BIPOLAR AND RELATED DISORDERS

Bipolar II Disorder

BD-II

DSM-5-TR 296.89 | ICD-10-CM F31.81

At least one hypomanic and one major depressive episode, with depression dominating course, disability, and suicide risk.

LIFETIME PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~0.5-1.1% (US adults)	Mid-20s; depression first	Roughly equal; ~1:1	Depression-predominant

CLINICAL PICTURE

- Patients present in depression and rarely report hypomania spontaneously, because they experience it as feeling well or being productive.
- Hypomania appears as reduced sleep need with sustained energy, increased talkativeness, and uncharacteristic confidence noticed by others.
- Collateral history from partners and family is often the only reliable route to identifying past hypomanic periods.
- Depressive episodes are more frequent, longer, and more treatment-resistant than in unipolar illness, with atypical features common.
- Interepisode subsyndromal depression occupies roughly half of follow-up time and drives most of the functional impairment.
- Antidepressant-associated agitation, insomnia, or new irritability frequently signals previously unrecognized bipolarity.

DIAGNOSTIC CRITERIA AT A GLANCE

- Requires at least one hypomanic episode lasting four or more consecutive days and at least one major depressive episode.
- Hypomania involves elevated or irritable mood plus increased activity with three additional symptoms, or four if mood is only irritable.
- The mood and activity change must be observable by others and represent an unequivocal difference from the person's usual functioning.
- Hypomania must not cause marked impairment, require hospitalization, or include psychosis; any of these makes the episode manic instead.
- A single lifetime manic episode reclassifies the case as Bipolar I; Bipolar II is not a milder variant but a distinct longitudinal course.

NEUROBIOLOGY & PHYSIOLOGY

- Genetic loading and heritability approach those of Bipolar I, with substantial familial overlap between the two diagnostic categories.
- Circadian instability and abnormal sleep architecture predict episode onset and remain measurable even during euthymic intervals.
- Reward circuitry hypersensitivity to goal attainment underlies hypomanic activation following success, praise, or other reinforcement.
- Amygdala-prefrontal connectivity deficits parallel those of Bipolar I but with less pronounced structural change on neuroimaging.
- Thyroid dysfunction, particularly subclinical hypothyroidism, is overrepresented and worsens rapid cycling when left untreated.
- Cardiometabolic comorbidity and elevated all-cause mortality mirror Bipolar I despite the absence of full manic episodes.

PSYCHOLOGICAL MECHANISMS

- Hypomania is ego-syntonic and often valued, producing systematic underreporting and diagnostic delays that average more than a decade.
- Behavioral activation system sensitivity links reward pursuit and ambitious goal striving to escalation of hypomanic symptoms.
- Rumination during depression and positive rumination during hypomania both amplify and prolong whichever state prevails.
- Shame about hypomanic-phase decisions, spending, or infidelity intensifies the self-attack of the subsequent depressive episode.
- Routine disruption, long-haul travel, and shift work destabilize biological rhythms and are direct psychotherapeutic targets.

DIFFERENTIAL & COMORBIDITY

- Most cases are initially misdiagnosed as unipolar depression; screen every depressed patient with the **MDQ** or a careful hypomania timeline.
- Borderline personality disorder features hours-long, interpersonally triggered shifts without sustained reduction in the need for sleep.
- Cyclothymic disorder never reaches full major depressive or hypomanic criteria, whereas Bipolar II requires both thresholds be met.
- Anxiety disorders, substance use disorders, eating disorders, and ADHD are highly comorbid and complicate pharmacologic management.
- Suicide attempt rates equal or exceed those in Bipolar I and carry high lethality, with depressive and mixed states at peak risk.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- **Quetiapine 300-600 mg/day** carries the strongest randomized evidence for acute bipolar II depression and for maintenance treatment.
- **Lithium 0.6-1.0 mEq/L** and **lamotrigine 100-200 mg/day** are preferred maintenance options, with lamotrigine for depressive predominance.
- **Lurasidone 20-120 mg/day** treats bipolar depression with low metabolic burden; give with at least 350 calories to ensure absorption.
- Antidepressant monotherapy is not recommended; if used at all, pair it with a mood stabilizer and monitor for switching and cycle acceleration.
- Screen thyroid, renal function, and a metabolic panel at baseline, then check lithium levels every 3 to 6 months once the patient is stable.

PSYCHOTHERAPY

- **IPSRT** protects sleep-wake and social rhythms, making it the modality most closely aligned with the disorder's circadian mechanism.
- **Psychoeducation** covering prodromes, early warning signs, and adherence reduces recurrence across roughly 12 to 21 sessions.
- **CBT** addresses depressive cognition and residual symptoms, which dominate the long interepisode periods in this population.
- **Family-focused therapy** lowers expressed emotion and improves depressive outcomes in both adolescents and adults.
- Therapy should explicitly map each patient's individual hypomanic signature so that early phases can be recognized and acted on.

ADJUNCT & SUPPORTIVE

- Daily mood charting is more diagnostically informative in this disorder than any single cross-sectional clinical interview.
- Sleep regularization, limited alcohol use, and caffeine reduction help prevent rhythm-driven episode onset and cycling.
- **rTMS** and **ECT** are options for refractory bipolar depression, delivered with mood-stabilizer cover to reduce switch risk.
- Bright light therapy delivered in the midday window shows benefit for bipolar depression with relatively low switch rates.
- Discuss reproductive planning early given valproate and carbamazepine teratogenicity and the need for prepregnancy regimen changes.

CLINICAL PEARLS

- Hypomania feels good; patients report the depressions and hide the highs.
- Bipolar II is not mild; suicide risk matches or exceeds Bipolar I.
- Four days, not seven, and no functional collapse defines hypomania.

References

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NOTE

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