DSM-IV diagnostic criteria for bipolar disorder (simplified)

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<th>Diagnosis</th>
<th>Criteria</th>
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| Bipolar I = manic episode, at least one (+ depression) | • One week of abnormally elevated, expansive, or irritable mood (or less if hospitalised) plus increased activity or energy  
• Three (or more) of the following seven symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:  
  1. Inflated self-esteem or grandiosity  
  2. Decreased need for sleep (e.g. feels rested after only three hours of sleep)  
  3. More talkative than usual or pressure to keep talking  
  4. Flight of ideas or subjective experience that thoughts are racing  
  5. Distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli)  
  6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation  
  7. Excessive involvement in pleasurable activities which have a high potential for painful consequences (e.g. engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)  
• The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalisation to prevent harm to self or others, or there are psychotic features  
• Symptoms are not caused by a drug of abuse, medication or a general medical condition |
| Bipolar II = hypomanic episode, at least one (+ depression) | • Four days of elevated, expansive or irritable mood plus increased activity or energy  
• Three (or more) of the following seven symptoms (1-7) listed above have persisted (four if the mood is only irritable) and have been present to a significant degree:  
  1. Inflated self-esteem or grandiosity  
  2. Increased activity or energy  
  3. More talkative than usual or pressure to keep talking  
  4. Flight of ideas or subjective experience that thoughts are racing  
  5. Distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli)  
  6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation  
  7. Excessive involvement in pleasurable activities which have a high potential for painful consequences (e.g. engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)  
• Symptoms are not caused by a drug of abuse, medication or a general medical condition  
• A hypomanic episode emerging during antidepressant treatment, and persisting after this has been stopped, counts as a hypomanic episode and implies a diagnosis of bipolar II disorder |

For a diagnosis of bipolar disorder, they are common and dominate the lifetime pattern of the condition: 50% of the time is spent in a euthymic (well) state, 38% in a depressed and 12% in a manic state. If there have only been depressive symptoms, it is not possible to exclude bipolar disorder. Whether depressed patients will develop bipolar disorder is not clear until the first (hypo-) manic symptoms actually occur (in around 10% of depressed patients), typically by their thirties.

‘Patients should undergo a risk assessment at the time of diagnosis’

Over three years, one in 25 people with major depression will develop bipolar disorder. Comorbid social anxiety disorder, generalised anxiety disorder, childhood abuse and problems with the patient’s social support group within the past year may predict this transition.

A family history of bipolar disorder also provides an index of suspicion, with diagnostic concordance highest in identical twins (40-70%) and first-degree relatives (a 5 to 10 times greater risk than in the general population).

Psychosocial influences, including childhood maltreatment, may predispose an individual to develop bipolar disorder in adult life, while social class, social support, and self-esteem may modify the course of episodes.

‘Questionnaires are not useful to identify bipolar disorder in primary care’

If bipolar disorder is diagnosed in secondary care, the secondary care team should liaise with primary care to generate a care plan developed in collaboration with the patient, and monitor mood and activity levels. Care that is integrated and contiguous between primary and secondary agencies favours the overall success of management.

If patients do not have the capacity to make decisions, healthcare professionals should follow the code of