized controlled trials (RCTs) of psychotherapy that include individuals with bipolar II disorder. We conclude with a discussion of recommendations for clinical practice and future directions.

## RATIONALE FOR PSYCHOTHERAPY IN BIPOLAR II DISORDER

There are compelling reasons to consider psychotherapy as a monotherapy or adjunctive to pharmacotherapy in the management of bipolar II disorder. First, the condition is characterized by multiple recurrent depressive episodes punctuated by infrequent hypomanic episodes. In one longitudinal study, the ratio of depressive to hypomanic episodes

### HIGHLIGHTS

- Evidence-based psychotherapies that help individuals with bipolar II disorder to understand and manage the illness may facilitate improved outcomes.
- For treatment during the acute phase of illness, preliminary evidence supports the use of interpersonal and social rhythm psychotherapy as either an acute monotherapy or adjunct to pharmacotherapy. There also is evidence to support the use of cognitive-behavioral therapy (CBT) and family-focused therapy as acute adjuncts to pharmacotherapy.
- For treatment during the maintenance phase of illness, findings are mixed for CBT and psychoeducation.
- Salience of psychotherapies may improve if modified to meet the needs of those with bipolar II disorder.

over time was 30:1 (10). Thus, the bipolar II phenotype is dominated by depression which, although less striking than mania, can be the more problematic pole of the disorder (11, 12). Second, because of its fluctuating course and the predominance of depressive episodes over hypomania, the disorder is difficult for both patients and providers to understand and therefore recognize. As a result, the illness may go undiagnosed for decades (7). Third, individuals may have trouble distinguishing hypomania from euthymia (13), and they may struggle to develop a core sense of self (14). Fourth, functional impairments associated with bipolar II disorder may be severe (3), resulting in substantial and persisting vocational and interpersonal difficulties. Psychotherapy targets all these domains.

Psychotherapy interventions that help individuals to understand symptoms and course of the disorder may enable individuals to manage their illness more effectively through early recognition of episodes and acquisition of strategies to target both symptoms and functioning. Interventions that help individuals develop skills needed to manage the psychosocial, neurocognitive, vocational, and interpersonal consequences of this disorder may decrease illness burden and limit associated impairment. Finally, interventions that are an alternative to pharmacotherapy may be preferred by some individuals with bipolar II disorder (15) and, unlike for those with bipolar I disorder, psychotherapy alone may provide a reasonable alternative (16). Overall, there is a compelling rationale to include psychotherapy as a principal tool in the management plan for bipolar II disorder.

## OVERVIEW OF EVIDENCE SUPPORTING EFFICACY OF PSYCHOTHERAPY FOR BIPOLAR II DISORDER

Data supporting the efficacy of bipolar-specific psychotherapies as treatments for individuals with bipolar II disorder are limited. To date, there have been only four reports from RCTs of psychosocial interventions that focus exclusively on individuals with bipolar II disorder (16–19). Because of the dearth of studies on this topic, we must rely on information garnered from trials that include subsets of individuals with bipolar II disorder, in addition to those with bipolar I or related bipolar disorders. Data derived from these hybrid trials can be used to infer information about the role of psychotherapy in the management of bipolar II disorder and inform current practice as we await additional studies focused specifically on this population.

## METHODS

To better understand the role of psychotherapy for patients with bipolar II disorder, we conducted a systematic literature review of RCTs, including acceptability and feasibility studies that tested psychosocial interventions for bipolar disorder and focused on adults (age ≥18). We conducted searches using PsychINFO databases. Results were restricted to those published between January 1, 2014, and February 1, 2018, in a journal, in the English language, and focused on adults. We restricted the lower limit of the search parameters for publication date to January 1, 2014, because we previously conducted a review of psychotherapy for all bipolar subtypes that covered the period through December 31, 2013 (20) and could easily combine our prior results with the current search results.

**Editor's Note:** This Special Article is adapted from a chapter that will appear in the upcoming book, *Bipolar II Disorder: Recognition, Understanding, and Treatment* (edited by Swartz HA, Suppes T) from American Psychiatric Association Publishing.

## RESULTS

We identified 69 relevant studies for inclusion. Because we were particularly interested in the bipolar II subtype, when information was not reported for the sample by subtype, we contacted corresponding authors of relevant manuscripts to request outcomes by subtype. Fifty-three percent (15/28) of authors contacted responded to our request for additional information. We further limited the sample to studies where ≥10% of the sample met criteria for bipolar II disorder and which included at least 10 participants with this condition. After applying these criteria, we included in the review 35 reports of 27 RCTs. Results of these trials are summarized in Table 1, and detailed information about individual studies is provided in the text for trials where results were reported separately for participants with bipolar II disorder.

Among the 27 RCTs, sample size ranged from 24 to 463 participants, including individuals with bipolar I, II, and related bipolar disorders or bipolar II disorder only. In total, 1,051 individuals with bipolar II disorder were included in these reports, representing almost 24% of the study population (N=4,394). Mood state at entry for these studies was quite variable and included individuals who were depressed, euthymic, and "in any mood state." Duration of follow-up varied from three months to eight years. Outcomes were almost uniformly favorable among those assigned to active psychotherapy, although studies that included active comparators typically reported no differences in outcomes between groups (18, 21, 22). In all protocols except two (16, 18), participants received medications (typically mood stabilizers) in addition to psychotherapy, suggesting that observed effects of psychotherapy were in addition to those of baseline pharmacotherapy. Below we discuss each type of psychotherapy for which there is at least some information about its use in bipolar II disorder because the sample included at least 10 participants with this disorder and the report detailed outcomes by bipolar subtype.

**TABLE 1. A summary of psychosocial treatment trials for bipolar disorder including participants with bipolar II disorder (BD II)[a]**

| Author | Treatment method | Treatment duration; follow-up | Sample | State at entry; other criteria | Overall outcome |
|---|---|---|---|---|---|
| **Individual and group psychoeducation** | | | | | |
| Colom et al. (19, 21, 22)[b] | Group PE or support group | 21 sessions; 2 years, 5 years | 2003: N=120, BDII=20 (17%), BDI=100; 2009: N=99 | Euthymic | At 2 years, group PE associated with sig. lower relapse rates, lower hospitalization rates, and much less time acutely ill. At 5 years, group PE continued to be associated with sig. fewer recurrences and less time acutely ill in the BD II group. |
| Kallestad et al. (23)[b] | Individual PE or group PE | PE: 3 sessions, group: 18 to 20 sessions; 27 months, 8 years | N=85, BDII=45 (53%), BDI=40 | Any | Group PE associated with sig. longer time to hospitalization. Pre-randomization characteristics but not intervention group explained variance. Group PE participants without substance use had longest survival and had small but sig. reduction in hospital use. BD II had worse outcomes than BD I. |
| Morris et al. (24) | Group PE or peer support | 21 sessions, 2 years | N=304, BDII=61 (20%), BDI=243 | Euthymic | No sig. differences. |
| Parikh et al. (25)[b] | Group PE or individual CBT | PE: 6 sessions, CBT: 20 sessions; 72 weeks | N=204, BDII=57 (28%), BDI=147 | Full or partial remission | No sig. differences. BD I and II outcomes were not different. |
| Zaretsky et al. (26) | PE + CBT or PE alone | PE: 7 sessions, PE + CBT: Addition of 13 CBT sessions; 1 year | N=79, BDII=27 (34%), BDI=52 | Euthymic or minimally symptomatic | PE + CBT associated with sig. fewer days of depressed mood and fewer increases in antidepressant dosage. |
| **Individual and group cognitive-behavioral therapy and cognitive therapy** | | | | | |
| Gomes et al. (27) | Group CBT or TAU | 18 sessions; 2 years | N=50, BDII=12 (24%), BDI=38 | Euthymic | Group MBCT did not sig. increase time in remission or decrease number of episodes. Group CBT group had sig. longer median time to first relapse. |
| Jones et al. (28) | Group recovery-focused CBT (RCBT) or TAU | Up to 18 sessions; 1 year, small proportion up to 15 months | N=67, BDII=14 (21%), BDI=53 | Within 5 years of onset of BD | Group RCBT sig. improved personal recovery up to 12 months and increased time to relapse up to 15 months follow-up. |
| Meyer & Hautzinger (29)[b] | CBT or supportive therapy | 20 sessions; 2 years | N=76, BDII=16 (21%), BDI=38 | Current mood episode | CBT showed a non-sig. trend for preventing any affective episode. No differences in relapse rates were observed overall, but BD II group had worse outcomes than BD I. |
| Miklowitz et al. (30)[b] | CBT, FFT, IPSRT, or CC | CBT, FFT, and IPSRT: 30 sessions, CC: 3 sessions; 9 months, 12 months | N=293, BDII=90 (31%), BDI=197, NOS=5 | Current depressive episode | At 9 months, CBT, FFT, and IPSRT all associated with better total functioning, relationship functioning, and life satisfaction scores. No differences among CBT, FFT, and IPSRT. At 1 year, CBT, FFT, and IPSRT were associated with more rapid recovery and greater likelihood of being well during any study month. BD II and I outcomes were not different. |
| Perich et al. (31) | Group MBCT or TAU | 8 sessions; 1 year | N=95, BDII=35 (37%), BDI=59, NOS=1 | Euthymic or minimally symptomatic | No sig. difference. |

*continued*

**TABLE 1,** *continued*

| Author | Treatment method | Treatment duration; follow-up | Sample | State at entry; other criteria | Overall outcome |
|---|---|---|---|---|---|
| **Interpersonal and social rhythm therapy** | | | | | |
| Inder et al. (32) | IPSRT or specialist supportive care | 12 weekly, then biweekly, and then monthly sessions, or as needed; 18 months, 3 years | N=100, BDII=17 (17%), BDI=78, NOS=5 | Any, ages 15 to 36 years | No sig. difference. |
| Swartz et al. (18)[b] | IPSRT or quetiapine pharmacotherapy | 12 sessions; 12 weeks | N=25, BDII=25 (100%) | Depressed | No sig. differences. |
| Swartz et al. (16)[b] | IPSRT + placebo pharmacotherapy or IPSRT + quetiapine pharmacotherapy | 20 sessions; 20 weeks | N=92, BDII=92 (100%) | Depressed | IPSRT + quetiapine yielded sig. faster depression and mania improvement. No sig. difference in response rates. Preference for psychotherapy was significantly associated with better outcomes with therapy alone. |
| **Integrated care management** | | | | | |
| Bauer et al. (33) | CC or TAU | 83 sessions; 3 years | N=306, BDII=41 (13%), BDI=265 | Current episode requiring acute psychiatric hospitalization; history of prior hospitalization | CC group had sig. fewer weeks in an affective episode, especially mania. CC associated with sig. improvements in some areas of functioning and quality of life. No sig. diff in symptomatic outcome and mean symptom levels. |
| Simon et al. (34) | SCM or TAU | Up to 48 sessions; 2 years | N=441, BDII=105 (24%), BDI=336 | Any | SCM group had sig. less severe mania and spent less time in a manic or hypomanic episode. No sig. intervention effect on severity or time in depression. |
| **Group functional remediation** | | | | | |
| Solé et al. (35)[b] Torrent et al. (36) | Group FR, group PE, or TAU | 21 sessions; 6 months | N=53 of 239, BDII=53 (100%) | Subsample of Torrent et al., 2013, BDII diagnosis; euthymic at study entry | No sig. group differences. Changes in global psychosocial functioning trended similarly to original study; may be insufficiently powered. Unlike the original study, FR was associated with sig. decrease in depressive symptoms in the BD II subgroup. |
| **Technology-assisted interventions** | | | | | |
| Barnes et al. (37) | Online PE + CBT or Internet control condition | 20 sessions over 12 months; 1 year | N=233, BDII=29 (12%), BDI=204 | No acute mania | No sig. difference. |
| Bilderbeck et al. (38) | Electronic mood monitoring and in-person therapist-administered PE or electronic mood monitoring and self-directed PE | 5 in-person sessions over 12 weeks with electronic mood monitoring; 1 year | N=121, BDII=42 (35%), BDI=79 | Euthymic | No sig. difference. |

*continued*

**TABLE 1,** *continued*

| Author | Treatment method | Treatment duration; follow-up | Sample | State at entry; other criteria | Overall outcome |
|---|---|---|---|---|---|
| Depp et al. (39) | In-person PE + electronic mood monitoring with feedback loop or in-person PE + paper-and-pencil mood monitoring | 4 PE sessions then 10 weeks of daily mood monitoring; 6 months | N=82, BDII=10 (12%), BDI=72 | No severe depressive or manic symptoms | PRISM was associated with sig. greater reduction in depressive symptoms at 6 and 12 weeks but not 24 weeks; no impact on manic symptoms or functional impairment. |
| Faurholt-Jepsen et al. (40) | In-person TAU and electronic mood monitoring with feedback loop or placebo smartphone without the app | Daily; 6 months | N=67, BDII=22 (33%), BDI=45 | No severe depressive or manic symptoms | No significant effect on depressive or manic symptoms. MONARCA associated with more sustained depressive symptoms. |
| Hidalgo-Mazzei et al. (41, 42) | Online pre- and post-personalized electronic psychoeducation | 3 months; 3 months | N=51 (2 excluded), BDII=13 (27%), BDI=33, NOS=3 | Euthymic | Completing SIMPLe was associated with sig. improved biological rhythm regularity, sleep, social rhythms, eating patterns, predominant rhythm. There was no sig. effect on activities. |
| Lauder et al. (43) | Online MoodSwings or online MoodSwings Plus | 1 module every 2 weeks for 10 weeks, then 3 booster sessions; 12 months | N=130, BDII=63 (49%), BDI=67 | Any | There were no sig. differences for mania or depression relapse rates. MoodSwings Plus group had lower levels of mania. |
| Todd et al. (44) | Online recovery-focused PE + CBT or in-person TAU | 10 modules, 6 months of access; 6 months | N=122, BDII=30 (25%), BDI=86 | Any | PE + CBT associated with greater improvement in psychological and physical domains of quality of life, well-being, and recovery. |
| **Other individual and group interventions** | | | | | |
| Fagiolini et al. (45) | SCBD + ECI or ECI only | SCBD + ECI: 12 weekly, 8 biweekly, then monthly sessions; 2 years | N=463, BDII=87 (19%), BDI=313, other=63 | Current mood episode | SCBD + ECI associated with sig. greater improvement in quality of life. |
| Castle et al. (46) | Collaborative therapy program: MAPS (CTP) or phone calls | 15 sessions; 1 year | N=84, BDII=21 (25%), BDI=62, NOS=1 | No acute episode of mania or depression | CTP associated with longer time to relapse and less time unwell. No sig. differences in post-treatment symptoms. |
| Van Dijk et al. (47) | DBTS-M or wait list | 12 sessions; 6 months | N=24, BDII=14 (58%), BDI=10 | Euthymic, depressed or hypomanic | DBTS-M was associated with a trend toward fewer depressive symptoms and fewer hospitalizations and emergency visits. |
| Weiss et al. (48) | IGT or group drug counseling | 20 sessions; 3 months | N=62, BDII=10 (16%), BDI=50, NOS=2 | Any, diagnosis of substance dependence other than nicotine | IGT group had better substance use outcomes but more depression and mania symptoms. No sig. difference for number of weeks ill. |

[a] Reprinted with permission from *Bipolar II Disorder: Recognition, Understanding, and Treatment* (Edited by Swartz HA, Suppes T) from American Psychiatric Association Publishing. BDI=bipolar I disorder; BDII=bipolar II disorder; CBT=cognitive-behavioral therapy; CC=collaborative care; DBTS-M=dialectical behavior therapy skills with mindfulness; ECI=enhanced clinical intervention; FFT=family-focused therapy; FR=functional remediation; IGT=integrated group therapy; IPSRT=interpersonal and social rhythm therapy; MAPS (CTP)=collaborative therapy program; MBCT=mindfulness-based cognitive-behavioral therapy; MONARCA=Monitoring, Treatment and Prediction of Bipolar Disorder Episodes app; NOS=not otherwise specified; PE=psychoeducation; PRISM=Personalized Real-Time Intervention for Stabilizing Mood; RCBT=recovery-focused CBT; SCBD=specialized care for bipolar disorder; SCM=systematic care management; sig=significantly; SIMPLe=smartphone application; TAU=treatment as usual.

[b] Reports outcomes specifically for BD II.

**Psychoeducation**

Psychoeducation consists of structured sessions that focus on empowering individuals to better understand their bipolar illness, recognize and manage symptoms, and adhere to pharmacotherapy. It can be administered individually or in a group format, or recently, remotely through a telephone, smartphone, or web-platform (see discussion of "Technology-Assisted Interventions" below). Psychoeducation can be administered as a stand-alone treatment or combined with strategies from other evidence-based interventions.

We identified five studies with face-to-face individual (23, 24) or group (21, 25, 26) psychoeducation as the active intervention. One group (24) studied psychoeducation in combination with cognitive-behavioral therapy (CBT). Individuals with bipolar II disorder comprised 17%–53% of the sample. Follow-up lasted one to eight years. Three studies reported results by bipolar subtype (21, 23, 25) and are summarized below.

Colom and colleagues compared group psychoeducation with an unstructured support group among participants with bipolar I and II disorder, all of whom were receiving pharmacotherapy and usual outpatient psychiatric care (25). Group psychoeducation was a manualized, structured program of 21 sessions developed by Colom and Vieta (27). Their program targeted treatment compliance, illness awareness, early detection of prodromal symptoms, and lifestyle regularity. At the two- and five-year follow-ups, assignment to group psychoeducation was associated with significantly lower relapse rates (25, 28). In a follow-up report analyzing data from the bipolar II subset only, at the five-year follow-up, group psychoeducation was associated with significant advantages over the support group (19): fewer participants with one or more episodes of recurrence (62.5% versus 100%), fewer days with symptoms of hypomania or depression (10.5% versus 47%), and higher levels of functioning. Colom and colleagues suggested that psychoeducation derives its effect from improved functioning, possibly attributable to the power of psychoeducation to reduce time depressed (versus hypomanic). Accordingly, they proposed that group psychoeducation may be improved for bipolar II disorder if modified to place more emphasis on depression, including subsyndromal and atypical symptoms, comorbid anxiety, and physical health care.

Parikh and colleagues randomly assigned individuals to either six weeks of group psychoeducation or 20 weeks of individual CBT as an adjunctive to naturalistic pharmacotherapy (21). Group psychoeducation was a manualized, structured program of six sessions designed to teach illness recognition and coping strategies and assist with creation of an explicit care plan to address triggers for mania and depression. Individual CBT included traditional CBT techniques in addition to an emphasis on understanding the diagnosis and course of bipolar disorder, personal warning signs, and a "relapse drill" of actions to reduce relapse. After 72 weeks, there were no treatment group effects for the primary outcome, mood burden over time, suggesting brief group psychoeducation may be as effective as a full course of individual CBT. Among those with bipolar II disorder, only one participant spent more than 50% of the time ill. Almost 18% spent no time ill, and most (76%) spent less than 25% of the time ill. Subsyndromal symptoms, particularly depressive type, accounted for as much as 23% of the mood symptoms experienced by individuals with bipolar II disorder, compared with only 17% of individuals with bipolar I disorder. Investigators concluded that combination pharmacotherapy and psychosocial interventions, whether individual or group, result in favorable outcomes for both bipolar I and II disorders.

In the third study, Kallestad and colleagues compared the effectiveness of individual and group psychoeducation (23). Individual psychoeducation was a three-session intervention based on a psychoeducation workbook from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). The workbook included information about bipolar disorder, importance of medication adherence, schedule management, dysfunctional cognitions, communication skills, and preventing mood episodes. Group psychoeducation was a 10-session manualized treatment based on Colom and Vieta's model (27). Although there were no significant group differences, there was a significant interaction between group and diagnosis. Compared with individuals with bipolar I disorder, individuals with bipolar II disorder benefited less from either intervention and fared significantly worse with individual psychoeducation than with group psychoeducation. Those with bipolar II disorder had significantly earlier admissions to the hospital and higher rates of comorbid substance use, another factor that was significantly and independently associated with earlier hospital admission. Kallestad and colleagues hypothesized that the poor outcomes associated with bipolar II disorder may be related to the high frequency of substance use, treatment-refractory depressive symptoms, and overall illness instability in the bipolar II population. They concluded that psychoeducation might need to be adapted specifically to meet the needs of those with bipolar II disorder.

In aggregate, it appears that psychoeducation is a helpful treatment to prevent recurrence of mood episodes for individuals with bipolar II disorder in the maintenance phase. There is no information about this treatment as an acute intervention for bipolar II disorder. For this population, psychoeducation may be most potent in a group format and when administered early in the course of illness (26). Given its prominent focus on disease recognition and management, psychoeducation may benefit from modification to increase its salience for those with bipolar II disorder. For instance, bipolar I and II disorders differ in presentation (e.g., mania and psychotic features), course (29), and illness management (9). It may be particularly helpful to emphasize the recognition and management of subthreshold symptoms, especially depressive in nature, unstable course of the illness, and comorbid substance use.

**CBT**

CBT, administered individually or in a group format, focuses on identifying and changing maladaptive thoughts, beliefs,

and behaviors that contribute to psychiatric symptoms (30). When tailored for bipolar disorder, CBT typically incorporates strategies such as management of sleep and routines, attention to medication adherence, and psychoeducation about bipolar disorder (31). This section includes variants of CBT such as cognitive therapy and mindfulness-based cognitive therapy (MBCT).

We identified three studies with face-to-face individual CBT (21, 32, 33) and three studies with group CBT (34–36) as the active intervention. Individuals with bipolar II disorder comprised 21% to 37% of the sample. Follow-up lasted one to two years. Three studies reported results by bipolar subtype (21, 32, 33). One study was described in the psychoeducation section and is not repeated here (21).

Miklowitz and colleagues reported bipolar II disorder outcomes from STEP-BD, a multi-site project that compared the efficacy of three individual psychotherapies—CBT, family-focused therapy (FFT), and interpersonal and social rhythm therapy (IPSRT)—with a three-session psychoeducation control intervention as treatments for acute bipolar depression (32). All participants were receiving pharmacotherapy. For the control condition, participants received a STEP-BD psychoeducation videotape and workbook, and sessions focused on review of these materials (content previously described in the psychoeducation section). CBT sessions included psychoeducation, life events scheduling, cognitive restructuring, problem-solving training, relapse prevention, and interventions for comorbidities, if applicable. FFT sessions included psychoeducation, strategies to foster the development of a common understanding between patients and relatives about the index episode, medication adherence, role of stress, relapse prevention, communication enhancement, and problem solving. IPSRT is discussed in detail in the IPSRT section. Briefly, IPSRT sessions included psychoeducation and a focus on interpersonal relationships with behavioral interventions to modify social rhythms. After controlling for site, family involvement, and bipolar subtype, assignment to any one of the three intensive psychotherapies was associated with significantly higher rates of recovery (64% versus 52%), shorter time to recovery (median=113±78.2 days versus 146±80.0 days), and greater improvement in functioning. Bipolar subtype did not alter the effect of interventions on these outcomes, suggesting that CBT, FFT, and IPSRT were comparably efficacious for participants with bipolar I or II disorder.

Meyer and Hautzinger compared CBT to supportive therapy (ST) (33). In the ST condition, therapists provided emotional support and general advice. CBT included psychoeducation, relapse prevention, cognitive and behavioral strategies for depression and mania, and training in communication skills and/or problem solving. No significant differences were observed between groups in relapse rates or mood symptoms, although assignment to CBT was associated with a trend for preventing any mood episode. Bipolar subtype was a nonspecific predictor of outcomes: those with bipolar II had a higher risk of recurrence and increased risk for depressive relapse. That is, CBT and ST were both less effective for the management of bipolar II than for bipolar I disorder.

On the basis of these RCTs, CBT and its variants appear to be efficacious for acute bipolar II depression and may also prevent recurrence—although one study suggested that those with bipolar II disorder had worse outcomes relative to bipolar I disorder. It seems likely that CBT may need some subtype-specific modifications. Like psychoeducation, CBT may be more beneficial with greater emphasis on the recognition and management of subthreshold symptoms. It may also be important to focus more on dysfunctional thoughts, beliefs, and behaviors acquired during years of living with an untreated and unrecognized illness.

**IPSRT**

IPSRT is a manualized treatment that addresses interpersonal problems and disrupted social rhythms (37). Social rhythms are those daily activities—such as time of getting out of bed, first contact with another person, start of daily activity, dinner, and time to go to bed—that are thought to exert an effect on underlying biological rhythms. IPSRT rests on an "instability model" that defines three interconnected pathways to bipolar recurrences: stressful life events, medication nonadherence, and social rhythm disruption. IPSRT helps individuals identify and manage symptoms, link mood to life events, mourn the loss of the healthy self, resolve a primary interpersonal problem area (role transitions, role disputes, interpersonal deficits, or grief), maintain a regular daily rhythm, and predict and problem-solve potential precipitants of rhythm dysregulation. IPSRT typically is administered individually but can be provided in a group format.

We identified four studies with face-to-face individual IPSRT as the active intervention (16, 18, 22, 32). Individuals with bipolar II disorder comprised 17% to 100% of the sample. Follow-up lasted three months to three years. Three studies provided results for participants with bipolar II disorder (16, 18, 32); one was discussed in the CBT section and is not repeated here (32). To date, the following two reports are the only RCTs to include samples exclusively composed of participants with bipolar II disorder.

Swartz and colleagues compared IPSRT to quetiapine for bipolar II depression among unmedicated participants (18). Over 12 weeks, both groups experienced improvements in depressive and manic symptoms, and there were no significant differences between groups. In a follow-up study, Swartz and colleagues compared IPSRT plus placebo to IPSRT plus quetiapine for bipolar II depression (16). IPSRT plus quetiapine was associated with significantly faster improvements in depression and manic symptoms, albeit with more side effects than with IPSRT alone. Side effects of IPSRT plus quetiapine included significantly higher body mass index over time and dry mouth. Response rates did not differ between groups.

Based on three investigations, it appears that IPSRT, as a monotherapy or adjunctive treatment, is an efficacious

treatment strategy for acute bipolar II depression. No data are available about its role in the maintenance phase. IPSRT monotherapy should be considered when individuals prefer, or need, a nonpharmacological modality. IPSRT has been modified for bipolar II disorder (38), with changes that include increased attention to the following: rationale for making changes to social rhythms, identification of mood states, regulation of levels of stimulation, management of grandiosity, addressing emotional dysregulation, and treating comorbid substance use.

**Integrated Care Management**

Integrated care management (ICM) is a multicomponent population-based intervention designed to improve clinical care and outcomes (39). ICM is founded in integrated care models for chronic illness care and includes evidence-based strategies for case management and patient- and provider-level interventions. We identified two studies with face-to-face ICM as the active intervention (40, 41). Individuals with bipolar II disorder comprised 13% and 24% of the sample, and follow-up lasted three and two years, respectively. Neither report included results by subtype, and therefore the specific utility of ICM for managing bipolar II disorder is not clear.

**Functional Remediation**

Functional remediation (FR) is a neurocognitive intervention designed to target attention, memory, and executive functioning deficits associated with bipolar disorder (42). FR includes structured group sessions providing neurocognitive techniques, psychoeducation on cognition-related issues, and problem-solving to enhance functioning. We identified one RCT of FR detailed across two reports (42, 43), including one report that exclusively detailed outcomes for the patients in the bipolar II subgroup (17).

Torrent and colleagues compared FR, psychoeducation, and treatment as usual (TAU) as therapies for impaired functioning among participants with bipolar I and II disorders (42). Compared with TAU, FR was associated with significantly greater improvement in global psychosocial functioning. No differences were observed between FR and psychoeducation. In post-hoc analyses of the bipolar II subset, Solé and colleagues assessed treatment effects on global psychosocial functioning (17). They found a nonsignificant trend favoring FR with a significant treatment-by-time interaction: participants with bipolar II receiving FR showed significant reductions of subsyndromal depressive symptoms compared with those receiving psychoeducation.

On the basis of the Torrent et al. study (17, 42), FR appears to be a promising strategy to address impairments in psychosocial functioning for euthymic individuals with bipolar II. No data are available on the effects of this intervention during an acute mood episode. Like other interventions reviewed, FR may confer its advantages by reducing depressive symptoms which, in turn, leads to improved functioning.

**Technology-Assisted Interventions**

Despite the strong rationale for psychotherapies in bipolar II disorder, barriers to their dissemination include limited availability of trained therapists and patient access to specialized mental health services (44). Adjunctive psychotherapies that utilize technology reduce this pressure. We identified seven studies evaluating technology-assisted interventions. One study compared an online intervention to in-person TAU (45). Two studies compared active online to control online interventions (46, 47). Three studies used a hybrid approach, combining an in-person intervention with an online component (48–50), and one study was a within-subject, pre- versus post-online intervention design (51, 52). Three interventions included elements of CBT (45–47). Psychoeducation and mood monitoring were central components of all interventions. Individuals with bipolar II disorder comprised 12% to 49% of the sample. Follow-up lasted three months to one year. We found no studies or subanalyses of outcomes for those with bipolar II disorder. Therefore, the specific utility of technology-assisted interventions for managing bipolar II disorder is unknown. Of note, because bipolar II disorder is a depression-predominant illness, Faurholt-Jepsen and colleagues' findings (see Table 1) of worsening depressive symptoms associated with an in-person intervention with an online component may be particularly important to consider when developing technology-assisted interventions for individuals with this disorder (48).

**Other Individual and Group Interventions**

We identified four studies that were not categorized elsewhere. One study examined face-to-face individual care (enhanced clinical intervention) in the context of a comprehensive care management program (53). A second trial compared group relapse prevention to TAU (54). A third study compared an integrated group model to group drug counseling for individuals with bipolar disorder and comorbid substance use disorders (55). The fourth was a pilot study comparing group dialectical behavior therapy to a wait-list control condition (56). Individuals with bipolar II disorder comprised 16% to 58% of the sample in these four studies, and follow-up lasted three months to two years. No report included results by subtype, and therefore their potential role in the management of bipolar II disorder is unclear.

**Common Factors and Clinical Recommendations**

In a prior review of this topic (57), we argued that several strategies are common to almost all of the empirically supported psychosocial interventions for bipolar disorder: 1) education about the illness, 2) education about medications, 3) careful review of medication side effects, 4) promotion of regular sleep-wake cycles, 5) daily mood monitoring, 6) discussion of prodromes and related approaches to relapse prevention, and 7) direct involvement of family members and significant others, or at a minimum, consideration of their role in the maintenance of wellness. These approaches

are also relevant to psychotherapies for bipolar II disorder. In addition, the following set of strategies should be considered when treating an individual with bipolar II disorder:

*Psychoeducation should be tailored to address the nuances of the bipolar II illness subtype.* Identification and recognition of hypomanic and mixed states is challenging for both clinician and patient. Hypomania may feel "really good," be mistaken for euthymia, and go unrecognized, as often happens. Mixed mood states are difficult to demarcate and track and may feel more characterological than illness-related. Weekly mood tracking and psychoeducation can be used to help patients identify, and ultimately address, hypomania and subthreshold mood fluctuations.

*Regular mood monitoring is important for those with bipolar II disorder, with a focus on identifying subthreshold depressive symptoms.* Therapeutic work should endeavor to help patients become experts in recognition of mood states, including subthreshold depression, through regular mood monitoring. Because depression predominates in bipolar II disorder and contributes to morbidity, helping patients recognize even subthreshold symptoms is important. Early recognition may pave the way for early intervention and successful relapse prevention.

*Depression-specific strategies should be enhanced for bipolar II disorder.* Because depression predominates in this illness, strategies that target its symptoms may need to be emphasized. For instance, behavioral activation may be utilized across interventions to target anergia and inactivity. Therapies that were originally developed for unipolar depression (CBT, interpersonal psychotherapy) may need to emphasize the depression-focused components of those treatments.

*Psychoeducation about medications and medication side effects is especially complex in bipolar II disorder because there is uncertainty about appropriate pharmacologic management.* Clinicians should educate themselves about what is currently known and help individuals understand the available information to facilitate informed decision making about concurrent pharmacotherapy.

*Illness recognition and understanding can be problematic for family members, especially when diagnosis has been incorrect or delayed for years or even decades.* Involving family members and significant others can be an important first step in addressing the inevitable strain caused by poorly managed bipolar II disorder and may help provide additional help in symptom monitoring and recognition.

*Comorbidities such as substance use, anxiety disorders, and personality disorders should be evaluated and addressed.* Bipolar II disorder frequently co-occurs with other disorders. Screening for commonly co-occurring disorders is an important step toward identifying them and, ultimately, helping the patient obtain additional targeted treatments.

## DISCUSSION

Our systematic review of psychotherapy for bipolar II disorder identified more than 1,000 individuals with this disorder who participated in RCTs testing psychosocial interventions to treat depression or prevent recurrence of mood symptoms. Relatively few of these trials—only eight of 27—examined outcomes of those with bipolar II separately (Table 1). No psychotherapy met conventional standards for efficacy, defined as at least two rigorous trials that show consistent positive effects and at least one significant long-term follow-up study (58). IPSRT has the greatest evidence supporting its efficacy for bipolar II disorder: one small RCT and one larger RCT supporting its use as a monotherapy for acute bipolar II depression. CBT and psychoeducation each have at least two positive studies supporting efficacy for bipolar II disorder, in conjunction with mood stabilizing medication, in either the acute or maintenance phase. Both psychoeducation and CBT, however, also have at least one negative study. FR and FFT are supported by secondary analyses from one trial. Despite growing interest in technology-assisted psychotherapy for bipolar disorder, it is difficult to make conclusions about its role in the management of bipolar II disorder absent analyses focused on this subgroup.

Salience of psychotherapies may improve if modified to meet the needs of those with bipolar II disorder. Investigators have specifically attended to this issue when testing IPSRT for patients with bipolar II disorder (38), and those who examined group psychoeducation for patients with bipolar II disorder made similar recommendations for its modification (19, 23). We endorse this approach to meet the needs of those with bipolar II disorder. Targeted approaches will likely include a greater focus on the bipolar II-specific course of illness, enhanced attention to recognition of hypomania, and additional strategies to address the depression-predominant phase of the illness.

## CONCLUSIONS

In summary, there is a strong rationale for using psychotherapy to manage bipolar II disorder, either as a monotherapy or adjunctive to pharmacotherapy. The evidence base, although growing, remains sparse. Preliminary evidence supports the use of IPSRT, CBT, psychoeducation, and, to a lesser extent, FR, and FFT. Modification of bipolar-specific psychotherapies to meet the needs of those with bipolar II disorder is indicated. More studies are needed, however, to fully understand the role of psychotherapy in the management of bipolar II across the phases of the disorder.

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