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Design and Effectiveness of an Integrative Psychoeducational-Therapeutic Package on Psychological Flexibility in Patients with Bipolar II Disorder

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A B S T R A C T

Purpose: Bipolar II disorder is characterized by chronic mood instability, emotion dysregulation, and functional impairment. Reduced psychological flexibility may perpetuate symptoms and hinder adaptation. This study developed and tested an integrative psychoeducational-therapeutic package to improve psychological flexibility in Bipolar II patients, addressing the limitations of single-component interventions.

Materials and Methods: This study employed a sequential exploratory mixed-methods design. Qualitative analysis of semi-structured interviews with 20 patients, using Colaizzi's method, led to the development of an 8-session, 6-domain treatment package. In the quantitative phase, 40 patients from Vasei Hospital's Neurology and Psychiatry Department (Sabzevar, 2024) were randomly assigned to experimental (n=20) and control (n=20) groups. Psychological flexibility, measured by the AAQ-II (Bond et al., 2011), was assessed at pre-test, post-test, and 3-month follow-up. Data were analyzed using mixed-design repeated-measures ANOVA in SPSS 27.

Findigns: The Time × Group interaction significantly impacted psychological flexibility, $F(1.68, 63.80)=70.73$, $p<0.001$, $\eta 2=0.65$. Specifically, the experimental group's psychological flexibility rose from 29.61±2.03 at pre-test to 33.68±2.03 at post-test, then stabilized at 33.55±2.18 by follow-up. In contrast, the control group's scores remained consistent across all assessments (31.45±1.80 pre-test, 31.64±1.75 post-test, and 31.52±1.50 follow-up).

Conclusion: The integrative psychoeducational-therapeutic package effectively enhances psychological flexibility in Bipolar II disorder patients, with sustained gains. This protocol could complement pharmacotherapy in clinical settings.

Keywords: *Bipolar II disorder; psychological flexibility; integrative intervention; Acceptance and Action Questionnaire-II*

1. Introduction

Bipolar disorder is a severe, recurrent, and multidimensional psychiatric condition characterized by marked fluctuations in mood, energy, activity, cognition, and behavior. Among its clinical subtypes, Bipolar II disorder is distinguished by the occurrence of at least one major depressive episode and at least one hypomanic episode, without a history of a full manic episode. Although hypomania is generally less severe than mania, Bipolar II disorder should not be regarded as a milder form of bipolar illness. Patients frequently experience prolonged or recurrent depressive episodes, mood instability, impaired interpersonal functioning, occupational difficulties, disrupted biological rhythms, and an elevated risk of suicidal thoughts and behaviors. The predominance of depressive symptoms may also delay accurate diagnosis because hypomanic periods can remain unrecognized, be interpreted as normal productivity, or fail to attract clinical attention. Consequently, many patients undergo repeated periods of emotional suffering and functional deterioration before receiving appropriate treatment. Recent perspectives have further emphasized that mood stability in Bipolar II disorder depends not only on symptom suppression but also on autonomic and regulatory flexibility, suggesting that the capacity to modulate physiological and psychological responses may serve as a buffer against mood destabilization (Purcell, 2025).

Pharmacotherapy, particularly treatment with mood stabilizers and other psychotropic medications, remains an indispensable component of bipolar disorder management. Nevertheless, medication alone may not fully resolve the psychological, behavioral, and interpersonal difficulties that persist between acute episodes. Even during remission or partial remission, many patients continue to report residual depressive symptoms, sleep and circadian disruption, difficulties regulating emotion, fear of recurrence, low self-efficacy, social withdrawal, internalized stigma, cognitive rigidity, and impaired quality of life. Family members may also experience uncertainty regarding the nature of the disorder, frustration about treatment, and difficulty responding effectively to medication nonadherence. Qualitative evidence from family members of patients with bipolar disorder indicates that misunderstanding the illness, concerns regarding pharmacological treatment, and inadequate knowledge of relapse processes may contribute to nonadherence and tension within the family system (Mousavi et al., 2021). Accordingly, contemporary care increasingly recognizes the need for adjunctive psychological interventions that help patients understand their illness, recognize warning signs, regulate everyday routines, strengthen treatment engagement, and develop more adaptive responses to distress.

The chronic and recurrent nature of severe mental illness also means that patients' outcomes are influenced by the support available within their family and care environments. Transitional care programs that provide education, continuity, and structured support to family caregivers may help families respond more effectively to relapse risks and the long-term demands of psychiatric illness (Asgharzadeh et al., 2025). At the same time, caregiving can become psychologically burdensome when caregivers lack resilience, self-compassion, or flexible coping strategies. Psychological flexibility, resilience, and self-compassion have therefore been examined as important predictors of burden among caregivers of individuals with bipolar affective disorder (Baburaj, 2025). These findings suggest that bipolar disorder should be approached not only as a collection of mood symptoms but as a condition affecting adaptation, relationships, self-perception, treatment behavior, and the wider care system. An effective intervention may consequently need to combine illness education with skills that enable patients to respond constructively to emotional discomfort, stigma, interpersonal tension, and uncertainty.

Psychological flexibility has emerged as a particularly relevant transdiagnostic construct for understanding adaptive functioning in the presence of persistent psychological distress. It generally refers to the ability to remain in contact with present experience, including unpleasant thoughts and emotions, while choosing behavior that is consistent with personal values and situational demands. Rather than requiring the elimination of distress, psychological flexibility enables individuals to alter their relationship with internal experiences and to continue meaningful action despite discomfort. It involves openness to emotional experience, mindful awareness, perspective taking, clarification of values, and sustained value-consistent behavior. Psychological flexibility is therefore not equivalent to passive acceptance or resignation. It reflects an active and context-sensitive capacity to notice internal events without being dominated by them and to adjust behavior in ways that support long-term well-being. Contemporary conceptual analyses describe psychological flexibility as a multidimensional process that links

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acceptance, awareness, behavioral adaptation, and value-directed action (Malo et al., 2024).

The opposite pattern, psychological inflexibility, is characterized by rigid behavioral responding, experiential avoidance, cognitive fusion, disconnection from the present moment, an inflexible self-concept, unclear values, and behavioral inactivity or impulsivity. Experiential avoidance occurs when an individual attempts to suppress, escape, or control distressing private experiences even when these efforts produce greater long-term harm. Cognitive fusion refers to becoming excessively entangled with thoughts and treating them as literal facts rather than temporary mental events. These processes may be particularly problematic in mood disorders, in which patients can become preoccupied with self-critical beliefs, hopeless predictions, shame, fear of relapse, or beliefs that emotional discomfort must be immediately eliminated. The Acceptance and Action Questionnaire-II was developed as a concise measure of psychological inflexibility and experiential avoidance and has become one of the most commonly used instruments for assessing flexibility-related processes (Bond et al., 2011).

Evidence across diagnostic groups indicates that psychological flexibility is associated with emotion regulation, coping, resilience, symptom severity, and broader mental health outcomes. Among patients with mood disorders, greater psychological flexibility, mindfulness, and self-compassion have been associated with lower depression severity, indicating that flexible responding may protect individuals from becoming persistently absorbed in negative emotional states (Zargar et al., 2023). In patients with asthma, psychological flexibility and cognitive emotion regulation have similarly been associated with mental health outcomes, demonstrating that flexible adaptation is relevant even when individuals face chronic physical illness and recurring physiological distress (Hussain et al., 2023). Research conducted during the COVID-19 pandemic also showed that psychological flexibility, emotion-regulation difficulties, and intolerance of uncertainty were relevant to psychological distress and obsessive-compulsive symptoms among patients with type 2 diabetes (Davoudian et al., 2022). Furthermore, psychological flexibility and resilience have been associated with psychopharmacological treatment response among patients with obsessive-compulsive disorder (Deveci et al., 2024). Collectively, these findings support the view that flexibility is a broad process through which individuals adapt to difficult internal and external conditions rather than a mechanism limited to a single psychiatric diagnosis.

Research involving personality pathology provides additional evidence that inflexibility is related to enduring maladaptive patterns. Psychological flexibility and inflexibility have been examined alongside coping flexibility in relation to personality-disorder traits, suggesting that rigid coping and limited behavioral adjustment may contribute to persistent interpersonal and emotional difficulties (Watson, 2026). Patients with borderline personality disorder have also demonstrated clinically meaningful differences in psychological flexibility when compared with healthy individuals (Temircan, 2025). Although bipolar disorder differs diagnostically from personality disorders, these studies are relevant because they show how inflexible responding can become embedded in recurrent emotional and relational patterns. In bipolar illness, similar processes may be manifested through rigid attempts to control mood, avoidance of illness-related information, withdrawal from social roles, impulsive reactions to emotional states, or overidentification with the label of being mentally ill.

Within bipolar disorder specifically, cognitive and psychological flexibility appear closely connected to illness course and psychosocial functioning. Cognitive flexibility involves the ability to shift perspectives, modify problem-solving strategies, and adapt thinking in response to changing environmental demands. Studies of patients with bipolar disorder have identified associations among cognitive flexibility, theory of mind, and creative thinking, suggesting that rigidity may affect both cognitive performance and the interpretation of social situations (Köse & Hocaoğlu, 2025). During remission, impairment in theory of mind and psychological flexibility has also been associated with poorer social functioning, indicating that the absence of an acute mood episode does not necessarily imply full interpersonal recovery (Çifteci et al., 2026). These deficits may make it difficult for patients to interpret others' intentions accurately, respond flexibly during conflict, or adjust their behavior to complex social expectations.

Psychological inflexibility may additionally interact with internalized stigma and intimate relationship functioning. Patients who fuse with stigmatizing beliefs may begin to define themselves primarily through the disorder, interpret rejection as inevitable, and avoid social or relational experiences that could otherwise support recovery. A mediation model involving patients with bipolar disorder has linked dyadic adjustment, internalized stigma, psychological inflexibility, and playfulness, underscoring the relational consequences of rigid psychological responding (Güleç et

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al., 2026). Acceptance, values, and mindfulness may also exert distinct effects on functioning among patients with bipolar disorder in remission, which suggests that different components of flexibility may influence recovery through partially different pathways (Karatepe & Aktepe, 2020). Therefore, interventions should not conceptualize psychological flexibility as a single undifferentiated skill; rather, they should address acceptance, attention, values, cognition, behavior, and interpersonal functioning in an integrated manner.

Biological and behavioral regularity are also central to the management of bipolar disorder. Sleep disturbance, irregular daily activity, and disrupted circadian rhythms may precede or intensify mood episodes. Research on patients with bipolar disorder in remission has demonstrated relationships among biological rhythms, illness perception, and cognitive flexibility (Kocakaya & Yetkin, 2024). Patients who perceive their illness in rigid, catastrophic, or uncontrollable terms may find it difficult to establish consistent routines or respond adaptively to early warning signs. Conversely, improved awareness of sleep, mood, and activity patterns may enable earlier intervention and reduce the sense that mood changes are entirely unpredictable. From this perspective, psychoeducation concerning biological rhythms and relapse indicators can complement psychological flexibility training by helping patients distinguish between experiences that require acceptance and behaviors that can be actively modified.

The clinical importance of flexibility is further reinforced by longitudinal findings. Cognitive flexibility has been associated with the subsequent course of mood symptoms and suicidal ideation among young adults with childhood-onset bipolar disorder (MacPherson et al., 2022). This relationship is especially important because suicidal risk in bipolar disorder is not limited to periods of severe observable dysfunction; it may also emerge during depressive episodes, mixed emotional states, or periods of intense hopelessness and cognitive constriction. When patients experience distress as intolerable and perceive few behavioral alternatives, impulsive or self-destructive actions may become more likely. Improving flexibility may widen the range of perceived responses, strengthen willingness to seek help, and support behavior that remains connected to personally meaningful goals even when mood symptoms intensify.

Acceptance and Commitment Therapy represents one of the principal therapeutic approaches designed to enhance psychological flexibility. ACT seeks to reduce the dominance of experiential avoidance and cognitive fusion while strengthening present-moment awareness, self-as-context, values clarification, and committed action. Preliminary group-based ACT research involving patients with bipolar disorder and co-occurring anxiety has suggested that the approach is feasible and potentially beneficial (Pankowski et al., 2017). A randomized controlled trial also showed that ACT could reduce impulsivity and suicidality among clients with bipolar disorders, supporting its relevance to high-risk clinical outcomes (El-Sayed et al., 2023). More recent research has reported that group-based ACT can improve cognitive emotion regulation and psychological flexibility in patients with bipolar disorder (Shi et al., 2026). ACT-based treatment has likewise been associated with improvements in executive functions, psychological flexibility, and psychological well-being among men with Bipolar I disorder (Karim Soltani et al., 2025).

Despite these promising findings, the evidence base remains under development. A randomized controlled trial protocol has been proposed to evaluate ACT as a stand-alone treatment for bipolar disorder, reflecting both growing interest in the approach and the continuing need for rigorous clinical evidence (Khafif et al., 2026). Moreover, stand-alone ACT may not adequately cover all the practical needs of individuals with Bipolar II disorder. Patients may also require explicit information about illness characteristics, medication adherence, sleep hygiene, relapse warning signs, communication, anger management, stigma, and family support. Psychological flexibility skills may be difficult to apply when patients do not understand the relationship among mood, sleep, medication, stress, and daily routines. Thus, combining ACT-consistent processes with structured psychoeducation may provide a more clinically comprehensive intervention than either component alone.

Related intervention research supports the use of integrated or multicomponent programs. A mindfulness-based psychoeducational program has been shown to enhance psychological flexibility and reduce perceived stress among psychiatric patients (Gabal, 2025). Dialectical Behavior Therapy has also improved emotion regulation and cognitive flexibility among men with Bipolar I disorder, illustrating the value of integrating acceptance, regulation, and behavioral-change strategies (Sadeghi et al., 2025). In a complex clinical case involving autism, bipolar disorder, schizophrenia, and aggressive behavior, an intervention combining ACT-based methods with contingency contracting was used to address both behavior and

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psychological flexibility (Burke et al., 2024). Although case-based evidence cannot establish general effectiveness, it demonstrates that flexibility-oriented methods can be integrated with structured behavioral procedures to meet complex clinical needs.

The development of tailored educational–therapeutic packages may be especially useful when interventions need to reflect the lived experiences of a defined population. A psychological-flexibility-based educational–therapeutic package has been developed and validated for intensive care nurses through grounded theory, showing how qualitative findings can be translated into structured intervention content (Ebrahimi et al., 2024). Need-based therapeutic packages have also been evaluated in comparison with established approaches such as emotionally focused therapy, indicating broader interest in interventions derived from the specific psychological and relational needs of target groups (Shabaninia et al., 2025). In rehabilitation contexts, the integration of biological knowledge with psychosocial strategies has similarly been proposed as a means of addressing complex behavioral and recovery processes (Zhylin et al., 2024). These approaches support a movement away from rigid, one-size-fits-all protocols toward interventions that combine empirical theory with culturally and clinically grounded needs.

Nevertheless, several important gaps remain. First, many studies include heterogeneous bipolar samples or focus on Bipolar I disorder, despite the distinctive burden of recurrent depression, subtle hypomanic changes, and persistent functional difficulties in Bipolar II disorder. Second, previous flexibility-oriented interventions have often emphasized ACT without systematically integrating psychoeducation, mood monitoring, sleep regulation, relapse prevention, emotion-management skills, communication training, and stigma management. Third, relatively few programs have been developed directly from patients' lived experiences and then empirically evaluated. Fourth, the persistence of treatment gains remains important because short-term improvement may have limited clinical value in a recurrent condition. An intervention for Bipolar II disorder should therefore be theoretically coherent, culturally responsive, grounded in patients' needs, compatible with pharmacotherapy, and capable of producing changes that remain stable beyond the immediate treatment period.

Accordingly, the present study aimed to design and evaluate the effectiveness of an integrative psychoeducational–therapeutic package in improving psychological flexibility among patients with Bipolar II disorder.

2. Methods and Materials

The present study was developmental-applied in terms of purpose and employed a mixed-methods approach with a sequential exploratory design. The study was conducted in three main phases. The initial qualitative phase gathered data on patients' lived experiences, focusing on their educational and therapeutic needs. In the second phase, based on the findings of the qualitative phase and a systematic review of the theoretical foundations, an integrative psychoeducational-therapeutic package was developed and validated. In the third phase (quantitative section), the effectiveness of the developed package was examined using a quasi-experimental pretest-posttest design with a control group and a three-month follow-up period. The statistical population consisted of all patients with Bipolar II Disorder who had attended the psychiatric ward of Vasei Hospital in Sabzevar in 2024.

In the qualitative section, 20 patients were selected through purposive and convenience sampling. The sampling process and interviews continued until data saturation was reached, that is, when new data no longer contributed additional codes or themes.

Forty eligible patients from the target population were randomly assigned to either the experimental (n=20) or control (n=20) group for the quantitative section.

The inclusion criteria were as follows: a confirmed diagnosis of Bipolar II Disorder by a psychiatrist based on DSM-5 criteria; being in a clinically stable state (euthymic) or partial remission of symptoms; age range between 18 and 60 years; at least a middle-school level of education to ensure comprehension of the educational content; provision of informed consent; and the ability to attend sessions regularly. The exclusion criteria included: acute exacerbation of mood symptoms during the intervention; emergence of active suicidal or homicidal risk; active substance or alcohol abuse; concurrent receipt of other structured psychological interventions; absence from more than two treatment sessions; major changes in the pharmacological treatment protocol by the treating physician during the study period; and unwillingness to continue participation at any stage of the study.

Procedure and Development of the Therapeutic Package

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The integrative psychoeducational-therapeutic package was developed iteratively, integrating empirical data with theoretical foundations. Semi-structured interviews explored patients' experiences with mood symptoms, aggravating factors, coping strategies, family challenges, and treatment expectations.

Qualitative data were analyzed using Colaizzi's seven-step method, which involved repeated reading of transcripts, extracting significant statements, formulating meanings, clustering themes, integrating results into a comprehensive description, extracting the fundamental structure, and validating findings with participants. To ensure trustworthiness of the data, strategies such as member checking, peer debriefing, prolonged engagement with the data, and detailed step-by-step documentation of the analytic process were employed.

Finalization of the Therapeutic Package

The therapeutic package, designed in six domains (psychoeducation, daily mood and sleep monitoring, relapse prevention, emotion regulation, cognitive-behavioral modification, and sleep hygiene), was based on qualitative findings and integrative therapy literature. Content validity was assessed by 15 specialists (psychiatrists and clinical psychologists) who calculated the Content Validity Ratio (CVR) and Content Validity Index (CVI). Their suggested revisions led to the final protocol: eight 90-minute sessions for the experimental group, while the control group received only treatment as usual (TAU).

Acceptance and Adaptation

Acceptance and adaptation constituted another subtheme within the broader theme of effective care. Patients with bipolar disorder described adaptation and acceptance as a stage of life alongside their illness. They expressed that they had come to accept that one of their family members, like individuals with chronic illnesses such as diabetes or hypertension, required long-term care. As a result, they reported experiencing less tension and greater peace, refraining from complaining and protesting, and no longer feeling alienated from the condition. They sought greater acceptance of their circumstances and consequences, with some participants even calling this a form of personal growth.

One participant described this feeling as follows:

“Life is just like this, and you have to live with it. Right now, I do not feel bad. Thank God, and my conscience is at peace. I am not like those people who only talk about their misfortunes and keep sighing and complaining. Problems exist; everyone has problems, and I have mine too, but I try to face them. I have not become hopeless, and I will not. I do whatever I can.” (Participant 8)

Another participant stated:

“Now I have become calmer myself. I was not like this before; I was always ready to fight. Spiritually, I was in a very bad state, but now I have accepted that this was my destiny, that this is a problem God has given me. That is why I try to make peace with myself and my conditions so that I do not trouble others as well.” (Participant 6)

Another participant explained that at first, the illness had not been accepted; it was disliked, and there had been resistance to acknowledging it:

“The first time I was hospitalized, I simply could not come to terms with it. I thought I was the cause of all the family’s misfortunes. But gradually, my view changed, and I realized it was not under my control. Little by little, I accepted that I should stop being stubborn and stop sulking. I accepted that I should stand beside my family, not against them, and I started cooperating.” (Participant 10)

Another participant who had accepted the illness said:

“I accepted the illness, I truly accepted it. God has not deprived me of anything. Now I stand firm in the face of this destiny and fight for it so that I can recover and return to my life as it was before.” (Participant 5)

Another participant reported that at the beginning, admission to the hospital ward had been accompanied by distress, crying, and complaining, and that there had even been times when no visit was made to the hospital for an entire month. However, over time, adaptation to the new conditions gradually developed:

“At the beginning, when I was hospitalized, I cried so much that I thought everything was over for me. Whenever the ward called my family, it felt as if they were throwing me into hell, whether they wanted to see me, follow up on my affairs, or arrange my discharge. I kept arguing with the nurses and others, complaining to them and saying, ‘You feel comfortable, but what do you know about the pain I am in?’ But over time, I accepted it myself and stopped arguing and fighting.” (Participant 11)

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Table 1

Sample codes, themes, and their application in developing the intervention package

Psychological Flexibility Component	Related Themes From the Qualitative Table (Target Areas)	Intervention Approach in the Therapeutic Package
Acceptance	Acceptance and adaptation, endless suffering, struggling with consequences	Training openness to unpleasant experiences and reducing the struggle to eliminate or fully control illness, negative emotions, and psychological pain
Cognitive Defusion	Shame and worry, rejection, feelings of inadequacy	Teaching participants to distance themselves from self-critical and labeling thoughts; for example, shifting from "I am a failure" to "I am having thoughts that I am a failure"
Present Moment	Hypervigilance, unwanted disruptions	Mindfulness training aimed at reducing excessive preoccupation with the future and enhancing attention to present-moment experience
Self-as-Context	Compulsive dependencies, feelings of inability, exhaustion	Helping the individual separate personal identity from the illness label or the mere role of patient/caregiver and strengthening an observer perspective toward inner experiences
Values	Attention to spiritual growth, life balance	Identifying core personal and family values, including spirituality, relationships, personal growth, and balance in life, and orienting behavior toward them
Committed Action	Pursuing treatment and persistence, lifestyle change	Developing small, realistic, and consistent behaviors, such as treatment adherence, lifestyle regulation, physical activity, and communication skills, in line with personal values

This intervention package was developed based on themes extracted from the qualitative data and organized within the conceptual framework of psychological flexibility. In this sense, the identified themes not only reflected the lived difficulties of patients and their families but also served as direct targets for intervention. Accordingly, the package was structured to strengthen acceptance, cognitive defusion, present-moment awareness, self-as-context, values clarification, and committed action, to reduce psychological inflexibility and enhance psychosocial adaptation.

Methods: Quantitative Phase

In the quantitative phase of the study, following the acquisition of all required legal approvals and the ethics code, 40 patients with Bipolar II Disorder who met the inclusion criteria were selected and assigned through simple randomization to either the experimental group (n = 20) or the control group (n = 20). In the first stage, a baseline assessment (pretest) was conducted for both groups using the study instruments. Subsequently, participants in the experimental group received the integrative psychoeducational-therapeutic package, which had been developed with a specific focus on psychological flexibility, over the course of eight weekly 90-minute sessions (Table 2). During the same period, the control group did not receive the psychological intervention under investigation and remained under treatment as usual (TAU) only. A posttest was administered after the intervention, followed by a three-month follow-up to assess the stability of treatment effects.

Given the central role of biological treatment in bipolar disorder, the status of psychiatric medication use among all participants was carefully examined at study entry. A primary inclusion requirement was relative stability in the pharmacological regimen, such that major changes in the type or dosage of core medications, including mood stabilizers and sleep-related medications, during the intervention period were considered either exclusion criteria or potential confounding factors. Throughout the research process, participants' clinical status and pharmacological treatment course were monitored through medical records and consultation with the treating psychiatrist. In addition, participants were asked to report any changes in their treatment process or any new therapeutic referrals to the researcher.

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Table 2

Summary of the Integrative Psychoeducational-Therapeutic Package Sessions

Session	Session Title	Themes	Session Objective
1	Introduction and Mental Health Literacy	Lack of awareness and mutual mistrust; inner empowerment	To enhance knowledge about the disorder, establish a therapeutic alliance, and reduce misunderstandings
2	Acceptance and Adaptation	Acceptance and adaptation; life balance	To shift from resistance to illness toward realistic acceptance to reduce psychological exhaustion
3	Mindfulness in the Present Moment	Hypervigilance; avoidance of social withdrawal	To reduce the anxiety associated with constant vigilance and promote attention to the present moment rather than an uncertain future
4	Values Identification	Attention to spiritual growth; faith in God	To redefine life direction based on personal values, including spirituality, rather than becoming overwhelmed by the consequences of the illness
5	Emotion and Anger Management	Control of anger and aggression; escalating chronic conflicts	To teach emotion regulation skills to reduce domestic tension and interpersonal conflict
6	Communication Skills and Assertiveness	Improvement of communication skills; interaction with other families	To replace conflict-centered and destructive relational patterns with effective communication and appropriate help-seeking
7	Managing Stigma and Rejection	Rejection and support-seeking; shame and worry	To reconstruct self-esteem and improve management of social reactions, including responses to relatives' judgments
8	Treatment Adherence and Self-Efficacy	Pursuit of treatment and persistence; passive treatment orientation	To facilitate the transition from passive or non-scientific treatment approaches toward active and professional treatment engagement
9	Planning for the Future	Uncertainty and an unpredictable future; unwanted disruptions	To reduce ambiguity through small-scale occupational and personal goal setting
10	Review and Relapse Prevention	Active care; struggling with consequences	To review the acquired skills, strengthen social support, and consolidate psychological flexibility

Instruments

Acceptance and Action Questionnaire-II (AAQ-II; Bond et al., 2011)

The Acceptance and Action Questionnaire-II (AAQ-II), developed by Bond, Hayes, Baer, Carpenter, and Zettle (2011), assesses psychological inflexibility, focusing on experiential avoidance and willingness to act despite unwanted thoughts and feelings. The questionnaire consists of 7 items (Hong et al., 2021). Items are rated on a 7-point Likert scale ranging from 1 (never) to 7 (always). Higher scores on this scale indicate lower psychological flexibility and greater experiential avoidance. The mean Cronbach's alpha across six study samples was .84 (range = .78-.88), and the 3-month and 12-month test-retest reliabilities were .81 and .79, respectively (Bond et al., 2011). In Iran, the Cronbach's alpha coefficient of the AAQ-II has been reported as .71, and its test-retest reliability as .86 (Imani, 2016). In the study by Moradian and Isanejad (2023), the Cronbach's alpha for this scale was reported to be .87. In the present study, this scale was reverse-scored to assess the level of psychological flexibility.

Data Analysis

Data analysis included descriptive (mean and standard deviation for demographics and study variables) and inferential methods. Parametric test assumptions were met, with Shapiro-Wilk confirming normal data distribution for sleep disturbance variables ($p > .05$), Levene's test confirming homogeneity of variances, and Mauchly's test verifying sphericity ($p > .05$). A mixed repeated-measures ANOVA with Bonferroni post hoc tests was then used to compare groups over time. All analyses were conducted using SPSS version 27.

3. Findings and Results

The demographic characteristics showed that the mean age of the participants was 41.3 ± 2.9 years. The gender distribution was 57.5% female and 42.5% male. The descriptive statistics of the study variables by group and assessment stage are presented in Table 3.

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Table 3

Descriptive Statistics for Psychological Flexibility across Assessment Stages

Assessment Stage	Control Group (M ± SD)	Experimental Group (M ± SD)
Pre-test	31.45 ± 1.80	29.61 ± 2.03
Post-test	31.64 ± 1.75	33.68 ± 2.03
Follow-up	31.52 ± 1.50	33.55 ± 2.18

The experimental group demonstrated a substantial increase in psychological flexibility from pre-test (M = 29.61, SD = 2.03) to post-test (M = 33.68, SD = 2.03), with these gains maintained at the three-month follow-up (M = 33.55, SD = 2.18). Conversely, the control group exhibited negligible changes across all stages, with scores remaining stable from pre-test (M = 31.45, SD = 1.80) to follow-up (M = 31.52, SD = 1.50).

Table 4

Multivariate Test (Pillai's Trace) for Time and Time ×Group Interaction Effects

Effect	Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared (η^2)
Time	0.754	56.822	2.000	37.000	0.000	0.754
Time * Group	0.725	48.697	2.000	37.000	0.000	0.725

Multivariate analysis using Pillai's Trace demonstrated a significant main effect of Time ($F(2,37) = 56.82, p < 0.001, \eta^2 = 0.754$). Furthermore, the interaction effect of Time ×Group was statistically significant ($F(2,37) = 48.70, p < 0.001, \eta^2 = 0.725$). This substantial interaction effect size indicates that approximately 72.5% of the variance in psychological flexibility scores is explained by the therapeutic intervention over time.

Table 5

Tests of Within-Subjects Effects (Greenhouse-Geisser Corrected)

Source	Correction Method	Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared (η^2)
Time	Greenhouse-Geisser	114.327	1.679	68.078	80.860	0.000	0.680
Time * Group	Greenhouse-Geisser	99.998	1.679	59.545	70.725	0.000	0.650

Following the Greenhouse-Geisser correction, the within-subjects tests revealed a significant main effect of Time ($F(1.68,63.80) = 80.86, p < 0.001, \eta^2 = 0.680$). More importantly, a significant interaction effect of Time ×Group was observed ($F(1.68,63.80) = 70.72, p < 0.001, \eta^2 = 0.650$). This confirms that the pattern of change in psychological flexibility over time differed significantly between the experimental and control groups.

Table 6

Bonferroni Post-Hoc Pairwise Comparisons for Assessment Stages

Dependent Variable	(I) Time Stage	(J) Time Stage	Mean Difference (I-J)	Standard Error	Sig.
Psychological Flexibility	Pre-test	Post-test	-2.133*	0.201	0.000
	Pre-test	Follow-up	-2.002*	0.214	0.000
	Post-test	Follow-up	0.131	0.142	1.000

Pairwise comparisons using the Bonferroni adjustment revealed that psychological flexibility significantly increased from pre-test to post-test ($MD = -2.13, p < 0.001$) and remained significantly higher at follow-up compared to pre-test ($MD = -2.00, p < 0.001$). The difference between post-test and follow-up was not statistically significant ($MD = 0.13, p = 1.000$), demonstrating that the therapeutic gains were maintained over time.

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Table 7

Adjusted Marginally Mean Scores of Psychological Flexibility by Group and Time Stage

Group	Time Stage	Adjusted Mean	Standard Error	95% Confidence Interval (Lower Bound)	95% Confidence Interval (Upper Bound)
Control	Pre-test	31.449	0.429	30.581	32.317
	Post-test	31.644	0.424	30.786	32.501
	Follow-up	31.517	0.419	30.669	32.364
Experimental	Pre-test	29.610	0.429	28.741	30.478
	Post-test	33.681	0.424	32.823	34.539
	Follow-up	33.546	0.419	32.699	34.394

The profile of adjusted means indicates that while the control group's psychological flexibility scores remained flat across stages (Pre-test = 31.45, Post-test = 31.64, Follow-up = 31.52), the experimental group exhibited a significant increase from pre-test (29.61) to post-test (33.68), which was sustained through the follow-up stage (33.55). These results confirm the stability and durability of the integrative intervention.

4. Discussion and Conclusion

The present study examined the effectiveness of an integrative psychoeducational–therapeutic package in improving psychological flexibility among patients with Bipolar II disorder. The findings demonstrated a significant change in psychological flexibility over time and, more importantly, a significant Time × Group interaction. The experimental group's mean psychological flexibility score increased from 29.61 at pretest to 33.68 at posttest and remained nearly unchanged at 33.55 during the three-month follow-up. In contrast, the control group showed only minimal fluctuations across the three assessment stages, with mean scores of 31.45 at pretest, 31.64 at posttest, and 31.52 at follow-up. The significant interaction effect, $F(1.68, 63.80) = 70.73$, $p < .001$, with a partial eta squared of .65, indicated that the improvement was not attributable merely to the passage of time, repeated assessment, or routine pharmacological care. Rather, the pattern of change was substantially associated with participation in the integrative intervention.

The large effect size obtained for the Time × Group interaction suggests that the intervention produced a clinically meaningful change in the central process targeted by the package. The significant main effect of time, $F = 80.86$, $p < .001$, $\eta^2 = .68$, showed that scores changed across the assessment stages; however, the interaction effect clarified that this change occurred primarily in the experimental group. Bonferroni comparisons further showed that psychological flexibility increased significantly from pretest to posttest and from pretest to follow-up, whereas the difference between posttest and follow-up was not statistically significant. The absence of a decline between posttest and follow-up suggests that the benefits were maintained after the structured sessions had ended. This durability is particularly important in Bipolar II disorder because the condition is recurrent, and short-term emotional improvement does not necessarily translate into stable changes in coping, self-management, or psychosocial functioning.

The results can first be explained through the multidimensional nature of psychological flexibility. Psychological flexibility involves openness to internal experiences, awareness of the present moment, cognitive distancing from thoughts, clarification of personally meaningful values, and engagement in committed action. In contrast, psychological inflexibility is reflected in experiential avoidance, cognitive fusion, behavioral rigidity, and attempts to eliminate or control distressing thoughts and emotions at any cost. The intervention addressed these processes through an integrated set of educational and therapeutic components rather than focusing on symptom reduction alone. This interpretation is consistent with the conceptualization of psychological flexibility as a context-sensitive capacity that helps individuals respond adaptively to changing internal and environmental demands (Malo et al., 2024). It is also compatible with the theoretical foundation of the Acceptance and Action Questionnaire-II, which measures experiential avoidance and psychological inflexibility as central barriers to adaptive functioning (Bond et al., 2011).

The improvement observed in the experimental group may partly be attributed to the intervention's emphasis on acceptance and adaptation. Patients with Bipolar II disorder often experience recurrent depressive symptoms,

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uncertainty about relapse, fear of losing control, and frustration about the chronic nature of the illness. Persistent efforts to suppress, deny, or escape these experiences may intensify distress and reduce engagement in treatment or meaningful activities. Acceptance-based training does not require patients to approve of or surrender to their illness; rather, it helps them discontinue unproductive struggles with internal experiences and invest their energy in workable behavior. Previous findings have linked greater psychological flexibility, mindfulness, and self-compassion with lower depression severity among patients with mood disorders (Zargar et al., 2023). The present results extend this evidence by indicating that a structured package combining acceptance with illness-specific psychoeducation can significantly enhance flexibility in patients with Bipolar II disorder.

The findings are also consistent with studies supporting Acceptance and Commitment Therapy for bipolar-spectrum conditions. Group ACT has shown preliminary effectiveness for individuals with bipolar disorder and coexisting anxiety, particularly by increasing acceptance and supporting value-guided behavior (Pankowski et al., 2017). ACT has also been found to reduce impulsivity and suicidality among clients with bipolar disorders, suggesting that flexibility-oriented interventions can influence clinically serious outcomes rather than merely producing changes in self-reported coping (El-Sayed et al., 2023). Similarly, treatment based on acceptance and commitment has improved executive functioning, psychological flexibility, and psychological well-being among men with Bipolar I disorder (Karim Soltani et al., 2025). More recent evidence has demonstrated that group-based ACT can improve cognitive emotion regulation and psychological flexibility among patients with bipolar disorder (Shi et al., 2026). The present findings align with these studies but add to them by evaluating an intervention that combined flexibility-based processes with psychoeducation, relapse prevention, sleep-related self-management, communication skills, and treatment-adherence training.

The cognitive components of the intervention may also explain the observed improvement. Patients with bipolar disorder may become fused with thoughts such as “I cannot control my life,” “another episode will ruin everything,” or “my illness defines who I am.” When such thoughts are regarded as literal truths, they can narrow behavioral options and strengthen avoidance, shame, and passivity. Cognitive defusion and flexible perspective taking help patients observe thoughts as psychological events rather than indisputable facts. This mechanism is supported by research showing associations among cognitive flexibility, theory of mind, and creative thinking in bipolar disorder (Köse & Hocaoğlu, 2025). Psychological flexibility and theory-of-mind functioning have also been associated with social functioning during remission (Çifteci et al., 2026). These findings suggest that increased flexibility may allow patients to consider alternative interpretations, modify ineffective responses, and interact more adaptively with family members and others.

The results may further be understood in relation to cognitive flexibility and the longitudinal course of bipolar symptoms. Reduced flexibility can limit the individual’s ability to shift attention, revise maladaptive appraisals, and select alternative coping responses when mood symptoms emerge. A longitudinal study of young adults with childhood-onset bipolar disorder found that cognitive flexibility was related to the subsequent course of mood symptoms and suicidal ideation (MacPherson et al., 2022). Although cognitive flexibility and psychological flexibility are not identical constructs, both emphasize adaptive adjustment in response to changing conditions. The present intervention may have strengthened this capacity by teaching participants to notice early emotional or behavioral changes, reconsider rigid interpretations, and choose responses that were more compatible with treatment goals and personal values.

Emotion regulation was another likely mechanism underlying the findings. Bipolar II disorder is associated with recurrent shifts in emotional intensity, prolonged depressive states, and difficulty managing negative affect. Individuals who perceive emotions as intolerable may resort to avoidance, suppression, impulsive action, interpersonal conflict, or social withdrawal. The intervention included emotion-management strategies alongside acceptance and mindfulness, enabling participants to experience emotions without immediately reacting to them. This explanation is consistent with evidence that psychological flexibility and cognitive emotion regulation are associated with mental health outcomes in clinical populations (Hussain et al., 2023). It also corresponds with findings that Dialectical Behavior Therapy improved both emotional regulation and cognitive flexibility among men with Bipolar I disorder (Sadeghi et al., 2025). The integration of acceptance-oriented and regulation-oriented methods may therefore have enabled participants to respond more deliberately to mood-related distress.

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Mindfulness and present-moment awareness may have contributed to the maintenance of the treatment effects. Patients with Bipolar II disorder may spend considerable time anticipating relapse, reviewing past episodes, or monitoring their internal state for signs of deterioration. Although some monitoring is clinically useful, excessive vigilance can amplify anxiety and separate the individual from present activities. Mindfulness training can help patients distinguish current experience from feared future outcomes and reduce automatic reactions to distress. A mindfulness-based psychoeducational program has been found to increase psychological flexibility and decrease perceived stress among psychiatric patients (Gabal, 2025). Furthermore, acceptance, values, and mindfulness have been shown to make differential contributions to functioning among individuals with bipolar disorder in remission (Karatepe & Aktepe, 2020). These findings support the possibility that the mindfulness component of the present package helped participants maintain flexibility after treatment by providing a skill that could be practiced independently in daily life.

Psychoeducation and illness self-management were also important elements of the intervention. A purely acceptance-based approach may not be sufficient for bipolar disorder because patients must also understand the relationship among mood symptoms, biological rhythms, medication adherence, sleep patterns, psychosocial stress, and relapse risk. By providing structured information about the disorder and helping participants monitor mood and sleep, the intervention may have reduced uncertainty and increased perceived control. Research has shown that biological rhythms are related to illness perception and cognitive flexibility among patients with bipolar disorder in remission (Kocakaya & Yetkin, 2024). Autonomic flexibility has likewise been proposed as a physiological buffer supporting mood stability in Bipolar II disorder (Purcell, 2025). Consequently, combining psychological flexibility training with sleep hygiene, mood monitoring, and relapse-prevention education may have addressed both psychological and behavioral pathways involved in mood stability.

The treatment-adherence component may have strengthened the intervention's effect by encouraging participants to adopt an active role in their care. Nonadherence in bipolar disorder may result from inadequate illness knowledge, concerns about medication, denial of the disorder, adverse effects, family beliefs, or the subjective desirability of hypomanic experiences. Family members of individuals with bipolar disorder have described misunderstandings regarding the nature of the illness and pharmacological treatment as important contributors to medication nonadherence (Mousavi et al., 2021). Psychological flexibility may support adherence by helping patients tolerate ambivalence, unpleasant side effects, stigma, or illness-related thoughts without abandoning treatment impulsively. Transitional care research has also emphasized the value of education and caregiver support in preventing relapse among people with severe mental illness (Asgharzadeh et al., 2025). Thus, the intervention's psychoeducational and adherence-focused content may have converted increased awareness into sustained treatment-related behavior.

Interpersonal and stigma-management components may also explain the findings. Psychological inflexibility is not expressed only within the individual; it can also appear as rigid conflict patterns, withdrawal, defensiveness, dependency, or avoidance of social contact. Internalized stigma may cause patients to treat negative social beliefs as accurate descriptions of themselves, thereby reducing self-worth and willingness to participate in meaningful roles. Psychological inflexibility has been linked with internalized stigma and dyadic adjustment in bipolar disorder (Güleç et al., 2026). The package's attention to assertiveness, communication, rejection, and stigma may have helped participants separate their identity from the disorder and respond more flexibly in relationships. This broader interpersonal orientation distinguishes the intervention from approaches that focus exclusively on intrapersonal acceptance.

The values and committed-action components may be particularly important in explaining why gains persisted at follow-up. During depressive periods, individuals with Bipolar II disorder may lose contact with goals, social roles, and sources of meaning. Values clarification can help patients identify life directions that remain important even when mood symptoms or uncertainty are present. Committed action then translates these values into small, realistic, and repeated behaviors. Because such behaviors can continue after formal sessions end, they may help maintain treatment gains. Research on psychological flexibility across personality-related difficulties suggests that flexible coping and adaptive behavioral adjustment are relevant to persistent emotional and interpersonal functioning (Watson, 2026). Comparative evidence from borderline personality disorder likewise indicates that psychological flexibility distinguishes clinical from healthy

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functioning (Temircan, 2025). These studies support the broader proposition that durable change requires not only symptom relief but also a more flexible pattern of responding to internal and external demands.

The integrative structure of the package may itself have been a major source of effectiveness. Bipolar II disorder involves biological, emotional, cognitive, behavioral, relational, and treatment-related challenges; therefore, a single-component intervention may not adequately address its full clinical complexity. Flexibility-oriented packages have been developed successfully for other high-stress populations, including intensive care nurses, by translating qualitative findings into structured educational and therapeutic content (Ebrahimi et al., 2024). Combined interventions have also been used to address psychological flexibility and difficult behavior in complex psychiatric presentations (Burke et al., 2024). In addition, need-based educational packages have demonstrated the potential value of tailoring intervention content to the specific experiences of a target group (Shabaninia et al., 2025). The present package similarly drew on patients' lived experiences and incorporated illness-specific needs, which may have increased its relevance, acceptability, and practical usefulness.

The current findings should also be interpreted in light of emerging research that continues to investigate ACT as a stand-alone intervention for bipolar disorder (Khafif et al., 2026). While stand-alone ACT may improve flexibility, the present results suggest that integrating ACT-consistent processes with psychoeducation and behavioral self-management may be especially appropriate for Bipolar II disorder. The stability of gains at follow-up indicates that participants may have acquired transferable skills rather than experiencing only temporary reassurance or therapist-dependent improvement. The findings therefore support a process-based and integrative model in which psychological flexibility is treated as a central therapeutic target while illness literacy, relapse prevention, biological-rhythm regulation, communication, and adherence are addressed simultaneously.

This study had several limitations. The sample was relatively small and was recruited from a single clinical center, which restricts the generalizability of the findings to patients receiving care in other regions, private settings, or community-based services. The use of convenience and purposive recruitment may also have resulted in the inclusion of participants who were more motivated to engage in psychological treatment. Psychological flexibility was measured using a self-report questionnaire, and responses may have been affected by social desirability, insight, current mood, or participants' expectations regarding treatment. The control group received treatment as usual rather than an active psychological comparison intervention, making it difficult to determine whether the observed effects were attributable specifically to the therapeutic components of the package or partly to attention, group support, and therapist contact. Although pharmacological stability was monitored, medication type, dosage, adherence, and individual biological response could not be fully controlled. Finally, the three-month follow-up period was insufficient to determine whether the gains would remain stable across later depressive or hypomanic episodes.

Future studies should evaluate the intervention in larger, multisite randomized controlled trials involving patients from different socioeconomic, cultural, and clinical backgrounds. Longer follow-up periods of six months, one year, or more are recommended to determine whether improved psychological flexibility contributes to lower relapse rates, fewer hospitalizations, stronger medication adherence, or better occupational and interpersonal functioning. Researchers should compare the integrative package with standard psychoeducation, ACT alone, cognitive-behavioral therapy, and other active interventions to identify its specific and comparative effects. Future research should also assess potential mediators, including experiential avoidance, cognitive fusion, mindfulness, emotion regulation, sleep regularity, internalized stigma, and treatment self-efficacy. Examining moderators such as age, gender, illness duration, episode history, comorbidity, medication regimen, and baseline flexibility may clarify which patients benefit most. Incorporating clinician ratings, behavioral measures, ecological momentary assessment, sleep indicators, and qualitative follow-up interviews would provide a more comprehensive understanding of the process and durability of change.

Mental health professionals may use the integrative package as an adjunct to psychiatric and pharmacological treatment for clinically stable patients with Bipolar II disorder. Implementation should involve coordination with the treating psychiatrist, routine assessment of suicide risk, monitoring of mood and sleep changes, and clear procedures for responding to emerging hypomanic or depressive symptoms. Clinicians should adapt examples, values work, communication exercises, and relapse-prevention plans to each patient's cultural background, family structure, level of insight, and functional needs. Skills should be practiced

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between sessions through brief, manageable assignments, mood and sleep records, mindfulness exercises, and value-consistent behavioral goals. Involving family members in selected psychoeducational sessions may improve shared understanding, reduce stigma, and support adherence while preserving patient autonomy. Booster sessions and periodic follow-up contacts may also help patients consolidate skills and apply psychological flexibility processes when new stressors or early warning signs emerge.

Authors' Contributions

All authors significantly contributed to this study.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

In this study, to observe ethical considerations, participants were informed about the goals and importance of the research before the start of the interview and participated in the research with informed consent.

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