# Rhode Island Hospital researcher: Broadening bipolar disorder criteria is a bad idea

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A Rhode Island Hospital psychiatrist and researcher explains the negative impact of broadening the diagnostic criteria for bipolar disorder in the upcoming Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). In a newly published commentary in the *Journal of Clinical Psychiatry*, Mark Zimmerman, M.D., explains that lowering the diagnostic threshold for bipolar disorder will likely do more harm than good for patients.

As the debate continues over the revisions to DSM-IV, Zimmerman, the director of outpatient psychiatry at Rhode Island Hospital, says he and his colleagues recognize that the syndrome descriptions in DSM-IV are imperfect representations of an underlying condition. He suggests the DSM criteria should be conceptualized as a type of test for the etiologically defined illnesses (i.e. illnesses that are assigned a cause as determined through medical diagnosis).

Bipolar disorder is a symptom-based diagnosis, for which a diagnostic test does not exist. "In the absence of that test, clinicians must use the diagnostic criteria to identify the presence of the disease," he says. "Accordingly, as with any other diagnostic test, diagnoses based on DSM-IV criteria produce some false positive and some false negative results. In this context, I consider the controversy over whether the diagnostic threshold for bipolar disorder should be lowered."

"If we accept the proposition that DSM-IV criteria are imperfect in identifying bipolar illness, we must conceptualize these criteria as a type of test for bipolar illness that produces both false positives and false negatives," he says. "Shifting the diagnostic boundary downward, to be sure, will have many negative impacts upon patients, including inaccurate diagnoses and inappropriate treatment, not to mention the increased use of unnecessary medications."

For his research, he reviewed four longitudinal studies of the prognostic significance of sub-threshold bipolar disorder. He explains that while sub-threshold bipolarity is a risk factor for the emergence of the disease, the majority of individuals with sub-threshold bipolarity do not develop a future manic or hypomanic episode that is a hallmark of true bipolar disorder.

Zimmerman looked at various sides of the argument in lowering the diagnostic threshold including detecting bipolar disorder in depressed patients, diagnostic uncertainty, and unrecognized and over-diagnosed bipolar disorder. While he recognizes that the goal of lowering the criteria is to better diagnose this disorder, Zimmerman says, "The question is not whether diagnostic error exists, but rather which type of error predominates, and how much will shifting the diagnostic threshold impact the number of each of these diagnostic errors. Also important to consider are the clinical consequences of each type of error, and which error is more difficult to undo after it has been made."

At the end of his analysis Zimmerman indicates that there are four reasons for not broadening the criteria and strongly recommends against doing so because:

-- The results of the longitudinal studies suggest that lowering the diagnostic threshold for bipolar disorder will result in a greater increase in false positives than true positives;

-- There are no controlled studies demonstrating efficacy of mood stabilizers in treating sub-threshold bipolar disorder;
-- If a false negative diagnosis occurs and bipolar disorder is under-diagnosed, diagnosis and treatment can be changed when a manic or hypomanic episode emerges; and
-- If bipolar disorders is overdiagnosed and patients are inappropriately prescribed a mood stabilizer, the absence of a future manic/hypomanic episode would incorrectly be considered evidence of the efficacy of the treatment, and unnecessary medications that might cause medically significant side effects would not be discontinued.

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