

Correspondence

EDITED BY KIRIAKOS XENITIDIS and COLIN CAMPBELL

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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

from the study team, with particular attention being paid to addressing vulnerability factors determining relapse and presentations which were likely to lead to hospital readmission. This provisional finding implies that for this particular subgroup, targeted intensive case management which achieves improved costs and clinical outcomes might indeed benefit from or require small case-loads of around 1:10. This adds to the conclusion of Burns *et al* (2007) that as well as care structures such as case-load size, and the type and quality of care, it is also the targeted patient population that determines the impact of intensive case management.

Burns, T., Yiend, J., Doll, H., et al (2007) Using activity data to explore the influence of case-load size on care patterns. *British Journal of Psychiatry*, **190**, 217–222.

Harrison-Read, P., Lucas, B., Tyrer, P., et al (2002) Heavy users of acute psychiatric beds: randomized controlled trial of enhanced community management in an outer London borough. *Psychological Medicine*, **32**, 403–416.

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Authors' reply: Harrison-Read's observation of the impact of intensive case management on hospitalisation in highly selected heavy service users confirms a clinical observation with which we would

generally agree. The UK700 trial (Burns *et al*, 1999) generated considerable controversy and consequently we were reluctant to perform *post hoc* analyses. Subsequent work has generally confirmed and, to some extent, explained the UK 700 findings (Burns *et al*, 2002). It is quite possible that a low case-load size has particular advantages for some groups with severe mental illness, and the UK700 study did find such benefit for those with mild or moderate intellectual disability (Hassiotis *et al*, 2001); groups with very heavy service use may contain more of such service users.

We did not, however, conclude in our current paper (Burns *et al*, 2007) that '... there is no overall clinical advantage associated with any particular case-load size within the approximate range 1:10 to 1:20' as Harrison-Read states. Our conclusions are more limited, namely that there is a change in practice across this range but we make no claims about its impact on outcome. Indeed, we make it clear that we cannot draw such conclusions because of the way in which our two proxy measures were constructed. If anything, our findings confirm the likely importance of case-load size by demonstrating that different levels are associated with change in practice. The importance of our findings are that they challenge a strongly held belief that there is a predetermined case-load level at which intensive case management 'switches' to assertive community treatment. This view was frequently advanced to discount the

UK700 trial's results, claiming that the intensive case management case-load (1:15) was above this critical threshold.

We agree wholeheartedly with Harrison-Read that clarity and precision about case-load size, content of care and effective targeting of the patient population are all necessary for both good clinical care and for meaningful research. We hope that researchers will move on from trying to explain away differences in outcome studies to exploring differences to obtain a better understanding of which components are effective. Our original conclusion that 'how extra resource is used is more important than how it is organised' (Burns *et al*, 1999) remains valid.

Burns, T., Creed, F., Fahy, T., et al (1999) Intensive versus standard case management for severe psychotic illness: a randomised trial. *Lancet*, **353**, 2185–2189.

Burns, T., Catty, J., Watt, H., et al (2002) International differences in home treatment for mental health problems. Results of a systematic review. *British Journal of Psychiatry*, **181**, 375–382.

Hassiotis, A., Ukoumunne, O. C., Byford, S., et al (2001) Intellectual functioning and outcome of patients with severe psychotic illness randomised to intensive case management. Report from the UK700 trial. *British Journal of Psychiatry*, **178**, 166–171.

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One hundred years ago

On the Pathogenesis of some Impulsions (*Journ. Abnorm. Psychol.*, April, 1906) Janet, P.

A large number of patients have impulses to perform certain useless, bizarre, and even dangerous acts, not generally, however, very important acts; when it is a question of dangerous acts the patient is apt to feel himself drawn towards them rather than actually impelled to accomplish them. The mechanism of the impulsion is not always the same. Sometimes it is analogous to that of suggestion; at other times the impulsion

appears to develop subconsciously, entering the field of a retracted consciousness too late to be easily controlled. Beyond these and other causes there is, Janet believes, a mental disposition common among the obsessed and impulsive which plays an important part in many cases.

To illustrate the factor in question five cases are briefly narrated, all in young women. One is a case of periodical dipsomania, the attacks occurring at intervals of a few weeks or months and being followed by repentance and despair; another of the rarer impulsion to eat, the

patient feeling a constant need of support; the third of dromomania, or the mania for walking, the patient not beginning to feel at her ease until she has walked over forty kilometres along a public highway, so that no sanatorium can be found sufficiently spacious for her; the fourth must tear out her hairs one by one and eat them, and has thus lost a luxuriant head of hair; the fifth is never happy unless she tortures and wounds and bruises herself. These impulsions, though apparently different, have common clinical characteristics. They are periodic and irresistible, while their