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Psychotherapy for Bipolar II Disorder: The Role of Interpersonal and Social Rhythm Therapy

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Abstract

Although bipolar II disorder is a highly prevalent, chronic illness that is associated with burdensome psychosocial impairment, relatively little is known about the best ways to treat the disorder. Moreover, psychosocial interventions for the management of bipolar II disorder have been largely unexplored, leaving psychologists with few evidence-based recommendations for best treatment practices. In this article, we provide information about interpersonal and social rhythm therapy (IPSRT), an empirically supported treatment for bipolar I disorder that has preliminary evidence supporting its efficacy in bipolar II disorder. After reviewing the phenomenology of bipolar II disorder and differentiating it from bipolar I disorder, we summarize the extant empirical support for using psychotherapy in the management of bipolar II disorder. We explore what is known about the role of psychotherapy in the management of bipolar II disorder as well as lacunae in the evidence base. Next, we introduce IPSRT and discuss how it has been adapted for use as a treatment for individuals suffering from bipolar II disorder. Specific strategies of the treatment are detailed, and preliminary evidence for the efficacy of IPSRT in bipolar II disorder is described. Finally, we present a case vignette demonstrating the use of IPSRT for an individual with bipolar II disorder.

Keywords

psychotherapy; bipolar II disorder; interpersonal psychotherapy

Bipolar (BP) II disorder, a chronic illness (Judd, Akiskal, Schettler, Coryell, Endicott, et al., 2003) characterized by recurrent episodes of depression and hypomania (American Psychiatric Association, 1994), is associated with high levels of psychosocial impairment (Ruggero, Chelminski, Young, & Zimmerman, 2007). Recent cross-national studies of BP II disorder estimate a lifetime prevalence of 1.1% in the United States (Merikangas et al., 2011). Despite the fact that this is a very common illness associated with tremendous psychosocial challenges, relatively little is known about how best to treat BP II disorder (Ghaemi, Sachs, & Goodwin, 2000), and no psychosocial interventions have been tested specifically for its management. Thus, psychologists frequently find themselves in the difficult position of treating individuals who suffer from BP II disorder with little guidance from empirical evidence.

This article discusses the phenomenology of BP II disorder, reviews extant empirical support for using psychotherapies in the management of BP II disorder, and then describes in greater detail interpersonal and social rhythm therapy (IPSRT), an evidence-based psychotherapy that has been adapted as a treatment for BP II disorder. Preliminary evidence for efficacy in BP II disorder and a case vignette are also presented. This information will better equip practicing psychologists to recognize this common, debilitating disorder and provide them with information about an evidence-based psychotherapy that can be used to manage it.

Overview of Bipolar II Disorder

BP II disorder has been recognized as a distinct clinical entity since the 1970s (Dunner, Gershon, & Goodwin, 1976). The *DSM-IV* defines BP II disorder as a subtype of BP disorder characterized by a lifetime history of at least one episode of major depression and one hypomanic episode (American Psychiatric Association, 1994). BP II disorder is phenomenologically distinct from BP I disorder: in addition to the fact that individuals with BP II disorder, by definition, never experience psychosis or fully syndromal mania, compared to individuals with BP I disorder, those with BP II disorder are more likely to be female (Hendrick, Altshuler, Gitlin, Delrahim, & Hammen, 2000) and to have more episodes of rapid cycling (Akiskal et al., 2000) and more chronic courses of illness (Judd, Akiskal, Schettler, Coryell, Maser, et al., 2003). The diagnosis of BP II disorder appears to be stable over time, with fewer than 5% of patients developing a manic episode over a 2-year period (Coryell, Andreasen, Endicott, & Keller, 1987). Although BP II disorder was initially conceptualized as a more benign form of BP I disorder, growing evidence clarifies that individuals with BP II experience significant disease-related morbidity, including high rates of suicidal ideation/behavior (Novick, Swartz, & Frank, 2010), high levels of psychiatric comorbidity (Merikangas et al., 2011), significant psychosocial impairment (Ruggero et al., 2007), and poor health-related quality of life (Maina et al., 2007).

The classic conceptualization of BP II as an illness characterized by episodes of distinct and opposite polarity is inaccurate; rather, “mixed mood states” are very common in BP II disorder and have enormous clinical significance. Complex mixed states, defined as subsyndromal hypomanic symptoms co-occurring during a depressive episode (Benazzi, 2003) are very common and characteristic of individuals with BP II disorder (Benazzi, 2001a). Co-occurring hypomanic symptoms characteristically include irritability, distractibility, racing thoughts, and being more talkative (Benazzi, 2001b). From a clinical perspective, mixed moods are typically experienced as dysphoric, uncomfortable, energized states that one patient aptly described as “tired-wired.” Mixed mood states make it more difficult to track mood changes, evaluate outcomes in clinical trials, and recognize onsets of new episodes.

Because the manifestations of BP II disorder are protean, the disorder is often underrecognized and misdiagnosed (Smith et al., 2011). Misdiagnosis results from multiple factors, including 1) difficulty differentiating BP II depressive episodes from both unipolar depression and BP I depression (Ghaemi, Boiman, & Goodwin, 2000), 2) the relatively “ego syntonic” nature of hypomania for many patients (i.e., individuals do not recognize it as a

problem and do not complain about it unless asked; Angst et al., 2010), and 3) lack of clinician familiarity with the disorder (Ghaemi, Boiman, & Goodwin, 2000). Sequelae of incorrect diagnosis include iatrogenic injury in the form of early exposure to antidepressant medications, which may accelerate mood cycling (Perlis, 2005) and loss of benefits of early intervention.

Even when individuals are diagnosed correctly, the intricacies of BP II disorder complicate illness management. For example, although patients seek help for depressions, patients must accept that hypomanias—typically experienced as welcome relief from relentless depressions (Gartner, 2005) – are “pathological.” Teaching patients to monitor and identify their own mood states is very challenging, particularly as mild mood states may be difficult to differentiate from “normal.” This process may be exacerbated when complex mood states overlap with other sources of emotional arousal and mood instability such as character disorders (Magill, 2004) and other mood spectrum disorders (Angst et al., 2003).

Treating Bipolar II Disorder: The Role of Psychotherapy

Although there is little empirical information on psychotherapy for BP II disorder, there are many compelling reasons to consider its use as a principal tool in illness management (either with or without medication). BP II disorder is difficult for patients to understand and may go unrecognized for decades (Ghaemi, Sachs, & Goodwin, 2000). The psychosocial sequelae of the disorder may be severe, and living for years with an untreated and unrecognized illness is often traumatizing. Psychotherapy can provide strategies for 1) recognizing and attenuating cycling mood states, 2) addressing illness-associated traumas, and 3) managing psychosocial consequences of the illness.

To date, only one empirical report of psychotherapy specifically for individuals with BP II disorder has been published (Swartz, Frank, Frankel, Novick, & Houck, 2009). All other published studies of psychotherapy included individuals with both BP I and II disorder. Although lack of randomized trials of psychotherapy involving individuals with BP II disorder constitutes a limitation of the field, substantive information can be garnered from hybrid trials and used to inform current practice as we await additional research data. We therefore summarize studies where >10% of the sample met criteria for BP II (see Table 1). A literature review identified 18 reports of 16 studies examining psychosocial treatment of individuals with BP II disorder. Trial size ranged from 15–463 participants, including individuals with both BP I and II disorder.

In total, 481 individuals with BP II disorder were included in these reports. Outcomes were almost uniformly favorable among those assigned to active psychotherapy, with only a few trials reporting negative findings (see Table 1). In all protocols except one (Swartz et al., 2009), participants received medications (typically mood stabilizers) in addition to psychotherapy from the outset, limiting conclusions that can be drawn about psychotherapy monotherapy. In all trials pharmacotherapy was consistent across conditions, implying that observed effects of psychotherapy were *in addition to* those of baseline pharmacotherapy.

This literature review demonstrates 1) feasibility and acceptability of delivering psychotherapy to individuals with BP II disorder and 2) preliminary evidence for cognitive

therapy, cognitive-behavioral therapy, psychoeducation, family focused therapy, case management, and IPSRT as treatments for BP II disorder. It raises many questions as well: can some individuals with BP II disorder be managed adequately with psychotherapy alone? Are the existing psychotherapeutic strategies sufficient to address the mixed-symptom presentation that is characteristic of BP II disorder (Benazzi, 2003)? Can current psychotherapeutic methods interrupt or slow the rapid cycling typical of BP II disorder? Larger trials of psychotherapy in BP II disorder are needed to establish definitively treatment efficacy and to examine specific moderators and mediators of outcome.

Overview of Interpersonal and Social Rhythm Therapy

Interpersonal and Social Rhythm Therapy (IPSRT) has shown preliminary evidence of efficacy in BP II disorder (Miklowitz, Otto, Frank, Reilly-Harrington, Wisniewski, et al., 2007) and is the only psychotherapy to demonstrate feasibility of treating individuals with BP II with psychotherapy alone (Swartz et al., 2009). IPSRT rests on an “instability model” that defines three interconnected pathways to bipolar episode recurrence: stressful life events, medication nonadherence, and social rhythm disruption. IPSRT also relies on theories pertaining to the role of social and environmental cues in promoting/disrupting circadian rhythm integrity (Ehlers, Frank, & Kupfer, 1988). The theory suggests that the disruption of routine-establishing social cues has the potential to alter circadian and sleep-wake rhythms, in turn triggering an affective episode. Finally, IPSRT utilizes principles of interpersonal psychotherapy (IPT) for unipolar disorder (Klerman, Weissman, Rounsaville, & Chevron, 1984), arguing that improvement in interpersonal relationships can ameliorate affective symptoms and prevent their return.

Thus, IPSRT is comprised of three components: psychoeducation, social rhythm therapy (SRT), and interpersonal psychotherapy, with the therapist moving seamlessly among these components throughout the treatment. *Psychoeducation* focuses on the illness and its consequences, pharmacotherapeutic options and potential side effects, and detection of prodromal symptoms and early episode warning signs. *SRT* focuses on developing strategies to promote regular, rhythm entraining social cues and to reduce the impact of events that disrupt rhythms. This is accomplished by reviewing the patient’s social routines using the Social Rhythm Metric (SRM), an instrument used to measure rhythm regularity (Monk, Flaherty, Frank, Hoskinson, & Kupfer, 1990), by identifying behaviors that negatively influence rhythm stability and areas where rhythms could be regularized, and by working toward rhythm stability through graded, sequential lifestyle changes. Patients are encouraged to have as regular a schedule as possible. *IPT* interventions are used to help patients recognize the reciprocal relationship between interpersonal problems and mood dysregulation. Patients focus on one of five IPT problem areas in their efforts to ameliorate interpersonal and social role problems. Four of these come from the original IPT manual (grief, role transitions, role disputes, interpersonal deficits), and one has been added specifically for IPSRT, grief for the lost healthy self, in which patients have an opportunity to mourn the person they might have become if not for BP disorder. As an adjunct to pharmacotherapy, IPSRT has been shown to decrease time to recovery from an episode of depression in a mixed sample of individuals with BP I and II disorder (Miklowitz, Otto, Frank, Reilly-Harrington, Wisniewski, et al., 2007). Treatment with IPSRT also has been

associated with improvements in psychosocial and occupational functioning (Frank et al., 2008; Miklowitz, Otto, Frank, Reilly-Harrington, Kogan, et al., 2007).

Interpersonal and Social Rhythm Therapy for Bipolar II Disorder

To address the complexities of BP II disorder adequately, it is necessary to tailor IPSRT to the meet the needs of this patient population. Below we describe six strategies we have used in adapting IPSRT for individuals with BP II disorder.

1. Providing rationale for making changes to social rhythms—In IPSRT, patients are asked to make changes to their social rhythms in order to lead “supranormal” lives. Indeed, scores on the SRM of individuals completing IPSRT are higher (more regular) than those of healthy controls (Frank et al., 2005; Monk et al., 1990). In order to provide the rationale for these changes to patients with BP I disorder, the therapist points to historic disruptions in regularity of rhythms (especially sleep) that almost always precede destructive manic episodes and hospitalizations (Malkoff-Schwartz et al., 1998) as a compelling way to argue for increased rhythm regularity.

It is typically more difficult to convince individuals with BP II to make significant changes in their daily routines because there is initially little apparent reason to make these unappealing changes (i.e., go to bed at a regular time every night). The argument that these changes will prevent hypomania is not persuasive, as patients may welcome hypomania as a relief from unrelenting depression, and hypomania is not typically accompanied by the negative consequences associated with mania. Patients with BP II disorder may have less insight into their symptoms than those with BP I (Pallanti et al., 1999) or may not recognize the symptoms of hypomania. Alternate strategies to encourage rhythm regularity include 1) emphasizing the likelihood that a depressive episode will follow a hypomanic one and that the goal of IPSRT is to improve overall mood stability, 2) revisiting the “benign” nature of hypomania as some patients will begin to recognize that these episodes are, in fact, more destructive than they had realized, 3) asking patients to try it as an “experiment” to see if it helps with overall mood, energy, and motivation. Some who are initially reluctant to make social rhythm changes may benefit from observing a slight worsening of mood during a period of instability in their schedule. If patients are able to observe their own mood changes as they fail to maintain a regular schedule, they may be more willing to invest in sustaining rhythm stability over time.

2. Identifying mood states—Central to IPSRT is the capacity to identify and track mood states. Because of the subtlety of hypomania and the complexity of mixed states, it may be quite challenging for patients with BP II disorder to ascertain mood states correctly. Until the patient is able to identify and track mood accurately, it is difficult to make therapeutic gains. We have found it helpful to utilize Koukopoulos’s characterization of bipolar disorder as a disorder of energy, rather than mood (Koukopoulos, 2003), because changes in energy, which may be discrepant from mood states, may be easier to track than changes in mood. This may help patients distinguish between anergic depressive states and more activated mixed depressive states. On the SRM for BP II, we ask patients to rate their average daily mood and energy levels separately. We recommend that the therapist and patient devote

ample time in early sessions to the identification and labeling of mood and energy states, prior to working on regulating them.

3. Regulating levels of stimulation—In IPSRT, patients are taught to modulate levels of stimulation in their lives based on their mood states, increasing stimulation when their mood drops and decreasing stimulation when vulnerable to hypomania. Because individuals with BP II disorder commonly experience mixed or rapidly cycling mood states, they may feel like they live their lives in tangled states that alternate between “high gear” and “low gear.” The idea of making incremental and sustained steps toward euthymia can be quite foreign for patients who do not see any intermediary states between “on” and “off” speeds. Some patients paradoxically will create chaos in their lives when they start to feel better because “normal” or euthymic mood is experienced as “flat.” Alternately, hypomanic mood may motivate them to make choices that drive their mood even higher, without recognizing the potential of these choices to lead to interpersonal chaos or more severe changes in mood. Thus, therapists need to help patients identify maladaptive patterns of engaging in stimulating activities, to mourn loss of the “highs,” and to define appropriate activities to modulate stimulation.

4. Managing grandiosity—Individuals with BP II disorder may have elevated baseline levels of grandiosity and entitlement (Gartner, 2005) that may manifest as narcissistic disregard for the impact of their behavior on others. Though grandiosity may be a symptom of hypomania, high baseline levels of grandiosity may be present regardless of mood state. Most patients are receptive to having these behaviors pointed out by a supportive therapist with whom they have rapport. However, some patients with BP II may have difficulty fully trusting their therapist because of their essential narcissism. Entitlement may manifest itself in the therapeutic relationship as arriving late for sessions, being critical of the therapist, and so forth. Therapists must learn how to recognize, tolerate and manage these challenges within the therapeutic context while building a therapeutic relationship that can withstand explorations of maladaptive interpersonal patterns, including those that result from illness-dependent grandiosity and entitlement.

5. Minimizing emotional dysregulation—Individuals with mixed mood states have high levels of emotional reactivity (Henry et al., 2007), which may contribute to difficulty down-regulating levels of arousal, even when not in an acute mood state. Thus, in addition to standard IPT/IPSRT approaches to managing mood, individuals with BP II disorder may benefit from other ancillary strategies to dampen rapid oscillations of emotions such as breathing exercises, distraction, and self-soothing (Linehan, 1993). All of these approaches have been used to treat borderline personality disorder, which may have some symptom overlap with BP disorder (Magill, 2004).

6. Inquiring about substance abuse—Many individuals struggle with both BP II disorder and substance abuse (Merikangas et al., 2011). We recommend asking patients about both licit and illicit substance use at every visit and educating patients about the impact of these substances on mood. These substances may include alcohol, prescription drugs, street drugs, nicotine, and caffeine. Caffeine is often used to boost energy during low

periods and to heighten hypomania, although it has the potential to disturb sleep and exacerbate anxiety. Routine inquiry can help patients to see the maladaptive cycles of mood and self-medication. IPSRT is not a treatment for substance abuse, and a referral for dual diagnosis treatment may be indicated.

Case Vignette

Josh was a 28-year-old single White male (identifying information has been changed to protect confidentiality) who sought therapy with the chief complaint, “I can’t get over my girlfriend.” He reported pining for his ex-girlfriend, Annabeth, with whom he lived for two years until she broke up with him in order to attend out-of-state graduate school one year prior to his entering treatment. He described his mood as depressed with increased sleep, poor motivation, and decreased appetite. Upon questioning, he endorsed irritability, rapid thoughts, and psychomotor agitation. He worked different shifts every day (12 p.m. – 8 p.m., then 6 p.m. – 2 a.m., then 10 a.m. – 6 p.m.), so his sleep schedule was very erratic. His initial score on a self-report depression symptom inventory, the 16-item version of the Quick Inventory of Depressive Symptoms–Self Report (QIDS-SR) (Rush et al., 2003) was 18, which is in the severely depressed range. Josh reported recurrent depressive episodes since adolescence. He had previously been diagnosed with recurrent major depressive disorder (MDD), and, in the past, had been treated with several courses of antidepressants, none of which were helpful. In college, he experienced a protracted depressive episode that ultimately resulted in his dropping out of school. He never completed his degree and had been working in fast food restaurants for the past decade.

Josh initially denied periods of elated mood, but when the therapist rephrased the question to ask about periods of increased *energy* and *activity*, Josh described 5–6 day periods of decreased need for sleep (only requiring 3–4 hours per night), increased talkativeness and sociability, increased sexual interest, and rapid thoughts. These episodes occur two to three times a year, and Josh thought of them as his “good times.” Josh never mentioned them to his doctors because he did not consider them to be problematic. During the last such episode he spontaneously went to visit Annabeth, had “great sex,” and discussed reuniting. He began (somewhat impulsively) to make plans to move to her new community, initiated an application for the local community college, and contemplated buying Annabeth an engagement ring. The episode ended when Annabeth admitted that she had a new boyfriend and asked him to leave. He felt rejected by her, and the current depressive episode began soon afterward.

In Session 2 of IPSRT, Josh was given a diagnosis of bipolar II disorder. The therapist used psychoeducation to help Josh understand that several aspects of his history were characteristic of BP II disorder: 1) prior nonresponse to antidepressants (Sidor & MacQueen, 2011), 2) recurrent hypomanic episodes that seem like periods of better functioning, especially in contrast to the depressions, 3) predominance of depressive episodes over hypomanic episodes (Judd, Akiskal, Schettler, Coryell, Endicott, et al., 2003), 4) mixed symptom presentation of his current depressive episode, and 5) discordance between ability and vocational attainment. Although surprised to receive a diagnosis of BP II, Josh felt that this new diagnosis more accurately described his experiences than did MDD.

During the initial phase of IPSRT (Sessions 1–3), the therapist provided Josh with information about circadian biology and the importance of regularity of routines as a means of regulating mood. The therapist explained to Josh that regularity of routines will help him to regulate underlying biologic processes (entrain his circadian rhythms), thereby helping to diminish mood symptoms. The therapist stressed from the outset that Josh will be asked to develop a schedule that is *more regular* than that of his friends over the course of IPSRT.

At Session 3, Josh was given the Social Rhythm Metric (SRM) (Monk, Frank, Potts, & Kupfer, 2002) and asked to complete it prior to the next session. The following week, the therapist reviewed Josh's weekly schedule, focusing first on "out of bed" and "to bed" times. In Josh's case, his erratic work schedule contributed to marked variability in SRMs. When asked to speculate on the connection between his schedule and mood, Josh admitted that when he was living with Annabeth, he told his bosses that he could not work late shifts because he wanted to spend time with his girlfriend. As a result, he had a much more regular schedule. Since she moved out, he had been willing to work irregular shifts. Josh acknowledged that his mood was much worse since Annabeth left— but he attributed it to missing her rather than to a change in routines. The therapist suggested that although he was unable to influence Annabeth's decision to leave him, Josh did have control over his routines. In Session 5, Josh agreed to negotiate with his boss for a more regular work schedule. As his SRMs became more regular in Sessions 6 and 7, Josh's QIDS-SR score dropped to 11, reflecting a moderately depressed mood.

As the therapist worked with Josh to regulate his daily routines, she also identified an interpersonal problem area that was related to the onset of his mood episode. In IPT parlance, they agreed to work on the *role transition* from living with Annabeth to being single again. In addition to affecting Josh's daily routines, Annabeth's departure also had an impact on his social relationships. Previously, Josh and Annabeth had a shared social network that was tied to Annabeth's college circles. When she left for graduate school, Josh lost both a girlfriend and a group of friends. He admitted to being socially isolated for the past year, noting that he had not replaced the network he lost when Annabeth left. He acknowledged the need to rebuild his social life. Josh initially idealized his years with Annabeth, but the therapist encouraged Josh to explore both the positive *and the negative* aspects of their relationships in order to evaluate more realistically what had been lost. Josh admitted that Annabeth could be very controlling, and, at times, he felt like she made all of the decisions in their relationships. As the therapy progressed, he recognized that although he missed her, he felt "freer" since her departure.

The therapist and Josh also evaluated the impact of BP II disorder on his relationship with Annabeth. As Josh became better able to recognize the symptoms in himself, he came to realize that his mood swings, "on-off" libido, and occasional philandering (during hypomanias) likely contributed to the demise of his relationship. In working to broaden Josh's social network, Josh's therapist encouraged him to examine how his BP II disorder was affecting his interpersonal interactions so that he could avoid some of the struggles that emerged in his relationship with Annabeth. They also continued to monitor weekly SRMs, to set goals for rhythm regularity, and to examine the relationship between his mood and daily routines.

In the middle of treatment (Session 11), Josh ostensibly was doing better. His QIDS-SR score was 5 (in the not depressed range). Without consulting his therapist, Josh impulsively left town to visit Annabeth. The visit was a fiasco, as she was not expecting him and she was now living with her new boyfriend. Josh returned to therapy in an affectively dysregulated state with a QIDS-SR score backup to 16. He admitted that he went to visit Annabeth because he was feeling better (maybe a little “too good”), had learned so much about BP II disorder, and believed that Annabeth, now understanding the source of their difficulties, would accept him back. Josh also admitted that he had been feeling “flat” rather than “well,” a state that felt uncomfortable to him. During the remaining sessions (12–20), the therapist worked with Josh to understand that adjusting to a euthymic state after years of mood fluctuations is often difficult and that living with a “new normal” mood represents an important transition associated with treatment for BP II disorder. They agreed to discuss how to modulate stimulation in constructive (rather than destructive) ways in order to minimize the “flat” feeling as well as the tendency to engage in impulsive and mood-destabilizing acts. They also discussed strategies to help Josh regulate his mood when he experienced transient instability related to loss and rejection. Suggestions included scheduling of pleasurable activities, mindfulness, and distraction (Linehan, 1993). They continued to explore new sources of social support in order to help him to more successfully manage the role transition to being single again. QIDS-SR scores dropped back into the nondepressed range (below 6). Final sessions (19–20) were devoted to consolidating treatment gains, identifying early warning signs of relapse, and developing a plan for seeking treatment in the future should the need arise. A mutually agreed upon termination occurred at Session 20.

Conclusion

BP II disorder is a common and disabling illness. Psychologists are routinely called upon to treat individuals who suffer from this disorder, and yet little is known about how to manage them. IPSRT is an evidence-based psychotherapy for BP I disorder (Frank et al., 2005), and preliminary evidence supporting its use in BP II disorder is encouraging. Feasibility data are available for IPSRT as a treatment for BP II disorder in combination with medication (Miklowitz, Otto, Frank, Reilly-Harrington, Wisniewski, et al., 2007) and as monotherapy (Swartz et al., 2009). Larger trials of psychotherapy in BP II disorder are needed to establish definitively its efficacy.

IPSRT rests on theories related to the role of social and environmental cues in promoting/disrupting circadian rhythm integrity (Ehlers et al., 1988). Therapeutic strategies include psychoeducation, SRT, and IPT (Frank, 2005). For individuals with BP II disorder, additional attention is given to 1) identification of mixed mood states, 2) justification for regulating social rhythms, 3) emotion regulation, 4) management of grandiosity, 5) regulation of levels of stimulation, and 6) evaluation of comorbid substance abuse.

In addition to the nascent evidence base supporting its use, there are many compelling reasons to consider psychotherapy as a principal tool in illness management for those with BP II disorder. A BP II-specific intervention like IPSRT offers patients strategies for recognizing and attenuating cycling mood states, entraining biologic rhythms, and managing

psychosocial consequences of the illness. IPSRT, therefore, provides psychologists with a coherent approach to manage this complex and potentially devastating disorder in clinical practice.

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Table 1

Summary of Psychotherapy Trials That Included > 10% of Individuals With Bipolar II Disorder

Author	Intervention/Duration	Total sample	Mood at entry	Outcome
Bauer et al., 2006	TAU alone or TAU + CC, over 3 years *	BP I, BP II n = 306 (13.4% BP II)	Inpatient discharge	Greater reductions in weeks in episode ($p = .041$), mental quality of life ($p = .01$), social role functioning ($p = .003$) with CC vs. TAU alone
Castle et al., 2010	12 weekly group-based + 3 booster sessions + TAU, or TAU alone, for 1 year *	BP I, BP II, BPNOS n = 84 (25% BP II)	Not in acute episode	Lower depressive relapse rates ($p = .03$), less time unwell ($p = .02$) with group-based vs. TAU
Cochran, 1984	CBT or MC for 6 weeks, followed for 6 mos. *	BP affective illness n = 28 (14.3% BP II)	New to a lithium clinic	Lower non-adherence and hospitalization rates at post-treatment and six months in CBT vs. MC (all $p < .05$)
Colom et al., 2003	21 PE or non-structured group sessions, + 2 years follow-up *	BP I, BP II n = 120 (16.7% BP II)	Euthymic	Lower recurrence rate ($p < .010 - 0.05$), increased time to recurrence ($p < .01 - 0.05$), fewer/shorter hospitalizations ($p < .01 - 0.05$) in group PE vs. control
Colom et al., 2009	Re-analysis of 5-year follow-up data from Colom et al. (2003) *	Patients with BP II n = 20 (out of 120)	Euthymic	Higher levels of functioning ($p < .06$), less time with mood symptoms ($p < .004$), lower risk of recurrence ($p = .021$) by-5-years in PE vs. control
D'Souza Piskulic, & Sundram, 2010	12 weekly SIMSEP-BD sessions and later TAU, or TAU only, followed until week 60 *	BP I, BP II n = 58 (13.8% BP II)	Remitted	Lower relapse rate ($p = .013$), longer time to relapse ($p < .05$), improved medication adherence ($p = .001$), in SIMSEP-BD vs. TAU
Fagiolini et al., 2009	ECI + SBCD or SBCD alone, followed for 1–3 years *	BP I, BP II, BPNOS, n = 463 (19% BP II)	Currently in an episode	Added ECI improves quality of life vs. SBCD alone ($p = .04$)
Michalak Yatham, Wan, & Lam, 2005	8 weekly sessions group PE *	BP I, BP II n = 57 (21.1% BP II)	Euthymic	Higher quality of life post-treatment vs. baseline ($p < .002$) (but only 5 point score improvement)
Miklowitz et al., 2006	Optional psychosocial treatment over 1 year *	BP I, BP II, BPNOS, n = 248 (27% BP II) ‡	Depressed	Greater improvement in symptoms ($p = .044$) and functioning in more severely impaired patients ($p = .009$) with more psychotherapy sessions
Miklowitz, Otto, Frank, Reilly-Harrington, Wisniewski, et al., 2007	3 sessions CC, or intensive treatments for 30 sessions (CBT, FFT, or IPSRT), followed for 1 year *	BP I, BP II n = 293 (30.7% BP II)	Depressed	Higher rates of recovery ($p = .01$), more likely to be clinically well at any time point ($p = .003$) with intensive psychotherapies vs. CC
Patelis-Siotis et al., 2001	14 weekly sessions group CBT *	BP I, BP II n = 49 (63.3% BP II)	Euthymic or mildly depressed	No change in mood symptoms but improvement in psychosocial functioning ($p < .001$) medical outcomes ($p < .05$) over treatment
Scott Garland, & Moorhead, 2001	25 sessions CT or 6-month WLC then CT *	BP I, BP II n = 42 (19% BP II)	Any mental state	Greater improvements in symptoms/functioning in CT vs. WLC at 6 mos ($p = .007 - 0.05$); improvements in symptoms/functioning ($p = .001 - 0.04$), fewer met criteria for relapse/persistent illness ($p = .04$) after CT vs. pre-CT

Author	Intervention/Duration	Total sample	Mood at entry	Outcome
Simon et al., 2005	TAU or TAU plus systematic CM program for 12 months*	BP I, BP II n = 441 (23.8% BP II)	Any mood state	Less time (hypo)manic (0.9 weeks), lower mania scores ($p = .025$), greater decline in depression at 12 months ($p = .043$) with CM vs. TAU alone
Swartz, Frank, Frankel, Novick, & Houck, 2009	20 acute sessions of IPSRT; lamotrigine added for non-responders after session 12	BP II n = 17 (100% BP II)	Depressed	41% responded by visit 12, 53% responded by visit 20, 29% full remission by visit 20; symptom and illness severity improvements over time ($p = .001 - 0.045$)
Weber et al., 2010	8 weekly sessions MBCT + 1 booster session*	BP n = 15 (53.3% BP II)	Could not be manic	Change in mindfulness associated with change in depression severity from T1 to T2 ($p = .003 - 0.015$)
Weiss et al., 2000	12 or 20 weekly IGT sessions vs. assessment only*	BP I, BP II, BPNOS [§] n = 45 (17.8% BP II)	Psychiatric hospital discharge	Greater improvement in substance use outcomes ($p < .009 - 0.03$)
Weiss et al., 2007	20 weekly IGT or group drug counseling sessions, optional individual psychotherapy, +3 mos. follow-up*	BP I, BP II, BPNOS [§] n = 62 (16.1% BP II)	No current psychosis	Greater reduction of alcohol use ($p < .001 - 0.05$), less fluctuation in substance use ($p < 0.03$), more mood symptoms ($p < .001 - 0.05$) in IGT vs. control
Zaretsky Lancee, Miller, Harris, & Parikh, 2008	7 sessions PE alone or PE + 13 sessions CBT, for 1 year*	BP I, BP II n = 79 (34.2% BP II)	Not in episode	Greater decrease in days depressed ($p = .045$) from pre- to post-treatment with CBT vs. PE

Note.

* Some or all participants were receiving pharmacotherapy;

[§] Sample included those with substance dependence;

AD = Antidepressant; BP I = Bipolar I disorder; BP II = Bipolar II disorder; BPNOS = bipolar disorder not otherwise specified; CBT = Cognitive Behavior Therapy; CC = Collaborative Care; CM = Clinical/Care Management; ECI = Enhanced Clinical Intervention; FFT = Family Focused Treatment; IGT = Integrated Group Therapy; IPSRT = Interpersonal and Social Rhythm Therapy; MBCT = Mindfulness Based Cognitive Therapy; MC = Medication Clinic; PE = Psychoeducation; SBCD = Specialized Care for Bipolar Disorder; SIMSEP = Systematic Illness Management Skills Enhancement Program; TAU = Treatment As Usual.