Early and Accurate Diagnosis of Bipolar II Disorder Leads to Successful Outcomes

Mary Cullen-Drill, DNP(c), APN, BC, and Donna Cullen-Dolce, MST

PURPOSE. *Bipolar II disorder is often misdiagnosed as major depressive disorder. This paper addresses accurate diagnosis, proper treatment, and the chronic nature of the illness.*

CONCLUSIONS. *Key factors in treatment success are early and accurate diagnosis and the patient's acceptance of a chronic psychiatric illness. Once the diagnosis of bipolar II disorder and need for long-term treatment are accepted, a successful outcome is more likely (Keck, 2003).*

PRACTICE IMPLICATIONS. *The psychiatric advanced practice nurse contributes to successful treatment of bipolar II disorder through accurate diagnosis, evidence-based treatment, community referrals, coordination of care, professional organization participation, and patient advocacy.*

Search terms: *Bipolar, bipolar II, hypomania, mood stabilizer*

Mary Cullen-Drill, DNP(c), APN, BC, is a doctoral candidate, Columbia University School of Nursing, New York City, NY. She works as a psychiatric advanced practice nurse at Saint Clare's Health Services, Denville, NJ, and has a private psychotherapy and psychopharmacology practice in Montclair, NJ; and Donna Cullen-Dolce, MST, is an educator, freelance health education writer, and editor, Suffern, NY.

Nancy is an 18-year-old college freshman who was hospitalized 2 years ago for depression, active suicidal ideation, high irritability, and sleeplessness. Prior to the hospitalization, she had been misdiagnosed with major depression and was treated with antidepressant medication. After the addition of a second antidepressant, due to the lack of efficacy of the first, Nancy's condition worsened. She was eventually diagnosed with bipolar II disorder and successfully treated. Nancy is not alone.

Bipolar II disorder is a chronic mental illness that affects many aspects of a person's life—as it did in Nancy's case—including psychological stability, physical health, family relationships, social functioning, and employment. It is characterized by recurrent major depressive episodes with the occurrence of at least one hypomanic episode, according to the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition, text revision) (American Psychiatric Association [APA], 2000); and to make the diagnosis, the patient must have had at least one episode of major depression and one episode of hypomania of a 4-day duration. Bipolar II disorder can be treated and controlled, but not cured. The course of illness tends to be episodic and relapsing (Newman, Leahy, Beck, Reilly-Harrington, & Gyulai, 2002). Despite its chronic nature, when correctly diagnosed and treated, long-term outcomes can be good.

In Nancy's case, she was subsequently hospitalized, diagnosed with bipolar II disorder, and successfully treated with topiramate and fluoxetine. Although topiramate is not indicated by the Food and Drug

Names and details about the cases have been changed to protect the anonymity of the individuals.

Administration (FDA) for the treatment of bipolar disorder, Nancy refused to take any medication that might cause weight gain; hence, divalproex sodium, lithium, and most antipsychotic medications were not acceptable options for her. Because topiramate's side-effect profile does not include weight gain and it is a Texas Implementation of Medication Algorithms (TIMA) Guideline Stage 3 medication for hypomania (Suppes et al., 2005), it was prescribed on a trial basis. It has been helpful in treating Nancy's hypomanic symptoms, especially sleeplessness and irritability, without unwanted side effects, such as weight gain, acne, and the need for frequent blood monitoring.

A recent systematic review did not find topiramate to be an effective treatment for the bipolar disorder (Vasudev, Macritchie, Geddes, Watson, & Young, 2006). However, in the experience of this psychiatric advanced practice nurse (APN), topiramate has been effective in the treatment of hypomanic symptoms in some patients. Furthermore, the use of topiramate has not been specifically studied in bipolar II disorder. It may have greater efficacy in hypomania than mania, but studies are needed to investigate its efficacy in bipolar II disorder before it can be widely recommended. Upon discharge, the medication was continued, and Nancy was referred for psychotherapy. She has been stable for 2 years and is attending college.

Epidemiology

Bipolar II disorder was first distinguished as a separate disorder in the 1970s (Baldessarini, Tohen, & Tondo, 2000). It was observed that many patients experienced recurring major depressive episodes but also experienced hypomanic symptoms, "manic like" symptoms of a much milder nature, including elevated, irritable, or expansive mood, talkativeness, racing thoughts, distractibility, psychomotor agitation, grandiosity, decreased need for sleep, impulsivity, and excessive pleasure-seeking or goal-directed behavior that lasted for a minimum of 4 days (APA, 2000). Often, patients enjoy these periods of mood expansiveness.

For example, Greg, a 55-year-old married photographer, had experienced recurrent depression since he was 19 years old and had undergone long-term psychotherapy in the past. He had a history of past episodes of elevated mood. Greg did not think this was a problem but rather an asset. He didn't need much sleep during these periods and would instead take short "naps" that would refresh him enormously. He felt these episodes contributed to his creativity.

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In addition, patients with bipolar II disorder do not respond as well to traditional treatment for major depression. Frequently, they either do not respond to antidepressants or they develop adverse effects from the medication. This is an important feature that distinguishes bipolar II disorder as a separate phenomenon. Bipolar II disorder has previously been thought to affect 0.5% of the U.S. population (Sadock & Sadock, 2003). A new study from the National Institute of Mental Health found lifetime prevalence estimates to be as high as 1.1% for bipolar II disorder (Merikangas et al., 2007). It may be somewhat more prevalent in females than males; onset is usually at 15–19 years of age; and culture does not seem to influence the incidence of bipolar II disorder (Suppes & Keck, 2005).

Etiology

The risk factors for bipolar disorder include biological, medical, perinatal, genetic, life-event, personality, and psychosocial factors (Sadock & Sadock,

2003; Suppes & Keck, 2005). If one parent has a major affective disorder, then the child has a 20–25% risk of being affected. If both parents have an affective disorder, and one parent is bipolar, there is a 50–75% risk of the children developing an affective disorder. The heritability of bipolar disorder for monozygotic twins is 59% (Suppes & Keck).

In the case of Lynn, a 59-year-old divorced waitress who suffered from depressed mood, suicidal ideation, low energy, hypersomnolence, and anxiety, a thorough psychiatric history revealed several risk factors for bipolar II disorder. She experienced short periods of high energy characterized by elevated mood and hyperactivity but primarily suffered from longer episodes of depression. Her brother carried a bipolar I disorder diagnosis, and 9 of her other 11 siblings had suffered at least one episode of depression. Lynn's mother also experienced depression, irritability, and violent behavior. Lynn's maternal grandmother committed suicide.

First diagnosed with major depressive disorder 10 years ago, Lynn was treated with paroxetine and alprazolam but never achieved full remission. When an accurate diagnosis was made, she responded well to olanzapine/fluoxetine combination and lamotrigine. Lynn's mood is stable, and she has recovered completely from this episode.

Environmental factors also play a part in expression of the illness. Stressful occurrences, life events, and changes in the sleep–wake cycle can all precipitate bipolar episodes (Suppes & Keck, 2005). A history of childhood abuse, family substance abuse, comorbid substance abuse, rapid cycling, poor occupational functioning, and previously severe illness course are associated with a more difficult course of illness (Nolen et al., 2004).

Misdiagnosis

Presently, much controversy exists regarding the diagnosis. Many clinicians believe the prevalence may be higher than stated because it is frequently misdiagnosed as major depressive disorder (Benazzi, 2006; Suppes & Keck, 2005). Many clinicians find it difficult to distinguish between euthymia and hypomania in a chronically depressed patient. It takes an average of 12 years before patients with bipolar disorder are accurately diagnosed. This delay in accurate diagnosis is costly to the patient in terms of quality of life and level of functioning (Akiskal, Benazzi, Perugi, & Rihmer, 2005; Hadjipavlou, Mok, & Yatham, 2004). Obtaining a thorough and accurate history is critical in making the correct diagnosis early in treatment. Many patients pay a price for such a delay in diagnosis.

For example, Ethan, a 34-year-old married carpenter and father of three, reported having a "temper" and battling mood swings and depression all his life. He had a history of violence and verbal abuse. Receiving the diagnosis of bipolar II disorder clarified for Ethan why he had such difficulties with his mood all his life. Now Ethan accepts the chronic nature of his illness and is committed to taking his divalproex sodium medication.

Bipolar II depression is often associated with a lack of energy, hypersomnia, and early onset of illness (Baldessarini et al., 2000). In addition, patients are often irritable, suffer from racing thoughts (Benazzi, 2006), and have a higher instance of substance abuse, which significantly complicates treatment (Hadjipavlou et al., 2004). In Ethan's case, he learned that alcohol abuse exacerbated his illness, so he stopped drinking. When accurately diagnosed and treated, he addressed other untreated medical problems such as hypertension, hypercholesterolemia, and smoking.

Clinicians need to look for signs and symptoms specific to bipolar II disorder in order to distinguish it from major depression early in treatment. Patients may not report hypomanic episodes because they often are not seen as problematic. In fact, the patient may recall these episodes as highly productive times when they needed little sleep and felt exceedingly well. This can lead to a denial on the part of the patient that anything is wrong. Clinicians need to ask specific questions about periods of high productivity, diminished need for sleep,

and impulsive behavior, such as uncharacteristic shopping sprees or hypersexuality, when obtaining the history, because these questions will help elucidate hypomanic symptoms from periods of euthymia (see Table 2). Distinguishing between these disorders is essential because the treatment for the two disorders differs substantially. Treating patients with bipolar II disorder with antidepressants alone can exacerbate rapid cycling and hypomania, worsening the illness (Miklowitz et al., 2000).

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It is estimated that bipolar depression sufferers have a 2.0 times greater risk of suicide attempts than patients suffering from unipolar depression and 6.0 times greater risk than any other psychiatric disorder (Tasman, Kay, & Lieberman, 2003). The frequent delay in diagnosis and correct treatment for bipolar disorder patients may partially explain the high suicide attempt rate.

Long-Term Illness Management

Bipolar II disorder requires accurate diagnosis and treatment. How patients cope with the diagnosis of a chronic mental illness greatly influences the outcome of treatment. Bipolar patients often become symptomatic at a young age and have a difficult time accepting that they have a mental illness that requires life-long treatment (Newman et al., 2002). A patient's acceptance and adaptability are strong determinants of adherence to the treatment and functional recovery. Addressing the patient's reaction to the illness and the effects on self-concept during the treatment is more likely to lead to a successful outcome (Ball, Mitchell, Malhi, Skillecorn, & Smith, 2003).

Greg, the 55-year-old photographer, did not accept the diagnosis of bipolar II disorder. The idea of a chronic mental illness and the need for long-term treatment was unacceptable to him. Despite being educated on the illness—and the fact that it is not a sign of character weakness but rather an illness influenced by genetics, biology, and stress—Greg refused pharmacological treatment because he viewed taking medication as a sign of weakness.

Greg's denial of his illness affects his family as well. His wife and school-age children must deal with his irritability and depressed mood, short episodes of grandiosity, angry outbursts, and his lack of involvement in family life. Perhaps someday he will accept the chronic nature of his illness and the need for long-term treatment. For now, he lives in denial at great cost to himself and his family.

Greg's desire to avoid the stigma of mental illness and medication treatment is not unusual. In fact, it constitutes another reason why patients may deny the diagnosis of bipolar II disorder (Worley, 1997). The need for long-term treatment is difficult for patients to accept and contributes to patients stopping their medication. Many bipolar patients repeat this cycle over and over; denial of the illness often leads to repeated episodes and worsening of the illness (Newman et al., 2002).

The good news is that with proper treatment, patients can live productive lives. For example, Leslie, a 34-year-old single mother with symptoms of recurrent depression, suicidal thoughts, irritability, sleeplessness, agitation, and racing thoughts, accepted the diagnosis of bipolar II depression and found that it explained many of the difficulties she experienced in her life. Prior to successful treatment, she had frequent thoughts of throwing herself on the train tracks during her daily commute to work. She has been very motivated to continue medication treatment and has also benefited from short-term psychotherapy. She has

Table 1. Medications With the Food and Drug Administration (FDA) Indication for Bipolar Disorder

Medications with the FDA indication for bipolar disorder (hypomania may also respond to antimanic medications)	Bipolar disorder, acute mania	Bipolar disorder, depressive episodes	Bipolar disorder, mixed episode	Bipolar disorder maintenance
Divalproex sodium	X		X	X
Divalproex sodium (extended release)	X			
Lithium carbonate	X			X
Lamotrigine				X
Olanzapine/fluoxetine		X		
Quetiapine	X	X		
Ziprasidone	X		X	
Aripiprazole	X		X	X
Olanzapine	X		X	X
Risperidone	X			
Carbamazepine (extended release)	X			

Adapted from: *Physicians' Desk Reference* (2007).

learned about bipolar II disorder and has educated her family on the illness as well.

Treatment

Pharmacotherapy

Pharmacotherapy is the cornerstone of the treatment of bipolar disorder. While there is a tremendous amount of research focused on medication treatment of bipolar disorder, research is scant as to which medications lead to the best outcomes. Medications that are frequently used include mood stabilizers, anticonvulsants, atypical antipsychotics, and antidepressants. There are many FDA-approved medications for different phases of bipolar disorder available in the United States (see Table 1), but the psychiatric APN must take into account many considerations when prescribing specifically to treat bipolar II disorder. Practice guidelines, expert consensus recommendations, efficacy, and psychiatric and medical comorbid conditions play an important role in deciding which medications to use. Equally important are drug tolerability, side-effect profile, and patient preference. In order for patients to benefit from any medication, they first must be willing to take it.

Jane, a 35-year-old woman, was referred for treatment of postpartum depression. Six months after the birth of her son, Jane was feeling depressed and disinterested in her baby. A detailed interview revealed a history of periods of elevated mood, high energy, hypersexuality, impulsivity, and a decreased need for sleep. Invariably, however, these episodes were followed by a longer period of depression, characterized by a lack of energy and motivation, irritability, hypersomnolence, hyperphagia, weight gain, and social withdrawal.

Because of this pattern, Jane was diagnosed with bipolar II disorder and treated with lamotrigine, an option since Jane was not breastfeeding. Her depressive symptoms gradually improved with lamotrigine, individual psychotherapy, and postpartum support-group attendance. She achieved remission within 3 months and is functioning well. Education included the need for birth control while on lamotrigine. Although lamotrigine is classified as pregnancy

Table 2. Questions to Ask When Evaluating a Patient for Bipolar II Disorder

"Have you found that there are times you need little or no sleep, yet still feel energetic?"
"Are there times when you are involved in pleasurable activities that have a high risk of painful consequences such as buying sprees or sexual indiscretions?"
"Do you ever feel like your thoughts are racing or you have more than one thought at a time?"
"Do you experience periods when you are extremely irritable or easily angered?"
"Have you experienced periods of distractibility characterized by excessive talking or rapid changes in activities?"
"Are there periods when you are overly involved in goal-directed activities or experience psychomotor agitation?"
"Do you experience times when your self-esteem is inflated or you feel grandiose?"
"Have any of these symptoms lasted for at least four days?"

Adapted from: American Psychiatric Association (2000); Suppes and Keck (2005).

category C, new reports indicate there may be an increased risk of cleft palate malformations in babies exposed in the first 3 months *in utero* to lamotrigine (Physicians' Desk Reference, 2007).

Practice guidelines are important when deciding which medications to use in bipolar disorder, along with tolerability, patient preference, and other important factors stated previously. The TIMA Guidelines for bipolar I disorder were updated in 2005 (Suppes et al., 2005). According to the guidelines, treatment of the hypomanic/manic phase primarily specifies the use of lithium (especially in euphoric mania), anticonvulsants, and atypical antipsychotics with the first three stages. Topiramate and oxcarbazepine are added as options in stage 3.

The treatment of the depressive phase specifies:

Stage 1: Antimanic agent plus lamotrigine or lamotrigine monotherapy.

Stage 2: Quetiapine or olanzapine/fluoxetine combination, an antidepressant and antipsychotic combination.

Stage 3: Combination from lithium, lamotrigine, quetiapine, or olanzapine/fluoxetine combination.

Stage 4: Use of antidepressants such as selective serotonin reuptake inhibitors, bupropion, and venlafaxine plus mood stabilizer.

It should be noted, however, that the above TIMA guidelines are for bipolar I disorder, depressed phase. The APA's guidelines for acute depression in bipolar disorder recommend treating first with lithium or lamotrigine; but, in the case of severe depression, consider adding an antidepressant in the first phase (Hirschfeld et al., 2002).

Guidelines specifically for bipolar II disorder are needed because, unlike in bipolar I disorder, patients do not suffer from manic episodes and they may be at a lower risk for manic switch (Altshuler et al., 2006). Both TIMA (Suppes et al., 2005) and APA guidelines for bipolar disorder (Hirschfeld et al., 2002) emphasize the importance of maximizing the dose and achieving a serum level in the therapeutic range (0.8 mEq/L for lithium) before moving on to the next stage in treatment.

There is some controversy as to whether some patients with bipolar disorder can be safely managed with antidepressants due to the risk of a manic switch (Gijsman, Geddes, Rendell, Goodwin, & Nolen, 2005; Hadjipavlou et al., 2004). As recommended in practice guidelines, most often a mood stabilizer alone or with an antidepressant is used to treat the depression and prevent a manic switch. There is considerable evidence in the literature that antidepressants induce mania and rapid cycling in bipolar II disorder. The tricyclic antidepressants seem to have a greater risk of inducing mania than the selective serotonin reuptake inhibitors and atypical antidepressants (Mackin & Young, 2004). The risk of inducing rapid cycling or hypomanic symptoms is quite real with any

antidepressant, and caution is advised to prevent this adverse outcome. Some experts believe the use of antidepressants in bipolar II disorder may worsen the long-term prognosis by causing more mood instability (Miklowitz et al., 2000). However, new research suggests there may be a lower switch rate in depressed patients with bipolar II disorder than with bipolar I disorder when treated with antidepressants in addition to mood-stabilizing medication (Altshuler et al., 2006). In a recent study, fluoxetine monotherapy was shown to be effective in bipolar II depression with a low switch rate, although it is too soon to conclude that this is safe practice (Amsterdam & Shults, 2005). The controversy of the use of antidepressants in bipolar II disorder clearly persists, and more studies are needed to clarify the role of antidepressants in the treatment of bipolar II disorder.

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Psychological Treatments

Psychological treatments are recommended to address the patient's emotional reaction to being diagnosed with a chronic mood disorder. These treatments have been found to aid in keeping patients on medication when they start to feel better because patients often stop their medication when their symptoms improve (Newman et al., 2002). Several different psychotherapeutic approaches have been found to be helpful in bipolar disorder. These include cognitive behavioral therapy (Ball et al., 2003), interpersonal and social rhythm therapy (Frank, 2007), and family-focused treatment (Newman et al.; Stuart & Frank, 2004; Suppes & Keck, 2005).

Interpersonal and social rhythm therapy addresses the recurrence in bipolar disorder by focusing on the management of medication nonadherence, stressful life events, and disruption in social rhythms. Two large-scale studies have supported its efficacy in bipolar disorder in conjunction with pharmacotherapy (Frank, 2007).

Family-focused treatment recognizes that the illness and recovery exist in the context of the patient and his or her family. Involvement of the support system of the patient with a chronic illness may aid the treatment by improving communication and conflict resolution to promote the stability of the patient.

Cognitive therapy, according to its founder Aaron Beck, is based on the premise that one's affect and behavior are determined by the way one structures the world (Sadock & Sadock, 2003). Cognitive behavioral therapy addresses both cognitive and behavioral aspects of the disorder, and specific techniques are often used in the treatment (Tasman et al., 2003).

There is no one type of psychological treatment that is clearly superior; instead, all of the above treatments have been shown to be effective (Suppes & Keck, 2005). The combination of psychopharmacology and psychotherapy has been shown to be more effective than either treatment alone (Pampallona, Bollini, Tibaldi, Kupelnick, & Munizza, 2004). In cases of bipolar II disorder where there is a co-occurring substance disorder, both illnesses need to be addressed by the psychiatric APN in integrated treatment. In addition, an addiction treatment referral may be indicated.

Psychoeducation

Chronic illness requires a long-term management plan to optimize outcomes. Patients and families need to know the signs of early relapse, as well as effective treatments, genetic risks, stress management techniques, the importance of stable sleep-rest patterns, good nutrition and exercise, and the adverse effects of alcohol and other substance abuse on outcomes (Miklowitz et al., 2000). Education about the illness

empowers the patient to be an active participant in the treatment. Support groups for patients and families can be helpful. Family members who understand the illness are likely to be more supportive regarding the importance of treatment.

Rachel, a married nurse in her early 30s, is a good example for whom medication along with education and psychological treatment were combined to produce an effective outcome. Rachel began treatment during her second pregnancy. She had a history of postpartum depression after the birth of her first child and was fearful that the illness was reoccurring. She was treated successfully for depression during the pregnancy with fluoxetine at the minimum effective dose. Unfortunately, her symptoms recurred postpartum. Despite an increase in fluoxetine, her symptoms continued to worsen. She was switched to escitalopram, and oxcarbazepine was added to treat the hypomanic symptoms of irritability, racing thoughts, and inability to sleep. A diagnosis of bipolar II disorder was made.

Although oxcarbazepine does not have the FDA indication for the treatment of bipolar disorder, a recent review reported efficacy in acute mania and that it may be a useful add-on in treating bipolar depression and bipolar maintenance (Pratoomsri, Yatham, Bond, Lam, & Sohn, 2006). Also, the TIMA (Suppes et al., 2005) guidelines for bipolar mania/hypomania list oxcarbazepine in Stage 3 of the treatment algorithm. In addition, Rachel, like the young college student mentioned earlier, refused to take any medication that had a potential for weight gain. This eliminated nearly all FDA-approved medications for bipolar disorder. Rachel improved substantially, but the depression persisted, albeit on a lower level. Lamotrigine, which is more effective for depressive symptoms, was added, and the residual symptoms improved. She is now functioning at 90–95% and is pleased with her symptom management. It should be noted that Rachel did not breastfeed, as lamotrigine is not safe in lactation, and the safety of oxcarbazepine in breastfeeding is unknown (Physicians' Desk Reference, 2007).

Initially, Rachel did not accept the diagnosis of bipolar II disorder and hoped her history of thyroid disorder would explain her psychiatric symptoms, even though her endocrinologist agreed that her thyroid disorder had been effectively treated with medication. So Rachel decided to taper off her medication to see if she still needed it. The symptoms of depression, irritability, and sleep problems quickly returned, and she resumed her medication. Rachel has now accepted the bipolar II diagnosis. Individual cognitive behavioral psychotherapy and a postpartum support group helped her to accept the illness and the need for life-long treatment.

Community Resources

Many organizations provide evaluation and treatment of bipolar illness, including local hospitals, outpatient community mental health agencies, and private psychiatric practices. Mental health practitioners need to provide educational materials to patients and their families, as well as information on community resources. The National Institute of Mental Health (www.nimh.nih.gov), the National Alliance on Mental Illness (www.nami.org), the Depression and Bipolar Support Alliance (www.dbsalliance.org), and the International Society of Psychiatric-Mental Health Nurses (www.ispn-psych.org) are resources for information and support for bipolar patients and their families. The division of the state department of mental health can provide details on local resources. Information regarding short- and long-term disability should be provided when appropriate, as well as information on vocational rehabilitation programs, medical insurance, and government assistance programs.

Implications for Nursing Practice

Accurate diagnosis, proper treatment, and the importance of establishing a therapeutic relationship cannot be overstated (Tasman et al., 2003). Pharmacology is the cornerstone of treatment and must be considered when treating patients with bipolar disorder. Evidence-based

pharmacological practice is crucial to successful treatment. Also critical is addressing the chronic nature of the illness and promoting acceptance and adaptation in the interest of positive long-term outcomes (Newman et al., 2002). When patients deny the illness, it may increase the frequency and number of recurrent episodes. It is difficult for patients to achieve vocational goals, satisfying relationships, and financial security when suffering from a mental illness. The psychiatric APN should provide or refer patients for psychological treatments in addition to pharmacotherapy, as treatment outcomes are superior with the two interventions combined. These may include psychotherapy, family treatment, and group therapy. Psychosocial interventions can be useful as well and include support groups, community resources, and psychoeducational programs as an adjunct to the medication treatment. Family members should be included in treatment and education when appropriate. Families have their own structure and patterns, and understanding this can be critical in helping the patient adapt to the illness (Napier & Whitaker, 1978).

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The psychiatric APN must collaborate with primary care providers and other specialists and refer patients for medical, nutritional, and specialist evaluations when indicated. In addition, referrals for job support, financial counseling, and housing programs should be considered. Education regarding the genetic aspects of bipolar II disorder and associated mood disorders should be provided to the patient and family. This information is important for future decisions regarding marriage and children.

Maintaining knowledge of current research in bipolar disorder and chronic illness management will aid the psychiatric APN in basing treatment on evidence-based practice (Perlis, 2005). The psychiatric APN works with the interdisciplinary healthcare team to improve the quality of care and should be on the forefront of state and national efforts through professional organizations such as the American Nurses Association and the American Psychiatric Nurses Association to preserve and expand the practice of nursing, ensure access to nursing providers, and advocate for humane mental health policy. Support of relevant legislation on an individual and professional level is critical to advanced practice nursing.

Conclusion

In conclusion, bipolar II disorder is a chronic psychiatric illness that requires long-term treatment and is often misdiagnosed as major depression. This delay in accurate diagnosis may lead to frequent relapse into illness, which takes its toll on the patient's quality of life and successful achievement of developmental tasks. When an accurate diagnosis is made, the patient's ability to accept the diagnosis of a chronic illness and adapt to the need for long-term treatment is critical to a successful outcome. This process of integrating the diagnosis of a life-long illness is an important aspect of the treatment. If the patient's thoughts, feelings, and reaction to having a chronic illness are dealt with early in the treatment, acceptance and adaptation are more likely to occur, leading to adherence to treatment and successful outcomes.

Author contact: mcullendrill@aol.com, with a copy to the Editor: mary@artwindows.com

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