Overview of Bipolar Affective Disorder; Differences between Bipolar I Affective Disorder and Bipolar II Affective Disorder

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Abstract

Bipolar affective disorder is one of a group of mood disorders, which also includes unipolar depression and dysthymia. Bipolar disorder has been classified into two main subtypes, bipolar I and bipolar II. It is important to diagnose patients with the correct subtype of bipolar disorder, as treatment and management differs between the two. Misdiagnosis leading to inappropriate treatment carries the risk of harm to others or suicide, most notably in patients with bipolar I. Bipolar I and bipolar II disorder can be largely thought of as similar conditions but at different poles on a spectrum of severity. In fact, a diagnosis of bipolar II disorder is sometimes amended to the more severe bipolar I disorder in a proportion of patients. This paper aims to explore the similarities and differences between the two conditions, as differentiation between the two conditions can often be difficult.

Key Words: bipolar I affective disorder, bipolar II affective disorder.

Introduction

Bipolar affective disorder is a common psychiatric condition previously known as manic–depressive disorder. It is episodic in nature, with fluctuation between depression and elevated mood. The lifetime prevalence of bipolar I disorder varies from 0.4%-1.6% (1). and for bipolar II it is approximately 0.5% (1). With an estimated prevalence of around 1% in the population some research in the USA has pointed out that this does not include people who have symptoms of bipolar disorder but are sub-threshold for the diagnosis criteria outlined in the DSM (Diagnostic and Statistical Manual of Mental Disorders) (1). The study found that prevalence could be as high as 6.4% if all people suffering symptoms are included (2). Although there is no simple 'cure' for bipolar disorder, the management of the condition centres on symptom control, and this can be challenging at times. There may be situations of diagnostic uncertainty when first presented with the symptoms; over a five-year period about 5-15 % of individuals with bipolar II disorder will develop a manic episode and their diagnosis has to be changed to bipolar I (1). With the change in diagnosis, the approach to management also needs to change, in order to minimise risk. Symptoms of each condition are described in more detail below.

Comparison of bipolar I and II disorders

The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM IV), 1994, (1) provides the criteria to distinguish between bipolar I and bipolar II. The following information is from the DSM.

Manic/hypomanic episodes

While bipolar I disorder is characterised by periods of mania, patients with bipolar II disorder have episodes of hypomania, which is less severe than mania (1). The presentation of mania is so florid, distinctive and clear that the diagnosis is usually straightforward (1). In hypomania, the symptoms are not so obvious and additional information is often required to ensure that the right diagnosis is made. At times, the distinction between mania and hypomania can be difficult to make, however, distinguishing the two is important because the risk of harm to the patient (e.g. suicide/self harm/consequences of high risk activities) increases significantly with mania (1). See table 1 for a comparison of symptoms seen in mania and hypomania.

Both manic and hypomanic episodes start suddenly and develop rapidly. They are often triggered by a stressful event. According to DSM IV, a manic episode is defined by a distinct period during which there is an abnormally and persistently elevated, expansive or irritable mood, which lasts at least one week (or less if hospitalization is required) (1). The definition of a hypomanic episode is similar, the main difference being that the mood change is sufficient to be noticeable but not to cause a great deal of impairment in social function or require hospitalisation, unlike in mania (1). In some cases, hypomanic episodes can develop into mania.

In manic episodes of bipolar I, inflated self-esteem is typically present and may be one of the first symptoms that makes the psychiatrist suspect this disorder. It can also be present in a milder form in hypomania. This 'grandiosity' in manic episodes may become delusional, and other psychotic symptoms such as hallucinations can occur; this is termed affective psychosis (1). These additional psychotic symptoms are rarely present in hypomania.

In both conditions the amount of sleep is reduced, which goes along with increased level of energy. Manic speech is the hallmark of the disorder. The patient speaks non-stop and very quickly; it is like a waterfall of words, powerful and unstoppable. The patient's thoughts jump from one topic to another (1). If the flight of ideas is severe, the speech may become disorganized and incoherent. When an attempt is made to interrupt a patient in mania this can provoke irritability and aggression (1). The speech in hypomania is often louder and more rapid than usual but it is not typically difficult to interrupt (1). Flight of ideas is not common. In Bipolar I, there is significant increase in goal-directed activities, which very often lack touch with reality and which other people find strange (1). In hypomania individuals often become more creative and productive but their activities are not bizarre (1).

The patient is seldom aware of the change in their mood during the manic/hypomanic episode; it is something that is usually recognised by people around them. However, retrospectively patients often regret their behaviour and actions during the episode and are aware that they were not behaving in a way that was normal for them.

Depressive episodes

One or more major depressive episodes can be seen in both bipolar I and bipolar II disorders but in bipolar II, such an episode is a requirement for the diagnosis (1). If a major depressive episode presents in the context of Bipolar I disorder, it is more likely to coexist with psychotic symptoms, possibly owing to the greater severity of bipolar I (1). Therefore, in any patient who has a psychotic depressive episode, the possibility of bipolar disorder should be considered and specific enquiry should be made regarding any history of possible manic or hypomanic episodes.

Some patients also have panic attacks during depressive episodes, as well as appearing anxious and developing phobias. For some patients, the symptoms manifest themselves physically as pain in the abdomen, joints, head or other parts of the body.

A study in Sweden showed that training for better recognition of depression, as part of bipolar disorders as well as major depressive disorder, significantly reduced the rate of depressive suicide in the period after the training (3). This shows that early recognition and treatment of depressive episodes can decrease probability of the worst outcome from this aspect of the disorder.

Mixed episodes

Bipolar I disorder can, less commonly, present as a mixed episode. The DSM-IV criteria for a mixed episode are: 1) the presentation must meet the criteria for both a manic episode and for a major depressive episode nearly every day during at least a one-week period; 2) 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 hospitalization to prevent harm to self or others; 3) the symptoms are not due to the direct physiological effects of a substance or a general medical condition (1).

The 5th edition of diagnostic and Statistical Manual of Mental Disorders, DSM-5 will be released soon. While the DSM IV defined mixed episodes separately from episodes of hypomania, mania and depression, the new classification will experiment with allowing symptoms of the opposite pole to be recognised if they arise during an episode, even if they are insufficient to qualify as a mixed episode. Identification of subthreshold non-overlapping symptoms of the opposite pole will done using a "mixed features" specifier to be applied to manic episodes in bipolar disorder I (BD I), hypomanic, and major depressive episodes in BD I, BD II, bipolar disorder not otherwise specified, and major depressive disorder. This may have an impact on future treatment and demographics of the disorder (4).

Psychosocial effects

The manic episodes of bipolar I disorder tend to cause more disruption to the life of the patient than the hypomanic episodes of bipolar II disorder; people with hypomania often continue going to work, even though they are prone to make mistakes. People in mania cannot function at all; their occupational functioning is completely impaired. In between episodes, the majority of patients with both forms of this disorder return to a fully functional level. However a proportion of patients continually experience mood instability and difficulties in functioning between episodes; this happens in 20-30% of those with bipolar I, and in 15% of those affected by bipolar II (1). The associated cognitive impairment is one of the reasons why many people with bipolar disorder may find it difficult to keep jobs (5).

Effects of age

For all forms of bipolar disorder the episodes tend to become more frequent with age and more difficult to treat. This could be because advancing age is associated with changes in the sleep-wake cycle and this can precipitate either a hypomanic or a manic episode.

Gender differences

As there are two aspects to the disorder, mania and depression, either of these changes in mood can present first. If a male develops any form of bipolar affective disorder, the first episode is more likely to be manic, while in women, it is more likely to be depressive. Bipolar I disorder is thought to be equally distributed among both sexes, while bipolar II is more common in women.

Neurobiology

While bipolar II disorder is commonly described as being a milder form of bipolar I disorder on a spectrum, recent research comparing neurological activity in the ventral striatum in the two disorders has shown that this region is significantly more active in bipolar II disorder during reward anticipation compared to bipolar I and normal controls (6). This could suggest that bipolar II disorder represents a more extensive change in neurological processes, or a different aetiology compared to bipolar I disorder. However very little is known about the neurobiology of the disorders and more research is required to elucidate mechanisms affected in the brain.

Diagnosing bipolar disorder

It is recognised that it can be difficult to make a diagnosis based on a limited time period of history, which is why time is a helpful diagnostic tool throughout management.

The DSM IV classification contains the criteria to diagnose bipolar disorders. For the diagnosis of bipolar I disorder, one single manic or a mixed episode is sufficient. In order to make a diagnosis of bipolar II disorder there must be one or more major depressive episodes and at least one clear hypomanic episode. In both conditions the mood disturbance must be accompanied by at least three additional symptoms. These symptoms include: inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation and excessive involvement in pleasurable activities with a high potential for painful consequences. If the mood is irritable (rather than elevated or expansive) at least four of the additional symptoms must be present. Together with these symptoms there is an impairment in social, occupational or other important areas of functioning in both conditions, but to a greater degree in bipolar I than bipolar II.

Differential diagnoses must be considered for patients presenting with mood disturbances. The main feature to establish in any case is whether the change has been caused by any medications or other substances (substance-induced mood disorder). Another possibility is that it is an element of another medical condition that the patient may have. A diagnosis of bipolar I or II cannot be considered if such causes can explain the mood changes

In addition, it can be particularly difficult to distinguish between bipolar I and II if the predominant change is increase in irritability, as this could be a feature of a depressive, manic, hypomanic or mixed episode, as seen in table 1. Irritability also overlaps into a number of other conditions, including major depressive disorder or dementia in the elderly, or even just a change in life circumstances leading to a reasonable reaction in keeping with the individual's personality.

For symptoms of increased excitability, as well as distinguishing between a manic, hypomanic or a mixed episode, other causes could include ADHD (especially when symptoms were present in childhood), or a euthymic period of time in patients who have chronic major depressive disorder.

Conclusion

Bipolar affective disorder is a complex and challenging condition. In some cases the diagnosis is relatively straightforward. There is a gradation between bipolar I and bipolar II disorder, where bipolar I is the more complete form of this disorder. It therefore follows that, although the risks are similar between the two, they are of greater degree in bipolar I. In particular both conditions carry an important risk of suicide (2,3), which can be decreased by effective treatment with mood stabilisers.

GP Comment

What have I learned from this paper?

I enjoyed reading this excellent clear summary of bipolar I and II. As a generalist, we often expect patients with bipolar to have 'bipolar I', so it is useful to consider the more subtle presentation of bipolar II to help detect this as early as possible. This article highlighted to me how helpful a collateral history can be regarding hypomanic episodes and these episodes could present to a GP indirectly, as concern expressed by a relative about another patient on the list. By being alert to the condition, as I will be now, we can help to diagnose it sooner.

Dr Abigail Davis, GP Trainee.

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Table 1: Comparison of different mood states

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	Mania	Hypomania	Depression	Mixed
Most associated disorder	BAD I*	BAD II	BAD II (+ I)	BAD I
Mood	Persistently elevated/expansive/irritable mood	Persistently elevated/expansive /irritable mood	Depressed mood Can also be irritable	Alternating: sadness, irritability, dysphoria, euphoria
Psychomotor effects	Agitation, sometimes catatonic	Agitation	Agitation/retardation	Features of mania/depression
Duration	≥ 1 week	≥ 4 days	≥ 2 weeks	≥ 1 week
Severity:				
Noticed by others	Yes	Yes, but only those who know patient well	Yes	Yes
Requires hospitalisation	Sometimes	No	Sometimes	Sometimes
Psychotic symptoms	Sometimes	No	Sometimes	Yes
Self-esteem	Greatly increased (grandiosity)	Increased	Reduced (guilt, suicidal)	Alternating
Distractibility	Very High	High	Inability to concentrate	High
Speech	Rapid, unstoppable	Louder, stoppable, jokes, puns	Quiet, withdrawn	Alternating
Flight of ideas	Yes	Uncommon, brief if present	No	Sometimes
Goal directed activities	Yes, often bizarre, more associated danger	Yes, but more creative or productive, Less dangerous	No, Indecisiveness, anhedonia	Sometimes
Sleep	Reduced		Insomnia/hypersomnia	Alternating
Energy	Increased		Reduced	Depends on individual
Weight	Unaffected		Loss/gain	-

Information from the Diagnostic and Statistical Manual of Mental Disorders DSM IV
*Bipolar affective disorder I