

VIEWS & REVIEWS

FROM THE FRONTLINE

Bad medicine: bipolar II disorder

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News stories report a rise in bipolar illness.

In fact, this reflects an increase in bipolar II disorder, which, unlike bipolar I, has no mania or psychotic features. For the diagnosis of bipolar II there need only be one episode of depression and one episode of hypomania (periods of increased productivity, a reduced need for sleep, risk taking, and inflated self esteem), this hypomania lasting more than four days. Recent UK research claims that up to 21% of primary care patients with depression have in fact unrecognised bipolar disorder (Smith et al, Unrecognised bipolar disorder in primary care patients with depression. *Br J Psychiatry* published online 3 February 2011). This has enormous implications—there were 40 million prescriptions for antidepressants in England in 2010. No family is untouched, but have these medications made us happier? We are on the cusp of a massive increase in the diagnosis of bipolar II, with prescribing of mood stabilisers such as valproic acid increasing by 130% and quetiapine increasing by 160% since 2005 (www.nhs.uk/PrescriptionServices/Documents/PPDPrescribingAnalysisCharts/CNS_Nov_10.pdf). However, a diagnosis of bipolar disorder has lifelong implications for employment and the children of sufferers, and is a life sentence

of polypharmacy. So are we absolutely sure about the diagnosis of bipolar II?

Modern psychiatry, for all its evidence, is merely an intellectual construct, neither fact nor science. Psychiatry uses crude generalisations to generate models to explain the unexplainable and to know the unknowable. The diagnosis of hypomania in bipolar II is not a model that I as a clinician can accept. The questionnaires used are leading, suggestive, and reduced to only 16 simplistic questions, one of which is, “I drink more coffee.” Doctors should consider whether or not the diagnosis of hypomania has any real world validity. Regrettably, the internet has already spawned an online so called quick test for bipolar II.

But what of the evidence for treating bipolar II? Most is mere extension from bipolar with mania (www.nice.org.uk/nicemedia/live/10990/30193/30193.pdf). For bipolar II I could find little evidence on drug treatment and no long term data. The most quoted evidence was for quetiapine. But the two landmark studies are covered in the fingerprints of big pharma (*J Clin Psychopharmacol* 2006;26:600-9; *Am J Psychiatry* 2005;162:1351-60). Bipolar I and II are mixed together in the studies, so it is no surprise that antipsychotics were effective. I could find no good research exclusively considering quetiapine in bipolar II. With quetiapine costing over £2000 (£2250; \$3330) a year, could this be a deliberate attempt to pollute and confuse the research?

Is psychiatry causing more iatrogenic harm than good? Is rampant overdiagnosis now the real issue? These are questions for all doctors. Psychiatry has a duty to the sick but also to the well. The ever widening of spectrum disorders is simply narrowing the middle and what it means to be well. This is bad medicine.

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