Facts about Bipolar II Disorder

What is Bipolar II Disorder?
Bipolar disorder II is a major psychiatric disorder in which the person experiences occasional episodes of hypomania. Persons with this disorder also experience episodes of extremely low mood (depression). In between these extremes, the person's mood may be normal.

Roughly 60%-70% of the hypomanic episodes in Bipolar II disorder occur immediately before or after a Major Depressive episode. Completed suicide (usually during Major Depressive Episodes) is a significant risk, occurring in 10% -15% of persons with Bipolar II Disorder.

How Common is Bipolar Disorder?
About one in every 200 hundred people (0.5 percent) develops bipolar II disorder some time during his or her life.

How is the Disorder Diagnosed?
Bipolar II disorder can only be diagnosed by a clinical interview. The purpose of this interview is to determine whether the client has experienced specific "symptoms" of the disorder for a sufficiently long period of time (4 days for hypomania). In addition to conducting the interview, the diagnostician must make sure other physical problems are not present that could produce symptoms similar to those found in bipolar disorder, such as a brain tumor or alcohol or drug abuse. Bipolar II disorder *cannot* be diagnosed with a blood test, an X ray, a CAT scan, or any other laboratory test.

There are two broad types of symptoms typically experiences by persons with bipolar II disorder: hypomanic symptoms and depressive symptoms. The diagnosis of bipolar disorder requires that the person has experienced a major depressive episode, a period of at least two weeks in which symptoms of depression predominate and hypomania, that is, a period of a least 4 days in which hypomanic symptoms have been present to a significant degree. There is no psychosis and the depression and hypomania does not happen at the same time (mixed). If the person has experienced only symptoms of depression, but not mania, he or she is given a diagnosis of major depression, rather than bipolar disorder.

Symptoms of Hypomania
In general, the symptoms of mania involve an excess in behavioral activity, mood states (in particular, irritability or positive feelings), and self-esteem and confidence.

Euphoric or Expansive Mood. The client's mood is abnormally elevated; for example, he or she is extremely happy or excited (euphoria). The person may tend to talk more and with greater enthusiasm or emphasis on certain topics (expansiveness).

Irritability. The client is easily angered or persistently irritable, especially when others seem to interfere with his or her plans or goals, however unrealistic they may be.

Inflated Self-Esteem or Grandiosity. The client is extremely self-confident and may be unrealistic about his or her abilities (grandiosity). For example, the client may believe he or she is a brilliant artist or inventor, a wealthy person, a shrewd businessperson, or a healer when he or she had no special competence in these areas.

Decreased Need for Sleep. Only a few hours of sleep are needed each night (such as less than four hours) for the client to feel rested.

Talkativeness. The client talks excessively and may be difficult to interrupt. The client may jump quickly from one topic to another (called flight of ideas), making it hard for others to understand.

Racing Thoughts. Thoughts come so rapidly that the client finds it hard to keep up with them or express them.

Distractibility. The client's attention is easily drawn to irrelevant stimuli, such as the sound of a car honking, outside on the street.

Increased Goal-Directed Activity. A great deal of time is spent pursuing specific goals, at work, school, or sexually.

Excessive Involvement in Pleasurable Activities with High Potential for Negative Consequences. Common problem areas include spending sprees, sexual indiscretions, increased substance abuse, or making foolish business investments. Not all symptoms must be present for the client to have had a depressive syndrome.

Symptoms of Depression

Depressive symptoms reflect the opposite end of the continuum of mood from manic symptoms, with a low mood and behavioral inactivity as the major features.

Depressed Mood. Mood is low most of the time, according to the client for significant others.

Diminished Interest or Pleasure. The client has few interests and gets little pleasure from anything, including activities previously found enjoyable.

Change in Appetite and/or Weight. Loss of appetite (and weight), when not dieting, or increased appetite (and weight gain) are evident.

Change in Sleep Pattern. The client may have difficult falling asleep or staying asleep, or may wake early in the morning and not be able to get back to sleep. Alternatively, the client may sleep excessively (such as over twelve hours per night), spending much of the day in bed.

Change in Activity Level. Decreased activity level is reflected by slowness and lethargy, in terms of both the client's behavior and his or her thought processes. Alternatively, the client may feel agitated, "on edge," and restless.

Fatigue or Loss of Energy. The client experiences fatigue throughout the day, or there is a chronic feeling of loss of energy.

Feelings of Worthlessness, Hopelessness, Helplessness. Clients may feel they are worthless as people, that there is not hope for improving their lives, or that they are helpless to improve their unhappy situation.

Inappropriate Guilt. Feelings of guilt may be present about events that the client did not even cause, such as a catastrophe, a crime or an illness.

Recurrent Thoughts about Death. The client thinks about death a great deal and may contemplate (or even attempt) suicide.

Decreased Concentration or Ability to Make Decisions. Significant decreases in the ability to concentrate make it difficult for the client to pay attention to others or complete rudimentary tasks. The client may be quite indecisive about even minor things.

How Is Bipolar Disorder II Distinguished from Bipolar I Disorder

Many persons with a diagnosis of bipolar I disorder also have had, at some point, diagnoses of schizophrenia or schizoaffective disorder. Diagnostic uncertainty results because during a symptom flare-up, a psychotic symptom such as delusional grandiosity (for example, a belief that a person is Jesus Christ) may reflect either mania, schizophrenia, or a schizoaffective disorder. However, over time, the symptoms of these three disorders tend to differ. Of particular importance, when their moods are stable, persons with bipolar disorder do not usually experience psychotic symptoms, while persons with schizophrenia or schizoaffective disorder often do.

Persons with Bipolar II disorder do not have psychotic symptoms. The hypomanic episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. The disturbance in mood and the change in functioning are observable by others and is uncharacteristic of the person when not having symptoms.

What Causes Bipolar II Disorder?

No one knows the cause of Bipolar II disorder. Theories suggest that the illness may be caused by an imbalance in chemicals in the brain, particularly the chemical called norepinephrine. It is believed that the imbalance is determined by genetic factors.

Are There Factors That Might Increase the Likelihood of Relapse?

Sleep deprivation and substance abuse tend to increase the possibility that a hypomanic episode will develop. Depressive episodes often occur when the individual is confronting a loss or life change.

How is Bipolar II Treated?

Effective pharmacological treatments are available for bipolar II disorder. These medications do not "cure" the disorder, but they reduce the symptoms and prevent relapses from occurring. Lithium is the most common drug used for bipolar disorder. Carbamazepine (Tegretol) valproic acid, Trileptal are also effective medications.

Many persons with the disorder can benefit from supportive counseling to learn how to manage the disorder, as well as deal with its impact on their lives. Some types of family therapy also can reduce stress and teach family members how to monitor the disorder.

Consult mental health professionals (such as a psychiatrist, psychologist, social worker or psychiatric nurse) about any questions you have concerning this handout.