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Review Article

Diagnostic guidelines for bipolar disorder: a summary of the *International Society for Bipolar Disorders* Diagnostic Guidelines Task Force Report

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The Diagnostic Guidelines Task Force of the International Society for Bipolar Disorders (ISBD) presents in this document and this special issue a summary of the current nosological status of bipolar illness, a discussion of possible revisions to current DSM-IV and ICD-10 definitions, an examination of the relevant literature, explication of areas of consensus and dissensus, and proposed definitions that might guide clinicians in the most valid approach to diagnosis of these conditions given the current state of our knowledge.

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*See Appendix 1 for the complete list of the ISBD Diagnostic Guidelines Task Force Members.

In the bipolar disorder literature, treatment guidelines are common (1, 2), but diagnostic guidelines (outside of DSM-IV and ICD-10) are infrequent or added onto treatment guidelines as a matter of form, rarely adding substantively to this body of literature; as such, diagnostic guidelines are almost an afterthought. Yet, in the practice of psychopharmacology, treatment decisions are often straightforward once diagnostic judgments are made; it is often rather the diagnostic assessments that are more complex (3). This is especially the

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case with bipolar illness, a condition that overlaps with multiple mood, psychotic, anxiety, and personality disorders (4, 5). Before one can enter into questions of treatment, diagnostic agreement needs to be achieved. To address this problem, the *International Society for Bipolar Disorders* (ISBD), with Samuel Gershon as president, convened a diagnostic task force that began work in 2004 and presents in this issue of *Bipolar Disorders* the results of its deliberations. The purpose of this task force was to (i) evaluate all current diagnostic systems, (ii) elucidate the key similarities and differences among these systems, and (iii) arrive at some reconciliation of the existing data that provides a useful organizational schema for diagnosis of bipolar disorder across many different cultures while outlining the remaining differences for further study.

The goals of this task force were partly to feed into the next revision of the DSM nosology but also to be useful for clinicians in their understanding of how best to diagnose bipolar conditions, and to be useful to researchers in highlighting areas of dissensus and ignorance.

Methods

This project was conducted almost entirely through electronic communication, with two meetings of some of the members of the task force at the 2005 and 2007 International Conference on Bipolar Disorder (ICBD) meetings in Pittsburgh, PA, USA. The task force was conceptualized, chosen, and convened solely through the involvement of the ISBD executive committee without any outside input. The president and executive committee of ISBD recommended the first author as chairperson and together with him they selected individuals who had demonstrated research activity in diagnosis of bipolar disorders for the task force. Obviously not all experts were included in the task force, but all those included are experts. The work of the task force was coordinated by administrative staff of ISBD. The results of the task force have been solely written and examined by the authors of the task force. Each of the papers has undergone independent peer review as per the requirements of the journal in addition to editorial review both by the Guest Editor and Editors-in-Chief.

The task force divided into subgroups based on diagnostic subtypes for more intensive analysis, and each subgroup was led by a chairperson, represented as coauthors on this summary paper; the subgroups were acute mania, mixed states, bipolar depression, rapid cycling, spectrum concepts, schizoaffective disorder, pediatric bipolar disorder, and bipolar disorder type II. More subgroupings were considered but these eight groups were chosen as covering most of the relevant diagnostic material. Each subgroup included three to five individuals. A few individuals were also included in the task force who did not have bipolar specialization but who had expertise in psychiatric nosology in general; they provided general input to a number of subgroups.

To maximize consistency of subgroup reports, the task force decided to organize them around three sections. In the first section, members of the task force were asked to assess the classic diagnostic validators used in psychiatric nosology (6): phenomenology, genetics, longitudinal course, treatment response (where diagnostically relevant), and neurobiology (to the extent available and relevant). In the second section, special topics that are important in nosology were assessed: these included gender, functional impairment, quality of life, the role of value judgments, cultural aspects, the role of personality, clinical utility, dimensional versus categorical concepts, the boundary problem [how to distinguish the condition from other illnesses (7)], and the threshold problem [how to distinguish the condition from normal psychological experience (8)]. In the third section, members were asked to reconcile the available information, assessing areas of consensus and 'dissensus' [as suggested by task force member William Fulford to identify disagreement (9)].

Summary of results

The results of each task force subgroup, except mixed states, are published in this issue. In this paper, we provide an overview of those results in two parts. The first part (Table 1) provides a summary description of the conclusions for each diagnostic subtype; the second part provides proposed changes to ICD-10 descriptions and DSM-IV criteria.

PART I: Summary of review of the literature for bipolar diagnostic subtypes

Mania

This diagnostic subtype is of course the fundamental basis for the DSM-IV nosology, and was instituted as such in DSM-III in 1980. This task force subgroup, headed by Frederick Cassidy (10), thus was assessing the current mainstream view of bipolar nosology. It concluded that the main basis for this subtype of bipolar disorder is

Table 1. Tabular summary of the deliberations of the Diagnostic Guidelines Task Force of the *International Society for Bipolar Disorders*

Diagnostic validators	Mania	Bipolar depression	Rapid cycling	Type II	Bipolar spectrum illness	Pediatric bipolar disorder	Schizoaffective disorder
Phenomenology	++++	++	+	++++	++	+++	++++
Course	+/−	+++	++++	++	++	++	+++
Genetics	+	+++	+/−	++	+	++	+++
Treatment response	++	++	++	+	++	+	+/−
Neurobiology	++	+/−	+/−	+	+/−	+/−	++
Special topics	Pure mania often includes dysphoric/irritable presentations	Probabilistic differentiation from unipolar depression proposed	Dimensional approach to ultradian cycling merits investigation	Value judgments important in identifying it versus mania or normality	Clinical utility important	Key diagnostic overlap with ADHD and ODD	Dimensional model of psychosis is suggested
Areas of consensus	Broaden definition to include irritable/dysphoric states	Some key features are more common than in unipolar depression	Importance for prognosis	Severe depressive morbidity is prominent	Importance for future investigation	Narrow grandiose euphoric phenotype is similar to adult bipolar disorder	Does not represent a separate categorical disease-entity
Areas of dissensus	None	Relevance for treatment response	Association with antidepressant use	Relevance for treatment response	Underlying validity of broadened model, and relevance for treatment response	Diagnostic validity of broad irritable/aggressive phenotype; relevance for treatment response	Whether a dimensional one-psychosis model is implied versus comorbidity of schizophrenia and severe affective disorder

++++ = data strongly informative for diagnostic validity; +++ = data moderately informative for diagnostic validity; ++ = data mildly informative for diagnostic validity; + = data slightly informative for diagnostic validity; +/− = equivocal or no data informative for diagnostic validity; ODD = oppositional defiant disorder; ADHD = attention-deficit hyperactivity disorder.

based on phenomenology: the presentation of acute mania is rather classic and dates back to Kraepelin's era (11). This subgroup did note that a good deal of evidence is emerging that some mixed features (like irritability and aggression) are commonly present in manic presentations. Thus, when assessing the issue of mixed states from the perspective of mania, phenomenological studies suggest that the definitions given to acute mania should include an irritable/aggressive/dysphoric component. The relevance of biology, course of illness, and treatment response to our diagnostic of acute mania seem rather limited at present, and genetic studies of mania per se were not discussed by the subgroup. Among special topics, the task force noted the importance of substance abuse and seasonal patterns. It concluded that less restrictive definitions of mixed mania appear to be warranted. Given the absence of much evidence outside of symptom phenomenology, the task force highlighted the need for more attention, both in practice and in research, to other diagnostic validators like course, genetic predisposition, treatment response, and comorbidities.

Bipolar depression

This task force subgroup, headed by Philip Mitchell (12), viewed bipolar depression as able to be distinguished from unipolar depression dimensionally, not categorically, based primarily again on phenomenology, particularly with hypersomnia/hyperphagia, psychomotor changes, and psychotic features. Course is also informative, with briefer and more recurrent depressive episodes in bipolar illness compared with unipolar depression. Postpartum and early age of onset are also important course markers for bipolar versus unipolar depression. Genetic information is also relevant as bipolar disorder family history is more prominent in bipolar depression, compared with unipolar depressive illness. Treatment response is controversial and data are conflicting. Although some data suggest differential response, at least with increased risk of antidepressant-induced

mania in bipolar as opposed to unipolar depression, neurobiological data do not seem to differentiate bipolar depression from other depressive conditions, although such evidence is limited. Although the task force concludes that there are no pathognomonic characteristics that identify bipolar depression compared with unipolar depression, certain features are more frequent and clinically informative. The subgroup describes this as a 'probabilistic' approach to the differentiation of bipolar from unipolar depression, and offers a heuristic of operationalized criteria to be studied empirically. Areas of dissensus persist on some features, such as the relative frequency of atypical and melancholic depressive features in bipolar versus unipolar depression, as well as in the nature of antidepressant response (same, better, or worse), or antidepressant-related worsening, in bipolar depression compared with unipolar depressive illness.

Rapid cycling

This task force subgroup, headed by Michael Bauer (13), focused on the course of illness as key to identifying rapid cycling bipolar disorder. It found mostly supportive evidence for the current approach of defining this condition categorically by the presence of four or more mood episodes in a one-year period. However, it noted that some evidence existed for further examining dimensional approaches to descriptions of concepts like ultra-rapid cycling, as well as the boundary between such ultra-rapid mood swing states and mixed episodes. Genetic data and neurobiological studies were limited. Treatment response focused on the controversy about the role of antidepressants as causative agents for rapid cycling bipolar illness. There is clearly dissensus on this latter issue, although it is key to determining whether rapid cycling is mostly an iatrogenic condition, or whether it possesses independent nosological status.

Type II bipolar disorder

This subgroup, headed by Eduard Vieta (14), examined the type II diagnosis, which was introduced into DSM-IV in 1994. The concept of type II bipolar disorder is primarily based on phenomenology and functional impairment: the occurrence of manic symptoms without significant social or occupational impairment of function picks out the hypomanic episode (a duration criterion that is shorter than the one-week criterion for mania is also relevant). The epidemiology literature indicates that bipolar type II disorder is relatively common, more so apparently than type I bipolar disorder, and according to at least some genetic data, this presentation may be the most common phenotype of bipolar illness in the community. It is unclear whether type II bipolar disorder is inherited preferentially in persons with type II bipolar disorder as opposed to type I bipolar disorder. The course of bipolar II disorder involves, by definition, less severe morbidity than type I illness for manic episodes, but at least as much, if not more, morbidity than type I illness for depressive illness. Rapid cycling may be more prevalent as well in type II illness. Colom et al. (15) have suggested that predominant polarity is an important nosologic aspect of bipolar illness, and clearly depressive polarity is much more prominent in type II illness than in type I illness. The suicide rate is also perhaps somewhat higher than in type I illness. Treatment response to antidepressants, which might differentiate this illness both from type I bipolar disorder and from unipolar depression, remains controversial. Some evidence suggests lower acute manic switch rates in type II bipolar illness than in type I bipolar disorder, yet it is unclear whether similar benefit is seen in type II bipolar disorder with antidepressants as is seen in unipolar depression. Early neurobiological data suggest some differences between types I and II bipolar disorder. Perhaps the greatest nosological problem with type II bipolar disorder is the threshold problem in differentiating hypomania from normal happy mood. To some extent, Hagop Akiskal's quip about the relevance of course of illness ['hypomania is recurrent; happiness is not' (16)] reminds us that hypomania is not a one-time event, but should, as with all the above conditions discussed in this paper, be seen in the context of the overall course of illness, family history, and treatment response. Nonetheless, differentiating hypomania from mania is highly value-based (what is functional versus not among manic symptoms?), as is differentiating hypomania from normal happiness. These value-related issues account for the observation in DSM-IV field trials that type II bipolar disorder was among the least reliable diagnoses. This subgroup concluded that type II bipolar disorder is perhaps best conceptualized as part of the spectrum of bipolar illness, although a part of the spectrum that is getting better identified clinically and therapeutically. There is still a need for good nosological work, however, to differentiate this illness, located in the middle of such a proposed spectrum, from the extreme of clear mania and the other extreme of clear normality.

Bipolar spectrum illness

This task force subgroup, headed by James Phelps (17), determined that the phenomenological and epidemiological literature was somewhat supportive of a spectrum model of bipolar disorder, i.e., one that views the different presentations of this condition as more or less manic symptoms, rather than simply presence or absence of the full manic or hypomanic syndrome (as in DSM-IV type I or type II bipolar disorders). Yet the task force was also mindful of the need to better validate this proposal, and the possibility that nosological studies may not validate it. This judgment is made partly on the phenomenology studies, but also based on treatment response studies, and somewhat on evidence from course. The genetic evidence as yet is limited, and no meaningful biological data are informative. In relation to treatment response, it appears that such milder varieties of manic or hypomanic symptoms may be associated with worsened antidepressant response compared with pure unipolar depressive conditions. The course of these proposed bipolar spectrum conditions are also more similar to classic bipolar type I illness than classic unipolar depression, e.g., by being more recurrent or severe. The task force focused on the conceptual and practical advantages if such a spectrum model were accepted, and noted that the matter may not require an either/or decision: it could be that the same nosological material can be interpreted dimensionally or categorically depending on the purposes of one's interpretation. This subgroup recommends that future researchers and clinicians, and the next revisions of DSM and ICD, be open to spectrum interpretations of bipolar disorders.

Pediatric bipolar disorder

This task force, headed by Eric Youngstrom (18), was faced with another controversial topic. It noted that studies of phenomenology could inform diagnostic progress in children with bipolar disorder. For instance, elation when present appears to rule in, but when absent does not rule out, bipolar illness in children; in contrast, irritability when absent may rule out, but when present does not rule in, pediatric bipolar illness. Thus, phenomenology is quite informative. Although genetic studies in children have not been conducted much, nonetheless the genetic component of diagnostic validation appears important as the presence of bipolar illness in the parents of such children is an important diagnostic marker. The course of illness in children with bipolar disorders tends to involve mixed episodes with rapidly fluctuating mood states, and such an early onset of bipolar illness may predict worse prognosis into adulthood. Treatment response may also be informative if, as some data suggest, antidepressants and/or amphetamines may lead to mania or mixed states (including possibly suicidality) in children with bipolar disorder. Neurobiological evidence is limited here, with emerging consensus about morphological and functional changes associated with pediatric bipolar disorder, but meager evidence as to whether such findings are specific to cases with bipolar versus other forms of pathology. Areas of consensus include the idea that some presentations in children are similar to manic symptoms in adulthood, that bipolar disorder in children is not reducible to attention-deficit hyperactivity disorder (ADHD; though they often co-present), and that there is more risk of bipolar disorder in children whose families include persons with bipolar disorder. Areas of dissensus include the relative importance of elation versus irritability in the phenomenology of the manic syndrome in childhood, the risks of antidepressant/amphetamine use, the overlap with ADHD (whether this represents true comorbidity versus an early presentation of bipolar illness), and the role of temperament (e.g., whether some mood swing-like symptoms may represent normal childhood development). This task force elegantly demonstrates that much more is known about the nosology of pediatric bipolar disorder than many assume, although much disagreement exists, requiring even more research.

Schizoaffective disorder

This subgroup, led by Gin Malhi (19), reviewed the available evidence of the nosological status of schizoaffective disorder. It noted that the concept of schizoaffective disorder largely stems from phenomenological and course literature, indicating a syndrome in which mood and psychotic symptoms appear to occur together in a chronic fashion. There has been a good deal of genetic research that may help clarify the nosology of this disorder. The subgroup noted that those genetic studies clearly demonstrate that schizoaffective disorder does not run true in families, separate from bipolar disorder and schizophrenia. Hence, it is likely not a separate disease entity. On the other hand, those same genetic studies suggest a good deal of familial overlap between schizophrenia, schizoaffective disorder, and bipolar disorder; specifically it appears that both schizophrenia and bipolar disorder are overrepresented in families of persons with

schizoaffective presentations. This observation is consistent with a dimensional model of liability to psychosis or severe bipolar disorder; it is also consistent with schizoaffective disorder as representing comorbidity of schizophrenia and bipolar disorder. The two possibilities can be partly assessed based on epidemiological data; since the prevalence of schizoaffective disorder in epidemiological research appears to be quite low, the comorbidity hypothesis may be better supported than the 'one-psychosis' dimensional model. Other aspects of the genetic research that may be relevant to future nosology include some studies which suggest that the bipolar subtype of schizoaffective disorder preferentially aggregates with bipolar disorder in families, and thus might be seen as a more severe variety of bipolar disorder. In contrast, schizoaffective disorder depressed type seems to aggregate familially with schizophrenia and thus might represent a milder variety of schizophrenia. Neurobiological data on schizoaffective disorder itself are scarce, although plenty of research compares schizophrenia with bipolar disorder, with some studies finding similar neurobiological mechanisms and others finding different mechanisms. In all, this task force subgroup suggests that the nosologic status of schizoaffective disorder is *not* consistent with a valid separate diagnostic entity, but rather as evidence of dimensionality to psychotic illness, or a heterogeneous entity.

The task force members therefore recommend dropping the schizoaffective disorder diagnostic category altogether from DSM-V, and replacing it with additional specifiers for chronic psychosis in mood disorders, and new specifiers for mood episodes in schizophrenia.

Mixed states

This task force subgroup, which examined the concept of mixed states (especially in its relation to our current, broad, and heterogenous concepts of depression) turned out to have the most difficult task in the overall task force, if judged by the barriers of peer review. A separate editorial in this issue discusses this topic.

PART II: Summary of clinical diagnostic definitions proposed by the task force, as modified from ICD-10 and DSM-IV

The following clinical summaries are provided based on the ICD-10 and DSM-IV approaches to defining bipolar disorder. In four cases (excluding pediatric bipolar, rapid cycling, and bipolar spectrum), the ICD definitions were available and used as a baseline template for proposed revisions. In three cases, ICD-10 definitions were not available and new clinical summaries were presented. Both ICD-10- and DSM-IV-based suggested revisions are provided so that the guidelines could have international, as well as American, relevance. Where ICD had not described diagnostic subtypes, a new ICD-like description is provided. Suggested changes in ICD-10 and DSM-IV language are in 'bold font'. Although both DSM-V and ICD-11 are expected to include new modules concerning dimensional assessment and perhaps biological markers (20) the following proposals will focus exclusively on diagnostic criteria for the (categorical) classification of bipolar disorders. However, Table 1 provides input from the task forces with regard to issues that go beyond the categorical diagnosis which may be helpful to support the validity of the diagnostic subtype and the supplementary modules expected to be included in the coming versions of the DSM and WHO classifications.

ICD-10 revision: Acute Mania

This condition is characterized by elevated or irritable mood. Often it is also associated with dysphoria or anxiety or even simply depressed mood, and concomitant aggressive behavior can occur. In classic presentations, the mood state is euphoric. This mood state is associated with increased energy, resulting in overactivity (often goal-directed and thus not dysfunctional), flight of ideas, pressure of speech, and a decreased need for sleep. Normal social inhibitions are lost, attention cannot be sustained, and there is often marked distractability. Self-esteem is inflated, and grandiose or over-optimistic ideas can be freely expressed. **Classic impulsive behaviors when present are often diagnostic, but when absent, do not rule out the condition**. The individual may embark on extravagant and impractical schemes, spend money recklessly, or become aggressive, amorous, or facetious in inappropriate circumstances. The first attack occurs most commonly between the ages of 15 and 30 years, but may occur at any age from late childhood to the seventh or eighth decade. **The episode should last for at least 1 week and should be severe enough to disrupt ordinary work and social activities more or less completely. The mood change should be accompanied by decreased need for sleep (which can occur with either increased energy with normal/decreased sleep, or normal/increased energy with decreased sleep) and several of the symptoms referred to above (particularly pressured speech, increased goal-directed activities, and flight of ideas). Notable functional impairment is present.**

DSM-IV revision: Acute Mania

None suggested.

Bipolar Depression

ICD-10-like description:

In depressive episodes of all varieties, the individual usually suffers from depressed mood, loss of interest and enjoyment, and reduced energy leading to increased fatiguability and diminished activity. Marked tiredness after only slight effort is common. Other common symptoms are: reduced concentration and attention, reduced self-esteem and self-confidence, ideas of guilt and unworthiness (even in a mild type of episode), bleak and pessimistic views of the future, ideas or acts of self-harm or suicide, decreased or increased sleep, and diminished or excessive appetite. The lowered mood varies little from day to day, and is often unresponsive to circumstances, yet may show a characteristic diurnal variation as the day goes on. For depressive episodes of all grades of severity, a duration of at least 2 weeks is usually required for diagnosis. **Psychotic symptoms of delusions or hallucinations may or may not occur. Some of the above symptoms may be especially characteristic of bipolar, as opposed to unipolar, depression. These include: increased sleep and/or appetite, marked psychomotor retardation, psychotic features, mood lability, early age of onset of depression (< 20 years), a highly recurrent course (> 5 episodes), psychomotor changes, brief major depressive episodes (< 3 months in duration), a rapid cycling course, and a positive family history of bipolar disorder.**

DSM-IV revision: Bipolar Depression

A. A past Manic or Hypomanic Episode
B. A Major Depressive Episode characterized by five (or more) of the following symptoms has been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (i) depressed mood or (ii) loss of interest or pleasure:

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). *Note:* In children and adolescents, can be irritable mood
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

C. The symptoms do not meet criteria for a Mixed Episode
D. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)
F. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation
G. Special consideration should be given to presence of (i) atypical depressive symptoms (hypersomnia, hyperphagia, or leaden paralysis), (ii) psychomotor disturbance, (iii) psychotic features or pathological guilt, and (iv) a positive family history of bipolar disorder

ICD-10 revision: Rapid Cycling

This is a course criterion which is characterized by at least four mood episodes (whether depressive, hypomanic, or manic) in a 12-month period. This course is seen in about 20% of persons with bipolar disorder, but is rare in Unipolar Depression. The majority of episodes appear to be depressive, and thus frequent manic episodes are not required to meet this criterion.

Rapid cycling appears to be more frequent in women than men, and in Type II than Type I Bipolar Disorder. Association with antidepressant use may exist in some cases. Rapid cycling course is a poor prognostic factor. The possibility of very rapid cycling within days or weeks may also be entertained, although extreme rapidity of cycling of mood, such as within one day, is difficult to distinguish from a Mixed Episode.

DSM-IV revision: Rapid Cycling

Specify if:

With Rapid Cycling [can be applied to Bipolar I Disorder, Bipolar II Disorder, or **Bipolar Disorder not otherwise specified (NOS)**].

At least four episodes of a mood disturbance in the previous 12 months that meet criteria for a Major Depressive, Manic, Mixed, or Hypomanic Episode. **Specify episode criteria (full duration or briefer) and duration of interepisodic interval.**

Note: Episodes are demarcated either by partial or full remission for a least 2 months (**and in brief mood episodes a full remission for at least 2 weeks**) or a switch to an episode of opposite polarity (e.g., Major Depressive Episode to Manic Episode).

ICD-10 revision: Type II Bipolar Disorder

This condition is characterized by at least one major depressive episode, and at least one hypomanic episode. Hypomania is a lesser degree of mania, in which there is a persistent mild elevation of mood (for at least several days on end), increased energy and activity, and usually marked feelings of well-being and both physical and mental efficiency. Increased sociability, talkativeness, overfamiliarity, increased sexual energy, and a decreased need for sleep are often present but not to the extent that they lead to severe disruption of work or result in social rejection. Irritability, conceit, and boorish behavior may take the place of the more usual euphoric sociability. **Several of the features mentioned above, consistent with elevated or changed mood and increased activity, should be present for at least several days on end. If there is considerable interference with work or social activity, mania should be diagnosed**.

DSM-IV revision: Bipolar II Disorder

Criteria for a Hypomanic Episode

A. A distinct period of persistently elevated, expansive, depressed, or irritable mood, lasting throughout **at least 2 days,** that is clearly different from the usual non-depressed mood
B. During the period of mood disturbance, three (or more) of the following 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 3 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 that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic
D. The disturbance in mood and the change in functioning are observable by others
E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features, **although mild-to-moderate depressive symptoms may be present (mixed hypomania)**
F. The symptoms are not because of the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism), **but may happen in the context of medication, substance intake, or physical illness as far as the symptoms are not clearly etiologically related to those**

Criteria for Bipolar II Disorder

A. Presence (or history) of one or more Major Depressive Episodes
B. Presence (or history) of at least one Hypomanic Episode
C. There has never been a Manic Episode or a Mixed **Manic** Episode
D. The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizo-

phrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS

E. The depressive symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning; the hypomanic symptoms do not necessarily cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

Course specifiers:

With hypomanic or depressive predominant polarity

Bipolar Spectrum Illness

ICD-10-like description:

The concept of the bipolar spectrum can be used to denote varieties of manic presentations milder than the Manic or Hypomanic Episodes described above, either with or without concurrent depressive episodes. When severe recurrent Major Depressive Episodes occur, yet spontaneous Mania or Hypomania is absent, other features of bipolarity may pick out individuals that can be seen as demonstrating Bipolar Spectrum Illness. Those features, all of which are more common in Bipolar Disorder than Unipolar illness but none of which are pathognomonic of either condition, include a positive family history of Bipolar Disorder in a first-degree relative, antidepressant-induced Mania/Hypomania, and a course of depressive episodes characterized by early age of onset (before age 20), postpartum onset, highly recurrent (> 5episodes), presence of rapid cycling (as defined above), and brief depressive episodes (< 3 months duration).

DSM-IV revision: Bipolar Disorder NOS

The Bipolar Disorder NOS category includes disorders with bipolar features that do not meet criteria for any specific bipolar disorder. Examples include:

1. Very rapid alternation (over days) between manic symptoms and depressive symptoms that do not meet minimal duration criteria for a Manic Episode or a Major Depressive Episode
2. Recurrent Hypomanic Episodes without intercurrent depressive symptoms
3. A Manic or Mixed Episode superimposed on a Delusional Disorder, Residual Schizophrenia, or Psychotic Disorder NOS
4. Situations in which the clinician has concluded that a Bipolar Disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced
5. **Subthreshold Hypomanic Episodes in the context of multiple other signs of bipolarity***
6. **Multiple signs of bipolarity without Hypomanic or Manic Episodes (also known as Bipolar Spectrum Disorder)***

***Clinicians should specify precisely which such signs are present and include this list in their assessment statement, as follows:**

a. Family history (bipolar diagnoses; multi-generational mental illness; alcohol and other substance use; suicides)
b. Depressive symptom phenomenology (atypical, seasonal, psychomotor slowing, psychosis)
c. Course of illness (early age of onset, short duration of episodes, greater number of episodes)

ICD-10 revision: Schizoaffective Disorder

These are episodic disorders in which both affective and schizophrenic symptoms are prominent within the same episode of illness, preferably simultaneously, but at least within a few days of each other, and in which a chronic psychotic course is present (psychosis is not limited to the period of a mood episode). **Although it is given a separate category, this condition likely does not represent a disease-entity separate from Schizophrenia and severe affective disorders; nosologically it may represent the middle of a psychotic spectrum of illness or it may represent the comorbidity of Schizophrenia with severe affective disorder. The two subtypes may also in some cases be variations on Schizophrenia or severe affective disorder. A diagnosis of Schizoaffective Disorder should be made only when both definite schizophrenic and definite affective symptoms are prominent simultaneously, or within a few days of each other, within the same episode of illness, and when, as a consequence of this, the episode of illness does not meet criteria for either Schizophrenia or a Depressive or Manic Episode**. Delusions of reference, grandeur, or persecution may be present, as can be auditory hallucinations, but the typical flat affect and other negative symptoms of schizophrenia are not prominent. A chronic course of psychotic symptoms is present as in Schizophrenia, although long-term functional impairment may or may not be marked (unlike Schizophrenia where long-term decline in function is part of its definition). The schizoaffective diagnosis should not be applied to patients who exhibit schizophrenic symptoms and affective symptoms only in different

episodes of illness. It is common, for example, for a schizophrenic patient to present with depressive symptoms in the aftermath of a psychotic episode (such as post-schizophrenic depression).

Two subtypes can be defined, bipolar or depressive. In the bipolar subtype, at least one Manic Episode as described above has occurred; in the depressive subtype at least one Major Depressive Episode and no Manic Episode has occurred. The bipolar subtype may represent a severe variant of Bipolar Disorder; the depressed subtype may represent a milder variant of Schizophrenia.

DSM-IV revision: Schizoaffective Disorder

In Schizophrenia, add two specifiers:

1. **With symptoms meeting criteria for Mania or Mixed features**
2. **With symptoms meeting criteria for Major Depressive Disorder**

In Bipolar Disorder, add two specifiers:
During depressive or manic or mixed episodes:

1. **With psychotic symptoms meeting Criterion A for Schizophrenia (i.e., one month) and for at least two weeks without prominent mood features**
2. **With psychotic symptoms meeting Criterion A for Schizophrenia with consistent concurrent mood features**

In Major Depressive Disorder, add two specifiers:

1. **With psychotic symptoms meeting Criterion A for schizophrenia (i.e., one month) and for at least two weeks without prominent mood features**
2. **With psychotic symptoms meeting Criterion A for Schizophrenia with consistent concurrent mood features.**

Pediatric Bipolar Disorder

ICD-10-like description:

There is now substantial research evidence documenting prepubertal occurrences of disorder that fulfill DSM-IV criteria for Manic or Mixed Episodes, and thus meet criteria for Bipolar Disorder. Another group of children show adequate number and intensity of symptoms, but the index mood episodes do not last for 7 days for mania or 4 days for hypomania. There is discussion about classifying childhood presentation of Bipolar Disorder into narrow or broad definitions. The narrow phenotype, which is less controversial, involves the presence of episodic euphoric mood or grandiosity along with episodic decreased need for sleep or other symptoms, as seen in adult mania. It has also been posited that there is potentially a broad phenotype, which remains to be validated. The putative 'broad phenotype,' which may or may not be related to Bipolar Disorder, involves the presence of chronically irritable mood, along with other manic symptoms. The latter presentation may be difficult to distinguish from ADHD, Oppositional Defiant Disorder, and Conduct Disorder. Expanding clinical assessment beyond the cross-sectional symptom profile is informative. Presence of family history of Bipolar Disorder, Major Depressive Episodes with early onset and psychotic features, pharmacologically induced mania/hypomania, and a highly episodic course of illness should increase the index of suspicion for pediatric bipolar disorder and should be carefully monitored for the possibility of developing Bipolar Disorder.

DSM-IV revision: Pediatric Bipolar Disorder

A. **Presence of an acute manic or mixed or hypomanic plus depressed episodes prior to age 18**
B. **The definition of the acute manic or hypomanic or mixed episode meets adult criteria**

If only irritable mood is present, and not euphoria, documented spontaneously episodic fluctuations in the presence/absence of symptoms of mania are required for the diagnosis of an acute manic, hypomanic, or mixed episode.

Conclusions

The Diagnostic Guidelines Task Force of the *International Society for Bipolar Disorders* presents in this document and this special issue a summary of the current nosologic status of bipolar illness, a discussion of possible revisions to current DSM-IV and ICD-10 definitions, an examination of the relevant literature, explication of areas of consensus and dissensus, and proposed definitions that might guide clinicians in the most valid approach to diagnosis of these conditions given the current state of our knowledge.

Disclosures

SNG receives grants from Janssen, GlaxoSmithKline, and Pfizer; serves on speakers bureaus of GlaxoSmithKline, AstraZeneca, Pfizer, and Abbott Laboratories; has served on advisory boards for GlaxoSmithKline, Janssen, Pfizer, Shire, and Abbott Laboratories. MB has received grant/research support from the Stanley Medical Research Institute, NARSAD, GlaxoSmithKline, Eli Lilly & Co., AstraZeneca, and Wyeth; has served as an advisor for Eli Lilly & Co., GlaxoSmithKline, Novartis, Servier Deutschland, Bristol-

Myers Squibb, and Wyeth; and has received speaker honoraria from AstraZeneca, Eli Lilly & Co., Lundbeck, GlaxoSmithKline, Pfizer, Sanofi-Aventis, and Wyeth. FC has received grants/research support from Pfizer, Organon, Corcept, and NARSAD; has participated in advisory boards for Shire; has been a past speaker for Pfizer; and has owned stock in Pfizer. GSM has received funding for research from Pfizer, AstraZeneca, Eli Lilly & Co., and Wyeth; and serves on the advisory boards of Eli Lilly & Co., Wyeth, and AstraZeneca. PBM has received remuneration for lectures or advisory board membership from AstraZeneca, Eli Lilly & Co., GlaxoSmithKline, Janssen-Cilag, or Lundbeck in the last 5 years. JP serves on the speakers bureau for GlaxoSmithKline, AstraZeneca, and Abbott and does not own any stock in these or other pharmaceutical companies and has posted an extended discussion of these relationships on his website, http://www.PsychEducation.org; he receives royalties from a book for patients and families based on the bipolar spectrum concept. EV has received grants, acted as a consultant to, or served on the speakers bureau for Almirall, AstraZeneca, Bial, Bristol-Myers Squibb, Eli Lilly & Co., GlaxoSmithKline, Janssen-Cilag, Lundbeck, Merck Sharp & Dohme, Novartis, Organon, Otsuka, Pfizer, Sanofi-Aventis, Servier, and UCB; has received grants from and acted as consultant to the Spanish Ministry of Health and the Stanley Medical Research Institute. EAY has previously acted as a consultant for Otsuka and Eli Lilly & Co.

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Appendix 1: ISBD Diagnostic Guidelines Task Force Members