

Managing bipolar II disorder in the community

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Bipolar II disorder has a significant prevalence and presents considerable risks in terms of impairment, social indiscretion and suicide. It can be readily diagnosed if appropriate criteria are respected, and its management involves a triad of medication, development of a wellbeing plan and psychoeducation. Most people with the condition can be primarily managed by their GP and do well.

This article is an abstract of a more detailed monograph that focuses on several issues addressed here and reflects the author's interpretation of the literature and clinical observations in managing patients with bipolar II disorder over time.¹

Types of bipolar disorder

The bipolar disorders are marked by distinct oscillations in mood states. There are three principal bipolar disorders. Bipolar I and II have a base of hypomanic or manic features during the elevated phase and generally share melancholic features in the depressive phase. However, people with a bipolar I disorder are psychotic when 'high' and a small percentage of these patients have episodes of psychotic depression during the depressed phase.

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People with bipolar II disorder are never psychotic in the manic phase and very rarely so in the depressed phase. Bipolar III disorder is an applicable diagnosis when a patient develops hypomanic or manic symptoms after the introduction, rapid increase in dose or rapid cessation of an antidepressant, but these symptoms can also occur in response to a number of other drugs. It is likely that in a certain percentage of such cases the

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exposure drug has brought out a bipolar condition in someone who is so predisposed but in many other instances it is an iatrogenic reaction.

Community estimates in western countries generally quantify a lifetime risk of a bipolar II disorder at around 0.5% but, in the author's opinion, the true rate is closer to 3%, with the lower figure reflecting limitations to *Diagnostic and*

KEY POINTS

- Bipolar II disorder has a significant prevalence and presents considerable risks for the patient.
- Of late, Australian GPs have successfully taken up the assessment and management of patients with depression.
- Therefore, there is a strong argument for GPs to feel comfortable about diagnosing and initially managing those with a bipolar II condition as well.
- Management of bipolar II disorder involves a triad of medication, development of a wellbeing plan and psychoeducation.

Statistical Manual of Mental Disorders (DSM-5) criteria as detailed below.

The author believes that Australian GPs have taken up the assessment and management of depression well in the past two decades, and there is a strong argument for them to feel comfortable about diagnosing and initially managing those with a bipolar II condition as well.

Diagnosis

As most patients with a bipolar II disorder present to their GP during the depressed phase (generally melancholic in type, as noted earlier), all patients with depression should be screened for the possibility of a bipolar disorder. After obtaining details about their depressive symptoms, it is suggested that GPs ask the patient, 'Do you have times when you are neither depressed nor in a normal mood state but feel highly energised and wired?' (the terms 'energised' and 'wired' going to the heart of a hypomanic or manic episode).

If these initial probe questions are not affirmed, it may be helpful to ask one or two additional screening questions, using synonyms for 'energised' and 'wired' and, if these are denied, you may feel relatively comfortable about excluding a bipolar disorder. If the probe question is affirmed, you can follow up with a series of specific questions (Box). Those with a true bipolar II condition will acknowledge most of the symptoms described in these specific questions but deny any psychotic features.

Next, ask whether there was a 'trend break' when such symptoms appeared and became distinctive; most patients will report the onset of such 'highs' in adolescence or early adulthood. Then, ask about the average length of 'highs' and depressive episodes. Also pursue a family history of depression or bipolar disorder. About 80% of patients with a true bipolar II condition report such a history in first- and/or second-degree relatives, while about 10% report a family history of suicide.

As noted earlier, most people with a bipolar II disorder experience episodes of melancholic depression; therefore, weight such features (along with the hypomanic symptoms) in making the diagnosis. Key features of melancholic depression include a severely anhedonic and nonreactive depressive mood, anergia (particularly having difficulty in getting out of bed), 'foggy' (impaired) concentration and diurnal variation (with mood and energy worse in the mornings).

Although bipolar II disorder is generally positioned as a 'milder' condition than bipolar I, the suicide rate is higher among patients with bipolar II disorder, probably reflecting the precipitous descent from a 'high' into a depressive episode experienced by these patients (compared with a slower mood drop in those with a bipolar I disorder), and the individual dreading going back to such a state.

As noted, DSM-5 criteria effectively underestimate the likelihood of bipolar II disorder. First, DSM-5 requires that the hypomanic episodes last four or more days, with that impost reflecting opinion rather than empirical studies. Research has shown that many people with a true bipolar II disorder will have episodes lasting hours or a couple of days only. If the DSM-5 duration criterion is imposed, up to 60% of people with a true bipolar II disorder will not receive the diagnosis.

Second, DSM-5 requires that there must be a level of impairment – at variance with the evidence that up to 70% of people with a bipolar II condition report improved performance, which explains why so many people with a bipolar II disorder are highly successful and reach the heights of their profession (including six former British prime ministers²).

Management

Managing a bipolar II state has three principal components: medication, the development of a stay-well plan and psychoeducation.

Medication

In terms of medication, most international treatment guidelines recommend a mood stabiliser, with lithium and lamotrigine the two most commonly nominated stabilisers. In the author's view, lamotrigine is the drug of choice and has a distinctively superior cost-benefit ratio to lithium in managing those with a bipolar II disorder. Lithium has a number of significant side effects (including weight gain, tremor and a deceptively common significant cognitive impairment) and requires close monitoring to ensure that thyroid and renal function are not compromised.

As most patients with a bipolar II disorder present to their GP during the depressed phase, all patients with depression should be screened for a possible bipolar disorder.

However, there are several nuances to lamotrigine prescription. The key concern is that it might cause allergic responses such as Stevens-Johnson syndrome (SJS). To avert such a risk it is strongly recommended that lamotrigine be started at a dose of 25 mg every night for one week, and increased by 25 mg a week to a maximum of 200 mg as the target endpoint (this off-label dosage is based on the author's practice for the past 10 years, and most psychiatrists work to a similar schedule). However, about 10% of patients will need only 100 mg, 10% will need up to 300 mg and 5% may need up to 400 mg. The risk of SJS is forewarned by a rash occurring on any part of the body; therefore, the patient should be instructed to cease lamotrigine immediately if such a rash occurs. The occurrence of a rash is uncommon (found in five to 10% of cases) and when it does occur, it generally appears in the first few weeks.

Lamotrigine can also cause toxic epidermal necrolysis (TEN) and drug reaction involving eosinophilia and

systemic symptoms (DRESS) – severe reactions that, albeit very rare, may require hospitalisation. Another important consideration, based on the author's personal observation, is that the branded version of the drug should be prescribed as many of the generic preparations appear to have either insufficient or too much lamotrigine. Many patients who, after years of successful management on branded lamotrigine, have been encouraged by pharmacists to take a generic formulation either assume that the medication must have 'pooped out' (become ineffective), or develop a late skin reaction – indicating insufficient and excessive real doses, respectively.

Apart from the risk of rash, side effects of branded lamotrigine are extremely rare, and the prescriber can expect about 70% of patients will report that the medication has stabilised their mood and they have no significant side effects (including no weight gain or sexual dysfunction) – a profile that is quite rare for psychotropic medications.

If lamotrigine fails, then lithium and sodium valproate are the next most commonly recommended mood stabilisers, although the latter should never be prescribed for women in their years of fertility in light of risking induction of polycystic ovarian syndrome. In a small percentage of patients, selective serotonin reuptake inhibitors and serotonin-norepinephrine reuptake inhibitors can achieve mood stabilisation as monotherapies (with several studies showing their utility), although they may become ineffective after months or several years.

For those patients experiencing breakthrough episodes of depression, the addition of an antidepressant should be considered (although antidepressants can occasionally flip the person into a high or a 'mixed state'). For breakthrough hypomanic episodes that do not respond to nondrug strategies, an atypical antipsychotic can be useful when prescribed at a low dose and is usually only required for a brief period.

SCREENING QUESTIONS FOR A POSSIBLE BIPOLAR DISORDER

All patients with depression should be screened for the possibility of a bipolar disorder. It is suggested that you ask an initial probe question along the lines of: ‘Do you have times when you are neither depressed nor in a normal mood state but feel “highly energised” and “wired”?’ If this is affirmed, you can follow up by asking the patient a series of specific questions as below.

At such times, do you:

- Talk more?
- Talk over people?
- Become louder in conversation?
- Spend more money?
- Have increased libido?
- Need less sleep and not feel tired?
- Become verbally or socially indiscreet?
- Feel more creative?
- Feel more happily grandiose? (although 20% feel ‘snappy’ rather than ‘happy’)
- Feel ‘bulletproof’ or invulnerable?
- Note that your levels of anxiety or worry disappear, or are considerably less?
- Feel that you can achieve great things?
- Become irritable or angry in a disinhibited manner?
- Take more risks?
- Ever experience delusions or hallucinations?

A stay-well plan

With respect to nondrug strategies, the development of a stay-well plan is central in managing bipolar II disorder. In essence, the patient is trained to use a daily mood chart to identify their early warning signs and triggers for depressive or hypomanic episodes, and to develop a plan for preventing the episode getting out of control and creating ‘collateral damage’. Early warning signs

include sleep disruption, the person becoming energised or showing other hypomanic symptoms, increasing their level of alcohol and/or drugs (many of which fuel highs) or being unusually argumentative.

The patient should also be encouraged to develop a wellbeing plan, which is best undertaken when their mood is stable and in conjunction with a relative or friend whom they trust. The plan includes the patient accepting that the other person can alert them to the risk of a mood swing being observed and agreeing that certain actions can be employed when early warning signs and risk factors are in play, especially if the patient’s mood state advances to being noncompliant.

If the Diagnostic and Statistical Manual of Mental Disorders duration criterion is imposed, up to 60% of people with a true bipolar II disorder will not receive the diagnosis.

Psychoeducation

There are a number of psychological therapies that are advocated for treating patients with bipolar disorder including cognitive behavioural therapy, interpersonal and social rhythm therapy, and family-focused therapy, but these generally involve ‘fitting’ the patient to such a psychological treatment or paradigm, which is usually more relevant for the nonbiological depressive and anxiety states. Thus, it is more effective to implement a program in which the therapist (generally a skilled psychologist with extensive experience in managing bipolar disorder) works with the patient or, ideally, a group of patients, with bipolar II disorder to provide them with education about the condition, focusing on triggers, early warning signs, treatment options and psychological strategies that may be specifically beneficial.

Conclusion

GPs should feel comfortable in diagnosing and initiating management for people with a bipolar II disorder. If the patient does not respond well to the first treatment choice, then referral to a psychiatrist with skills in managing bipolar disorder would be the next step. Such management is extremely rewarding as many patients state their appreciation for ‘getting their life back’.

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References

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2. Davidson MD. Downing Street blues: a history of depression and other mental afflictions in British prime ministers. Jefferson, NC: McFarland; 2011.

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