Bipolar II – hypomanic episode

Criterion A – 4+ days of…

- Abnormally and persistently elevated, expansive or irritable mood
- ↑ goal directed activity/energy

Criterion B – 3+ of symptoms

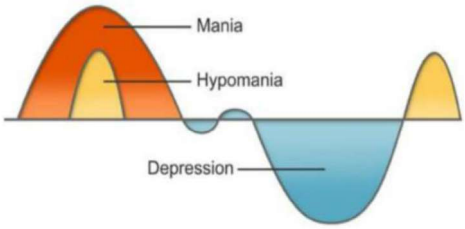
Other criteria

- Change is uncharacteristic of individual
- Disturbance observable by others who know the individual well
- Not severe enough to cause marked impairment or hospitalisation
- No psychotic features
- Not due to substances or medical condition

Diagnostic differences

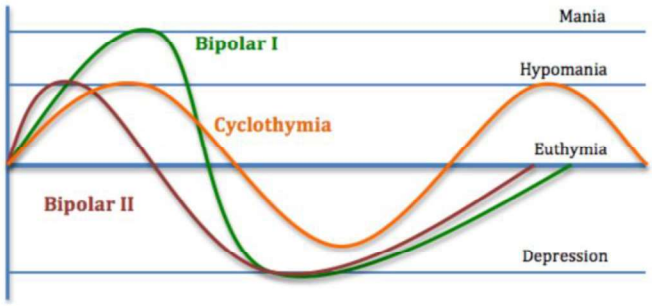
➢ Distinct patterns of manic, hypomanic and depressive episodes

	Bipolar I	Bipolar II
Major depressive episode	Can be present but not necessary for diagnosis	✓
Manic episode	✓	✗
Hypomanic episode	Can be present but not necessary for diagnosis	✓



Cyclothymic disorder

- Chronic, less severe form of Bipolar Disorder
- Cycles of hypomanic and depressive symptoms that aren't severe enough to meet criteria for manic or major depressive episode
- Symptoms for 2+ years w/ no more than 2 months w/out symptoms
- Symptoms cause distress or impairment in functioning



Epidemiology

- **Lifetime prevalence** (Aus)
  - Bipolar I – 1%
  - Bipolar II – 5%
- **12 month prevalence** – 1%
- **No gender differences**
- **Onset** – peak at 15-25 years

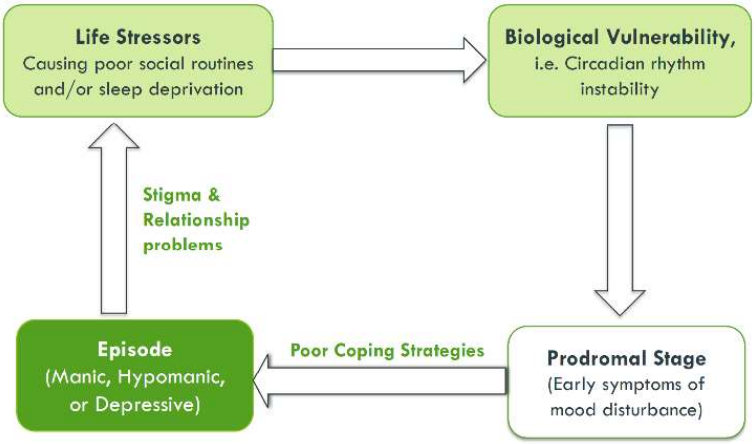
- **Course** – 10-20 years delay in seeking treatment
  - 90% have recurrent episodes
  - Untreated – 8-10 lifetime episodes of mania and depression
  - Treated – 40% relapse in 1 year, 70% in 5 years
  - Predominantly depressive
    - Bipolar I – 32% time depression, 9% manic
    - Bipolar II – 50% time depression, 1% hypomanic
    - Rapid cycling – 10% of sufferers have 4+ episodes per year
- High rates of **comorbidity**
  - Anxiety Disorders (50%) e.g. panic, GAD, social phobia
  - Substance misuse (40%) e.g. self-medication
- 25% attempt **suicide**, 15% complete suicide – mostly during depressive episode

Aetiology

- **Genetic/biological factors**
  - 10% lifetime risk for family members of BP patients
  - 80% heritability rate in identical twins
  - Neurobiological disorder – malfunction of serotonin, dopamine, noradrenaline
  - May lie dormant and be activated/triggered by stressors
- **Environmental and life stressors**
  - ***Manic episodes often preceded by…***
    - Disruption to routine and sleep-wake cycle
    - Excessive focus on goal attainment
  - ***Depressive episode often preceded by…***
    - Low social support
    - Low self-esteem
- **Psychological factors**
  - Negative cognitive style enhances vulnerability to episodes
  - Mania may be defence to counter -ve thoughts/low self-esteem → overcompensation in opposite direction i.e. precursors of depression cause mania
  - Perfection and sociotropy (excessive need for approval by others)

Diathesis-stress model

- Support needed at prodromal stage to prevent episode



Treatment

- Depends on illness stage (e.g. acute, maintenance), predominant polarity (e.g. depressive, hypo/manic)
- Best treatment = pharmacological + psychological interventions (biopsychosocial model)

Pharmacotherapy

- ***Mood stabilisers*** – *mood stabiliser*, main component of standard care, treat/prevent episodes w/out triggering mood shift to opposite pole e.g. lithium esp. lithium
- ***Anticonvulsants*** – for patients w/ risky behaviours or cyclical BP e.g. Lamotrigine
- ***Atypical Antipsychotics*** – for patients with delusions, hallucinations e.g. Olanzapine
- ***Sedative Hypnotics*** – to calm e.g. Benzodiazepines
- ***Anti-depressants*** – lower doses than more unipolar depression, combined w/ mood stabiliser to prevent inducing mania

Psychological

Electro-Convulsive Therapy (ECT)

- Used when medication not viable e.g. pregnant
- Effective for treating manic and depressive episodes
- Short term side effects incl. confusion, disorientation, memory loss
- Pharmacotherapy required to maintain mood stability, prevent relapse

Psychoeducation

- Providing patient and family w/info on…
  - Identifying early signs of relapse
  - Strategies to cope with stressors
  - Need for routines
  - Importance of medication compliance
- Mood monitoring e.g. mood diary – reveal patterns, role of particular stressors

Cognitive Behavioural Therapy (CBT)

- More effective for depressive episodes/less severe
- Cognitive restructuring – patients encourages to…
  - Monitor symptoms
  - Challenge hyper-positive cognitions e.g. "I'm fine, I don't need medication"
  - Improve medication adherence
  - Foster self-efficacy – avoiding/managing risky behaviours

Summary of bipolar

- Manic/hypomanic episodes usually w/ depressive episodes
- **Symptoms** of manic/hypomanic episodes
  - Elevated/irritable mood
  - ↑ activity, self-esteem, talkativeness, risky behaviours
  - ↓ need for sleep
- Mania/hypomania may be **defensive** attempt to avoid depressive symptoms
- **Causes**
  - Biological vulnerability
  - Disrupted routine
  - Medication non-adherence
  - Dysfunctional interpretations of events