Psychosocial Interventions for Adults with Bipolar II Disorder: A Literature Review

Abstract

Although Bipolar II Disorder is a highly prevalent, debilitating, and complex chronic illness, relatively little is known about how to best manage it with psychotherapy. Given the paucity of psychotherapy research specific to Bipolar II cohorts, tentative treatment recommendations can be derived from published mixed-sample studies, the majority of which examined individuals with Bipolar I or II Disorder. This article reviews several well-documented psychosocial interventions, along with their evidence base for treating Bipolar II Disorder: interpersonal and social rhythm therapy (IPSRT), psychoeducation, cognitive-behavioural therapy (CBT), mindfulness-based cognitive therapy (MBCT), family-focused therapy (FFT), functional remediation (FR), and the life goals program (LGP). Studies evaluating these interventions have been considered if the sample included adults who met criteria for Bipolar II Disorder. Each identified psychosocial intervention, in conjunction with medication, has shown promise of improving clinical and quality-of-life outcomes for this client population. IPSRT has demonstrated feasibility of treating Bipolar II Disorder with psychotherapy alone. Preliminary evidence suggests that some interventions may be more effective than others with some clients at particular points during the course of illness. While mental health professionals await more psychotherapy research specifically for Bipolar II Disorder, available findings can be used to inform current practice.

Keywords: Bipolar II Disorder, psychosocial intervention, psychotherapy

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Bipolar II Disorder is a chronic mental illness with an estimated lifetime prevalence of 0.57% in Canada (McDonald et al., 2015) and 0.4% worldwide (Merikangas et al., 2011). Evidence suggests that it is at least as debilitating as Bipolar I Disorder (Rosa et al., 2010; Ruggero, Chelminski, Young, & Zimmerman, 2007). Bipolar II Disorder is characterized by high mood instability with predominant symptoms of depression and is associated with tremendous psychosocial challenges (American Psychiatric Association [APA], 2013; Rosa et al., 2010). Almost one in three individuals with this chronic illness has a lifetime history of at least one serious suicide attempt (Ruggero et al., 2007). Despite the high prevalence and morbidity of Bipolar II Disorder, relatively little is known about how to best manage it with psychotherapy. Most psychosocial interventions do not address the specific needs of individuals diagnosed with Bipolar II Disorder, separately from the needs of individuals diagnosed with other subtypes of Bipolar Disorder (Colom et al., 2009; Swartz, Levenson, & Frank, 2012).

Bipolar II Disorder is a debilitating mental illness with a complex course, presentation, and outcome (APA, 2013). The purpose of this literature review is to summarize recent discussions and research findings that can inform psychotherapy for adults with Bipolar II Disorder, with a focus on evidence-based treatment options. By drawing on available psychosocial interventions with evidence base for Bipolar II Disorder, practitioners can tailor their treatment approaches to the needs of individual clients at different phases of this chronic illness. The discussion begins with an overview of Bipolar II Disorder and the role of psychotherapy in managing it. Next, the article reviews several well-documented psychosocial interventions, along with their evidence base for treating Bipolar II Disorder: interpersonal and social rhythm therapy (IPSRT), psychoeducation, cognitive-behavioural therapy (CBT),

mindfulness-based cognitive therapy (MBCT), family-focused therapy (FFT), functional remediation (FR), and the life goals program (LGP). The following section discusses limitations of the reviewed studies and provides recommendations for future research. Finally, the article presents a summary of the reviewed literature and tentative recommendations for practice.

Four electronic databases were searched for relevant literature published between 2008 and 2015: Academic Search Complete, PsycINFO, ScienceDirect, and Google Scholar. The main search was carried out using the keyword *bipolar* combined with *therapy*, *psychosocial*, *psychoeducation*, or *treatment*. Studies of psychosocial interventions were selected if the sample included adults, aged 18 years or older, who met criteria for Bipolar II Disorder. Other search strategies involved reference lists of identified articles and the ScienceDirect suggestions automatically generated for selected articles.

Overview of Bipolar II Disorder

Bipolar II Disorder is defined by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; APA, 2013) as a subtype of Bipolar Disorder characterized by a lifetime history of at least one episode of major depression, lasting two weeks or more, and one hypomanic episode, lasting at least four consecutive days. The number of lifetime episodes tends to be higher for Bipolar II Disorder than for other major mood disorders. The recurrent depressive episodes are often frequent and protracted. Although hypomanic episodes do not typically cause impairment, they may be associated with erratic behavior. Mixed mood states, marked by co-occurring depressive and hypomanic symptoms, are common in individuals with Bipolar II Disorder, especially in females. Rapid cycling, with four or more mood episodes within a year, is also common among females. Some individuals have a history of psychotic symptoms experienced during Bipolar II depression. The course and presentation of Bipolar II

Disorder are often further complicated by one or more co-occurring mental disorders, such as anxiety, substance use, and eating disorders (APA, 2013).

In addition to tremendous psychological suffering caused by persistent mood instability, predominant major depressive episodes, and debilitating and confusing mixed mood states, Bipolar II Disorder is also associated with functional impairment (APA, 2013; Swartz, Levenson, & Frank, 2012). The affected individuals tend to experience various psychosocial difficulties, especially in the areas of interpersonal and occupational functioning (Rosa et al., 2010; Ruggero et al., 2007). Neurocognitive impairment affecting attention, verbal memory, and executive functions may contribute to these difficulties (Solé et al., 2012). Functional recovery tends to lag significantly behind symptomatic recovery in Bipolar II Disorder, resulting in compromised quality of life (APA, 2013; Rosa et al., 2010).

The diagnosis of Bipolar II Disorder appears to correlate with certain personality, temperament, and cognitive styles. Individuals with this chronic illness tend to be impulsive, irritable, anxious, self-critical, and self-focused (APA, 2013; Fletcher, Parker, Barrett, Synnott, & McCraw, 2012; Gudmundsson, 2015). They are more likely to have elevated interpersonal sensitivity, low self-esteem, high levels of perfectionism, obsessive-compulsive and paranoid tendencies, and chronic suicidal ideation (Fletcher et al., 2012; Gudmundsson, 2015). It is rather common for individuals with Bipolar II Disorder to have high personal standards of achievement and believe that their personal happiness depends on others (Perich, Manicavasagar, Mitchell, Ball, & Hadzi-Pavlovic, 2013). The emotional states of Bipolar II Disorder appear to have overlapping phenomenology with several personality disorders, primarily with Borderline Personality Disorder (Yao et al., 2015).

Many of the personality, temperament, and cognitive styles associated with Bipolar II Disorder may influence the course of illness. For instance, due to the affected individuals' elevated interpersonal sensitivity, their mood episodes may be more easily triggered by interpersonal events (Fletcher et al., 2012). High levels of emotional reactivity may contribute to the individuals' difficulty regulating their levels of arousal (Swartz, Levenson, & Frank, 2012). Hypomania and depression appear to be mediated by various cognitive processes and behaviours, particularly by the affected individuals' attitude toward hypomania (Fletcher, Parker, & Manicavasagar, 2013). Their inability to recognize hypomania as pathological may result in risky behaviors, such as medication nonadherence and reduced sleep, which may interfere with illness management (Fletcher et al., 2013; Swartz, Levenson, & Frank, 2012).

The Role of Psychotherapy in Managing Bipolar II Disorder

The recommended approach to managing Bipolar II Disorder involves a combination of pharmacotherapy and psychotherapy (Malhi et al., 2009; Yatham et al., 2013). Many issues associated with this illness, which include interpersonal difficulties, cognitive impairment (Solé et al., 2012), decline in occupational functioning (Ruggero et al., 2007), anxiety, low self-esteem, and substance dependence (Gudmundsson, 2015), lend themselves to psychosocial interventions (Swartz, Frank, Frankel, Novick, & Houck, 2009). Various psychosocial factors, such as cognitive styles (Fletcher et al., 2013), life events (Frank, 2007), and family environment (Morris, Miklowitz, & Waxmonsky, 2007), can influence the course of illness. Psychotherapy can provide clients with Bipolar II Disorder with strategies for understanding their illness, recognizing and managing their mood symptoms, addressing illness-related triggers and traumas, and enhancing psychosocial functioning (Swartz, Frank, & Cheng, 2012; Swartz et al., 2009).

Another rationale for treating Bipolar II Disorder with psychotherapy is based on the assumption that, given the predominance of depressive episodes, this illness can be treated with the same interventions that have been shown to be effective in treating unipolar depression (Yatham et al., 2013). Preliminary evidence has provided support to this assumption, showing that psychotherapy can be effective in treating Bipolar II depression (Swartz, Frank, & Cheng, 2012; Swartz et al., 2009). Research has demonstrated that adjunctive psychotherapy can also address subclinical depressive symptoms, reduce recurrence and time spent in mood episodes, and improve psychosocial functioning in individuals with Bipolar II Disorder (Colom et al., 2009; Solé et al., 2015).

Swartz, Frank, and Cheng (2012) have proposed that a subset of clients with Bipolar II Disorder, who are at low risk of experiencing manic episodes or psychosis, may be treated with psychotherapy alone. Preliminary evidence supports the feasibility of this approach (Swartz, Frank, & Cheng, 2012; Swartz et al., 2009). The research finding that psychotherapy alone can be effective in treating Bipolar II depression has important clinical implications, especially for individuals with Bipolar II Disorder who cannot tolerate pharmacotherapy (Swartz et al., 2009).

Psychosocial Interventions with Evidence Base for Bipolar II Disorder

To date, only a few studies of psychotherapy have reported results specifically for individuals with Bipolar II Disorder (Colom et al., 2009; Faria et al., 2014; Solé et al., 2015; Swartz, Frank, & Cheng, 2012; Swartz et al., 2009). Most published studies have examined mixed samples of individuals with Bipolar I or II Disorder. While mental health professionals await additional research data, meaningful information about psychotherapy for Bipolar II Disorder can be derived from these studies (see Table A1) and used to inform current practice.

Well-documented psychosocial interventions with evidence base for treating adults with Bipolar II Disorder are outlined next.

Interpersonal and Social Rhythm Therapy

Canadian psychiatric practice guidelines recommend IPSRT, in addition to pharmacotherapy, for acute management of Bipolar II depression (Yatham et al., 2013). The overall goal of IPSRT is to reduce the frequency of mood episodes and to prolong euthymic mood states (Frank, 2007). The therapy aims to directly address each of the three pathways hypothesized to lead to relapses in Bipolar Disorder: nonadherence to mood stabilizing medication; stressful life events; and disruption in social rhythms, or social and environmental cues that have the potential to alter circadian rhythms. In addition to providing medication-adherence training, IPSRT targets the denial that often interferes with treatment adherence. The therapy attempts to reduce the number and severity of stressful events by addressing clients' interpersonal and social-role difficulties. To reduce disruption in social rhythms, clients are encouraged to maintain daily routines and a regular sleep-wake schedule (Frank, 2007).

IPSRT is an integrative approach that combines psychoeducation, social rhythm therapy, and interpersonal psychotherapy (Frank, 2007; Swartz, Levenson, & Frank, 2012). The therapist utilizes these components based on the changing client needs over the course of treatment. The focus of psychoeducation is on providing clients with information about their illness, its symptoms and consequences, available medication, and potential side effects. Clients are also taught how to detect early warning signs of mood episodes and to prevent relapses. The purpose of social rhythm therapy is to assist clients in stabilizing their circadian rhythms. This is accomplished by first identifying the events and behaviours that disrupt rhythm stability. Clients are then encouraged to make the lifestyle changes necessary to regularize their daily routines,

sleep-wake times, and patterns of social stimulation. Interpersonal psychotherapy is used to help clients gain insight into the bidirectional relationship between stressful interpersonal events and mood instability. Clients focus on ameliorating interpersonal or social-role difficulties in one of five areas: unresolved grief experiences, transitions in major life roles, role disputes with significant others, generalized interpersonal deficits, or grief for the self they would have been if they did not have Bipolar Disorder (Frank, 2007; Swartz, Levenson, & Frank, 2012).

To date, IPSRT is the only intervention that has been adapted for treating Bipolar II Disorder. The adaptation, developed by Swartz, Levenson, and Frank (2012), includes six additional strategies: providing rationale for making changes to social rhythms, identifying mood states, regulating levels of stimulation, managing grandiosity, minimizing emotional dysregulation, and inquiring about substance abuse. According to Swartz, Levenson, and Frank, it is often difficult to convince individuals with Bipolar II Disorder to make significant lifestyle changes in order to stabilize their rhythms, primarily because they see no need to prevent hypomania. To encourage rhythm regularity, the therapist is advised to emphasize that hypomania is more destructive than it appears and that it often leads to depressive episodes. The therapist may ask clients to observe, as an experiment, if stability in schedule helps with overall mood symptoms. It can be difficult for clients with Bipolar II Disorder to recognize their mood states, especially hypomania and mixed states. The therapist can help them overcome this challenge by describing Bipolar II Disorder as a disorder of energy, rather than mood, because changes in energy are easier to identify and track. The therapist is advised to spend enough time at the beginning of therapy teaching clients how to accurately identify their mood and energy states (Swartz, Levenson, & Frank, 2012).

In IPSRT, clients are taught to regulate their levels of arousal by increasing stimulation when they are depressed and decreasing it when their energy is high (Swartz, Levenson, & Frank, 2012). Swartz, Levenson, and Frank (2012) recognize that this task may be challenging for individuals with Bipolar II Disorder, who often experience mixed mood states and rapid cycling. Some individuals may be motivated to drive their hypomanic mood even higher or avoid euthymic mood because it is experienced as "flat" (Swartz, Levenson, & Frank, 2012, p. 149). They may need help recognizing these maladaptive patterns and replacing them with efforts to regulate their levels of stimulation. To minimize emotional dysregulation, clients may benefit from the strategies offered by Linehan (1993) for individuals with Borderline Personality Disorder, such as distraction, breathing exercises, and self-soothing. To work effectively with clients who have Bipolar II Disorder, the therapist must be able to recognize and manage their grandiosity and entitlement, which may be elevated during hypomanic episodes. Most clients respond well to having their maladaptive behaviors pointed out to them in the context of a strong therapeutic relationship. The therapist is also advised to regularly ask clients about their use of licit and illicit drugs, alcohol, nicotine, and caffeine, and to educate them about the impact of these substances on circadian rhythms and mood (Swartz, Levenson, & Frank, 2012).

To date, IPSRT is the only intervention with empirical evidence for treating Bipolar II Disorder with psychotherapy alone. In a study conducted to determine the feasibility of using IPSRT as monotherapy for the acute treatment of Bipolar II depression, most participants achieved significant improvement in mood symptoms over 20 weeks (Swartz et al., 2009). In another study, participants with Bipolar II depression were treated either with quetiapine or IPSRT; both treatment groups experienced significant reductions in mood and anxiety symptoms over 12 weeks (Swartz, Frank, & Cheng, 2012). As an adjunct to pharmacotherapy, IPSRT has

been shown to reduce time to recovery from acute depressive episodes, delay recurrence (Miklowitz, Otto, Frank, Reilly-Harrington, Wisniewski, et al., 2007), and improve psychosocial functioning (Miklowitz, Otto, Frank, Reilly-Harrington, Kogan, et al., 2007) in a mixed sample that included individuals with Bipolar II Disorder.

Psychoeducation

Canadian psychiatric practice guidelines recommend the combination of pharmacotherapy and psychoeducation as the first line of maintenance treatment for Bipolar II Disorder (Yatham et al., 2013). Standalone psychoeducation is a simple and straightforward approach that involves providing clients with information about Bipolar Disorder, to empower them to better manage their illness (Stafford & Colom, 2013). Therapists using this approach emphasise awareness of the disorder, treatment compliance, early detection and management of mood symptoms, lifestyle regularity, risks of substance misuse, and stress management (Stafford & Colom, 2013). Psychoeducation is delivered in a group or individual format and may include immediate family members (Griffiths & Smith, 2010). The group format may offer the added benefit of providing clients with an opportunity to share their experiences, knowledge, and insights about Bipolar Disorder with each other (Griffiths & Smith, 2010). Psychoeducation is not recommended for clients in acute episodes, who may be unable to make full use of this intervention (Stafford & Colom, 2013).

Two studies have explored the benefits of adjunctive psychoeducation specifically for individuals with Bipolar II Disorder. A recent randomized control trial found that six individual sessions of adjunctive psychoeducation had no statistically significant impact on the regulation of biological rhythms (Faria et al., 2014). However, the score trajectory showed a trend toward improvement, potentially indicating a positive impact of psychoeducation on treatment over a

longer period of time. A post-hoc analysis of 20 individuals with Bipolar II Disorder, who had participated in a single-blind randomized control trial, examined the acute and long-term efficacy of 21-session group psychoeducation as compared with unstructured support groups of the same intensity (Colom et al., 2009). The psychoeducation group had significantly better two- and five-year outcomes with respect to the number of mood episodes, time spent in those episodes, and psychosocial functioning. Preliminary findings from mixed-sample studies suggest that psychoeducation may be less effective with clients who have a higher number of previous mood episodes (Colom et al., 2010; de Barros Pellegrinelli et al., 2013). De Barros Pellegrinelli et al. (2013) found that individuals with more than 14 episodes did not benefit from psychoeducation. The authors concluded that psychoeducation should be delivered as early as possible in the course of illness.

Two recent randomized control trials explored the feasibility and efficacy of utilizing mobile and web technologies to improve access to adjunctive psychoeducation for Bipolar Disorder and enhance its efficacy (Barnes, Hadzi-Pavlovic, Wilhelm, & Mitchell, 2015; Depp et al., 2015). Both studies used mixed samples that included individuals with Bipolar II Disorder. The results of one study suggest that automated mobile-phone interventions linking client-reported mood states with personalized self-management strategies may enhance the impact of brief psychoeducation on depressive symptoms; however, this improvement may become lost over time without ongoing interventions (Depp et al., 2015). Another study found no significant differences in clinical outcomes between web-based psychoeducation for Bipolar Disorder and control treatments that involved general online instructions on healthy living (Barnes et al., 2015). While the reasons behind these findings remain unclear, Stafford and Colom (2013)

maintain that effective psychoeducation requires client-therapist communication, bidirectional flow of information, client involvement, and a trusting relationship.

Cognitive-Behavioural Therapy

The adaptation of CBT for Bipolar Disorder is based on the premise that mood and behaviour of the affected individuals are influenced by distortions in their core beliefs, in addition to physiological factors (Newman, Leahy, Beck, Reilly-Harrington, & Gyulai, 2002). Negative core beliefs are activated during episodes of depression, triggering overly pessimistic automatic thoughts. During hypomania, the core beliefs of individuals with Bipolar Disorder are often associated with overly optimistic attitudes. The individuals' reactions to their cognitive and affective symptoms can exacerbate their bipolar cycle by decreasing functioning and creating psychosocial problems. Stress related to these problems can cause the symptoms to worsen. The goal of CBT for Bipolar Disorder is to manage and prevent cognitive, affective, and behavioural symptoms associated with mood episodes, reducing their impact on psychosocial functioning (Newman et al., 2002).

In CBT, clients and, in some cases, their family members are educated about Bipolar Disorder, available pharmacological treatments, and the ways in which cognitions, behaviours, and environmental factors can influence the course of illness (Basco, Ladd, Myers, & Tyler, 2007; da Costa et al., 2011). Clients learn how to monitor their symptoms and recognize early warning signs of mood episodes. Their compliance with pharmacotherapy is promoted through psychoeducation and modification of maladaptive beliefs. Clients are encouraged to make lifestyles changes critical to managing Bipolar Disorder, such as maintaining a regular sleep schedule and reducing stimulation. They are taught cognitive-behavioural skills for managing affective symptoms, stress factors, and common psychosocial challenges associated with Bipolar

Disorder. Clients may also work on the emotional adjustment required to accept their diagnosis (Basco et al. 2007; da Costa et al., 2011).

The efficacy of adjunctive CBT in treating Bipolar Disorder has been tested with mixed samples that included individuals with Bipolar II Disorder. In one study, individual CBT was shown to facilitate recovery from acute depressive episodes and to delay recurrence (Miklowitz, Otto, Frank, Reilly-Harrington, Wisniewski, et al., 2007). A real-world study demonstrated a distinct superiority of a longer course of adjunctive CBT over a shorter course of psychoeducation in the management of depressive episodes (Zaretsky, Lancee, Miller, Harris, & Parikh, 2008). In another study, individuals who were treated with adjunctive group CBT had fewer symptoms of hypomania, depression, and anxiety, as well as fewer and shorter mood episodes, than those who were treated with medication alone (da Costa et al., 2011). However, several studies found no clinical benefits of adjunctive CBT for Bipolar Disorders over less expensive group psychoeducation (Parikh et al. 2012), supportive therapy of equal intensity (Meyer & Hautzinger, 2012), or pharmacotherapy alone (Gomes et al., 2011). Thus, the evidence for the efficacy of adjunctive CBT in treating Bipolar Disorder remains inconclusive.

In contrast to earlier forms of CBT that aim to prevent relapse, a new CBT approach called *Think Effectively About Mood Swings* (TEAMS) focuses on specific current challenges experienced by individuals with Bipolar Disorder (Searson, Mansell, Lowens, & Tai, 2012). According to the cognitive theory that informs TEAMS, individuals with Bipolar Disorder rarely reach stability in mood because they strive to control it in extreme ways, disrupting their attempts to pursue their broader goals in life (Mansell, Morrison, Reid, Lowens, & Tai, 2007). The goal of TEAMS is to help clients to replace these maladaptive efforts with more functional ways of responding to their internal states (Mansell et al., 2007). The therapy focuses on

facilitating clients' awareness of how their cognition and behaviors maintain and exacerbate their current symptoms (Mansell et al., 2007). A case series of the TEAMS approach has provided preliminary evidence that CBT based on this model can facilitate improvements in affective symptoms, psychosocial functioning, cognitions, and self-critical processes of clients with Bipolar II Disorder (Searson et al., 2012).

Another CBT adaptation for Bipolar Disorder, Sorensen's Therapy for Instability in Mood (STIM), was developed to replace lengthy and expensive therapy with a four-session intervention that could be delivered by therapists with relatively little training (Sorensen, Done, & Rhodes, 2007). STIM targets four pathways to mood episodes: biological vulnerability, medication nonadherence, disrupted social rhythms, and stressful life events (Sorensen et al., 2007). The therapy aims to help clients understand their personal experience of Bipolar Disorder in terms of biological, psychological, and social factors; enhance their awareness of early signs and triggers of mood episodes; and develop effective and personally meaningful coping strategies (Gutierrez, Sorensen, & Tomlinson, 2011). According to the results of a case series evaluation of STIM, CBT based on this model may be able to reduce hopelessness and improve perceived control over internal states in clients with Bipolar II Disorder (Gutierrez et al., 2011).

Preliminary evidence suggests that adjunctive CBT can be effective in treating Bipolar II Disorder and comorbid substance dependence. In a randomized controlled trial, a 12-session group CBT that focused on the relationship and similarities between the two disorders was found to reduce substance use and mood symptoms in a mixed sample that included individuals with Bipolar II Disorder (Weiss et al., 2009). Similar improvements were observed in a mixed-sample study that tested the feasibility of integrating CBT with motivational interviewing to treat Bipolar Disorder and comorbid substance dependence (Jones et al., 2011).

Mindfulness-Based Cognitive Therapy

MBCT integrates elements of CBT with mindfulness-based meditative practices (Sipe & Eisendrath, 2012). Like CBT, MBCT aims to interrupt automatic cognitive processes that can trigger mood episodes. However, MBCT places little emphasis on altering or challenging specific cognitions. Rather, it encourages clients to adopt a new way of being and relating to their thoughts and feelings. Clients are taught to focus less on reacting to distressing stimuli, and instead accept and observe them without judgment. By cultivating mindful awareness of their experiences, clients may interrupt their cognitive reactivity that could otherwise escalate their mood symptoms (Sipe & Eisendrath, 2012).

The skill of mindful awareness is taught through a variety of meditative practices that may include guided body scans, different types of sitting and walking meditations, mindful observance of everyday activities, three-minute breathing spaces, and mindful movement (Sipe & Eisendrath, 2012). The therapy also provides psychoeducation about mood changes and triggers, and instructions on mindful awareness of early mood symptoms (Deckersbach et al., 2012; Miklowitz et al., 2009). Other CBT elements may include mood monitoring, problem solving, and cognitive strategies to promote regular mindfulness practice and pleasant experiences that enhance wellbeing (Deckersbach et al., 2012).

The benefits of adjunctive MBCT in treating Bipolar Disorder have been studied with mixed samples that included individuals with Bipolar II Disorder. In one of the first studies, modest reductions were observed in depressive and hypomanic symptoms, suicidal ideation, and anxiety over eight weeks of treatment (Miklowitz et al., 2009). In a later eight-week study, MBCT was well perceived among the participants, whose improvement in mindfulness skills was significantly associated with improvement in depressive symptoms, even though no

significant increase of mindfulness skills was detected during the trial (Weber et al., 2010). This association was confirmed by a recent study, which found that the quantity of mindfulness meditation practice positively correlated with improvements in depression and anxiety symptoms (Perich, Manicavasagar, Mitchell, & Ball, 2013).

Two other studies reported reductions in anxiety symptoms after MBCT, in addition to improvements in emotion regulation (Ives-Deliperi, Meintjes, Howells, Stein, & Horn, 2013) or dysfunctional attitudes surrounding ideas of achievement (Perich, Manicavasagar, Mitchell, Ball, & Hadzi-Pavlovic, 2013). However, the latter study found no significant reductions in time to mood episodes, total number of episodes, and symptom severity over a 12-month follow-up period. These findings are consistent with the observation that most gains obtained during MBCT for Bipolar Disorder tend to diminish after the treatment, with the exception of improvements in cognitive functioning, which may persist after three months (Stange et al., 2011). Another study, which examined the effects of a 12-weeks group MBCT for Bipolar Disorder, noted improvements in mood, emotion regulation, wellbeing, as well as cognitive and psychosocial functioning, in individuals with residual symptoms of Bipolar Disorder (Deckersbach et al., 2012). Despite some inconclusive findings, mixed-sample research has provided preliminary support to the potential of adjunctive MBCT to improve outcomes in Bipolar II Disorder.

Family-Focused Therapy

FFT for Bipolar Disorder was developed based on the observed association between increased rates of relapse and caregivers' criticism, hostility, and emotional overinvolvement (Morris et al., 2007). The therapy involves clients and their caregivers, or family members, in up to 21 sessions of psychoeducation, communication enhancement training, and problem-solving

skills training. During psychoeducation, clients and caregivers learn about Bipolar Disorder and available treatment, the biological and social factors that can influence mood episodes, and the importance of stress management and adherence to medication in reducing the likelihood of relapse. The communication and problem-solving training modules focus on modifying unproductive patterns of family interaction in order to reduce criticism, hostility, or emotional overinvolvement (Morris et al., 2007).

The efficacy of adjunctive FFT in treating Bipolar Disorder has been tested with mixed samples that included individuals with Bipolar II Disorder. In one study, FFT was shown to improve recovery from the episodes of depression and to delay recurrence (Miklowitz, Otto, Frank, Reilly-Harrington, Wisniewski, et al., 2007). Two studies found that educating caregivers about Bipolar Disorder might result in benefits for the affected individuals even if the latter are not available for treatment. In one randomised controlled trial, adults whose caregivers attended 12 sessions of group psychoeducation had longer intervals before hypomanic episodes than did those whose caregivers did not participate in FFT (Reinares et al., 2008). In another trial, individuals with Bipolar Disorder whose caregivers attended 12–15 FFT education sessions showed significant decreases in depressive symptoms, especially if caregivers also showed mood improvement (Perlick et al., 2010). Preliminary evidence suggests that FFT, with relevant cultural adaptations, can be used to help clients with Bipolar II Disorder in non-Western cultures (Ozerdem, Oguz, Miklowitz, & Cimilli, 2009).

Functional Remediation

Lower psychosocial functioning in individuals with Bipolar II Disorder has been linked to neurocognitive deficits, primarily in the areas of verbal memory, attention, and executive functions (Solé et al., 2012). The FR therapy, proposed by Martínez-Arán et al. (2011) for

clients with Bipolar Disorder, aims to restore psychosocial functioning by addressing neurocognitive deficits. The therapy consists of 21 weekly sessions and involves education about cognitive dysfunctions and their impact on psychosocial functioning, neurocognitive training, and problem solving. Following psychoeducation, the FR sessions focus on improving attention in everyday situations and on techniques and strategies to manage memory deficits. The executive dysfunctions are addressed through training in problem solving, reasoning, time management, prioritizing, and planning. The remaining sessions focus on improving communication and interpersonal relationships, autonomy, and stress management. The FR interventions utilize real-world examples, individual and group tasks, role-playing, modelling techniques, verbal instructions, self-instructions, positive reinforcement, metacognitive cues, and practical homework exercises. To facilitate practice and reinforcement of the acquired strategies, clients' family members may be involved in the therapeutic process (Martínez-Arán et al., 2011).

Preliminary evidence suggests that FR can be effective in improving psychosocial functioning of euthymic individuals with Bipolar II Disorder who receive pharmacological treatment. Torrent et al. (2013) compared adjunctive FR with pharmacotherapy alone and an established psychoeducational program for Bipolar Disorder, using a mixed sample that included participants with Bipolar II Disorder. The FR program proved to be more effective in enhancing psychosocial functioning, especially in the interpersonal and occupational domains. Solé et al. (2015) replicated these findings in a sample of participants with Bipolar II Disorder. In addition, Solé et al. found a decrease in subclinical depressive symptoms in the group treated with FR. These results are consistent with earlier findings, which suggest that addressing cognitive impairment and residual depressive symptoms in individuals with Bipolar II Disorder may lead to improvements in their psychosocial functioning (Deckersbach et al., 2010).

Life Goals Program

The LGP approach, a manualized group psychotherapy program for individuals with Bipolar Disorder, aims at improving illness management skills and psychosocial functioning (Bauer & McBride, 2003). Phase I of LGP consists of six weekly sessions of psychoeducation, focused primarily on providing clients with information about Bipolar Disorder, teaching them how to identify early signs and triggers of mood episodes, and helping them to develop effective coping strategies. Phase II is optional and does not have a predetermined number of sessions. It is focused on addressing the psychosocial aspects of Bipolar Disorder as they affect clients' lives. In this phase, group members are encouraged to identify and achieve life goals that have not been reached because of Bipolar Disorder, or important goals related to illness management, such as improving medication adherence or sleep hygiene. Clients are assisted in the process of achieving their goals through the feedback and support they receive from their therapist and peers. They can stay in the program until their goals have been reached (Bauer & McBride, 2003).

The efficacy of adjunctive LGP has been tested with mixed samples that included individuals with Bipolar II Disorder. The results of an open study suggest that LGP can be well perceived by individuals with Bipolar II Disorder and have a positive impact on their mood stability, relapse prevention and coping, and ability to reach specific goals (De Andrés et al., 2006). A randomized control trial has demonstrated that both the psychoeducation component of LGP and the full two-phase program can have long-term positive effects on mood stability and relapse prevention in individuals with Bipolar II Disorder (Aubry et al., 2012). According to the result of the same trial, participation in the second phase may be particularly beneficial to clients who wish to improve their social relationships. Sajatovic et al. (2009) have found that adjunctive

LGP can improve medication adherence attitudes; however, this effect may gradually diminish over time without ongoing psychotherapy. In addition, Sajatovic et al. have suggested that individuals with Bipolar Disorder may have reduced response to LGP during depressive episodes and that the nature of group psychotherapy may be more acceptable to women than men.

Recommendations for Research

Although the results of available studies are encouraging for using IPSRT, standalone psychoeducation, CBT, MBCT, FFT, FR, and LGP as adjunctive psychosocial interventions for managing Bipolar II Disorder, these findings should be interpreted with caution. Given that most studies evaluating these interventions were carried out with mixed samples, future research needs to evaluate psychosocial interventions specifically for Bipolar II Cohorts. In addition to having distinct clinical and psychosocial needs (APA, 2013), individuals with Bipolar II Disorder may respond differently to psychosocial interventions, compared with individuals who have other subtypes of Bipolar Disorder. Research has found apparent differences in response to medication between Bipolar I and Bipolar II cohorts (Bond, Noronha, Kauer-Sant'Anna, Lam, & Yatham, 2008). This finding highlights the importance of creating treatment recommendations specifically for Bipolar II Disorder, as opposed to extrapolating such recommendations from mixed-sample research. It remains unclear whether standalone psychoeducation, CBT, MBCT, FFT, FR, and LGP require adjustments to better meet the needs of individuals with Bipolar II Disorder.

The extent to which treatment recommendations for Bipolar II Disorder can be drawn from available research is further limited by the fact that the reviewed studies were extremely heterogeneous, in terms of participant characteristics, applied interventions, design, and outcome measurements. This limitation needs to be addressed by new studies that compare efficacy of

several interventions using large and homogenous samples. Future psychotherapy research for Bipolar II Disorder should also clarify the change processes, mediators, and predictors of treatment outcome. Additional work is needed to better understand how, for whom, and under what circumstances various psychosocial interventions can be effective, as well as which aspects of psychotherapy are appropriate for which phases of Bipolar II Disorder. Future research needs to be based on clearer theoretical models of this illness and consider cultural adaptations of empirically supported psychosocial interventions.

Summary and Conclusion

Bipolar II Disorder is a highly recurrent and debilitating chronic illness. The impairment can result from persistent mood volatility, frequent and lengthy episodes of depression, and instability in interpersonal and occupational functioning (APA, 2013). Mixed mood states can be difficult to recognize. Hypomania may cause denial. The illness presentation can be further clouded by comorbidity, personality, temperament, and behavior. Given its complex course, manifestation, and outcome, Bipolar II Disorder requires sophisticated management.

Psychotherapy, in conjunction with medication, has shown promise of improving quality of life and clinical outcomes for individuals with Bipolar II Disorder. To date, a number of well-documented psychosocial interventions have accumulated evidence for addressing the needs of this client population: IPSRT, standalone psychoeducation, CBT, MBCT, FFT, FR, and LGP. Each identified intervention incorporates a substantial psychoeducational component, focused on helping clients to better understand and manage their illness. Most interventions emphasize medication adherence, regular schedule, self-monitoring, moderating behaviors, and effective stress and symptom management. Several interventions aim to reduce interpersonal conflict that can trigger episode onset, and to enhance clients' ability to recognize warning signs and intervene early with relapse.

Apart from these commonalities, the identified interventions differ in their focus on particular mechanisms of change. Specifically, the main goal of standalone psychoeducation is to provide clients with information that can empower them to better manage their illness (Stafford & Colom, 2013). IPSRT adds a focus on helping clients to stabilize their social rhythms and to improve their interpersonal functioning (Frank, 2007). CBT emphasizes changing distorted cognitions that can trigger or escalate mood episodes (Newman et al., 2002). MBCT aims to reduce clients' cognitive reactivity by encouraging them to cultivate mindful awareness of their experiences (Sipe & Eisendrath, 2012). FFT seeks to improve clients' environments and reduce stress by involving family members in psychoeducation and modifying patterns of family interaction (Morris et al., 2007). FR focuses on restoring clients' psychosocial functioning by addressing their neurocognitive deficits (Martínez-Arán et al., 2011). LGP enhances psychoeducation with a focus on helping clients to achieve their illness-related important goals (Bauer & McBride, 2003).

Preliminary evidence suggests that each identified psychosocial intervention may have something to offer some clients at particular points in their Bipolar II journey. For instance, euthymic individuals in the early stages of their illness may benefit from adjunctive psychoeducation (de Barros Pellegrinelli et al., 2013; Stafford & Colom, 2013), which has been shown to enhance long-term clinical outcomes and psychosocial functioning (Colom et al., 2010). However, for clients with a long history of Bipolar II Disorder, standalone psychoeducation or group psychoeducation offered by LGP might not be sufficient (Aubry et al., 2012; de Barros Pellegrinelli et al., 2013). For these individuals, additional adjunctive treatment, such as cognitive rehabilitation offered by FR, may be necessary to improve overall functioning and prevent relapse (Aubry et al., 2012; Deckersbach et al., 2010).

Whereas standalone psychoeducation has been recommended as adjunctive maintenance therapy for Bipolar II Disorder (Yatham et al., 2013), evidence suggests that adjunctive IPSRT may be a better option for acute management of Bipolar II depression (Swartz, Frank, & Cheng, 2012). Moreover, preliminary findings indicate the potential of IPSRT to help clients who are nonresponsive to pharmacotherapy or who have discontinued pharmacotherapy due to adverse side effects (Swartz et al., 2009). Clients with Bipolar II Disorder and comorbid substance dependence may benefit from an adaptation of CBT (Jones et al., 2011; Weiss et al., 2009), whereas MBCT might be better suited for clients with Bipolar II Disorder and comorbid anxiety (Ives-Deliperi et al., 2013; Perich, Manicavasagar, Mitchell, Ball, & Hadzi-Pavlovic, 2013). Adjunctive FFT may be indicated for clients with Bipolar II Disorder who live in toxic family environments (Perlick et al., 2010; Reinares et al., 2008), whereas euthymic female clients with this illness may respond well to group therapy offered by LGP (Sajatovic et al., 2009). Adjunctive FR may be beneficial to euthymic clients with Bipolar II Disorder who wish to improve their psychosocial functioning (Solé et al., 2015).

While mental health professionals await more psychotherapy research specifically for Bipolar II Disorder, available findings can guide their efforts to help adult clients with this complex illness. The effectiveness of treatment may largely depend on the practitioner's ability to target selective issues in specific phases of the disorder while considering the client’s history of illness and context. Knowledge of available psychosocial interventions and their effectiveness in treating Bipolar II Disorder can help practitioners to tailor their therapeutic approaches to the needs of individual clients.

Appendix

Table A1

Summary of Psychotherapy Studies That Included Individuals With Bipolar II Disorder

Authors	Treatment	Sample	Mood at entry	Outcome
Aubry et al., 2012	LGP: Phase I (6 sessions) + Phase II (3-74 months)*	*n* = 85, 43.5% BD II, 55 in Phase I, 35 in both phases	Euthymic or mildly depressed	Significant reduction in number of hospitalizations from 3 years before to 3 years after Phase I ($p = 0.017$) or both phases ($p = 0.035$); subjective improvements in mood stability, relapse prevention and coping after each phase; perceived improvement of social relationships significantly higher after Phase II vs. Phase I
Barnes, Hadzi-Pavlovic, Wilhelm, & Mitchell, 2015	12 months of web-based PE or online instructions on healthy living*	*n* = 233, 12.4% BD II	Euthymic, depressed, or hypo-/manic	No significant differences between groups on any definitions of recurrence
Colom et al., 2009	21 PE or non-structured group sessions + 5-year follow-up*	*n* = 20, 100% BD II	Euthymic	Significantly better 5-year outcomes with PE vs. control: lower risk of recurrence ($p = 0.021$), less time with mood symptoms ($p < 0.004$), higher levels of functioning ($p < 0.06$)
Colom et al., 2010	21 PE or non-structured group sessions + 5-year follow-up*	*n* = 120, 16.7% BD II	Euthymic	5-year outcomes with PE vs. control: < 7 episodes at entry – reduction in time spent in any episode; 7+ episodes – no significant improvement in time to recurrence; 7-8 episodes – fewer days spent in hypomania, depression, and mixed episodes; 9–14 episodes – fewer days spent in hypomania and depression, but not in mixed states; 14+ episodes – no

				reduction in time spent ill
Da Costa et al., 2011	14 sessions of group CBT or TAU*	*n* = 41, 16% BD II	Euthymic, mildly depressed, or mildly hypo-manic	Significant improvements in depressive symptoms with CBT vs. TAU ($p = 0.002$); fewer symptoms of hypomania ($p = 0.151$) and anxiety ($p = 0.027$); fewer and shorter mood episodes
De Andrés et al., 2006	LGP: Phase I (6 sessions) + Phase II (1 year)*	*n* = 45, 33.3% BD II, 36 in Phase I, 17 in both phases	Could not be manic	High satisfaction (82.4%) with Phase I; significant improvements in mood stability after Phase II ($p = 0.016$); subjective improvement in mood stability, relapse prevention and coping, ability to reach goals after Phase II
De Barros Pellegrinelli et al., 2013	16 sessions of PE or placebo*	*n* = 55, BP I or II	Euthymic	Subjective improvement in clinical global impression with PE; no improvement in mood symptoms or psychosocial functioning; positive correlation between psychosocial treatment compliance and global functioning, social adjustment, sociability, clinical global impression
Deckersbach et al., 2010	14 sessions of FR*	*n* = 18, 16.7% BP II	Euthymic	Lower residual depressive symptoms, increased occupational ($p = 0.19–0.001$) and general psychosocial ($p = 0.03$) functioning, sustained at 3-month follow-up; neuropsychological impairment predicted treatment response; improvements in executive functioning led to improvements in occupational functioning
Deckersbach et al., 2012	12 group sessions of MBCT*	*n* = 12, 25% BP II	Residual depressive symptoms	Improvements in mindfulness, depressive symptoms ($p = 0.006$), rumination ($p = 0.026$), emotion regulation ($p = 0.03$),

				attention (p = 0.025), psychological well-being, positive affect, psychosocial functioning; gains sustained at 3-month follow-up
Depp et al., 2015	4 weeks of PE + (automated mobile-phone intervention or paper-and-pencil mood monitoring)*	n = 82, BP I or II	Not in acute episode	Significantly greater reductions in depressive symptoms with mobile-phone intervention vs. control at 6 and 12 weeks (Cohen's d = 0.48 for both); gains lost by 24 weeks
Faria et al., 2014	6 sessions of PE or TAU*	n = 45, 100% BP II	Could be any	No statistically significant impact on regulation of biological rhythms with PE vs. TAU; the score trajectory showed a trend towards potential improvement over time
Gomes et al., 2011	18 group sessions of CBT or TAU*	n = 50, 24% BP II	Euthymic	No difference in time to recurrence and number of episodes between groups; median time to relapse was shorter with TAU
Gutierrez, Sorensen, & Tomlinson, 2011	4 sessions of CBT (STIM)*	n = 12, BP I or II	Could not be hypo-/manic, or mixed state	Significant improvements to depression, perceived control (at 1- and 3-month follow-ups), and hopelessness (at 3 months); recovery rates at 3 months: 50% for depression, 41.6% for hopelessness, 25% for perceived control; no significant changes for mania or insight
Ives-Deliperi, Meintjes, Howells, Stein, & Horn, 2013	8 weeks of MBCT*	n = 16, BP I or II	Mild or sub threshold mood symptoms	Significant improvements to mindfulness (p = 0.01), anxiety (p = 0.05), emotion regulation (p = 0.001), working memory (p = 0.01), spatial memory (p = 0.04), verbal fluency (p = 0.02)
Jones et al.,	Up to 21	n = 5,	Could not	Reduced use of drugs or alcohol

2011	sessions of motivational interviewing and CBT*	BP I or II + substance use	be acutely depressed or manic	at the end of therapy, sustained at 6-month follow-up; potential improvements in mood symptoms and impulsiveness
Meyer & Hautzinger, 2012	20 sessions of CBT or supportive therapy*	*n* = 76, 21% BP II	Not in episode	No difference in relapse rates between groups; nonsignificant trend for preventing affective episodes during CBT; number of prior episodes, number of therapy sessions, and diagnosis of BD II predicted shorter time before relapse
Miklowitz, Otto, Frank, Reilly-Harrington, Kogan, et al., 2007	30 sessions of intensive treatment (IPSRT, CBT, or FFT) or 3 sessions of CC*	*n* = 152, 31% BP II	Depressed	Greater improvements in overall functioning ($p = 0.04$), relationship functioning ($p = 0.02$), and life satisfaction ($p = 0.048$) with intensive treatments vs. CC
Miklowitz, Otto, Frank, Reilly-Harrington, Wisniewski, et al., 2007	Up to 30 sessions of intensive treatment (IPSRT, CBT, or FFT) or 3 sessions of CC*	*n* = 293, 31% BP II	Depressed	Significantly higher year-end recovery rates ($p = 0.01$), more likely to be clinically well during study ($p = 0.003$) with intensive treatments vs. CC
Miklowitz et al., 2009	8 weeks of MBCT*	*n* = 22, 36.4% BP II	Not in episode	Reductions in depressive symptoms (Cohen's $d = 0.49$), suicidal ideation ($d = 0.51$), hypo-/manic symptoms ($d = 0.17$), and anxiety ($d = 0.23$) in16 individuals who completed treatment
Ozerdem, Oguz, Miklowitz, & Cimilli, 2009	21 sessions of FFT*	*n* = 10, 20% BP II	Not in episode	Improvements in episode frequency (Cohen's $d = 1.01$), psychosocial functioning ($d = 0.56–0.59$), and clinical global impression ($d = 0.13–0.22$) from pre- to posttreatment and follow-up

Parikh et al. 2012	20 sessions of individual CBT or 6 group sessions of PE*	*n* = 204, 27.9% BP II	Not in episode	Significant reductions in mood symptoms ($p < 0.01$) in both groups; no difference in symptom reduction or likelihood of relapse between groups
Perich, Manicavasagar, Mitchell, & Ball, 2013	8 weeks of MBCT*	*n* = 34, BP I or II	Not in episode	Significant inverse correlation between number of days meditated and depression ($p = 0.024$) at 12-month follow-up; significant differences between those who meditated 3+ days/ week and those who meditated less often on trait anxiety posttreatment ($p = 0.015$) and depression scores at 12-month follow-up ($p = 0.025$)
Perich, Manicavasagar, Mitchell, Ball, & Hadzi-Pavlovic, 2013	8 weeks of MBCT or TAU*	*n* = 95, 36.8% BP II	Not in episode	Significant reduction in anxiety ($p = 0.048$) and stress ($p = 0.088$) with MBCT vs. TAU; no significant differences between groups in time to relapse, total number of episodes, or mood symptom severity at 12-month follow-up
Perlick et al., 2010	12-15 sessions of FFT or 8-12 sessions of videotaped health education for caregivers*	*n* = 40, 15% BP II	Could be any	Significant reductions in caregiver depressive symptoms ($p = 0.037$) and health risk behaviors ($p = 0.029$) with FFT vs. control; greater decreases in depressive symptoms ($p = 0.025$) and hypo-/manic symptoms ($p = 0.037$) with FFT vs. control
Reinares et al., 2008	12 sessions of FFT for caregivers + follow-up for 12 months*	*n* = 113, 16.8% BD II	Euthymic	Fewer clients with hypo-/manic recurrence ($p = 0.017$) and longer time to such episodes ($p = 0.015$) at 12-month follow-up with FFT vs. control; insignificant differences in preventing depressive and

				mixed episodes
Sajatovic et al., 2009	LGP: Phase I (up to 6 sessions) + Phase II (optional)*	*n* = 128, BP I or II	Could be any	Improved attitudes toward medication at 3- and 6-month follow-ups in those who attended LGP at least partially vs. those who did not; no differences between groups in treatment attitudes at 12-month follow-up
Searson, Mansell, Lowens, & Tai, 2012	12 sessions of CBT (TEAMS)*	*n* = 7, 71.4% BD II	Depressed, euthymic, or hypo-manic	Improvements in symptoms, especially depression (Cohen's *d* = 2.35–2.95), functioning, and cognitions at end of therapy and 1-month follow-up; 5 participants showed clinically significant reduction in depression at both time-points
Solé et al., 2015	21 sessions of FR, PE, or TAU*	*n* = 53, 100% BP II	Euthymic	Significant functional improvement over time with FR vs. PE or TAU ($p = 0.037$); significant reduction in subdepressive symptoms with FR vs. PE ($p = 0.041$); post-hoc test revealed favorable trend in outcome for FR vs. PE or TAU
Sorensen, Done, & Rhodes, 2007	4 sessions of CBT (STIM)*	*n* = 13, BP I or II	Could not be manic	Significant improvements in suicide risk ($p = 0.001$), perceived control over internal states ($p = 0.003 – 0.001$), and satisfaction with treatment, 1 and 5 weeks after treatment
Stange et al., 2011	12 2-hour sessions of MBCT*	*n* = 8, 25% BP II	Residual depression and few hypo-/manic symptoms	Significant improvements in executive functioning, memory, ability to initiate and complete tasks ($p < 0.05$); change in cognitive functioning associated with change in mindfulness ($p < 0.10 – 0.01$)
Swartz, Frank, & Cheng, 2012	12 sessions of IPSRT or	*n* = 25, 100% BP II	Depressed	Significant improvements in depressive ($p < 0.0001$) and

	quetiapine			hypomanic (p = 0.0002) symptoms over time in both groups; 29% in IPSRT and 27% in quetiapine group had at least 50% reduction of depression without increase in hypomania
Swartz, Frank, Frankel, Novick, & Houck, 2009	20 sessions of IPSRT; lamotrigine added for non-responders after session 12	n = 17, 100% BP II	Depressed	41% responded by week 12; 53% responded and 29% full remission by week 20; symptom (p = 0.001) and illness severity (p = 0.045) improvements over time
Torrent et al., 2013	21 sessions of FR, PE, or TAU*	n = 239, BP I or II	Euthymic	Significant functional improvement (p = 0.002) with FR vs. TAU; post hoc: FR differed more from TAU (p = 0.001) than from PE (p = 0.056)
Weber et al., 2010	8 sessions of MBCT + 1 booster session*	n = 15, 53.3% BP II	Could not be manic	Change in mindfulness associated with change in depression severity (p = 0.003)
Weiss et al., 2009	12 group sessions of CBT (for substance dependence) or group drug counseling*	n = 61, 14.8% BP II + substance dependence	Could not be manic	Greater reduction in substance use (p < 0.001) and risk of mood episodes (p < 0.001) by end of treatment in group CBT vs. drug counselling
Zaretsky, Lancee, Miller, Harris, & Parikh, 2008	7 sessions of PE or PE + 13 sessions of CBT, followed for 1 year*	n = 79, 34.2% BP II	Not in episode	Greater decrease in time spent depressed (p = 0.045) with CBT vs. PE alone

Note. * Participants were receiving pharmacotherapy; BP I = Bipolar I Disorder; BP II = Bipolar II Disorder; CBT = cognitive-behavioural therapy; CC = collaborative care; FFT = family-

focused therapy; FR = functional remediation; IPSRT = interpersonal and social rhythm therapy; LGP = the life goals program; MBCT = mindfulness-based cognitive therapy; PE = psychoeducation; STIM = Sorensen's Therapy for Instability in Mood; TAU = treatment as usual; TEAMS = Think Effectively About Mood Swings.

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