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BMHP6029-Psychopathological Classifications and Provisions

Component 2: Written Assignment (Report)

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Introduction

Bipolar disorder is a recurrent mood disorder characterised by episodes of altered mood, energy and activity, with presentations ranging from mania or hypomania to depression. It is an important mental health condition because symptoms can affect relationships, education, employment, physical health, cognition and safety. Bipolar disorders affect more than 1% of the global population and are associated with substantial disability and increased mortality (Vieta et al., 2018). This report critically examines bipolar disorder as classified in the International Classification of Diseases, 11th Revision (ICD-11), focusing particularly on bipolar type I and type II disorder. It evaluates diagnosis, treatment and rehabilitation, before considering current debates about categorical diagnosis, neurodivergence, stigma and reclassification. The report argues that ICD-11 provides a clinically useful framework, but diagnosis and recovery should not depend on diagnostic labels alone. A longitudinal, person-centred and function-focused approach is required.

Classification and Diagnosis:

Within ICD-11 Chapter 6, bipolar disorder is classified under 'Mood disorders' within 'Bipolar and related disorders'. ICD-11 identifies Bipolar type I disorder (6A60) and Bipolar type II disorder (6A61), with additional codes describing the current or most recent episode, psychotic symptoms and remission status (World Health Organization, 2024). This structure recognises that bipolar disorder has different presentations and allows diagnosis to reflect whether an individual is experiencing mania, hypomania, depression, a mixed episode or remission.

ICD-11 uses the term 'disorder' rather than 'illness' or 'condition', reflecting a classification system concerned with clinically significant disturbances in mood, activity and functioning. Bipolar type I is characterised by at least one manic or mixed episode. Mania involves an extreme mood state accompanied by increased activity or energy and symptoms such as pressured speech, racing thoughts, grandiosity, reduced need for sleep, distractibility and impulsive behaviour. Psychotic symptoms may occur in severe presentations (World Health Organization, 2024). An important strength is that bipolar I can be diagnosed following a manic or mixed episode even where a depressive episode has not been documented.

Bipolar type II requires at least one hypomanic episode and one depressive episode, with no history of mania or a mixed episode. Hypomania involves a persistent change in mood and increased activity or energy, alongside symptoms such as reduced need for sleep, increased

talkativeness, racing thoughts, increased self-esteem and distractibility. Unlike mania, hypomania does not cause marked functional impairment, require hospitalisation or involve psychotic symptoms. The depressive episode involves depressed mood or reduced interest for at least two weeks, alongside symptoms including fatigue, sleep or appetite changes, poor concentration, guilt, hopelessness and suicidal thoughts (World Health Organization, 2024).

Diagnosis is clinical rather than based on a single laboratory test or biomarker. Assessment should establish the history, duration and severity of mood episodes, changes from baseline, functional consequences, family history, medication and substance use, physical health and previous treatment. Differential diagnosis is important because bipolar depression can resemble unipolar depression, while mood instability may overlap with trauma-related conditions, personality disorder, substance-induced symptoms and neurodevelopmental conditions. Nierenberg et al. (2023) emphasise the complexity of diagnosing bipolar disorder and distinguishing bipolar depression from other depressive states. Collateral information may also be useful when insight is reduced during severe episodes.

A limitation of categorical diagnosis is that fixed thresholds may give an impression of greater precision than clinical reality allows. Bipolar disorder is heterogeneous, with differences in symptoms, cognition, functioning and treatment response. Genetic research also suggests biological heterogeneity, raising the possibility of more clinically meaningful subgroups in future classification (McGrouther et al., 2024). Therefore, ICD-11 should support clinical communication while remaining complemented by individual formulation and longitudinal assessment.

Treatment and Rehabilitation:

Treatment for bipolar disorder commonly combines medication, psychological interventions, relapse prevention and support for social and occupational functioning. NICE (2025) recommends lithium as a first-line long-term treatment where appropriate because of its effectiveness in relapse prevention. Antipsychotics, including quetiapine, olanzapine, risperidone, aripiprazole and asenapine, may be used according to the episode and individual circumstances. Lamotrigine also has a role in bipolar depression and maintenance. The CANMAT/ISBD evidence update emphasises that treatment should reflect illness phase, previous treatment response, safety and patient preference (Keramatian, Chithra and Yatham, 2023).

However, medication has important limitations. Lithium requires regular blood monitoring and attention to renal and thyroid function, while antipsychotics can cause weight gain, metabolic problems and sedation. Valproate is subject to significant UK safety restrictions because of reproductive and other risks, requiring clinicians to follow current MHRA guidance (NICE, 2025). Side effects, stigma and limited insight during mania can also affect adherence. Shared decision-making is therefore important rather than viewing adherence simply as patient compliance.

Psychological treatment provides an important complement to medication. NICE (2025) recommends structured psychological interventions for bipolar disorder, including approaches based on cognitive behavioural therapy, interpersonal therapy and behavioural couples therapy. Psychoeducation can help individuals recognise warning signs, understand triggers, monitor mood and develop relapse-management plans. Family-focused approaches may also improve communication and help relatives identify early changes. These interventions are valuable because medication may reduce symptoms without fully restoring relationships, confidence and occupational functioning.

Rehabilitation should therefore extend beyond symptom reduction. NICE recommends individualised social and emotional recovery goals, physical health monitoring, healthy eating, physical activity and access to specialist or community services where required (NICE, 2025). Cognitive and functional rehabilitation is an emerging area because cognitive difficulties can persist between episodes and affect memory, attention and executive functioning. Evidence suggests that cognitive and functional remediation may improve cognition and functioning, although studies remain heterogeneous and further research is required (Miskowiak et al., 2019; Hosseini et al., 2024).

Rehabilitation should also address employment, education, relationships, housing, physical health and social inclusion. A recovery approach recognises that individuals can develop

meaningful lives even when some symptoms remain. Functional impairment may persist despite mood improvement, demonstrating why recovery should not be measured solely by symptom reduction (Bonnín et al., 2019). Suicide prevention is also essential because bipolar disorder is associated with substantially increased suicide risk. Routine risk assessment, safety planning and rapid access to care are therefore required during deterioration (Izadi et al., 2023). Lithium may also have a protective association with suicide risk, although findings should be interpreted cautiously because studies differ in design (Tondo and Vázquez, 2023).

Current Debates and Emerging Issues:

A major debate concerns whether bipolar disorder is best understood as a set of discrete disorders or as a spectrum. The distinction between bipolar I and II is clinically useful because mania and hypomania differ in severity and consequences, but real-world mood experiences do not always fit neatly into fixed categories. Some individuals experience subthreshold symptoms, mixed features, rapid changes or patterns that vary across time. The challenge is therefore to retain reliable diagnostic communication while recognising dimensional differences in severity, impairment and course. ICD-11's use of episode and remission specifiers partly addresses this problem by adding detail to the core diagnosis (World Health Organization, 2024).

Another debate concerns the relationship between bipolar disorder and neurodivergence. Neurodiversity is an umbrella concept describing variation in human neurological functioning, but there is no universal agreement that bipolar disorder should automatically be classified as a neurodivergent condition. Autism and ADHD are explicitly classified by ICD-11 as neurodevelopmental disorders, whereas bipolar disorder is classified as a mood disorder. Treating bipolar disorder as neurodivergence may reduce deficit-based assumptions and support reasonable adjustments, but it may also create confusion if the term is used to minimise the seriousness of episodes that can involve psychosis, hospitalisation or substantial suicide risk. A balanced position is that people with bipolar disorder may use neurodivergent identity if it is meaningful to them, while clinicians should continue to recognise bipolar disorder as a potentially severe mood disorder requiring evidence-based care.

Reclassification debates also arise because current psychiatric categories do not map perfectly onto biological mechanisms. Bipolar disorder is influenced by genetic, neurobiological, psychological and environmental factors, but there is currently no sufficiently specific biomarker that can replace clinical diagnosis. Genetic studies demonstrating heterogeneity may eventually support more precise subtyping (McGrouther et al., 2024), but premature biological reclassification could introduce new problems if findings cannot yet predict prognosis or treatment response. The most defensible approach is therefore progressive refinement: retain clinically useful categories while increasing dimensional, longitudinal and biological information.

Stigma is another important emerging issue. A systematic review found that people with bipolar disorder and their families can experience stigma across social, family and healthcare contexts, with consequences for self-esteem, relationships and help-seeking (Latifian et al., 2023). Public stereotypes may portray people with bipolar disorder as unpredictable or dangerous, while the opposite problem can occur when manic symptoms are romanticised as creativity or productivity. Both extremes can undermine appropriate support. Policy should therefore combine anti-stigma education with practical access to specialist care, crisis services, employment support and physical healthcare.

Recommendations:

First, assessment should become more longitudinal and formulation-based. Services should document episode history, baseline functioning, sleep, triggers, substance use, physical health, family observations and treatment response rather than relying on a single assessment. Structured diagnostic tools can support consistency but should not replace clinical judgement. Where uncertainty exists, follow-up assessment should be prioritised.

Second, treatment should use shared decision-making. Clinicians should explain benefits, side effects and monitoring requirements while considering physical health, occupation, lifestyle and personal goals. NICE's emphasis on lithium and updated safety advice for valproate should be supported by accessible monitoring and medication reviews (NICE, 2025). Better continuity between primary, secondary and community services could reduce fragmented care.

Third, rehabilitation should be a core component rather than an optional addition. Services should provide psychoeducation, family support, psychological therapy, cognitive rehabilitation, employment or education support, physical health interventions and personalised relapse plans. Outcomes should include quality of life, social functioning, employment, relationships and recovery goals, not only symptoms.

Finally, research should develop more personalised and dimensional approaches. Studies should examine whether biological subgroups predict treatment response, whether digital mood monitoring can safely support early intervention, and which rehabilitation strategies achieve sustained recovery. Research should involve people with lived experience when considering diagnostic language, stigma and engagement. This could ensure future classification remains clinically useful without reducing individuals to diagnostic labels.

Conclusion

Bipolar disorder is a complex and recurrent mood disorder that requires more than a narrow focus on acute symptom control. ICD-11 provides a structured classification through bipolar type I and type II and detailed episode and remission specifications, supporting diagnostic communication while acknowledging differences in clinical presentation. However, categorical diagnosis has limitations because bipolar experiences are heterogeneous and can change across time. Effective care therefore requires careful longitudinal assessment, evidence-based medication, psychological interventions, suicide prevention and rehabilitation focused on functioning and quality of life. Current debates concerning spectrum models, neurodivergence and biological reclassification demonstrate that psychiatric classification is evolving. The strongest future approach is likely to combine reliable diagnostic categories with dimensional assessment, personalised treatment and recovery-oriented rehabilitation. Such an approach can improve clinical practice and policy while preserving the person's voice, autonomy and social identity.

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