

EDITORIAL

The prevalence of bipolar disorders in the general population: a growing trending topic?

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In the current issue of *Revista Brasileira de Psiquiatria*, Clemente et al.¹ report the first meta-analysis of the prevalence of bipolar disorder (BD) from population-based studies. Strengths of the manuscript include the use of suitable methods of analysis, reporting both annual and lifetime prevalence rates, and providing separate data for bipolar subtypes I and II. The latter is relevant because type II is not simply a milder or minor form of BD.

This publication is of considerable interest, firstly because it confirms that the frequency of BD in the general population is low and closer to the conservative estimates of 1-2%, as suggested by historical data.^{2,3} It is worth pointing out that these might be underestimates because, compared to longitudinal studies, data from population-based cross-sectional studies may underestimate the real prevalence of BD.⁴

More importantly, the authors found an increase in prevalence estimates over recent decades, in parallel with changing DSM diagnostic criteria. Lifetime prevalence of BD type I has virtually doubled with each edition from DSM-III to DSM-IV. The increase in type II is only marginally significant, although the number of studies is also lower. This is quite surprising, since the only relevant change in the bipolar section of the DSM over the last three decades was the appearance of BD type II in DSM-III-R, whereas criteria for type I have remained essentially the same. In a conservative explanation, the authors attribute the increase in type I to the use of different instruments, whereas growth in type II frequency would be the result of changing DSM criteria.

However, this meta-analysis leaves some key questions “blowing in the wind.” For instance, how much of this growth is real or artificial? In other words, is it the result of increased awareness by clinicians, more accurate nosologies, broadening of diagnostic criteria, or just another vogue? Recently, there has been much controversy about an epidemic of BD, and psychiatry is facing risks for both bipolar “overdiagnosis” and “underdiagnosis.” The results of this paper will surely fuel the debate. Interestingly, if one assumes that a genuine increase in bipolar frequency

has taken place, it would be relatively independent of the gradual expansion of the bipolar phenotype, from the narrowly-defined “classic” manic-depressive illness (BD type I) to the broadly-defined “full bipolar spectrum.” The latter may present with higher rates, but is more difficult to capture; therefore, its prevalence has been less examined in community samples.

Another fascinating issue is why increased prevalence in non-clinical samples is more obvious in BD type I. One could expect a similar, or even greater, trend for BD type II. Some reflections about hypomania, which lies between the narrow and broad bipolar phenotypes, merit further discussion. Recognition of mania is straightforward, with exceptionally high concordance rates among clinicians. However, an accurate diagnosis of hypomania is usually difficult in clinical practice – even more so in community surveys! On the one hand, patients certainly do not label hypomania as abnormal. On the other hand, the successive DSM editions have refined the diagnostic criteria for hypomania, but its definition remains controversial. Hypomania has not gone through Robins and Guze’s gold-standard criteria to establish the validity and reliability of major mental disorders.³ Indeed, its dissection from mania does not rely on quantity or quality of symptoms, which are identical, with the exception of psychotic features. Rather, it is based on the somewhat arbitrary, non-symptom criteria of minimum duration of 7 days, need for hospitalization, and marked functional impairment in the case of mania.⁵ Moreover, marked impairment is not clearly operationalized in DSM.⁶ All of this likely leads to underestimation of the true prevalence of BD type II, especially in the general population. As mentioned by the authors, its prevalence is greater in clinical samples. That also seems to be the case among adolescents, an age group in which lifetime prevalence rates of hypomania can reach 3-4% in prospective community samples.⁷ This question must await further inquiry, because the present systematic review focused only on adult samples. Future meta-analyses should also reveal whether the inclusion of studies using the ICD diagnostic system would modify the present findings.

Certainly, establishing the prevalence of bipolar and other psychiatric disorders is a complex endeavor. Differences in settings (general population, primary care vs. psychiatric clinics), types of prevalence estimates

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(e.g., point, 12-month, lifetime), assessment instruments, and changing diagnostic criteria may affect prevalence rates and comparisons of studies. These factors may likely account for much of the discrepancy in the literature regarding BD prevalence. However, defining the boundaries of the phenotype is unique to BD and represents a major source of this variability, as mentioned above.

BD is among the leading causes of disability worldwide. Robust and reliable prevalence estimates, such as those from the present meta-analysis, represent a relevant addition to the epidemiology of this disorder and have clinical, socioeconomic, and policy-making implications. For instance, they may help inform planning of health care and services. People with BD deserve more effective treatments, and advancing a better definition, ideally based on a better understanding of BD neurobiology, is a key step.⁶ Clearly, there is substantial room for improvement of our current diagnostic systems. In this regard, recent proposals, such as clinical staging systems⁸ and Research Domain Criteria,⁹ will hopefully move the field forward and improve clinical outcomes.

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Disclosure

The authors report no conflicts of interest.

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