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Letter to the Editor in response to 2012 article by Frances and Jones

Trisha Suppes^a, Ellen Frank^b, J Raymond DePaulo^c, Lori Davis^d, Carlos A Zarate Jr^e, Jules Angst^f, and Jan Fawcett^g

^aDepartment of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Palo Alto Veterans Affairs Health Care System, Palo Alto, CA ^bDepartment of Psychiatry, University of Pittsburgh, Pittsburgh, PA ^cDepartment of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, MD ^dDepartment of Psychiatry, University of Alabama School of Medicine, Birmingham, AL ^eIntramural Research Program, Experimental Therapeutics & Pathophysiology Branch, National Institute of Mental Health, Bethesda, MD, USA ^fZurich University Psychiatric Hospital, Zurich, Switzerland ^gDepartment of Psychiatry, University of New Mexico School of Medicine, Albuquerque, NM, USA

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To the Editor:

In the August 2012 issue of *Bipolar Disorders* we read with great interest the commentary ‘Bipolar disorder type II revisited’ (1). Although our letter is in response to an article published in 2012, we feel that the issues are still current and that clarification on potential misinformation is essential to guide clinicians to a more complete understanding of the DSM-5 criteria for bipolar disorder. Additionally, even though we knew what we had proposed for DSM-5, since there were so many levels of required approval (Task Force, etc., and finally the Board of Trustees), we waited until it was certain that these proposals would actually appear in print (2) before submitting this response.

The authors expressed concerns about the potential damage to the definition and evaluation of bipolar disorder if the duration criteria for a hypomanic episode were decreased, as well as if Criterion A for mania and hypomania was modified so that increased energy alone, without mood changes, would be adequate to meet criteria for a manic episode. We would like to correct some mistaken impressions that could be taken from that article and address

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Corresponding author: Trisha Suppes, MD, PhD, Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Palo Alto Veterans Health Care System, 3801 Miranda Avenue (151T), Palo Alto, CA 94304, USA, Fax: 650 849 1913, tsuppes@stanford.edu.

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concerns expressed by the authors that do not accurately reflect either the DSM-5 Mood Disorders Work Group's process or final recommendations (3, 4).

Perhaps we should begin by pointing out that the authors mistakenly imply that the DSM-5 Mood Disorders Work Group had actually proposed a change to the duration requirement for hypomania episodes or that Criterion A consist of energy changes only. The Work Group never advanced a proposal to decrease the required length of time for a hypomanic episode or, by extension, the severity threshold for bipolar II disorder, nor was there a proposal to change Criterion A for mania and hypomania to requiring only a change in energy. Although both potential shifts were among the many things discussed and debated by Work Group members over the last five years, the Work Group never preferentially endorsed either change and neither approach was ever formally proposed for the manual's next edition.

Additionally, the authors of the article predicted that the Work Group's proposed changes to the DSM would lower the threshold for diagnosing bipolar disorder, increasing false positives without materially decreasing false negatives. However, this does not accurately reflect the Work Group's focus throughout the DSM-5 revision process on decreasing both false positives and false negatives. In particular, the actual proposed change to Criterion A requires mood changes *and* increased activity or energy. As such, it is geared toward decreasing false negatives—the failure to diagnose people who have bipolar disorder—as well as toward reducing false positives—the over-diagnosis of people who do not have bipolar disorder. The Work Group actually never proposed the change implied in the article that only *increased energy* should be required to meet episode criteria for mania or hypomania, though this was certainly discussed and relevant papers reviewed.

The change to Criterion A is aimed at balancing the importance of treatment with the risk of over-diagnosis. It makes clear that an increase in energy or activity is a hallmark of the illness, and, more importantly, that bipolar disorder is not diagnosed by any single symptom, but by clusters of symptoms occurring simultaneously.

If there is umbrage to be taken at this recent commentary, it might be at the assumption that the Work Group sought to expand the territory of their diagnoses. In the authors' commentary, they state that '... rarely, if ever, has an expert made a suggestion that would reduce the boundary of his or her pet disorder'. Yet all of the Mood Disorder Work Group's recommendations addressing bipolar disorder were aimed at narrowing the parameters to make diagnosis more specific, without loss of sensitivity. The Work Group recognized that this disorder is both under-diagnosed (especially in those presenting in an episode of depression) and over-diagnosed (in those with other forms of mood instability). In the Work Group's DSM-5 revision process, a strong effort was made to consider what impact any proposed changes would have on the prevalence of the disorder. Every proposed change was looked at in terms of its potential to reduce false positives and false negatives.

It is true that the treatment implications for individuals with one or two symptoms of bipolar disorder are not yet known. Should all patients with subsyndromal bipolar disorder receive treatment? Who should receive treatment? While the authors of the article are correct in raising concerns about over-medication through overbroad diagnostic practices, we would

like to emphasize that under-medication through overly narrow diagnostic practices is a historically key problem in the treatment of bipolar disorder, and one that merits equal consideration. Medicating individuals with bipolar disorder should not be presented as bad practice. Simply looking at the history, individuals with mania prior to the advent of effective treatments in the 1800s could die from a number of preventable causes, such as exhaustion or cessation of fluid intake. We continue to feel strongly that minimizing in any way the severity, chronicity, and need for lifelong medication for patients with bipolar I disorder would be deeply disrespectful of the individuals with this illness. The Work Group considered the spectrum nature of bipolar disorder and the need for further study of where to draw diagnostic lines (2).

We are in agreement with the authors—over the last 10 years, the threshold to diagnose this serious and major mental illness has slipped lower, perhaps in part as a result of the significant funds devoted to marketing new compounds for the treatment of bipolar disorder. The DSM-5 Mood Disorders Work Group fully recognized this trend and worked to refine bipolar disorder for DSM-5 in a way that would minimize false positives and negatives and sharpen our definitions. While the authors made many valid points, the article in question raises implications about the Work Group's process, priorities, and final suggestions that, if taken concretely, are simply untrue.

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References

1. Frances A, Jones KD. Bipolar disorder type II revisited. *Bipolar Disord.* 2012; 14:474–477. [PubMed: 22834459]
2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th edn.. Arlington, VA: American Psychiatric Association; 2013.
3. Kupfer DJ, Regier DA. Neuroscience, clinical evidence, and the future of psychiatric classification in DSM-5. *Am J Psychiatry.* 2011; 168:672–674. [PubMed: 21724672]
4. Regier DA, Kuhl EA, Kupfer DJ. The DSM-5: classification and criteria changes. *World Psychiatry.* 2013; 12:92–98. [PubMed: 23737408]