

Correspondence

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Problems in diagnosing bipolar disorder

Angst (2007) provides more balanced views on the much publicised concerns about the underdiagnosis of bipolar disorder. Psychiatric diagnoses are not robust entities (Baca-Garcia *et al*, 2007) and most recent research in mood disorders has arisen from redefining and often rigidly applying the DSM criteria, which has proved a hindrance to research. The problem in mood disorder research lies in our failure to define the core features of mania/hypomania and bipolar depression. Surprisingly, hardly any advance has been made in our understanding of and our ability to accurately diagnose an active hypomanic/manic episode (excluding retrospective accounts), and we are guided by epidemiological studies and expert opinions rather than basing diagnosis on a new phenomenological understanding. Moreover, we rely on a range of self-report checklists. Unfortunately, there are few advocates for people with wrongly diagnosed bipolar disorder. It is like initiating antihypertensive treatment for suspected hypertension. Unless they have clinical consequences, temperament and vegetative lability, like blood pressure and heart rate, should not be considered pathological. The success of future research lies in a greater understanding of the phenomenology of episodes of depression and in bipolar disorder and the differences in biological depression that result from psychosocial factors.

Angst, J. (2007) The bipolar spectrum. *British Journal of Psychiatry*, **190**, 189–191.

Baca-Garcia, E., Perez-Rodriguez, M. M., Basurte-Villamor, I., et al (2007) Diagnostic stability of psychiatric disorders in clinical practice. *British Journal of Psychiatry*, **190**, 210–216.

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Author's reply: Although the underdiagnosis of bipolar disorder remains a fact, Dr Gangdev makes the valid point that there are very few advocates for those wrongly diagnosed as having bipolar disorder and mentions that temperament and vegetative lability should not be considered pathological.

This is in full agreement with the spectrum concept presented in my editorial: temperament and hypomanic symptoms *per se* are variations within the normal range. It would therefore be wrong to diagnose bipolar II disorder in a person with major depression and a cyclothymic temperament. Although a cyclothymic temperament is a correlate of bipolar disorder, many people with such a temperament may develop only depression. However, this is again a hypothesis which must be tested in prospective community studies. In 1921 Kretschmer distinguished clearly between cyclothymic temperament as a normal trait and cycloid personality, which was a pathological state of mood swings (corresponding to a personality disorder in current terminology).

Dr Gangdev hopes that phenomenology will bring about the necessary progress. Our Zurich Study interview, which included 30 symptoms of depression, was unfortunately unable to find any qualitative differences between the symptom profiles of bipolar II depression and unipolar major depression. Phenomenology may not be able to solve the diagnostic problem of bipolar II disorder. Moreover, both the Mood Disorder Questionnaire (including 20 symptoms of hypomania) and the self-assessment Hypomania Checklist–32 (with 32 symptoms) demonstrated only a continuum between high scores within the normal range and pathological hypomania.

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Intensive case management: targeted population as important as case-load size

In their re-examination of data from the UK700 study of standard *v.* intensive case management, Burns *et al* (2007) conclude that although case-load size can affect the quantity and possibly the type and quality of community care delivered to people with severe psychotic disorders, there is no overall clinical advantage associated with any particular case-load size within the approximate range 1:10 to 1:20.

The results of another randomised controlled trial involving 193 'heavy users' of psychiatric in-patient services (Harrison-Read *et al*, 2002) can also throw light on this issue. In this study, intensive case management was delivered to 'enhance' the care already provided by the standard locality mental health service in a socially deprived outer-London borough. The case-load size of the standard service was 1:20 or more, and although the case-load size of the intensive case management team varied between only 1:8 and 1:15, and achieved a mean 2.4-fold increase in community contacts compared with the standard service alone, overall the intervention produced no statistically significant benefits on hospital bed use, direct costs of care or clinical outcomes.

In about one-fifth of the 'heavy users' in the study group, needs were already being adequately met by the standard service, and the study team did little more than serve a care coordination role, with very low rates of community contact. These users were mainly managed by the standard service, as of course were all those in the control group. However, after excluding this subgroup of users in a *post hoc* analysis, there were still no measureable benefits from the study intervention. Since minimal intervention corresponds to greater 'virtual' case-load size (Burns *et al*, 2007), the implication of this finding is that case-load size in the approximate range 1:10 to 1:20 does not have a major impact on health and cost outcomes of intensive case management in a sample of this type.

By contrast, when the impact of the study intervention was re-examined in a subgroup of 'very heavy users' representing the upper quartile of the study sample ($n=23$), the healthcare costs were nearly halved in comparison with controls ($n=25$, $P<0.001$). These 'very heavy users' tended to receive the most intensive care