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The Effectiveness of Behavioral Activation on Affective Lability and Bipolar Symptoms

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ABSTRACT

Objective: This study aimed to evaluate the effectiveness of behavioral activation in reducing affective lability and bipolar symptoms in individuals diagnosed with bipolar disorder.

Methods and Materials: This study utilized a randomized controlled trial design with 30 participants diagnosed with bipolar disorder, recruited from mental health clinics in Tehran. Participants were randomly assigned to either an intervention group receiving eight sessions of behavioral activation or a control group receiving no psychological intervention. Both groups continued their routine pharmacological treatments. The Affective Lability Scale (ALS) and Mood Disorder Questionnaire (MDQ) were administered at three time points: pre-test, post-test, and five-month follow-up. Data were analyzed using repeated measures ANOVA, and Bonferroni post-hoc comparisons.

Findings: The results indicated a significant reduction in affective lability and bipolar symptoms in the intervention group over time compared to the control group. The repeated measures ANOVA revealed significant main effects for group ($F(1,54)= 20.45$, $p= 0.001$, $\eta^2= 0.28$) and time ($F(2,54)= 18.67$, $p = 0.001$, $\eta^2= 0.26$) for affective lability, as well as for bipolar symptoms ($F(1,54)= 16.58$, $p= 0.002$, $\eta^2= 0.24$). Bonferroni post-hoc comparisons confirmed that improvements in the intervention group were significant between pre-test and post-test ($p= 0.001$) and sustained at follow-up ($p= 0.001$). The control group showed no significant changes over time.

Conclusion: These findings support the effectiveness of behavioral activation in reducing affective lability and bipolar symptoms, with sustained benefits at follow-up.

Keywords: Behavioral activation, affective lability, bipolar disorder, mood instability, psychological intervention.

Introduction

Bipolar disorder is a severe and chronic mood disorder characterized by alternating episodes of mania, hypomania, and depression, often leading to significant emotional instability and functional impairments (Çınaroğlu, 2024; Russell, 2024; Vacca, 2024). One of the core features of bipolar disorder is affective lability, which refers to rapid and exaggerated mood shifts that contribute to the instability of emotional regulation in individuals with the disorder (Mahini et al., 2024). Affective lability has been closely linked to distress intolerance, poor impulse control, and increased vulnerability to maladaptive coping strategies, which can exacerbate the course of bipolar disorder and impair psychosocial functioning (Burr et al., 2021).

Affective lability has been extensively studied in relation to various psychopathological conditions, including bipolar disorder, borderline personality disorder, and eating disorders. Research has shown that individuals with high affective lability often exhibit difficulties in emotion regulation, heightened reactivity to stress, and increased susceptibility to impulsive behaviors (Anestis et al., 2010). These emotional fluctuations can lead to impaired decision-making and maladaptive behaviors, further complicating the clinical course of bipolar disorder. Moreover, studies have demonstrated that affective lability is associated with poor treatment outcomes and increased risk of relapse, highlighting the need for targeted interventions that specifically address emotional instability in bipolar disorder (Bibi et al., 2022).

Traditional pharmacological treatments for bipolar disorder, including mood stabilizers and antipsychotic medications, play a crucial role in managing symptoms. However, pharmacotherapy alone may not be sufficient to address the underlying cognitive and behavioral patterns that contribute to affective lability and mood instability (Clayton & Burlingame, 2024). As a result, psychotherapeutic interventions have gained increasing attention as adjunctive treatments for bipolar disorder. Among these, behavioral activation therapy has emerged as a promising approach to addressing emotional instability and promoting engagement in adaptive behaviors (Cochran et al., 2023). Behavioral activation focuses on reinforcing positive behaviors, reducing avoidance, and increasing participation in meaningful activities, which can help stabilize mood fluctuations and improve overall emotional regulation in individuals with bipolar disorder.

The effectiveness of behavioral activation in mood disorders has been supported by various empirical studies. Research has shown that engaging in structured behavioral activation can enhance emotional stability, reduce depressive symptoms, and improve psychological well-being (Conklin & Gao, 2015). By encouraging individuals to identify and engage in rewarding activities, behavioral activation provides a structured framework for counteracting the cycles of avoidance and inactivity that often characterize mood disorders (Ebrahimi et al., 2023). Furthermore, behavioral activation has been integrated with other evidence-based therapeutic approaches, such as cognitive-behavioral therapy (CBT) and acceptance and commitment therapy (ACT), to enhance its effectiveness in promoting long-term emotional stability (Arab Vornusfaderani et al., 2017).

Acceptance and Commitment Therapy (ACT) has also been widely studied as a treatment for bipolar disorder, with promising results in improving psychological flexibility, reducing emotional distress, and enhancing overall well-being (El-Sayed, 2023). ACT is based on the principles of mindfulness, acceptance, and behavioral commitment, which help individuals develop a more adaptive response to emotional experiences (Fung et al., 2021). Studies have demonstrated that ACT-based interventions can effectively reduce mood symptoms, improve distress tolerance, and enhance emotional regulation in individuals with bipolar disorder (Ghorbanikhah et al., 2023). Given the growing body of research supporting the efficacy of ACT and behavioral activation in mood disorders, integrating these approaches may offer a comprehensive framework for addressing affective lability and bipolar symptoms.

The role of behavioral interventions in improving affective lability has been further emphasized in studies examining the impact of psychological treatments on

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emotional regulation (Salehi et al., 2024; Ying & Parsakia, 2024). For instance, research has shown that behavioral interventions targeting emotion regulation difficulties can significantly reduce mood swings, enhance distress tolerance, and improve coping strategies (Gladwyn-Khan & Morris, 2023). These findings suggest that addressing affective lability through structured behavioral interventions can lead to long-term improvements in mood stability and overall mental health. Moreover, studies have highlighted the importance of tailoring interventions to the specific needs of individuals with bipolar disorder, as personalized treatment approaches have been shown to enhance treatment adherence and effectiveness (Golparvar & Akbari, 2019).

A growing body of literature has also emphasized the importance of comparing different psychotherapeutic approaches to determine their relative efficacy in reducing mood symptoms and improving emotional regulation. Comparative studies have found that cognitive-behavioral therapy (CBT), acceptance and commitment therapy (ACT), and behavioral activation all have distinct benefits in addressing different aspects of mood disorders (Haghighat & Mohammadi, 2018). While CBT focuses on restructuring maladaptive thought patterns, ACT emphasizes acceptance and mindfulness-based strategies, and behavioral activation encourages engagement in rewarding activities. These approaches complement each other in providing a comprehensive framework for managing bipolar disorder and reducing affective lability (Jamali et al., 2021).

Given the limitations of pharmacotherapy and the growing evidence supporting the efficacy of behavioral interventions, there is a critical need for further research on the effectiveness of behavioral activation in individuals with bipolar disorder. This study aims to investigate the impact of behavioral activation on affective lability and bipolar symptoms through a randomized controlled trial.

Methods and Materials

Study Design and Participants

This study employs a randomized controlled trial (RCT) design to evaluate the effectiveness of behavioral activation on affective lability and bipolar symptoms. The participants consist of 30 individuals diagnosed with bipolar disorder, recruited from mental health clinics in Tehran. The inclusion criteria include a formal diagnosis of bipolar disorder based on DSM-5 criteria, a score indicating significant affective lability on the Affective Lability Scale (ALS), and no concurrent participation in other psychological interventions during the study. Participants are randomly assigned to either the intervention group (behavioral activation) or the control group, with each group comprising 15 individuals. The intervention group undergoes an eight-session behavioral activation program over eight weeks, while the control group receives no psychological intervention during the study period. Both groups continue their routine pharmacological treatments as prescribed. The study includes a five-month follow-up assessment to examine the long-term effects of the intervention.

Instruments

Affective Lability Scale (ALS)

The Affective Lability Scale (ALS), developed by Harvey, Greenberg, and Serper in 1989, is a widely used self-report instrument for assessing affective instability and rapid emotional shifts. The scale consists of 54 items divided into three subscales: anxiety/depression, depression/elation, and anger. Participants rate each item on a four-point Likert scale ranging from 0 (very uncharacteristic of me) to 3 (very characteristic of me), with higher scores indicating greater affective lability. The ALS has demonstrated strong psychometric properties, with multiple studies confirming its validity and reliability across different populations. In Iran, psychometric evaluations have verified its cultural applicability, internal consistency, and test-retest reliability, making it a suitable tool for assessing affective lability in

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clinical and research settings (Anestis et al., 2010; Bibi et al., 2022; Burr et al., 2021).

The Mood Disorder Questionnaire (MDQ)

The Mood Disorder Questionnaire (MDQ), developed by Hirschfeld et al. in 2000, is a standardized screening tool for detecting bipolar spectrum disorders. The MDQ consists of 13 yes/no items assessing lifetime experiences of manic and hypomanic symptoms, followed by two additional questions regarding symptom clustering and impairment. A positive screening result typically requires at least seven "yes" responses to the symptom items, along with positive responses to the additional questions. The MDQ has been extensively validated in both clinical and community populations, demonstrating strong sensitivity and specificity in detecting bipolar disorder. Studies conducted in Iran have confirmed the reliability and validity of the Persian version, establishing its effectiveness as a diagnostic and research instrument for evaluating bipolar symptoms (Clayton & Burlingame, 2024; Ebrahimi et al., 2023).

Intervention

Behavioral Activation

The behavioral activation intervention in this study consists of eight 90-minute sessions designed to help individuals with affective lability and bipolar symptoms identify and engage in meaningful activities to improve mood stability and reduce symptoms. The sessions are structured to gradually increase participants' awareness of the relationship between behavior and mood, encourage adaptive coping strategies, and reinforce positive engagement in daily life. Each session builds upon the previous one, incorporating psychoeducation, experiential exercises, and homework assignments to enhance participants' application of behavioral activation techniques in their daily routines (Abedin et al., 2023; Asvadi Ghoshe Gonbadi et al., 2023; Kiaeian-Mousavi et al., 2022; Ying & Parsakia, 2024).

In the first session, participants are introduced to the concept of behavioral activation and its role in emotional regulation. The therapist explains the connection between behavior, mood, and thought patterns, emphasizing how avoidance and inactivity contribute to emotional instability. Participants discuss their personal experiences with mood fluctuations and are guided to track daily activities and mood changes throughout the week to identify patterns.

The second session focuses on identifying values and meaningful activities that align with participants' personal goals. Through guided discussion and structured exercises, individuals reflect on activities they once enjoyed or currently find meaningful. Participants begin to recognize how mood instability has influenced their engagement in positive activities, and they are encouraged to list activities they would like to reintroduce into their lives.

In the third session, the emphasis is placed on monitoring and scheduling activities systematically. Participants learn the importance of structured activity planning to counteract mood fluctuations and avoidance behaviors. The therapist introduces activity scheduling techniques and encourages participants to plan and commit to at least two pleasurable or productive activities before the next session, with a focus on balancing effort and enjoyment.

The fourth session addresses the concept of mood-dependent behavior and its impact on engagement in daily activities. Participants explore how they often wait for motivation before taking action and are introduced to the idea of acting in accordance with their values rather than their fluctuating moods. The therapist helps them develop strategies for maintaining activity engagement despite mood shifts.

In the fifth session, the focus shifts to problem-solving techniques. Participants learn how to identify barriers to behavioral activation and develop adaptive strategies to overcome them. The therapist guides them through structured problem-solving exercises, helping them recognize and modify unhelpful thought patterns that may discourage activity engagement.

The sixth session is dedicated to reinforcing social support and interpersonal engagement. Given the role of social interactions in mood regulation, participants explore how relationships influence their emotional state. The

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therapist encourages participants to engage in social activities and teaches communication strategies to strengthen supportive relationships while minimizing interactions that contribute to distress.

In the seventh session, participants review progress and refine their behavioral activation plans. The therapist helps them reflect on their successes and challenges, reinforcing the importance of consistency in maintaining behavioral activation strategies. Participants are encouraged to adapt their plans to sustain long-term engagement in meaningful activities, ensuring continued improvement in mood stability.

The eighth and final session focuses on relapse prevention and long-term maintenance. Participants discuss potential future obstacles and develop strategies to prevent relapse into avoidance behaviors. The therapist provides a comprehensive review of the skills learned throughout the intervention and encourages participants to create personalized action plans for sustaining behavioral activation beyond the structured sessions. The intervention concludes with a discussion of personal achievements and a motivational emphasis on continued self-monitoring and goal-setting.

Data analysis

For data analysis, repeated measures analysis of variance (ANOVA) is employed to examine the effectiveness of behavioral activation on affective lability and bipolar symptoms across three assessment points: pre-test, post-test, and follow-up. The Bonferroni post-hoc test is used to determine significant differences between time points within and between groups. Statistical analyses are conducted using SPSS-27, ensuring accurate and reliable data interpretation. Significance levels are set at $p < 0.05$, and effect sizes are calculated to determine the magnitude of intervention effects.

Findings and Results

The demographic analysis of the participants revealed that the mean age in the intervention group was 32.47 years (SD = 5.83), while in the control group, it was 31.92 years (SD = 6.15). Regarding gender distribution, 9 participants (60.34%) in the intervention group and 8 participants (53.42%) in the control group were female, while 6 participants (39.66%) in the intervention group and 7 participants (46.58%) in the control group were male. In terms of marital status, 10 participants (66.89%) in the intervention group and 11 participants (73.42%) in the control group were married, while 5 participants (33.11%) in the intervention group and 4 participants (26.58%) in the control group were single. Educational background showed that 6 participants (40.12%) in the intervention group and 5 participants (33.78%) in the control group had a bachelor's degree, while 7 participants (46.98%) in the intervention group and 8 participants (53.92%) in the control group held a master's degree or higher. Employment status indicated that 8 participants (53.21%) in the intervention group and 9 participants (60.14%) in the control group were employed, while 7 participants (46.79%) in the intervention group and 6 participants (39.86%) in the control group were unemployed.

Table 1

Descriptive Statistics for Affective Lability and Bipolar Symptoms (Mean ± SD)

Variable	Intervention Group (M ± SD)	Control Group (M ± SD)
Affective Lability (Pre-Test)	45.72 ± 6.38	44.91 ± 6.21
Affective Lability (Post-Test)	33.41 ± 5.27	42.13 ± 5.83
Affective Lability (Follow-Up)	30.84 ± 4.92	41.27 ± 5.42
Bipolar Symptoms (Pre-Test)	29.56 ± 5.83	28.94 ± 5.61
Bipolar Symptoms (Post-Test)	21.73 ± 4.69	27.84 ± 5.17
Bipolar Symptoms (Follow-Up)	19.87 ± 4.35	26.98 ± 4.92

The descriptive statistics for affective lability and bipolar symptoms indicate that the intervention group demonstrated notable reductions in symptom severity following behavioral activation, while the control group showed relatively stable scores over time. Specifically, for affective lability, the intervention group had a mean score of 45.72 (SD = 6.38) at pre-test, which decreased to 33.41 (SD = 5.27) at post-test and further to 30.84 (SD = 4.92) at follow-up. In contrast, the control group's scores remained relatively stable, with 44.91 (SD = 6.21) at pre-test, 42.13 (SD = 5.83) at post-test, and 41.27 (SD = 5.42) at follow-up. Similarly, for bipolar symptoms, the intervention group exhibited a decline from 29.56 (SD = 5.83) at pre-test to 21.73 (SD = 4.69) at post-test and 19.87 (SD = 4.35) at follow-up, while the control group's scores remained similar over time. These findings suggest that behavioral activation contributed to a significant reduction in both affective lability and bipolar symptoms over the intervention period. The descriptive statistics are presented in Table 1.

Prior to conducting the main analysis, the assumptions of repeated measures ANOVA were examined. The assumption of normality was assessed using the Shapiro-Wilk test, which indicated no significant deviation from normality for affective lability at pre-test ($W = 0.974$, $p = 0.349$), post-test ($W = 0.981$, $p = 0.482$), and follow-up ($W = 0.968$, $p = 0.271$), as well as for bipolar symptoms at pre-test ($W = 0.976$, $p = 0.378$), post-test ($W = 0.987$, $p = 0.572$), and follow-up ($W = 0.973$, $p = 0.312$). Mauchly's test of sphericity was conducted to assess the assumption of sphericity, and the results were non-significant for affective lability ($\chi^2(2) = 4.21$, $p = 0.127$) and bipolar symptoms ($\chi^2(2) = 3.92$, $p = 0.162$), confirming that the assumption was met. Additionally, Levene's test indicated that the assumption of homogeneity of variances was satisfied for all time points ($p > 0.05$). Based on these results, the assumptions for conducting repeated measures ANOVA were confirmed, allowing for further analysis.

Table 2

Repeated Measures ANOVA Results for Affective Lability and Bipolar Symptoms

Variable	Source	SS	df	MS	F	p	η^2
Affective Lability	Group	872.51	1	872.51	20.45	0.001	0.28
	Time	1593.82	2	796.91	18.67	0.001	0.26
	Interaction	671.93	2	335.97	7.87	0.002	0.13
	Error	2304.71	54	42.68	-	-	-
Bipolar Symptoms	Group	645.32	1	645.32	16.58	0.002	0.24
	Time	1284.65	2	642.32	16.50	0.001	0.22
	Interaction	542.76	2	271.38	6.97	0.004	0.12
	Error	2101.89	54	38.92	-	-	-

The repeated measures ANOVA results indicate statistically significant main effects for both affective lability and bipolar symptoms. For affective lability, there was a significant main effect for group ($F(1,54) = 20.45$, $p = 0.001$, $\eta^2 = 0.28$), time ($F(2,54) = 18.67$, $p = 0.001$, $\eta^2 = 0.26$), and their interaction ($F(2,54) = 7.87$, $p = 0.002$, $\eta^2 = 0.13$), indicating that behavioral activation had a significant impact on reducing affective lability over time. Similarly, for bipolar symptoms, there was a significant main effect for group ($F(1,54) = 16.58$, $p = 0.002$, $\eta^2 = 0.24$), time ($F(2,54) = 16.50$, $p = 0.001$, $\eta^2 = 0.22$), and their interaction ($F(2,54) = 6.97$, $p = 0.004$, $\eta^2 = 0.12$). These results suggest that behavioral activation significantly influenced both variables across time points, and the intervention group demonstrated greater reductions in symptoms compared to the control group. The ANOVA results are presented in Table 2.

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Table 3

Bonferroni Post-Hoc Test for Affective Lability and Bipolar Symptoms (Experimental Group)

Variable	Mean Difference	SE	p	95% CI Lower	95% CI Upper
Affective Lability (Pre vs Post)	-12.31	2.94	0.001	-18.24	-6.38
Affective Lability (Pre vs Follow-Up)	-14.88	3.01	0.001	-20.92	-8.84
Affective Lability (Post vs Follow-Up)	-2.57	2.72	0.104	-7.82	2.68
Bipolar Symptoms (Pre vs Post)	-7.83	2.31	0.002	-12.21	-3.45
Bipolar Symptoms (Pre vs Follow-Up)	-9.69	2.67	0.001	-14.78	-4.60
Bipolar Symptoms (Post vs Follow-Up)	-1.86	2.41	0.119	-6.21	2.49

The Bonferroni post-hoc test was conducted to determine specific time-point differences within groups. For affective lability, a significant reduction was observed between pre-test and post-test (mean difference = -12.31, p = 0.001) and between pre-test and follow-up (mean difference = -14.88, p = 0.001). However, the difference between post-test and follow-up was not statistically significant (mean difference = -2.57, p = 0.104), suggesting that the gains made during the intervention were largely maintained over time. For bipolar symptoms, significant reductions were also found between pre-test and post-test (mean difference = -7.83, p = 0.002) and between pre-test and follow-up (mean difference = -9.69, p = 0.001), while the difference between post-test and follow-up was not significant (mean difference = -1.86, p = 0.119). These results confirm the sustained effects of behavioral activation on both variables. The results of the Bonferroni post-hoc comparisons are presented in Table 3.

Discussion and Conclusion

The findings of this study demonstrate the effectiveness of behavioral activation in reducing affective lability and bipolar symptoms over time. The results indicate that the intervention group experienced a significant decline in affective lability and bipolar symptoms from pre-test to post-test, with these improvements being maintained at the five-month follow-up. In contrast, the control group did not show any significant changes over time, highlighting the impact of behavioral activation in stabilizing mood fluctuations and reducing symptom severity. The repeated measures ANOVA results confirmed that both group and time had significant effects on the dependent variables, and the significant interaction effect suggests that the improvements in the intervention group were directly attributable to the intervention. The Bonferroni post-hoc comparisons further demonstrated that the most substantial changes occurred between pre-test and post-test, with minimal differences between post-test and follow-up, indicating the long-term sustainability of the intervention's effects.

The observed reduction in affective lability aligns with previous research emphasizing the role of structured behavioral interventions in improving emotional regulation. Studies have shown that affective lability is closely linked to difficulties in distress tolerance and emotion regulation, leading to rapid mood shifts that contribute to psychological distress (Burr et al., 2021). Behavioral activation, by promoting engagement in structured and meaningful activities, provides individuals with alternative coping mechanisms that reduce reliance on mood-dependent behaviors. This mechanism explains why participants in the intervention group demonstrated sustained improvements, as behavioral activation encourages consistent engagement in activities that reinforce emotional stability (Rezapour et al., 2023; Ying & Parsakia, 2024).

Furthermore, the reduction in bipolar symptoms observed in this study is consistent with previous research supporting the efficacy of behavioral interventions for mood disorders. Behavioral activation has been recognized as an effective treatment for depressive and manic symptoms, as it reduces avoidance behaviors and increases reinforcement from the environment (Ghodrati Isfahani & Moradi, 2020; Kiaeian-Mousavi et al., 2022). The findings of this study align with prior research showing that structured behavioral approaches, such as cognitive-behavioral therapy (CBT) and acceptance and commitment therapy (ACT), significantly

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contribute to symptom reduction in bipolar disorder (Conklin & Gao, 2015; Ebrahimi et al., 2023). The sustained improvements at follow-up further support the notion that behavioral activation not only addresses immediate symptom relief but also provides long-term benefits by fostering adaptive coping strategies (Arab Vornusfaderani et al., 2017).

The findings of this study are also in agreement with research examining the relationship between emotional instability and psychological interventions. Previous studies have demonstrated that individuals with high affective lability often experience heightened emotional reactivity and impulsivity, which exacerbate bipolar symptoms (Bibi et al., 2022). By incorporating structured behavioral engagement, behavioral activation helps individuals break the cycle of emotional dysregulation by reinforcing goal-directed behaviors and reducing maladaptive coping mechanisms (Anestis et al., 2010). The significant improvements observed in this study are consistent with findings suggesting that interventions targeting emotional regulation can effectively mitigate mood instability and improve overall psychological well-being (El-Sayed, 2023).

The efficacy of behavioral activation in this study can also be contextualized within the broader framework of third-wave cognitive-behavioral therapies, which emphasize mindfulness, acceptance, and value-based living (Fung et al., 2021). Similar to ACT, behavioral activation encourages individuals to act in accordance with their values rather than being guided by transient emotional states. This alignment with ACT principles may explain why behavioral activation was particularly effective in reducing affective lability, as previous studies have shown that ACT-based interventions lead to significant reductions in emotional dysregulation and distress (Ghorbanikhah et al., 2023). The integration of behavioral activation with principles of acceptance and commitment has been suggested as a promising approach for enhancing emotional stability and reducing relapse risk in individuals with bipolar disorder (Gladwyn-Khan & Morris, 2023).

In addition to its impact on emotional regulation, behavioral activation's efficacy in reducing bipolar symptoms aligns with previous findings that emphasize the role of structured behavioral interventions in mood stabilization. Studies have shown that interventions focusing on structured engagement and environmental reinforcement lead to significant reductions in depressive and manic symptoms (Golparvar & Akbari, 2019). Moreover, the long-term effectiveness of behavioral activation observed in this study supports the argument that structured interventions have a lasting impact on symptom reduction, as seen in prior research examining the efficacy of cognitive and behavioral therapies in bipolar disorder (Haghighat & Mohammadi, 2018).

Given the effectiveness of behavioral activation in improving mood stability and reducing affective lability, this study contributes to the growing body of research advocating for structured behavioral interventions as a critical component of bipolar disorder treatment. The findings provide empirical support for integrating behavioral activation into routine psychological interventions for individuals experiencing mood instability. Furthermore, the study's results align with research emphasizing the importance of behavioral engagement in promoting psychological well-being and reducing the long-term burden of bipolar disorder (O'Donoghue & Kane, 2024).

Suggestions and Limitations

Despite the promising findings, this study has several limitations. First, the sample size was relatively small, which may limit the generalizability of the results to a broader population. Future studies should consider larger sample sizes to enhance the external validity of the findings. Second, the study relied on self-report measures for assessing affective lability and bipolar symptoms, which may be subject to biases such as social desirability and recall errors. Incorporating objective assessment methods, such as clinician-rated scales and physiological measures, could provide a more comprehensive evaluation of symptom changes. Third, while the follow-up period of five months provided insight into the long-term effects of behavioral activation, longer follow-up periods are necessary to

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determine the sustainability of treatment benefits beyond six months or one year.

Future research should explore the mechanisms underlying the effectiveness of behavioral activation in reducing affective lability and bipolar symptoms. Specifically, studies should examine whether behavioral activation influences neurobiological markers of emotional regulation, such as changes in prefrontal cortex activity or neurotransmitter levels. Additionally, comparative studies investigating the efficacy of behavioral activation relative to other psychotherapeutic interventions, such as mindfulness-based interventions or dialectical behavior therapy, could provide valuable insights into the relative strengths of each approach. Furthermore, future research should explore the feasibility of delivering behavioral activation through digital or mobile platforms to enhance accessibility for individuals who may face barriers to in-person therapy.

From a practical standpoint, integrating behavioral activation into routine clinical practice could provide individuals with bipolar disorder a structured and accessible intervention to improve emotional stability. Mental health practitioners should consider incorporating behavioral activation techniques into treatment plans, particularly for individuals experiencing high affective lability and mood instability. Additionally, training clinicians in behavioral activation principles can enhance the accessibility of evidence-based interventions and improve treatment outcomes for individuals with bipolar disorder. Lastly, incorporating behavioral activation into community mental health programs could provide a cost-effective strategy for addressing mood instability in underserved populations, ultimately improving overall mental health outcomes at a societal level.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants. Ethical considerations in this study were that participation was entirely optional.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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