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Review

Differentiating bipolar I and II disorders and the likely contribution of DSM-5 classification to their cleavage

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ABSTRACT

Current diagnostic criteria define bipolar I (BP I) and bipolar II (BP II) disorders as distinct conditions, differing only slightly by clinical features. This review seeks to identify commonalities and differentiating features across the two sub-types, and emphasize that differences in causes and treatments are likely to be highly dependent on the diagnostic criteria used to define and differentiate the two conditions. We undertake a literature review of candidate clinical features that might be anticipated to vary or be shared across BP I and BP II disorders, and consider the impact of DSM definition on such applied findings. Studies respecting DSM-IV differentiation of BP I and BP II disorders have generated relatively few differences across the conditions, which may reflect definitional similarity or commonalities across the two conditions. As DSM-5 decision rules are similar to those used by DSM-IV to differentiate BP I and BP II disorders, we argue for application studies employing DSM-5 decisions to examine the differential impact of three features that weight BP I assignment (i.e. psychosis, hospitalization and/or impairment) and examine other sets of differentiating criteria.

Contents

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1. Introduction

Bipolar I (BP I) and bipolar II (BP II) disorders are generally viewed as dimensionally or categorically separate conditions by theoreticians, with the latter model weighted in the fourth edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV; American Psychiatric Association, 1994) and currently in DSM-5 (American Psychiatric Association, 2013). Their clinical distinction is of central importance if they differ etiologically, in their natural course or by showing differential treatment responses to differing treatment modalities. While there have been a number of detailed reviews of BP II disorder (e.g. Dunner, 1993; Vieta and Suppes, 2008), we are not aware of any published review of features differentiating the two conditions, and so address that topic. The recent release of DSM-5 provides an opportune time to review the relevant literature but also invites a question. DSM-5 criteria for BP I and BP II disorders are strikingly similar (as they were for DSM-IV). If the two conditions differentiate minimally across studies considering their clinical features, causes and treatment response, does this argue against their classification as separate (as against dimensionally varying) conditions, or might it more reflect the lack of differential DSM-based defining features?

2. A brief historical overview

As noted by Goodwin and Jamison (2007) medical 'conceptions of mania and depression are as old as medicine itself,' and, while 'few maladies have been represented with such unvarying language,' the 'boundaries that define mania and depression and the relationship between them have changed during that time' (p. 3). Both those authors and Shorter (2012) detailed nuances to the multiple definitions of manic-depressive illness over the centuries. For example, while Kraepelin included all expressions of depression and mania under the one 'manic-depressive' categorical umbrella, Kleist et al. subsequently positioned two types of depression – one associated with unipolar disorders and the other with bipolar disorders.

Diagnostic conceptualizations of BP II are less clear, but again, changed definitions are observable over time. Hecker (1989) described a cyclothymic illness with periods of chronic depression and hypomanic periods. As overviewed by Dunner (1993), a series of biological National Institute of Mental Health-based studies of mood disorders conducted in the 1960s prompted suggestions by Bunney, and Goodwin et al. that bipolar patients might be more meaningfully classified into BP I and BP II sub-groups. Their criteria for BP I disorder required a history of mania severe enough to result in treatment and usually hospitalization, and often associated with psychotic features. By contrast, BP II disorder criteria required episodes of depression necessitating hospitalization, and hypomanic episodes. Dunner et al. (1970) then subdivided bipolar patients into three sub-types: (i) BP I – for patients hospitalized specifically for mania, (ii) BP II – for patients hospitalized for depression (only) and with a history of hypomania not requiring treatment, and (iii) BP III – for patients hospitalized for depression, having hypomanic episodes not requiring treatment. As some 80% of the non-BP I patients had never been treated for hypomania, the initial BP II and III groups were subsequently consolidated into a single 'BP II' category, and a 3-day minimum duration of hypomania imposed to exclude false positive diagnoses reflecting premenstrual mood symptoms (Dunner et al., 1976). Two decades later, BP II disorder was formally included for the first time as a discrete diagnostic entity by DSM-IV and such a distinction has continued in DSM-5.

Subsequently, other diagnostic nuances have entered the psychiatric lexicon, including 'bipolar NOS' or 'not otherwise specified' (generally reflecting the bipolar condition not meeting duration criteria), 'sub-threshold' bipolar (generally reflecting conditions not meeting full symptom or duration criteria) or 'soft' bipolar reflecting a lack of 'hard' pathognomonic symptoms, course of illness and treatment response variables (Ghaemi et al., 2002), but with this review not considering these variants in any detail.

We now overview a number of candidate domains that allow consideration as to whether BP I and BP II disorders share commonalities or evidence differential features, and note that the majority of studies considered employed adopted DSM-IV criteria for BP I and II disorders.

3. Studies examining for commonalities and differences across BP I and BP II disorders

3.1. Epidemiology

Prevalence estimates vary widely over time and geographical regions, clearly influenced by diagnostic criteria and measurement strategies. Hadjipavlou et al. (2012a) reviewed several historical studies, before concluding that 'a reasonable overall figure' for the lifetime prevalence of bipolar disorder (in general) is 'in the vicinity of 5%'. Merikangas et al. (2011) compared aggregated lifetime prevalence rates of DSM-IV-defined BP I and BP II disorders across 11 countries, quantifying rates of 0.6% and 0.4%, respectively, and with a 'sub-threshold bipolar disorder' rate of 1.4% (with this latter category again likely comprising many individuals meeting DSM-defined BP II disorder other than duration criteria), suggesting a likely higher prevalence rate of BP II relative to BP I disorder. Thus, variable minimum DSM-IV duration criteria appear particularly likely to influence BP II prevalence rates. As noted by Vieta and Suppes (2008), broader definitions of hypomania would likely transfer a significant amount of bipolar NOS cases to the BP II category.

Extending that point, while several studies (Weissman et al., 1991; Cicero et al., 2009) have reported slightly higher prevalence rates of BP I than BP II disorder, more recent studies with relaxed DSM duration criteria quantify BP II as the more common bipolar condition. For example, the Zurich Cohort Study (Angst, 1998) quantified lifetime rates of 0.5% and 1.7% for DSM-IV-defined BP I and BP II respectively – but with prevalence rates of BP II disorder rising to 5.3% and 11.0% respectively when 'hard' or 'soft' Zurich criteria were applied (while the BP I rate remained constant). Similarly, a Hong Kong study (Lee et al., 2009) quantified lifetime prevalence rates of 2.2% for BP I, 2.2% for BP II, and 10.7% for 'soft' BP II – with the last respecting DSM-IV criteria other than allowing its 4-day minimum duration criterion. Epidemiological data appear distinctly influenced by the diagnostic instrument used. For example, Mitchell et al. (2013) reported differing 12-month prevalence rates (1.5% vs. 0.5%) of BP I using an uncalibrated vs. recalibrated Composite International Diagnostic Interview (CIDI) compared to the Structured Clinical Interview for DSM-IV (SCID), while BP II disorder rates remained similar (0.2% vs. 0.4%).

It is commonly suggested that bipolar disorder diagnostic rates are increasing, and more distinctly for BP II disorder (Parker and Fletcher, 2012). Any such increase could reflect artefactual factors (e.g. greater awareness and help-seeking, destigmatization, improved screening, and methodological strategy) or a true increase. Community studies show the highest lifetime rates of bipolar disorder in younger subjects – seemingly paradoxical when it might be expected that lifetime rates for any condition should rise with age unless the condition has a high mortality rate. For example, the US National Comorbidity Survey Replication