Medical Services

BIPOLAR DISORDERS

1.   Description

1.1   Classifications and synonyms

Bipolar disorders are severe mental health conditions causing significant impairment and disability in those affected. They are characterised by marked swings of mood, which are pathological, and usually recurrent.

Typically, both depressive and manic or hypomanic (see **4.1**) episodes can occur, but various patterns have been recorded, and subgroups recognised.

Various terms have been used in the past, including the following:

- Bipolar affective disorder
- Manic depressive psychosis
- Manic depression
- Manic depressive illness
- Mania
- Hypomania.

The two internationally recognised classifications of mental illness are ICD10 and DSM IV. These descriptive classifications are broadly similar.

In the UK and Europe, ICD10 is widely used, though there is a degree of overlap with DSM IV being used, particularly in the clinical research environment. DSM IV is produced by the American Psychiatric Association, primarily for use in the USA.

The two classifications complement each other, and to assist the understanding of bipolar disorders, terms from both are referred to in this protocol.

The main similarities and differences between the two classifications are as follows:

- Both define individual episodes and patterns of recurrence.
- Both use severity of symptoms and impaired social functioning, to distinguish hypomania from mania.
- A single episode of hypomania or mania fulfils the diagnostic criteria for bipolar affective disorder in DSM IV.
- At least two episodes of mood disturbance, including one where mood has been elated, are required for the ICD10 criteria for bipolar affective disorder to be fulfilled.

DSM IV subdivides bipolar disorder into the following:

- Bipolar I – where an episode of mania has occurred at least once.
- Bipolar II – where there has been hypomania, but mania has not occurred.

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The different diagnostic codes and criteria for ICD10 relevant to this protocol, some further information about DSM IV, and more detail about the diagnostic differentiation between hypomania and mania have been included in the Appendix.

2. Aetiology

The German psychiatrist Kraepelin first used the term manic-depressive insanity in the early 1920's, highlighting in particular, the differences between these patients, and those with schizophrenia (then termed dementia praecox).

The term bipolar was not introduced until the 1960's, when clearer distinctions between unipolar and bipolar illness were drawn. Since that time there has been much research into possible aetiological factors.

A variety of theories as to aetiology have been explored, and it seems likely that both disposing and precipitating factors have a role to play.

2.1 Genetic factors

Of all psychiatric conditions it seems that bipolar disorders are the most genetically determined.

First degree relatives of those with a bipolar disorder have elevated rates of developing a mood disorder themselves. The rates for some of these conditions are as follows:[19]

- Bipolar I - 4% to 24%.
- Bipolar II - 1% to 5%.
- Major depressive disorder - 4% to 24%.

The importance of genetic factors is also strongly supported by the twin studies that have been carried out.

Twin studies have indicated a greater genetic contribution in bipolar disorder, compared with unipolar disorder (depression). If a monozygotic twin has bipolar disorder, the concordance rate for mood disorder in the other twin is 60% -70%. The rate is only 20% if the twins are dizygotic.

Although genetic factors are recognised as being of importance, it is still not known at what aetiological level they operate.

The search for specific causative genes continues, but has so far proved inconclusive. Nonetheless, it seems likely that genetic factors will prove the most important aetiologically, with other factors interacting to varying degrees in an individual.

2.2   Personality

Pre morbid personality would seem to be a relevant factor in some instances (see cyclothymia **4.2**).

2.3   Life events

In contrast with depression, life events play a more uncertain role in the aetiology of mania. It does seem however that on occasion, an event such as bereavement that might be expected to induce low mood, may in fact induce a manic episode. Once a bipolar illness has become established, environmental precipitants seem to assume less importance than at the outset of the illness.

2.4   Physical illness

Both physical illnesses and what might be termed altered physiological states, such as the puerperium can precipitate bipolar episodes. Endocrine changes are thought to be a causative factor in these circumstances.

2.5   Neurobiological factors

It has been known for some time that dopamine agonists such as bromocriptine can produce manic states.

Recent studies have suggested that patients at risk of mania may in some way respond differently to dopamine levels in the brain, although altered dopamine levels have not been demonstrated experimentally.

2.6   Water and electrolyte changes

Increase in the body's residual sodium levels has been noted in both depressive and manic patients. This may be in some way linked to the mode of action of lithium, in preventing relapse in these disorders.

2.7   Neuroanatomical factors

Structural changes ('patchy white matter lesions', and small temporal lobes or caudate nuclei) have been noted experimentally in various parts of the brain. However, studies have been of small numbers of patients, and results inconsistent. No firm conclusions have been drawn to date.[1]

3. Prevalence

Bipolar disorder can occur at any age from early adolescence to old age, and unlike depressive disorders, there are no gender differences evident. Childhood cases have been reported very occasionally.

On average, the condition is first diagnosed during the early to mid twenties. This is an earlier age of onset than for major depression.

Studies in the USA show a point prevalence of 0.4 – 1% and an incidence of 0.3%. Each year, some 600,000 patients are identified and treated in the USA.

In Western countries the lifetime risk is thought to be in the order of 0.6 – 1.1%.

If all diagnostic categories, including less severe forms are included, the lifetime risk is thought to be 2%.[2]

Some studies have shown a higher prevalence in higher social classes. It is not clear whether this is a true picture or whether it simply highlights differences in access to mental healthcare.

The prevalence figures at 6 months show little difference from lifetime figures, indicating chronicity of these conditions.

Mania has been described in a wide range of cultures, with no obvious cross-cultural variations noted.[2]

4. Diagnosis

4.1 Clinical features

The mood swings that characterise bipolar disorders usually include episodes of depression. These in their various forms are described in some detail in a separate protocol (Depressive Disorders). The relevant clinical features of depression will therefore not be described in any depth here.

An explanation of some common terms will help in understanding the clinical features.

Mood – This is a pervasive and sustained emotion. In the extreme, it markedly colours a person's perception of the world.

Elation – This is an elevated mood or exaggerated feeling of wellbeing, which is pathological and a feature seen in mania.

Affect – This differs from mood in that it is much less sustained, often varying in the short term. It can best be described as a pattern of observable behaviours that are the expression of a subjectively experienced feeling state (an emotion).

Mania and Hypomania – These represent different degrees of severity of mood elevation. In hypomania, the clinical features are less marked, and although day-to-day functioning will be affected, the clinical picture is less florid than that seen in mania. Psychotic features such as delusions or hallucinations are not seen in hypomania. In mania, the clinical features are much more marked and the individual's condition may rapidly decline to one of self-neglect, with features such as poor personal hygiene. Inattention to nutritional needs may lead to dehydration. Sustained physical overactivity and aggressive or violent behaviour may ensue.

In general, patients with hypomania or mania will display the following:

- Elevation of mood (although angry or irritable mood can also be displayed).
- Increased activity.
- Self-important ideas.

Physical appearance may be unusual or altered:

- Brightly coloured or ill-assorted clothes may be worn.
- Appearance may be dishevelled and untidy.
- They may appear to fluctuate between overactivity and physical exhaustion.

Observations of speech and thought processes may highlight:

- Rapid or copious speech, often termed 'pressure of speech' ('punning' or 'clanging' may feature).

- Expansive or unrealistic ideas.
- 'Flight of ideas'. This is where thoughts follow in rapid succession and appear to be connected by chance, although some association can be gathered by the listener.
- Extravagant or grandiose delusions.

An example of speech with clang associations would be 'Birmingham, Kingstanding; see the king he's standing, king, king, sing, sing, bird on the wing'[3].

Flight of ideas can be so marked that speech becomes incoherent.

In hypomania the overall train of thought is better retained, so called 'ordered flight of ideas'.

History taking or information from a third party may provide descriptions of the following:

- Increased energy
- Increased appetite
- Loss of normal social and sexual inhibitions
- Overspending
- Increased distractibility
- Reduced need for sleep
- Starting many tasks or activities but failing to complete them
- Poor attention span and ability to concentrate.

These relevant features may not be reported by the patient, who may lack insight into their condition.

As the patient deteriorates, these features may change, and delusions of persecution, 'ideas of reference' or passivity feelings may become manifest.

10 – 20 % of manic patients will display one of Schneider's first rank symptoms of schizophrenia. These are described in a separate protocol (Schizophrenia). In such cases, the common perceptual disturbance is hallucinatory.

Auditory hallucinations may be in the form of voices indicating that the patient has special powers. Visual hallucinations frequently have a religious content.

It is estimated that 60% of bipolar patients will have psychotic symptoms at some time during their illness.

Insight is frequently absent or variable.

The clinical picture may be mixed, with depressive and manic symptoms occurring at the same time. In these cases, a rapid sequence of changes may be seen.

4.2 Manic stupor

The clinical picture of a patient presenting in a manic stupor is very rarely seen now. The face has an elated appearance, and although fully conscious, they remain mute, unresponsive and akinetic throughout. On recovery they may remember having had 'flight of ideas'.

4.3 Rapid cycling disorder

Where the pattern of relapse and remission is frequent, (at least 4 episodes of illness a year), the condition is called rapid cycling disorder. The episodes may be manic, depressive or have a mixed picture. This variant can be triggered by anti-depressants, is more frequently seen in women and is associated with concomitant hypothyroidism. Unfortunately, lithium treatment is relatively ineffective in these cases.

4.4 Bipolar III disorder

This variant has been described by clinicians, but is not included in ICD10 or DSM IV.[1] It is also referred to as pseudo-unipolar bipolar disorder. Individuals with this condition have recurrent depressive episodes, with clinical features suggesting they may develop a bipolar disorder. These include pre-morbid personality, family history of bipolar disorder, and hypomania in response to anti-depressants.

4.5 False unipolar disorder

This term may be applied to recurrent depression originally classified as unipolar, where mania or hypomania develops subsequently. It has been estimated that between 10.7% and 28.4% of those diagnosed with unipolar depressive disorder are 'false unipolars'.[1]

4.6 Cyclothymia

Although not included in the ICD10 classification of bipolar disorders, it is convenient to make mention of cyclothymia at this point. It is classified as one of the persistent mood (affective) disorders in ICD10.

Other terms/synonyms for this include affective personality disorder, cycloid personality and cyclothymic personality.

The disorder is of persistent instability of mood, with both episodes of elation and depression featuring. Episodes are neither severe enough nor of sufficient length for other diagnostic criteria to be satisfied. It is common in relatives of patients with bipolar disorders, and a significant number (30%) will at some point go on to develop bipolar disorder themselves.

4.7 Dysthymia

Similarly, it is convenient to make brief mention of dysthymia, also a persistent mood (affective) disorder at this juncture. Essentially, the relevant clinical feature here is of low mood which although persistent and long standing, is never (or almost never) severe enough to fulfil the ICD10 criteria for a recurrent depressive disorder (mild or moderate severity). The duration will be of years, and can last indefinitely.

Other terms / synonyms for this include depressive neurosis, depressive personality disorder, neurotic depression (with more than 2 years duration) and persistent anxiety depression.

There is no association with the development of a more disabling mood disorder later in life.

4.8 Investigations

Assessment of patients with suspected bipolar disorder requires careful history taking and physical examination to exclude other possible causes (see **4.9**).

Information obtained from a relative or carer can prove vital, as the patient may be unable to recognise the extent of their abnormal behaviour.

In mania, hospital admission is likely to be advisable, as effective care at home is very difficult to achieve.

The following baseline investigations should be carried out to exclude other conditions such as anaemia, electrolyte disturbances or the effects of vitamin deficiencies. Metabolic disorders can also impact on prescribed therapy and need to be identified before treatment commences:

- Full blood count
- Urea and electrolytes
- Thyroid function tests
- Liver function tests
- Vitamin B12 and serum folate levels
- Syphilis serology
- Urine tests – including a screen for illegal substances
- EEG
- Psychometric testing.

4.9   Differential diagnosis

A number of other conditions can present as hypomania or mania, and must be excluded by clinical assessment or the appropriate tests.

- Organic disorders – including hyperthyroidism, anorexia nervosa and frontal lobe disease (tumours or HIV infection).
- Schizophrenia / schizoaffective disorders.
- Agitated depression.
- Endocrine disturbance – idiopathic Cushing's syndrome or steroid induced psychosis.
- Epilepsy.
- Severe physical illness (stroke in particular).
- Psychoactive substance use disorder (amphetamines, cocaine).
- Obsessive compulsive disorder (elation is not usually a feature here).
- Attention deficit hyperactivity disorder (elation is not usually a feature here).
- Transient psychoses induced by extreme stress (elation is not usually a feature here).
- Dissocial personality disorder.

4.10   Co-morbidity with other mental health conditions

This is common and likely to increase disability significantly. Relevant conditions include the various anxiety disorders, alcohol dependence and substance misuse disorders.[4]

Nearly 60% of patients with bipolar disorder are thought to have a substance misuse or alcohol dependence disorder at some point during their illness.[1] These co-morbid conditions are likely to have a significant impact on factors such as response to and compliance with treatment, social functioning and employment prospects.

5. Treatment

Bipolar disorders are not commonly encountered in the primary care setting. Indeed, most sufferers are likely to have been in contact with specialist mental health services.

The management of bipolar disorders can usefully be divided into the treatment of acute episodes, and long-term strategies to prevent relapse.

5.1 Management of acute mania/hypomania

This is best undertaken in a hospital setting. Whilst informal admission is preferable, compulsory admission under the Mental Health Act may be necessary if the patient's wellbeing or personal safety is seriously compromised.

The use of anti-psychotic medication has a pivotal role in the acute phase, the aim being to reduce both physical and mental overactivity, thus preventing the patient's health from deteriorating due to exhaustion or self-neglect. Psychotic features are also likely to improve with such medication.

Both **chlorpromazine** and **haloperidol** are used in the acute situation. They are effective even if clear psychotic symptoms are not apparent. In general, manic patients are likely to be treated with fairly high doses, so extra-pyramidal side effects may be induced (they may be particularly susceptible to these).

One feature of using these drugs alone is that they offer no protection against the depressive downswings that can often follow a manic episode.

In the USA, guidelines advocate the use of **lithium** or **valproate** in the acute situation. However, scrutinising hospital prescribing records indicates that anti-psychotics are still widely used.

Lithium has a slower onset of action compared with anti-psychotics. It is probably less suitable for patients with rapid cycling disorder, or who display prominent depressive symptoms or psychotic features.

Occasionally, newer atypical anti-psychotics such as **olanzapine** or **risperidone** may be used, but evidence to support their use preferentially is lacking.[5]

Other drugs which can be used include the anti-epileptic drugs **carbamazepine** and **valproate**.

In the short term, **benzodiazepines** may be added to the treatment regimen, their purpose being to try and restore normal sleep pattern and to reduce overactivity. Their use also allows lower doses of anti-psychotics to be prescribed.[5]

Electroconvulsive therapy (ECT) is effective in about 80% of patients with acute mania. In practice, it tends to be used in patients who have failed to respond to medication, or those with very severe illness, rather than as a first line option.

5.2   Longer term management

The aim here is to prevent relapse or recurrence. The medications initially prescribed for the acute illness will usually be continued for about 6 months. Anti-psychotic medication should be slowly withdrawn, to avoid sudden recrudescence of mania.

Maintenance treatment with a mood stabilizer should be considered if there have been two or more episodes of illness in less than 5 years.

Lithium is an effective prophylactic agent and remains the drug of choice for long term management of bipolar disorders.[6]

Lithium prevents recurrences of both mania and depression. About 50% of patients respond well to lithium. The remainder demonstrate either no response, or only partial response.[7]

If any of the following features are present then lithium is less likely to be effective:

- Chronic depression
- Rapid cycling disorders
- Mixed affective states
- Alcohol and drug misuse
- Mood incongruent psychotic features.

Contraindications to lithium treatment include:

- Renal insufficiency
- Cardiovascular insufficiency
- Addison's disease
- Untreated hypothyroidism.

Lithium is a toxic drug with a narrow therapeutic window and it can be fatal if taken in overdose. Patients need to have regular monitoring of blood levels whilst taking lithium. A blood level of 0.4-1.0 mmol/l 12 hours after the evening dose is aimed for.

Potential side effects from lithium include:

- Gastrointestinal disturbances
- Fine tremor
- Polyuria and polydipsia
- Weight gain
- Oedema
- Subjective memory disturbances.[6]

Signs of lithium intoxication include CNS disturbance, such as ataxia, coarse tremor and drowsiness.

Lithium can interact with a wide range of other prescribed drugs. Diuretics, in particular thiazides, should be avoided if possible.

Many clinicians believe that lithium has a specific anti-suicidal effect therapeutically. This important hypothesis has not yet been confirmed by research studies.[6]

Although far fewer clinical trials have been carried out, carbamazepine is thought to be as effective as lithium, and can be considered as an alternative in those who are intolerant of, or who respond poorly to lithium.

Valproate may also be used prophylactically with seemingly good effect, either on its own, or in combination with lithium or other mood stabilising drugs.

There is no evidence to date to indicate that valproate should be used in preference to lithium.[8]

Where patients become depressed in spite of lithium treatment, an anti-depressant can be added to the regimen. Treatment of depressive episodes in this way carries with it the risk of inducing manic symptoms or rapid cycling.[9]

Selective Serotonin Re-uptake Inhibitors (SSRIs) are thought to be less likely to induce mania or rapid cycling.

5.3 Cognitive behavioural therapy

Cognitive therapy can have a useful supporting role in the treatment of bipolar patients.[7] It focuses on helping the individual to accept the diagnosis and need for treatment. Patients can also be taught techniques that may avert negative thoughts or maladaptive beliefs.

One experimental study carried out in the UK concluded that cognitive behaviour therapy was useful in helping patients to identify early signs of manic relapse,[10] but that further studies were desirable to clarify the effect of this intervention.[11]

5.4 Compliance

This is an important issue in the management of patients with bipolar disorders. The reasons for non-compliance with treatment are complex. Some patients may be reluctant to stop experiencing the elevated mood swings that they perceive as being pleasurable. Side effects of medication may prove problematic, as may the need for regular blood test monitoring.

An interesting first hand account describing what it is like to have a severe bipolar disorder has been written by Dr Kay Redfield Jamison, herself a respected world authority on the subject.[12] She describes the personal dilemmas inherent in coming to terms with both the diagnosis and the management of the condition. It can certainly not be assumed that detailed knowledge of the condition will in itself ensure good compliance.

For patients who are on lithium, poor compliance is a major issue, as sudden discontinuation can precipitate illness recurrence.[13]

6. Prognosis

The average manic episode, treated or untreated, lasts 6 months. Whilst recovery from the acute episode is the usual outcome, the long-term prognosis is poorer than might be expected. The reasons for this have not been fully clarified by research studies.

Functional prognosis in terms of factors such as employment is similar to other severe mental illnesses such as schizophrenia.

90% of patients who have had a manic episode will have a manic or depressive recurrence.

Less than 20% of bipolar patients are able to achieve a sustained period (5 years) of clinical stability, and social and occupational performance are both significantly reduced.

Long-term follow-up studies (25 years) have shown that the average bipolar patient will have 10 further episodes of mood disturbance. The time interval between relapses tends to shorten with both increasing number of episodes and ageing.

10% of patients diagnosed with a depressive disorder will go on to have a manic illness.

The percentage of bipolar patients who attempt suicide at some point in their illness is estimated to be in the region of 50%.

The suicide rate amongst bipolar patients is increased at 15%.[13]   Premature mortality is also generally increased (with the increase not just attributable to suicide).

Patients with Bipolar II disorder seem to have a better prognosis (but retain the same suicide risk).

Cyclothymia generally runs a chronic course, with 30% of patients going on to develop a full-blown bipolar disorder.

The introduction of newer treatments has not had any measurable impact on prognosis.

In conclusion, in spite of available effective treatment for bipolar disorders, the long-term functional prognosis for these conditions remains disappointing, with high levels of mental health disability likely.

7.   Main Disabling Effects

Bipolar disorders are considered to be one of the 10 leading causes of disability world-wide, amongst adults aged 15-44 years.[14]

In general, rates of relapse are high, and disabling mood symptoms are likely to persist between relapses.[14]

These conditions can cause severe disruption to daily life, affecting all aspects. In severe cases, the ability to self-care in terms of being able to attend to personal hygiene and nutritional needs will be affected.

Motivation, concentration and cognitive ability may be reduced, affecting the ability to complete even simple daily tasks effectively.

Social interaction is frequently compromised, affecting relationships with others both in and outside the home. This feature is persistent and evident between, as well as during, relapses.[15,16] Research has consistently shown that long term psychosocial functioning is poor in up to 60% of patients.[14]

A study carried out in the UK, which looked at various aspects of social functioning, found that within the work environment, the following factors may be seriously affected:[10]

- Timekeeping
- Unauthorised absence
- Relations with peers and supervisors
- Quality or quantity of output.

Despite surveys showing that most people with severe mental illness would prefer to be able to work, unemployment figures amongst this group remain high.

In the USA, the figures range from 75-85%. In the UK the range is from 61-73%.[17]

A survey carried out by the Manic Depression Fellowship found that whilst 69% of those responding wanted to work, and 40% were graduates, only 19% were in full time employment.[14]

Recent research has indicated that supported employment, (placement in competitive employment whilst offering on-the-job support), is more effective than pre-vocational training, (a period of preparation before entering competitive employment), at helping those with severe mental illness to remain in the workplace.[17]

In the USA, supported employment schemes are more widely available compared to the UK, where prevocational training is more likely to be offered.

7.1   Assessing the Claimant

The history obtained from the claimant should be comprehensive, with careful attention paid to looking for consistency between the history, and all other evidence available.

Lack of insight and poor compliance are common features of these conditions, and although these may be obvious in some cases, may not be so apparent in others. Evidence for these features should therefore be actively sought. The mental state examination should cover these and all other relevant aspects. If mood is abnormally depressed or elevated, then this may well influence history features offered by the claimant.

If the claimant is seen with a companion, and wishes him or her to be present during the assessment, it may be possible to obtain useful 'third party' history about both past and present features. This may provide vital supporting evidence about their disability.

Variability is a strong feature of these conditions, and may prove difficult to address. Attempts to ascertain how the claimant is most of the time should be made.

7.2   IB-PCA Considerations

Severe mental illness is one of the exempt categories for PCA. The definition is worded as follows:

> *'involving the presence of mental disease, which severely and adversely affects a person's mood or behaviour, and which severely restricts his social functioning, or his awareness of his immediate environment'*

Social functioning is frequently affected in those with bipolar disorders. Those with established conditions are likely to be taking prescribed mood modifying drugs long-term.

As such, many claimants who have a bipolar disorder will not present for assessment at an examination centre, having been exempted at an earlier stage in the referral process.

The small numbers presenting for examination will require careful assessment of their condition. Prior study of the relevant documents should focus on the following features:

- Duration and severity of the condition
- Pattern of relapse and recurrence of symptoms
- Any previous history of suicidal ideation or behaviour
- Information about compliance and insight
- Co-morbid conditions.

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As with any mental health condition, a point may be reached at any stage in the assessment, where the examining doctor feels that giving exemption advice would be appropriate. Frequent and marked mood swings are likely to indicate a more disabling condition, and if severe, then exemption should be advised, with the usual procedures being followed.

Where a full mental health test is completed, all four areas of activity are likely to be affected, to a greater or lesser degree. Descriptor choice should, as usual, draw on all available sources, including the typical day history and informal observations of the claimant.

Appendix A - Diagnostic codes and criteria

ICD10

Using ICD10 criteria, hypomania is diagnosed if the symptoms of abnormal mood and behaviour are greater than for cyclothymia, last at least several days, and are considerable rather than severe (in terms of how they interfere with work or social activity).

For mania to be diagnosed, symptoms must be present for at least a week, and must be severe enough to disrupt work or social activities more or less completely. Mania is further classified depending on the presence or absence of psychotic symptoms.

The ICD codes for the conditions discussed in this protocol are as follows:

F30 Manic episode

F30.0 Hypomania

F30.1 Mania without psychotic symptoms

F30.2 Mania with psychotic symptoms

F30.8 Other manic episodes

F30.9 Manic episode, unspecified

F31 Bipolar affective disorder

F31.0 Bipolar affective disorder, current episode hypomanic

F31.1 Bipolar affective disorder, current episode manic without psychotic symptoms

F31.2 Bipolar affective disorder, current episode manic with psychotic symptoms

F31.3 Bipolar affective disorder, current episode mild or moderate depression

.30 Without somatic syndrome
.31 With somatic syndrome

F31.4 Bipolar affective disorder, current episode severe depression without psychotic symptoms

F31.5 Bipolar affective disorder, current episode severe depression with psychotic symptoms

F31.6 Bipolar affective disorder, current episode mixed

F31.7 Bipolar affective disorder, currently in remission

F31.8 Other bipolar affective disorders

F31.9 Bipolar affective disorder, unspecified

F34 Persistent mood [affective] disorders

> F34.0   Cyclothymia

> F34.1   Dysthymia

DSM IV – TR

For hypomania to be diagnosed using DSM IV, there has to have been elevated mood for at least 4 days. In addition, at least 3 additional symptoms from the following list must be present:

- Inflated self esteem or grandiosity (non-delusional)
- Decreased need for sleep
- Pressure of speech
- Flight of ideas
- Distractibility
- Increased involvement in goal-directed activities or psychomotor agitation
- Excessive involvement in pleasurable activities that have a high potential for painful consequences.

There should be no evidence of delusions or hallucinations.

Hypomania can be diagnosed if the mood is irritable rather than elevated, but in this instance, 4 of the above additional symptoms are required.

For mania to be diagnosed, the abnormal mood must last at least a week (less if the person is hospitalised). Again, there must also be 3 or 4 of the above symptoms depending on whether the mood is elevated or just irritable. There must also be marked impairment of social or occupational functioning, hospitalisation or the presence of psychotic features.

In DSM IV, the diagnostic criteria are grouped as follows:

Bipolar I disorder

> Single manic episode

> Most recent episode hypomanic

> Most recent episode manic

> Most recent episode mixed

> Most recent episode depressed

> Most recent episode unspecified

Bipolar II disorder

> Specify current or most recent episode hypomanic/ depressed

Cyclothymic disorder

Bipolar disorder not otherwise specified

Numerical codes are allocated which specify one of the above conditions. Severity, presence and absence of clinical features, and pattern of relapse and recovery are also indicated by the code used.

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