Bipolar II Disorder:
Modelling, Measuring and Managing

edited by Gordon Parker. Cambridge University Press, New York, New York, 2008, 304 pages, $120.00.

I opened *Bipolar II Disorder* edited by Gordon Parker with great anticipation. Here was a book with chapters by many prominent researchers and clinicians experienced in the treatment of bipolar disorder. Like most clinicians, I have seen patients like the 60-year-old depressed and agitated woman with a past history of depression and periods of being more energetic, somewhat grandiose about her creative output, and elated. These periods

never met criteria for a manic episode. What does the published evidence tell us about how to treat such a patient? Are antidepressants effective for such patients? Might they cause her to switch into a manic episode? Does she need a mood stabilizer instead of or prior to starting an antidepressant? What, if any, psychosocial treatments might be helpful? What should we tell patients or their family members about their diagnosis? With *DSM-V* in the early stages of development, this book is a very timely review of what we've learned about bipolar II disorder since it was included in *DSM-IV*. Does the distinction from bipolar I disorder still hold up? Or, rather than separate categories, is there a spectrum of bipolarity such that some patients have pure unipolar depressions with no symptoms of ever being high and others meet full criteria for a manic episode? Do some patients have some symptoms but not for long enough to meet the *DSM-IV* criteria?

This book reviews the evidence from the point of view of the individual authors and the editor who assembled them. In the final chapter of the book, "Rounding Up and Tying Down," Parker summarizes areas of agreement and highlights where the authors disagree. The authors generally agree that bipolar II is a clinically meaningful category with significant impact in terms of disability, economic cost, and risk of suicide. Parker notes that there is disagreement on the clinical utility of categorical as opposed to continuum models of bipolar disorder. He describes self-report measures such as the Mood Disorders Questionnaire and the utility of a Bipolarity Index. Clinicians are encouraged to screen patients for symptoms suggestive of a bipolar disorder such as "Feel very confident and capable," "See things in a new and exciting light," "Feel very creative with lots of ideas and plans," "Spend, or wish to spend, significant amounts of money," "Find that your thoughts race," "Feel irritated," "Laugh and find lots more things humorous," or "Sleep less and not feel tired." If clinicians do not screen for hypomanic symptoms, patients may not report them and the diagnosis will be missed.

Phelps warns that a diagnosis of bipolar disorder may be distressing to patients, and Ketter and Wang note that patients should be advised to avoid the risks of either trivializing or catastrophizing the disorder. Parker concludes that the *DSM* (and *ICD*) decision rules for distinguishing hypomania from mania are less than satisfactory and are worthy of revision. Parker notes that if bipolar I and II patients share a common neurobiology, then their treatment should be similar; the chapter by Malhi, however, notes that the currently available studies do not provide an answer to the question.

With respect to whether to use antidepressants as monotherapy, Parker summarizes the range of views from a "qualified yes" to "uncertain" to "no." Clinicians can review the arguments put forth by the different authors and reach their own conclusions. If an antidepressant is prescribed as monotherapy, the majority opinion seems to favor a selective serotonin reuptake inhibitor, a serotonin-norepinephrine reuptake inhibitor, or bupropion. The likelihood of a patient switching from a depressed to a hypomanic state is also controversial, but certainly bipolar patients need to be carefully monitored. It is noted that bipolar patients cycle even without an antidepressant, so a switch may be unrelated to drug treatment. Mood stabilizers are also widely used, with different preferences for lithium, valproate, and lamotrigine, the latter being encouraged for maintenance therapy. Parker notes the limited database on the use of atypical antipsychotic drugs in bipolar disorder, although some authors recommend their use, particularly quetiapine. Parker and others use fish oil to augment other pharmacotherapy and note that many patients prefer such a "natural" treatment. Ketter and Wang note the utility of "wellbeing plans" that help patients manage their illness and avoid stresses that may trigger a manic or depressive episode. The discussion of such plans has the added benefit of encouraging a collaboration between the patient and the treater. Patients should monitor their mood, adhere to their medication, change their lifestyle if needed, and involve family members if they can be supportive.

Although this book does not provide "the answers" to what a clinician should do in every instance of treating a patient with bipolar II disorder, it provides a wealth of data and informed opinion. Any clinician with bipolar II patients may want to consult this comprehensive volume when faced with a challenging bipolar II patient.

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