Based on the above episodes, the DSM-IV identifies only two primary bipolar sub-types / diagnoses. Bipolar I disorder, which is also considered the classic presentation of Bipolar illness, and Bipolar II disorder, often mistakenly considered a less severe presentation of the disorder. The different episodes serve as building blocks for reaching either a bipolar I or a bipolar II diagnosis.

A. Bipolar I Disorder

A diagnosis of bipolar I disorder requires the presence of only one manic episode, which is not due to the presence of a general medical condition (or any other underlying “organic cause”) or substance use. The manic episode should also be outside the context of a Schizo-Affective or a Schizophrenic disorder.

Nevertheless, psychotic symptoms similar to the ones observed in schizophrenia are often present during manic episodes (Keck et al., 2003). Patients with bipolar I disorder will often have severe major depressive episodes as well. However, their presence is not required for a diagnosis of Bipolar I disorder. Although there have been reported cases of unipolar mania (Abrams, Taylor et al. 1979; Perugi, Akiskal et al. 1998) this presentation is unusual and its diagnostic stability is weak. Most such cases are reported to have a depressive episode at some point in their lifetime or if the onset is later in life an “organic cause” is usually suspected (Moorhead and Young, 2003)

B. Bipolar II Disorder

Bipolar II disorder is defined by the presence of at least one hypomanic episode and at least one major depressive episode. Patients with a bipolar II diagnosis will primarily suffer with major depressive episodes. As a result of this presentation and also because of having the difficulty in differentiating a hypomanic episode from a return to a normal “well” period, cases of BPII are often misdiagnosed for unipolar depression (Ghaemi et al., 2001). An increase in the recent recognition of this problem has fuelled the development of screening measures for hypomanic states (Angst et al., 2005). Nevertheless our understanding and measurement of hypomanic states is still rather limited.

C. Other Sub-Types and Diagnostic challenges

The DMS-IV also provides other diagnostic categories based purely on the course of the disorder. These are called course specifiers. There is the Rapid Cycling specifier, which requires the presence of four or more bipolar episodes (MDE, Manic/Hypomanic, Mixed) in the past year, and the seasonal specifier in which episodes tend to occur at particular times of the year independently of any psychosocial stressors.

Finally, a milder and more common presentation of Bipolar disorder is defined in cyclothymia. Cyclothymia is diagnosed for people who experience hypomanic symptoms and depressive symptoms without meeting the diagnostic criteria for bipolar episodes for at least two years.

The above definitions determine what is known about the prevalence of the bipolar disorder in the community. Many of the proposed criteria particularly about the duration of Hypomanic episodes (four days is an ad-hoc time frame) have caused considerable debate among epidemiologists and diagnosticians (Benazzi, 2007a). Additional debates have arisen from DMS-IV's requirement of the presence of A1 symptom criteria (elevated or irritable mood) in order to allow the evaluation of the presence of further symptoms. Researchers (Benazzi, 2007b) (Bauer et al., 1991) who have challenged this practice argue that in hypomanic or mixed states the primary symptom is an increase in activity levels accompanied either by a positive or negative mood rather than a simply elevated or irritable mood that the patient may deny or not consider pathological. These problems often lead to missed episodes or even misdiagnosis, usually one of unipolar disorder. They also highlight the need for frequent and structured symptom monitoring in bipolar disorder, both for research and treatment/outcome monitoring purposes, and during all phases of the disorder.

Again the above diagnostic problems primarily plague the bipolar II sub-type and bipolar-spectrum cases. The severity of manic episodes present in bipolar I disorder has made it difficult for anyone to challenge their presence or deny their existence. Unlike other disorders, the diagnosis of what is considered the primary or classic presentation of bipolar disorder (Bipolar I) is a relatively easy task. The only requirement set out by the current diagnostic manuals is the presence of one manic episode. The diagnostic picture is complicated when one is trying to diagnose the disorder in milder bipolar-spectrum cases where a manic episode by definition is absent. This diagnostic problem is primarily a result of the difficulty we have in measuring and diagnosing hypomanic episodes as well as the difficulty of patients in reporting such states (Ghaemi et al., 2004), and also monitoring sub-syndromal presentations of these symptoms. However, all these problems and the obvious reliance on the course of the symptoms to derive a correct diagnosis make vital the use of prospective symptom severity and

diagnostic assessments for continuous monitoring.

key references

Keck, P. E., Jr., Mcelroy, S. L., Havens, J. R., Altshuler, L. L., Nolen, W. A., Frye, M. A., Suppes, T., Denicoff, K. D., Kupka, R., Leverich, G. S., Rush, A. J. & Post, R. M. 2003. Psychosis in bipolar disorder: phenomenology and impact on morbidity and course of illness. Compr Psychiatry, 44, 263-9.

Moorhead, S. R. & Young, A. H. 2003. Evidence for a late onset bipolar-I disorder sub-group from 50 years. J Affect Disord, 73, 271-7.

Ghaemi, S. N., Ko, J. Y. & Goodwin, F. K. 2001. The bipolar spectrum and the antidepressant view of the world. J Psychiatr Pract, 7, 287-97.

Angst, J., Adolfsson, R., Benazzi, F., Gamma, A., Hantouche, E., Meyer, T. D., Skeppar, P., Vieta, E. & Scott, J. 2005. The HCL-32: towards a self-assessment tool for hypomanic symptoms in outpatients. J Affect Disord, 88, 217-33.

Benazzi, F. 2007a. Challenging DSM-IV criteria for hypomania: diagnosing based on number of no-priority symptoms. Eur Psychiatry, 22, 99-103.

Benazzi, F. 2007b. Is overactivity the core feature of hypomania in bipolar II disorder? Psychopathology, 40, 54-60.

Bauer, M. S., Crits-Christoph, P., Ball, W. A., Dewees, E., Mcallister, T., Alahi, P., Cacciola, J. & Whybrow, P. C. 1991. Independent assessment of manic and depressive symptoms by self-rating. Scale characteristics and implications for the study of mania. Arch Gen Psychiatry, 48, 807-12.

Ghaemi, S. N. & Rosenquist, K. J. 2004. Is insight in mania state-dependent?: A meta-analysis. J Nerv Ment Dis, 192, 771-5.