Letters to the Editor

Changes to the Diagnostic Criteria for Bipolar Disorder in DSM-5 Make Little Difference to Lifetime Diagnosis: Findings From the U.K. Bipolar Disorder Research Network (BDRN) Study

TO THE EDITOR: DSM-5 criterion A for manic and hypomanic episodes includes the additional requirement of abnormally and persistently increased activity or energy. This requirement was not present in DSM-IV. This update raises the question of whether research groups and consortia with large DSM-IV bipolar disorder cohorts can combine these with DSM-5 cases in ongoing and future analyses.

One study has suggested that considerably fewer individual episodes may meet the new DSM-5 criteria for hypomania and mania than under DSM-IV (1). The study found that of 310 patients in tertiary care diagnosed with a DSM-IV episode of hypomania or mania at time of entry into the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) study, only 52% also met DSM-5 criteria. Interestingly, longitudinal clinical outcomes at 1 year did not differ between those who did and did not meet DSM-5 criteria. There have been no studies, however, that have examined the effect of the change in criteria on lifetime diagnosis. We sought to address this question using data from our large bipolar disorder research cohort.

We have rated the lifetime presence or absence of overactivity in the context of hypomanic or manic episodes in 3,993 cases with a lifetime diagnosis of DSM-IV bipolar I disorder (N=2,801) and bipolar II disorder (N=1,192) in our U.K. Bipolar Disorder Research Network (BDRN) program. Cases are recruited systematically through secondary psychiatric care, advertisements on our web site (BDRN.org), and patient support organizations. Best-estimate main lifetime diagnosis and clinical variables, including the presence of individual mood symptoms, are rated from semistructured interview data (Schedules for Clinical Assessment in Neuropsychiatry) and available clinical records. Interrater reliability between the research psychologists and psychiatrists conducting the interview, rating, and diagnostic procedures is high, with mean kappa statistics of 0.85 for DSM-IV diagnosis and between 0.81 and 0.99 for other key clinical categorical variables.

We found that 94% and 93% of our cases with a lifetime DSM-IV diagnosis of bipolar I disorder and of bipolar II disorder, respectively, experienced overactivity in the context of at least one manic or hypomanic episode and therefore would meet lifetime DSM-5 criteria for a bipolar disorder diagnosis. These findings are in agreement with a study that found increased motor activity to be the most frequent symptom of mania (85%–95% of cases) (2). The STEP-BD study found a much lower level of concordance between DSM-IV and DSM-5 diagnoses but measured only current symptoms using a clinician-rated monitoring form in currently unwell participants. We measured lifetime symptoms based on research interviews with euthymic participants in addition to available clinical records. Furthermore, the samples were drawn from different populations and as a result, there are potential differences in the clinical characteristics of the two samples. It is important to note that we did not measure hypomanic or manic increased energy in the BDRN because this was not part of DSM-IV criteria for either a manic or hypomanic episode. Therefore, 94% is an underestimation of the true proportion of BDRN participants who would reach lifetime DSM-5 criteria. Therefore, we are confident that our sample, and similar samples around the world, with main lifetime DSM-IV diagnoses of bipolar disorder can be combined with lifetime bipolar samples diagnosed according to DSM-5 in ongoing and future analyses.

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Commentary on the Risk of Treatment-Emergent Mania With Methylphenidate in Bipolar Disorder

TO THE EDITOR: The article by Alexander Viktorin and colleagues (1), published in the April 2017 issue of the *Journal*, reported findings from Swedish national registers regarding