Blurred boundaries in diagnostic criteria present a challenge to optimal treatment

Early, accurate diagnosis may hold the key to achieving significant improvements in the prospects for patients with bipolar disorder. However, the broad characterisation of the bipolar phenotype to encompass bipolar spectrum and bipolar not otherwise specified (NOS) makes differential diagnosis more challenging. These issues were among those explored at the 13th Latest Advances in Psychiatry Symposium held in London in March, which took biopsychosocial approaches to psychiatry as its overarching theme. Steve Titmarsh reports.

Professor Guy Goodwin, WA Handley Professor of Psychiatry at the University of Oxford, considered the issues around the validity of diagnosis and whether the current diagnostic tools, in particular DSM-V and to some extent ICD-10, are sufficient to allow clinicians to improve their detection and treatment of bipolar disorder.

Diagnosis is useful because it is moderately reliable, it provides some idea of the likely numbers of patients health services might have to care for, it gives patients some idea of prognosis, and it helps with treatment decisions.

However, diagnosis is not without its shortcomings. For example, while the characteristics of the core bipolar phenotype are relatively clear, the boundaries between different types of bipolar disorder (bipolar I, II, bipolar NOS) and unipolar depression are rather more blurred. Indeed, Professor Goodwin likened the boundaries between disorders to hypotheses – provisional rather than fact. So a diagnosis of bipolar disorder NOS, for example, is initially highly provisional, and we really do not know precisely what to do once that diagnosis is made, Professor Goodwin said. He commented: ‘…you might, particularly if things are not going well with treatments for unipolar depression, move to treatments for bipolar disease if there was a clinical indication that the person might be bipolar – if they had hypomanic symptoms from time to time, for example.’

An example of diagnosis going wrong as a result of extrapolation of treatment options from bipolar I to milder or non-bipolar conditions is the trend in the US to diagnosing chronic irritability in some children as bipolar disorder. That can lead to children being treated with drugs that have been developed for adults. DSM-V has tried to remedy the issue but in doing so has come up with what Professor Goodwin described as one of the most clumsy diagnostic categories he has encountered – disruptive mood dysregulation disorder.

Another area where DSM-V has tried to improve on DSM-IV is in defining mixed states. Under the definition in DSM-IV, the condition is rare because it requires patients to present with a full set of symptoms of depression and mania simultaneously, Professor Goodwin commented. DSM-V recognises clinical reality by requiring full criteria for the primary mood (depression, mania or hypomania) and just three or more symptoms of the other mood pole (excluding those common to both poles). The primary diagnosis is then described as ‘with mixed features’. Until there is a body of evidence which has collected the three different subtypes, there will be few if any implications for treatment, Professor Goodwin commented.

Another problem raised by the overlap of criteria for diagnosis of different conditions is that one condition can be mistaken for another. For example, bipolar disorder can be confused with borderline personality disorder if a lifetime perspective is not adopted. And that has implications for treatment and therefore outcomes.

As well as differentiatiing between disorders that share some diagnostic criteria, psychiatrists also face the challenge of diagnosing conditions such as bipolar disorder earlier in the life course. Most patients will say their symptoms started five or even 10 years before a formal diagnosis was made. So Professor Goodwin asked whether it was possible to make a diagnosis of bipolar disorder earlier and therefore start treatment sooner, and in doing so perhaps prevent some of the more severe symptoms and consequences associated with the disease.

Work by Jacobi et al. shows that anxiety disorders are the first to emerge in very young people, followed by bipolar disorder appearing in the teenage years. However, Hickie et al. in Australia have...
shown that, although symptoms can be detected earlier, it is difficult to know which treatment to use because it is usually not until patients are older that a discrete disorder can be identified or confidently diagnosed.\(^2\)

Even though the clinical clues which could aid an earlier diagnosis may be discernible, at least in theory, that diagnosis will still depend on the skill of the diagnostician – and that is an area where more training may be required. While an online survey of members of the Royal College of Psychiatrists carried out between September and November 2012 showed that respondents felt confident of their ability to differentiate between bipolar disorder and borderline personality disorder, unpublished data from audio recordings of psychiatric assessments suggest otherwise [in preparation for publication]. The study reveals a significant gap in the actual symptom information gathered during assessments on which diagnoses were based from that which would really be expected.

Professor Goodwin concluded that, with a consistent and systematic approach, accurate diagnosis is possible. Earlier diagnosis of bipolar disorder is worth striving for and could bring benefits in terms of outcomes for patients, but a significant research effort will be needed to make it achievable.

**Early intervention in depression**

Early intervention goes in and out of fashion and is in vogue currently, but it does make sense, Dr Paul Ramchandani, Head of the Academic Unit of Child and Adolescent Psychiatry at Imperial College, London, told delegates at the symposium. The so-called Heckman curve shows that investment early on – during preschool – produces the greatest returns in terms of human capital among disadvantaged children.\(^3\)

Data from the Dunedin cohort show that 50\% of those interviewed had a diagnosable psychiatric disorder before age 15 years, so people with mental illness often have a psychiatric disorder for a long time.\(^4\) Dr Ramchandani commented that early intervention has enormous potential and a lot to recommend it. That said, it is not necessarily the case that early intervention *per se* is inherently a good thing, he added. It is fine in the right circumstances and with the right people. However, used with the wrong people with the wrong disorder in the wrong circumstances, early intervention – be it psychological interventions or drugs – has enormous potential for harm, Dr Ramchandani cautioned.

So it is important to identify those at high risk properly and clearly, and to have effective interventions.

Depression affects around 1–2\% of pre-adolescents (10–12 year olds). However, they are not often seen in child and adolescent mental health services so it can be missed – indeed, people find it difficult to think about depression in children of this age. Nevertheless, there is likely to be a group within this age range who have chronic patterns of depression. The drawback is that at the moment the evidence for intervention is not strong.

Children born to mothers with antepartum or postnatal depression have an approximate doubling of risk of developing depression. A similar increase in risk is seen in children of depressed fathers. In addition, there is some evidence to suggest that the rates of depression and other mood disorders among adolescents fall if their mother’s depression is successfully treated\(^5\) – while other data suggest that parental total General Health Questionnaire scores improve when their adolescent children are treated for depression.\(^6\)

Although working with families with severe mental health problems can be very challenging, it is also possible that children in those families are likely to be the ones who gain the most from intervention. One reason for that is that they are the children most likely to carry susceptibility genes for anxiety and mood disorders, Dr Ramchandani explained. As a consequence those children are often the ones who will have the most reactive and most difficult temperaments; as a result they are differentially susceptible to environmental influences on their illnesses. So they are most likely to be affected by adverse environmental challenges and are more likely to respond to interventions such as psychological treatment.

**Bipolar and childbirth**

Professor Ian Jones, Professor of Psychiatry and Director of the National Centre for Mental Health at Cardiff University, talked about the significantly increased risk of episodes of severe mood disorder in the days and months following childbirth, focusing on bipolar disorder.\(^7\) The risk is greatest among women diagnosed with bipolar I disorder and for those who have a previous postpartum episode of mood disorder, especially the most severe form – postpartum psychosis – when there is a more than 50\% increased risk of an episode of illness in the second pregnancy.\(^8\)–\(^10\) He added that while there is also a risk associated with bipolar II and major depressive disorder, it appears to be lower.\(^11\)–\(^13\)

Professor Jones explained that it is important to recognise these risks and to identify women at greatest risk because suicide is a leading cause of maternal death in the UK.
A study by Professor Jones’ group involving over 1000 women has shown stronger evidence for childbirth as a trigger for episodes of mania or depression postpartum among women with bipolar I disorder and recurrent major depression than among women with bipolar II disorder.6

Professor Jones said that he worries there is a danger that, as the concept of bipolar spectrum disorder develops and is widened to include bipolar II, bipolar NOS and bipolar symptoms in women with major depression, some women will be worried unnecessarily about the risks that pregnancy and childbirth might pose in terms of triggering an episode of illness. Also, Professor Jones commented that including bipolar spectrum patients together with those with bipolar I disease when analysing data from clinical studies may lead to an underestimate of the risk to women with bipolar I. Consequently, accuracy of diagnosis becomes all important, not only from a clinical perspective when trying to decide on treatment approaches but also for the research which will ultimately underpin those treatment decisions. Further information and resources for patients can be found at the UK Postpartum Psychosis Network website: www.app-network.org.

References