

Editorial

Et tu bipolar II?

There is currently lively debate as regards the diagnosis of bipolar disorder. Generally, there is consensus that bipolar I disorder, characterised by mania, is distinct as compared to unipolar major depression. This is demonstrated to some extent across the phenomenology, population characteristics, genetics and neurobiology of the two phenotypes. However, the diagnosis of bipolar II disorder and the concept of a 'bipolar spectrum' have caused controversy. Clinicians have been accused of over-diagnosing bipolar disorder with the boundaries of the illness seemingly continuing to expand in all directions. For instance, age is a diminishing constraint, with a diagnosis of bipolar disorder in children no longer uncommon. In practice, the label 'bipolar' is being increasingly used to explain a wide variety of signs and symptoms, with the illness itself seemingly capable of mimicking all manner of presentations. Part of the reason for this is that many patterns of illness can be subsumed within 'bipolarity', given the complexity of its manifestations, for example sub-syndromal, prodromal, mixed states, rapid cycling, and antidepressant-induced hypomania (bipolar III), to name but a few. Complicating this further, subtypes beyond bipolar II have been proposed (1) that encompass combinations of hyperthymic temperament and depressive states (bipolar IV), and patients who appear phenotypically unipolar but have a bipolar 'genotype' (bipolar V). Many of these 'subtypes' are as yet unsubstantiated and remain largely theoretical; however, one subtype that clearly has risen to prominence is that of bipolar II disorder in which there is recurrent anergic depression along with hypomania. According to DSM-IV criteria, bipolar II disorder hypomania is said to last at least 4 days, and the episodes are characterised by a number of features, for example heightened cheerfulness, talkativeness, increased optimism and confidence, enhanced sexual drive and behaviour, disinhibition that results in over-involvement in new projects and a diminished need for sleep. The fact that there are changes in mood and energy that characterise hypomania and mania, and that clinically these are clearly very different from the

typical symptoms and signs of depression, is not a matter of contention. It is the duration and severity of these symptoms and signs and the variable context within which they occur that has resulted in diverse opinions.

A number of studies, old and new, have suggested that the modal duration of hypomania is 2 days as opposed to the somewhat arbitrary threshold of 4 days that is employed by DSM-IV (2,3). Some researchers have suggested that an even shorter duration of hypomania should suffice (4); and hence, in the past decade, a number of opinion leaders have attempted to achieve a consensus as regards diagnostic categories so as to test and validate the bipolar spectrum. In this regard, it is interesting to note that although, the Research Diagnostic Criteria defined both a 2-day and a more conservative 7-day duration criterion for hypomania, when these two definitions were used in a recent study that examined the course of bipolar II disorder, they failed to adequately distinguish illness-related parameters (5).

A fundamental problem may be the use of non-discriminatory items to define bipolar categories or alternatively, the application of categorical bipolar definitions to a dimensional disorder. In either case, just as Julius Caesar is likely to have wanted to say more than his final few words, there is evidently much more to be said about bipolar II disorder. To this end, further research is clearly warranted, especially if we are to make much of an advance beyond the ideas of Kahlbaum, Hecker and Kraepelin.

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