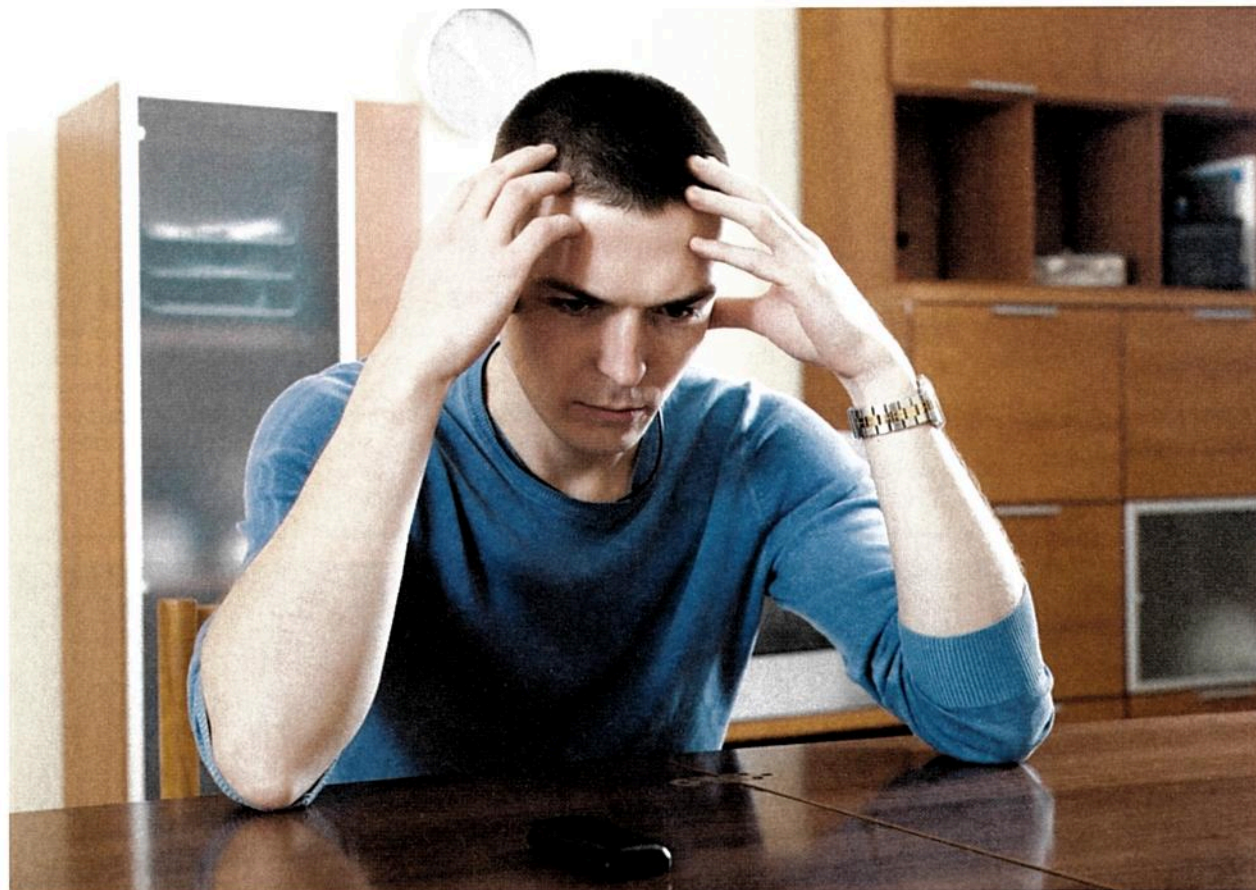
● Bipolar II disorder

Raising awareness of bipolar II disorder

The lesser known of this group of disorders, bipolar II disorder, has finally been put in the spotlight by actress Catherine Zeta-Jones... and it's about time, writes **Dr Richard Blennerhassett**, Clinical Director of Saint John of God Hospital



Bipolar II disorder, compared with bipolar I disorder, has a more chronic course, significantly more major and minor depressive episodes

In April 2011, Catherine Zeta Jones was admitted to the Silverhill Hospital in Connecticut and an announcement was made that she was suffering from bipolar II disorder. She had been under marked stress during the previous months following her husband Michael Douglas' diagnosis with throat cancer in 2010.

Little had previously been heard of this condition outside of psychiatric settings. Bipolar I disorder, in contrast, is well recognised. It is characterised by episodes of mania alternating with depression, and affects more than 1 per cent of the population.

Bipolar II disorder, in contrast, is characterised by recurrent episodes of depressive illness alternating with periods of mild mania, so called 'hypomania', and as such may less easily come to attention.

It was first described in 1976, but only introduced into the official classification manual of the American Psychiatric Association, the Diagnostic and Statistical Manual of Mental Disorders (DSM), in 1994. It is less easily recognised than bipolar I, yet also affects around 1 per cent of the population.

The following is an outline of the DSM 5 criteria for a hypomanic episode:

A. A distinct period of abnormally and persistently elevated, expansive or irritable mood, and an abnormal increase in activity or energy lasting at least four consecutive days.

B. Alongside the abnormal mood, the presence of three of the following symptoms, or four if the mood is only irritable, have persisted. These symptoms represent a noticeable change from usual behaviour;
1) Inflated self-esteem or grandiosity;
2) Decreased need for sleep, e.g. feels rested after only three hours of sleep;
3) More talkative than usual, or pressure to keep talking;
4) Flight of ideas or subjective experience that thoughts are racing;
5) Distractibility;
6) Activity in the work or social sphere – psychomotor agitation may be present;
7) Excessive involvement in activities that have a high potential for painful consequences, such as engaging in unrestrained buying sprees, sexual indiscretions or foolish business investments.

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to necessitate hospitalisation.

F. The episode is not attributable to the physiological effects of a substance.

Psychotic features

The difference between hypomania and mania is one of degree. In hypomania, the episodes are short lived, generally of a few days' duration. Psychotic features are absent and they don't cause a level of impairment such that hospitalisation is necessary. Nonetheless, they may cause significant disruption in a person's life.

Bipolar II disorder, in DSM VI, may be diagnosed if a person has met criteria for at least one hypomanic episode and at least one major depressive episode. They must never have had a manic episode. If criteria for mania has been met, the diagnosis is bipolar I disorder, which is more easily recognised. Bipolar I was previously termed manic-depressive psychosis.

Bipolar II disorder is difficult to spot. After all, people don't go to a doctor when they feel well, so such short episodes of hypomania may not be noted. In contrast, the person is likely to present to the doctor when they are feeling depressed and not functioning, and in such situations they are unlikely to mention their period of hypomania.

The situation can then arise that the person is diagnosed as having a depressive disorder rather than a bipolar disorder, and treated on this basis.

Does it matter? After all, depression is a common aspect of bipolar disorder, whether it is bipolar I or bipolar II. There has been an increasing focus on the presence of depression in bipolar disorder in recent years. In bipolar I – the more usual manic depressive presentation – a study that followed the weekly history of patients with this condition over 13 years, found that the patients were ill with depression for around 30 per cent of weeks compared to being ill with manic symptoms for around 15 per cent of the total weeks.

In the same study, looking at patients with a bipolar II condition, that is recurrent depressive episodes alternating with episodes of hypomania, patients experienced depressive symptoms over 50 per cent of the weeks of the follow up, compared with just 3 per cent of weeks suffering from hypomanic symptoms.

Bipolar II disorder compared with bipolar I disorder has a more chronic course, significantly more major and minor depressive episodes and shorter periods of wellness between episodes. Depression, indeed, is the main problem in both, but more so in bipolar II. There is also a higher risk of suicide over the lifetime associated with the latter.

There are limited studies on the course and treatment of bipolar II due to its relatively recent recognition. It is easy to miss in general practice settings and indeed in psychiatric outpatient clinics, unless it is looked for. It is often relatives or friends of the person who may draw attention to the periods of high behaviour, rather than the person themselves.

Clues to the presence of bipolar II disorder:

1. It is often a friend or family member who may contact the general practitioner.
2. Consider a patient presenting with depression at a younger age.
3. Patients with recurrent episodes of depression that are responding poorly to treatment
4. A family history of bipolar disorder.

A study, conducted in general practice in Britain of patients considered to have depressive disorder, concluded that up to 20 per cent of this group may have an undiagnosed bipolar disorder. These findings were similar to other studies in international settings.

Treatment:

The importance of recognising bipolar II disorder is that its treatment is different from recurrent depressive disorder – that is, a patient having repeated episodes of depression, but without any hypomanic or manic features.

In terms of medication, anti-depressants on their own may not be particularly helpful in this condition. They may not be effective and there is danger that they can cause the person to swing into hypomania.

The approach, therefore, is to use a mood stabiliser in a similar way to bipolar I disorder, with the common agents here being lithium and the anti-convulsant lamotrigine, sodium valporate and Tegretol (carbamazepine).

There is much less research in the treatment of bipolar II disorder than for bipolar I, and treatment recommendations are often derived from studies on bipolar I disorder.

The strongest evidence in regard to treatment is for lithium. Lamotrigine may have a particular role to play in the treatment of bipolar II disorders as it helps to prevent depressive relapses.

If an anti-depressant is used, it is best to combine it with a mood stabiliser. By definition, psychotic features are absent in bipolar II disorder, nonetheless the anti-psychotic medication quetiapine may be helpful in this condition due to its anti-depressant properties.

Alongside medication, psychological interventions, e.g. cognitive behavioural therapy (CBT) and participation in a wellness recovery programme, through which a person learns to deal with the stresses in their lives, are helpful in its management.

● **Catherine Zeta-Jones** had a further episode of illness in 2013 that resulted in her readmission to hospital. Speaking of her experience of bipolar II disorder, she has said: "It is a disorder that affects millions of people and I am one of them. If my revelation of having dipolar II disorder encouraged one person to seek help, then it is worth it."

Summary of treatment of bipolar II disorder:

1. Establish diagnosis; enquire about episodes of hypomania in patients with depressive episodes.
2. Be cautious with anti-depressant medication – SSRIs are probably less likely to rise to hypomania than combination agents such as venlafaxine or duloxetine. If the condition is troublesome, refer for psychiatric assessment.
3. More complex cases will likely require a mood stabiliser, an anti-psychotic medication, particularly quetiapine, psychological treatment with CBT and participation in a wellness recovery programme.