Effects of Interpersonal and Social Rhythm Therapy on Suicidal Ideation in Adults With Bipolar II Depression

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Abstract

Objective: Individuals with bipolar II disorder (BD II) have among the highest rates of suicide ideation (SI), attempts, and deaths. No studies to date have examined psychosocial treatment of SI in adults with BD II. The purpose of this study was to investigate whether patients with BD II depression receiving interpersonal and social rhythm therapy (IPSRT), an evidence-based psychotherapy for BD, experienced a decrease in SI, and whether this varied by use of adjunctive medication compared to IPSRT monotherapy.

Methods: In a post hoc analysis of Swartz et al (2018), adults meeting *DSM-IV* criteria for BD II, currently depressed (n = 92), were randomly assigned to receive IPSRT + placebo (IPSRT + P) or IPSRT + quetiapine (IPSRT + Q) and treated for 20 weeks. SI was assessed at baseline and weekly using the 17-item Hamilton Depression Rating Scale item 3. Multilevel logistic regression was used to model SI categorically.

Results: The results demonstrate a decrease in odds of SI over time (OR = 0.8719, 95% CI, 0.8166–0.9309, $P \leq .001$), with a 13% decrease in the odds of having SI for each additional week of treatment. There was no significant difference between those receiving IPSRT + P vs IPSRT + Q.

Conclusions: IPSRT has the potential to mitigate suicidal ideation in patients with BD II depression, regardless of whether they receive medication in addition to IPSRT. IPSRT alone may be a reasonable option to treat SI in an outpatient setting for some patients with BD II, especially those for whom medication is contraindicated or who prefer avoiding medication.

Trial Registration: ClinicalTrials.gov identifier: NCT01133821.

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Suicide is a major public health concern. In 2022, the number of deaths from suicide in the United States reached a record high since World War II.[1] Among all psychiatric and medical illnesses, bipolar disorders (BDs) are associated with the highest risk of death from suicide.[2] Research indicates up to 81% of adults with BDs report suicidal ideation (SI), and half have attempted suicide during their lifetime.[3,4] Compared to the general population, individuals with BDs have 20–30 times higher rates of suicide deaths.[3] Psychological autopsy reports indicate individuals with BDs represent between 22% and 61% of suicide victims.[5]

Individuals with bipolar II disorder (BD II) are among those at highest risk for SI, attempts, and deaths.[3] BD II is often thought of as a milder form of bipolar I disorder (BD I). However, BD II is associated with substantial clinical severity, disability, and mortality comparable to BD I.[6,7] BD II is characterized by frequent and often refractory depressive episodes, more mixed episodes and rapid cycling, comorbid anxiety and childhood trauma, and longer time to diagnosis—all risk factors for SI, behaviors, and deaths.[2,8–14] A systematic review[3] found patients with BD II are at the highest risk for death from suicide when compared to other bipolar spectrum disorders. Therefore, individuals with BD II are among the highest risk populations for death from suicide and in need of evidence-based treatments tailored to the complexities of this illness.

Research demonstrates some suicide-specific psychotherapies show effectiveness in reducing suicide risk among various populations, yet treatment gaps remain.[2,14–22] This includes the lack of research examining the effect of psychotherapy on suicide risk for BD II. Psychotherapy is an essential part of treatment in BD II. Diagnostic guidelines of treatment for BDs recognize the integral role of psychotherapy in the treatment of BDs (eg, International Society for Bipolar Disorders [ISBD] and Canadian Network of Mood and

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Clinical Points

- Little is known about treating suicidal ideation in bipolar II disorder.
- Psychotherapy alone may be used to treat suicidal ideation for bipolar II disorder. Interpersonal and social rhythm therapy may be an effective option.
- Shared patient decision-making should be considered when determining treatment.

Anxiety Treatments [CANMAT]).[23] Yet, despite distinct illness characteristics, course, and treatment targets, separate treatment considerations for psychotherapy in the treatment of BD I and BD II are not discussed. This may be due to the scarcity of research on psychotherapy for BD II as well as pervasive misunderstanding about the severity of BD II compared to BD I.

A major gap in research is the lack of clinical trials of bipolar-specific psychotherapy that examine suicide risk (ie, SI, suicide-related thoughts and behaviors, attempts, or deaths),[24,25] as treatment outcomes in patients with BDs.[26–28] Those studies that do report on suicide risk often focus on counts of adverse events (ie, deaths or attempts resulting in hospitalization). SI, although less of a hard endpoint than deaths or attempts, is less frequently examined, although it is an essential contributor to morbidity and mortality in BDs. SI is the third most potent predictor of death from suicide in general and specifically in BDs.[22] SI predicts suicide attempts[13] and increases risk for death from suicide.[12] Therefore, identifying strategies to mitigate SI is essential in preventing subsequent attempts and suicide deaths[29] in individuals with BDs. Yet, individuals with BD II have unique treatment needs, and it is unknown what treatment modality or possibly multimodal treatments are most efficacious in treating SI in BD II.

A review of the literature indicates that psychotherapy as a monotherapy has efficacy in decreasing SI in patients with unipolar depression comparable to medication.[30,31] Yet, across studies, only one-third of patients with unipolar depression respond to a single treatment modality (eg, psychotherapy alone or antidepressant alone).[31] Depression severity, including SI, is a predictor of the need for multimodal treatment for unipolar depression.[31] However, SI has been neglected as an outcome in psychotherapy trials of BDs in general and BD II in particular. One study of suicide risk in individuals with BD I found that interpersonal and social rhythm therapy (IPSRT) or intensive case management added to lithium produced a 3-fold decrease in suicide risk in acute treatment and a 17.5-fold decrease in suicide risk during maintenance treatment.[28] A small pilot study found reductions in suicide risk among individuals with BD, including BD II, treated with social rhythm therapy (SRT; a component of IPSRT).[32] Thus, the role of psychotherapy, and perhaps specifically IPSRT/SRT, in reducing suicide risk may be substantial, but this has not been adequately investigated.

Systematic studies of psychotherapy to treat suicide risk, and specifically SI, in BD II to our knowledge, have not been conducted. In this article, we report findings from a secondary data analysis of the only randomized controlled trial of a psychotherapy tested specifically in individuals with BD II.[33] This study tested IPSRT as a treatment for BD II depression. IPSRT has been shown to delay recurrence for individuals with BD I[34] and decrease time to remission in a sample with both individuals with BD I and BD II.[34] Because of burdensome side effects associated with psychotropic medications for BDs,[35–37] Swartz compared the efficacy of IPSRT monotherapy to IPSRT plus medication as treatments for BD II depression.[33] Although psychotherapy without adjunctive medication would be contraindicated for BD I due to the risk of full-blown mania and psychosis, Swartz et al (2018)[33] demonstrated psychotherapy alone (ie, IPSRT) may be a viable option for some individuals with BD II depression. In our secondary analysis of data from this trial,[33] we examine the outcome of SI in participants with BD II depression treated with IPSRT + placebo (IPSRT + P) compared to IPSRT + quetiapine (IPSRT + Q).

Purpose and Hypotheses

The purpose of this study was to compare the effects of IPSRT + Q to IPSRT + P on SI in individuals with BD II depression. We hypothesized that there would be a greater decrease in the odds of having SI over the 20-week treatment period when participants received psychotropic medication in addition to IPSRT.

METHODS

This was a post hoc analysis from data obtained from ClinicalTrials.gov identifier: NCT01133821, a 20-week double-blind randomized controlled trial (n = 92) examining the efficacy of IPSRT + P (n = 45) to IPSRT + Q (n = 47) in the treatment of BD II depression. Written informed consent was obtained from all participants prior to study entry, and the University of Pittsburgh Institutional Review Board approved all study protocol and procedures. The original dataset is available at the University of Pittsburgh and held by Dr Holly A. Swartz (swartzha@upmc.edu).

Participants

Inclusion criteria consisted of current diagnosis of BD II major depressive episode according to the *DSM-IV-TR* and assessed using the Structured Clinical Interview for *DSM-IV*,[38] age 18–65 years, and score of ≥15 on the

17-item Hamilton Rating Scale for Depression (HDRS-17) (ie, at least a moderate level of depression).[39] Exclusion criteria included current treatment with other psychotropic medication other than through study assignment, current involvement in individual psychotherapy outside study treatment, nonresponse to ≥12 weeks of prior IPSRT, nonresponse to ≥6 weeks of quetiapine 300 mg per day, diagnosis of psychotic disorder or BD I, diagnosis of substance use disorder in the past 6 months, diagnosis of borderline personality disorder or antisocial personality disorder, medical condition that better explained current mood symptoms, currently pregnant, non-English speaking, homicidal ideation, or in need of a higher level of care. SI was not an exclusion criterion. However, decisions about the need for higher level of care were made by the principal investigator (PI), who was a practicing psychiatrist with 2 decades of experience managing psychiatrically complex patients. Individuals were excluded when, in the judgement of the PI, they could not be reasonably or safely managed in an outpatient setting and therefore were referred to the emergency room, inpatient setting, or partial hospitalization program for more intensive services.

Allocation and Attrition

Of the 207 individuals assessed for eligibility, 92 were randomized to a treatment condition (IPSRT + Q [n = 47]; IPSRT + P [n = 45]). The study had 40% attrition (see Table 1), although without significant differences between treatment groups. Most of the study attrition was attributed to participants being lost to follow-up. Participants who decided to discontinue the allocated intervention (n = 13) dropped out for reasons documented as nonadherence to treatment, refusing treatment, preferred another treatment, or treatment was inconvenient to the participant. Further explanation of design and allocation can be found in the original article.[33]

Treatment

All participants received 45 minutes of individual therapy, IPSRT, weekly until remission, and then biweekly to study completion (week 20). Remission was defined as 3 consecutive weeks with HDRS-25[40] item ≤8 and Young Mania Rating Scale[41] (YMRS) ≤ 8. Therapists were master's level or doctoral level clinicians with 3 or more years of experience. Therapists participated in weekly expert supervision, and their therapy sessions were recorded and assessed to monitor fidelity utilizing the IPSRT Therapy Rating Scale.[42]

IPSRT, based on social rhythms disruption theory,[43] is an evidence-based therapy for BD.[34,44,45] IPSRT targets resolving interpersonal problems and regulating disruptions in social routines known to alter biological rhythms, such as sleep-wake cycles, which precipitate and exacerbate mood episodes in BD.[46–50] Therefore, IPSRT aims to resolve mood episodes, prevent recurrence, and improve functioning in individuals with BD. Further explanation of therapy processes and techniques is detailed in the IPSRT manual.[46]

Participants were randomly assigned to placebo or quetiapine, which were administered in identical capsules. Quetiapine was dosed flexibly, starting at 50 mg/d up to 300 mg daily, or participant tolerance. Mean dosage was 172.3 ± 71.3 mg/d (range, 50–300 mg).[33]

Table 1.
Study Attrition of Participants by Treatment Group

	IPSRT + Q	IPSRT + P
Week 0	47	45
Week 8	37	30
Week 12	33	29
Week 20	28	27

Abbreviations: IPSRT + P = interpersonal and social rhythm therapy + placebo, IPSRT + Q = interpersonal and social rhythm therapy + quetiapine.

Measures

Suicidal ideation and suicide-related thoughts. SI was defined as inclusive of both traditional SI and suicide-related thoughts[24,25] and was assessed at baseline and weekly using the HDRS-17[40] item 3. This item is rated on a scale of 0–4 (ie, 0 = absent, 1 = feels life is not worth living, 2 = wishes he/she were dead or thoughts of possible death to self, 3 = suicidal ideas or gesture, 4 = attempts at suicide). SI was measured categorically and reported descriptively as proportion of participants endorsing each level of the scale and coded dichotomously as 0 = no ideation and ≥1 indicating SI. Item 3 of the HDRS-17[40] is shown to be a valid way to assess SI and has concurrent validity with the gold standard for measuring SI, the Scale for Suicidal Ideation (item 1–5), and the suicide item of the Beck Depression Inventory.[51] HDRS item #3 also correlates significantly with number of previous suicide attempts.[51]

Data Analysis

Baseline differences in demographic and clinical characteristics of participants were compared using Pearson χ^2 tests to analyze categorical variables and Fisher exact tests when cell sizes were smaller than 5. For continuous variables, *t* tests were used and Wilcoxon rank sum tests when distributions were nonparametric. Statistical tests were evaluated at the 2-sided 5% significance level ($\alpha = .05$). Analyses were conducted using Stata, version 15 (Stata Corp, LLC, College Station, TX).

Multilevel logistic regression was used to examine the primary outcome variable (ie, SI), treated as a binary variable (0 = no SI and ≥1 = SI) and examined as a function of time, measured weekly across the study

period. Individual variation was accounted for by incorporating random intercepts for each individual into models.

Fully Bayesian model-based imputation[52] was used to perform an intent to treat analysis using Blimp 2.0 software.[53] Multiple imputation of outcome variables allowed for participants with only baseline data to be included and their attrition assumed to be missing at random based on identified auxiliary variables related to missingness.[54] Main variables used in the imputation model included independent, dependent variables, and covariates. Additional variables were also included, to increase specification, with 0.30 correlations or higher with indicators of missingness on study variables and variables with 0.32 correlations or higher with scores on the analysis variables themselves following conventions specified by Enders (2017).[55]

As a secondary analysis, the "pure depression dimension" factor structure[56] of the HDRS-17 was added as a level 2 covariate to isolate the effects of depression on SI outcomes. This was necessary given SI was measured using a single item (ie, item #3) from the depression scale (ie, HDRS-17). To test if the pure depression factor of the HDRS-17[40] predicted SI outcome, we included an interaction within the model with this predictor and time to test whether they changed the treatment response for SI overall.

Grand-mean centering was applied to the covariate of pure depression facture structure to aid interpretation of parameter estimates, following Enders and Tofighi (2017).[55] Time point of assessment, the only level-1 variable, had a meaningful zero point (baseline) and thus did not require centering, consistent with recommendation for longitudinal models.[55]

RESULTS

Baseline Demographic and Clinical Characteristics

Univariate. Baseline demographic and clinical characteristics for the entire sample are provided in Table 2. Participants had a mean age of 32.4 years; the majority were female (63.0%), Caucasian (71.7%), and non-Hispanic or Latino (96.7%). The majority of participants were never married (63.0%), with an annual household income of less than $30,000 (52.2%), and the vast majority had attended at least some college (85.9%). Mean HDRS-17 depression score at baseline was 20.3 (SD = 4.3, range = 10.0–30.0), consistent with moderate depression (Sharp[57]). Mean YMRS hypomania score was 6.2 (SD = 3.5, range = 0.0–15.0).

Bivariate. The only demographic or baseline clinical characteristics with significant differences between treatment groups was the number of prior hypomanic episodes. Participants randomized to IPSRT + Q had more hypomanic episodes (median = 12) than participants randomized to IPRST + P (median = 6) (P = .045).

Table 2.
Demographic and Clinical Characteristics

Variable	Total sample (n = 92)
Gender, n (%)	
Male	34 (37.0)
Female	58 (63.0)
Age mean ± SD, y	32.9 ± 10.8
Ethnicity, n (%)	
Hispanic or Latino	3 (3.3)
Non-Hispanic or Latino	89 (96.7)
Race, n (%)	
Caucasian	66 (71.7)
African American	16 (17.4)
Asian	8 (8.7)
American Indian	1 (1.1)
Other	1 (1.1)
Marital status, n (%)	
Never married	57 (63.0)
Married	4 (4.4)
Living as married	17 (18.5)
Separated	13 (14.1)
Widowed	1 (1.1)
Annual household income, n (%)	
Less than $30,000	48 (52.2)
$30,000–74,999	38 (41.3)
$75,000+	6 (6.5)
Years of education, n (%)	
High school diploma/GED or less	13 (14.1)
Some college, technical or associate's degree	48 (52.2)
College diploma	24 (26.1)
Graduate/professional degree	7 (7.6)
Lifetime diagnosis of anxiety, *DSM-IV*, n (%)	60 (65.2)
Current diagnosis of anxiety, *DSM-IV*, n (%)	54 (58.7)
Age at first hypomanic episode, mean ± SD, y	21.4 ± 14.2
No. of lifetime hypomanic episodes, median	22.5
Age at first depressive episode, mean ± SD, y	16.1 ± 6.2
No. of lifetime depressive episodes, median	10
HDRS-17 Depression score, mean ± SD	20.3 ± 4.3
HDRS-25 Depression score, mean ± SD	25.3 ± 5.2
YMRS Hypomania score, mean ± SD	6.2 ± 3.5
HDRS #3 Suicidal ideation, n (%)	
Suicidal ideation	42 (45.7)
No suicidal ideation	50 (54.3)
PROMIS anxiety score, mean ± SD	21.3 ± 6.4
CTQ total score, mean ± SD	47.2 ± 14.0

Abbreviations: CTQ = Childhood Trauma Questionnaire, GED = General Education Development Test, HDRS-17, HDRS-25 = Hamilton Depression Rating Scale 17-item and 25-item versions, n = number, PROMIS = Patient Reported Outcomes Measures Information System, YMRS = Young Mania Rating Scale.

Baseline suicidal ideation. At baseline, slightly fewer than half of participants (45.7%) reported some SI including suicide-related thoughts. No participants endorsed suicidal ideas, gesture, or attempts. Baseline SI between treatment groups is displayed in Table 3. Study variables did not have significant differences between groups at baseline.

Outcome: Suicidal Ideation

Table 4 displays results of the multilevel mixed-effect logistic regression for the outcome of SI over time. Results

Table 3.

Distribution of Suicidal Ideation at Baseline

HDRS #3 Suicide risk, n (%)	Total sample (n = 92)	IPSRT + Q (n = 47)	IPSRT + P (n = 45)	*P* value
Suicidal ideation	42 (45.7)	23 (25.0)	19 (20.6)	.518
Feels life is not worth living	33 (35.9)	17 (18.5)	16 (17.4)	
Wishes he/she were dead or thoughts of possible death to self	9 (9.9)	6 (6.5)	3 (3.3)	
Suicidal ideas or gesture	0 (0.0)	0 (0.0)	0 (0.0)	
Attempts at suicide	0 (0.0)	0 (0.0)	0 (0.0)	
No suicidal ideation	50 (54.4)	24 (26.1)	26 (28.3)	

Abbreviations: HDRS = Hamilton Depression Rating Scale, IPSRT + P = interpersonal and social rhythm therapy + placebo, IPSRT + Q = interpersonal and social rhythm therapy + quetiapine.

Table 4.

Multilevel Mixed Effects Logistic Regression Analyses for Suicidal Ideation

Analysis/variable	Odds ratio	SE	*t*	*P* > |*t*|	95% CI	
Analysis 1						
Study week (time)	0.8719	0.0201	−4.26	.000	0.8266	0.9309
Analysis 1.2 (treatment group)						
Study week (time)	0.8896	0.0346	−3.01	.005	0.8224	0.9623
Treatment group (IPSRT + Q)	0.8654	0.7297	−0.17	.864	0.1656	4.5211
Interaction between treatment group (IPSRT+Q) and study week (time)	0.9585	0.0509	−0.80	.429	0.8612	1.0668
Analysis 2 (pure depression)						
Study week (time)	0.8862	0.0331	−3.23	.002	0.8220	0.9555
Treatment group (IPSRT + Q)	0.6377	0.5369	−0.53	.593	0.1222	3.3264
Interaction between treatment group (IPSRT + Q) and study week (time)	0.9604	0.0474	−0.82	.416	0.8699	1.0602
Interaction between Pure depression factor structure (HDRS-17) and study week (time)	1.2601	0.0977	2.99	.003	1.0819	1.4691

Abbreviations: HDRS-17 = Hamilton Depression Rating Scale 17-item, IPSRT + Q = interpersonal and social rhythm therapy + quetiapine, SE = standard error.

demonstrate a significant time effect with a decrease in odds of SI over time (OR = 0.8719, 95% CI, 0.8166–0.9309, *P* = .000). That is, participants demonstrated a 13% decrease in the odds of endorsing SI for each additional week of treatment. However, there was not a significant time-by–treatment group effect, and the trajectories of the two treatment groups were not significantly different (OR = 0.9585, 95% CI, 0.8612–1.0668, *P* = .429 NS). Therefore, there was no significant difference in odds of SI over time or rate of change in SI between those receiving IPSRT + P and those receiving IPSRT + Q. By the end of the acute treatment period (ie, week 20), 85% of participants had no SI compared to 54% at the outset of the study. The interaction between the pure depression factor structure of the HDRS-17 and time was significant (OR = 1.2601, 95% CI, 1.0819–1.4691, *P* = .003). This indicates that participants improving in the pure depression factor structure of the HDRS-17 also improved in SI over time.

DISCUSSION

Main Findings

Participants with BD II depression who received IPSRT experienced a significant improvement in SI over the 20-week treatment period, regardless of whether they received quetiapine. In the overall sample, participants experienced a 13% decrease in odds of having SI for each week of participation in the study. Compared to 45.7% of the sample reporting SI at study entry, only 15% of participants reported any SI by end of acute treatment (week 20). This was inclusive of suicide-related thoughts, such as "life is not worth living." Improvements in depression predicted improvements in SI. Therefore, it may be impossible in this dataset to disentangle the two effects. Findings were inconsistent with our hypothesis that the addition of quetiapine to IPSRT would significantly improve SI outcomes compared to IPSRT alone.

Implications and Directions for Future Research

Results suggest that psychotherapy alone may be a reasonable treatment for some patients with BD II depression and mild-to-moderate SI. Our results did not support our hypothesis that those with BD II and SI would need more "complex" or multimodal treatment (ie, psychotherapy plus psychotropic medication); rather, they suggest that at least for some individuals with BD II psychotherapy alone may suffice, even to treat mild-to-moderate SI. These results align with results from

unipolar depression trials, finding that declines in SI with psychotherapy alone are comparable to those observed with medication.[58] This also underscores that treating SI and depression are important components of reducing suicide risk in BD II.

The critical question remains: For whom is psychotherapy alone a safe option? In this study, those with active suicide risk (ie, plan, intent, behaviors, or attempts) were referred to a higher level of care and excluded from study participation. This indicates that psychotherapy monotherapy may be a treatment option for those with SI and suicide-related thoughts. Yet, future research should examine the effect of psychotherapy and specifically IPSRT on those at higher suicide risk. In previous analyses of this clinical trial, investigators found that those who received IPSRT + Q experienced significantly more side effects (ie, weight gain, restlessness, and dry mouth) compared to those randomized to IPSRT + P, and those randomized to the treatment they preferred were 4.5 times more likely to respond to treatment.[33] This suggests that for individuals with BD II who do not want to risk these side effects or for whom medication is contraindicated, psychotherapy monotherapy may be an option, especially when they prefer it, even when they are experiencing SI and suicide-related thoughts. However, larger samples and additional treatment conditions (eg, medication alone or inactive psychotherapy comparator) are needed to definitively demonstrate efficacy. Future research should also investigate additional risk factors for SI such as stages of illness progression and illness severity, sleep and circadian rhythms, and other factors that worsen illness course and increase suicide risk.[59–61]

IPSRT, specifically, may be an effective treatment to reduce SI among the study sample. IPSRT, which focuses on resolving interpersonal problems and stabilizing social and circadian rhythms,[46–48] may resolve mild-to-moderate SI in adults with BD II since dysregulated circadian rhythms[61] are risk factors for suicide in individuals with BDs. This aligns with findings from Sankar et al,[32] who found reductions in suicide risk among individuals with BD, including BD II, when treated with SRT (a component of IPSRT). In this trial, only 1 psychotherapy modality was evaluated; therefore, these findings may not generalize to other psychotherapies. Future research should examine the potential and specific impact of sleep improvements and social functioning as mechanisms of change in IPSRT on suicide risk.

Limitations

The following limitations must be considered when interpreting these results. First, the study had a small sample size (n = 92) and therefore limited power to detect small effects. Second, high dropout rates (40%) indicate participants may not have received an adequate dose of treatment, and therefore, treatment effects may have been limited.[62] Third, absence of an inactive comparator group and a medication-only group limits conclusions that can be drawn from this study. Fourth, the composition of the sample consisted mainly of well-educated white people, and the gender and sexual identity of the participants is unknown; therefore, generalizability to other populations is limited. Fifth, the measure for SI in this study was 1 item from a depression measure (HDRS #3), not an independent valid and reliable measure of suicide risk. Further, this single item measure of suicide risk is problematic, as is conflated passive and active SI and SI and suicidal behavior. While item 3 on the HDRS-17 is shown to have concurrent validity with sound measures of SI,[51] the use of this measurement alone is not ideal, and replication with more robust measures is needed. Finally, participants with active suicide risk (ie, plan, intent, behaviors, or attempts), needing a higher level of care for their own safety, were excluded from participation or discontinued the study at the time they exhibited these symptoms. Therefore, psychotherapy alone may not be a good option for those with higher suicide risk.

CONCLUSIONS

In conclusion, adults with BD II depression treated with IPSRT plus placebo yielded comparable improvement in SI and suicide-related thoughts to those receiving IPSRT plus quetiapine. These results indicate that psychotherapy monotherapy may be a viable treatment option when targeting SI and suicide-related thoughts in outpatient treatment of BD II. Patient treatment preference should be considered when evaluating benefits and harms of treatment options. Patients' shared decision-making in treatment planning is encouraged. Further research is needed on BD II and clinical trials including individuals with suicide risk. Future research is needed before forming treatment recommendations.

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