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Short communication

Are manic symptoms that '*dip*' into depression the essence of mixed features? ☆

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ABSTRACT

Background: Three symptoms of (hypo)mania that clinically represent mood disorders mixed states have been omitted from the DSM-5 mixed features specifier because 'they fail to discriminate between manic and depressive syndromes'. Therefore, the present study examined the role of distractibility, irritability and psychomotor agitation (DIP) in characterising mixed depressive states.

Methods: Fifty in-patients at a specialist mood disorders unit underwent a detailed longitudinal clinical evaluation (3–6 weeks) and were assessed on a range of standardized measures to characterise their illness according to depression subtype, duration of illness and clinical features-including specifically depressive and manic symptoms and the context in which these occur.

Results: 49 patients met criteria for major depressive episode, and of these, 34 experienced at least one *dip* symptom. Patients who endorsed distractibility were more likely to be diagnosed with Bipolar Disorder than Major Depressive Disorder; patients who endorsed irritable mood were more likely to have non-melancholic depression (admixture of depressive and anxiety symptoms), and patients who reported psychomotor agitation experienced a significantly greater number of distinct periods of (hypo) manic symptoms compared with those who did not.

Limitations: The present study used a modest sample size and did not control for medication or comorbid illness. Although this is inevitable when examining real-world patients in a naturalistic setting, future research needs to allow for comorbidity and its impact, specifically anxiety.

Conclusions: The present findings suggest that all 3 symptoms that have been excluded from DSM-5 may be cardinal features of mixed states, as they '*dip*' into depressive symptoms to create a mixed state.

1. Introduction

Kraepelin (1921) conceptualised manic-depressive insanity as a unitary illness in which mood disorders undergo gradual transition from depressive to manic/hypomanic states. This vision of a continuum has been revived recently as the spectrum model (Akiskal, 2003; Angst et al., 2003; Benazzi, 2006), in which mania and psychotic depression each occupy the extremes. The spectrum comprises mood disorders of varying severity and subtype, and it is here that mixed states emerge.

1.1. Kraepelin to DSM IV

Kraepelin viewed mixed states as a combination of depressive and manic symptoms, with symptoms from the opposite pole arising in either a predominantly depressive or manic mood (Kraepelin, 1921). However, because early versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) emphasised polarity (Leonhard, 1957) instead of illness course and recurrence (Goodwin and Jamison, 2007), clinical and research interest in mixed states gradually subsided, until the publication of

☆*Note*: '*dip*' – refers to distractibility, irritability, psychomotor agitation.

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Research Diagnostic Criteria (Spitzer et al.,1978). This rekindled academic interest in mixed states and resulted in the inclusion of a mixed bipolar subtype in DSM-III (American Psychiatric Association, 1980). Eventually, DSM-IV introduced the mixed episode, but the definition proved too stringent, as it required a full manic and major depressive episode to occur in combination. As a consequence, this definition only captured mixed manic episodes, while episodes of mixed depression were not recognised separately. Instead, DSM-IV major depressive disorder engulfed mixed depressive presentations along with agitated depression, which had been distinguished in DSM-III as a depressive syndrome with additional psychomotor excitation.

Recognising these problems, various definitions of mixed depression emerged emphasising the importance of anxious and irritable mood along with psychomotor excitation (Koukopoulos et al., 1992). A mixed depressive syndrome was thus defined as an admixture of severe depressive symptoms and some manic symptoms (Akiskal, 1992; Benazzi, 2000).

1.2. DSM-5

In practice, the narrow definition of DSM-IV mixed episodes persisted until recently when it was supplanted by the DSM-5 mixed features specifier. The latter is a broader concept than DSM-IV mixed episodes and requires only 3 or more non-overlapping symptoms from the opposite pole, but critically, not all symptoms are included. Key features, such as distractibility, irritability and psychomotor agitation, that arguably characterise mood disorders mixed states have been omitted. However, the potential for some of these symptoms to define and differentiate mixed states has been the focus of recent research (Koukopoulos and Sani, 2014; Malhi et al., 2015, 2014). This suggests that three clinical

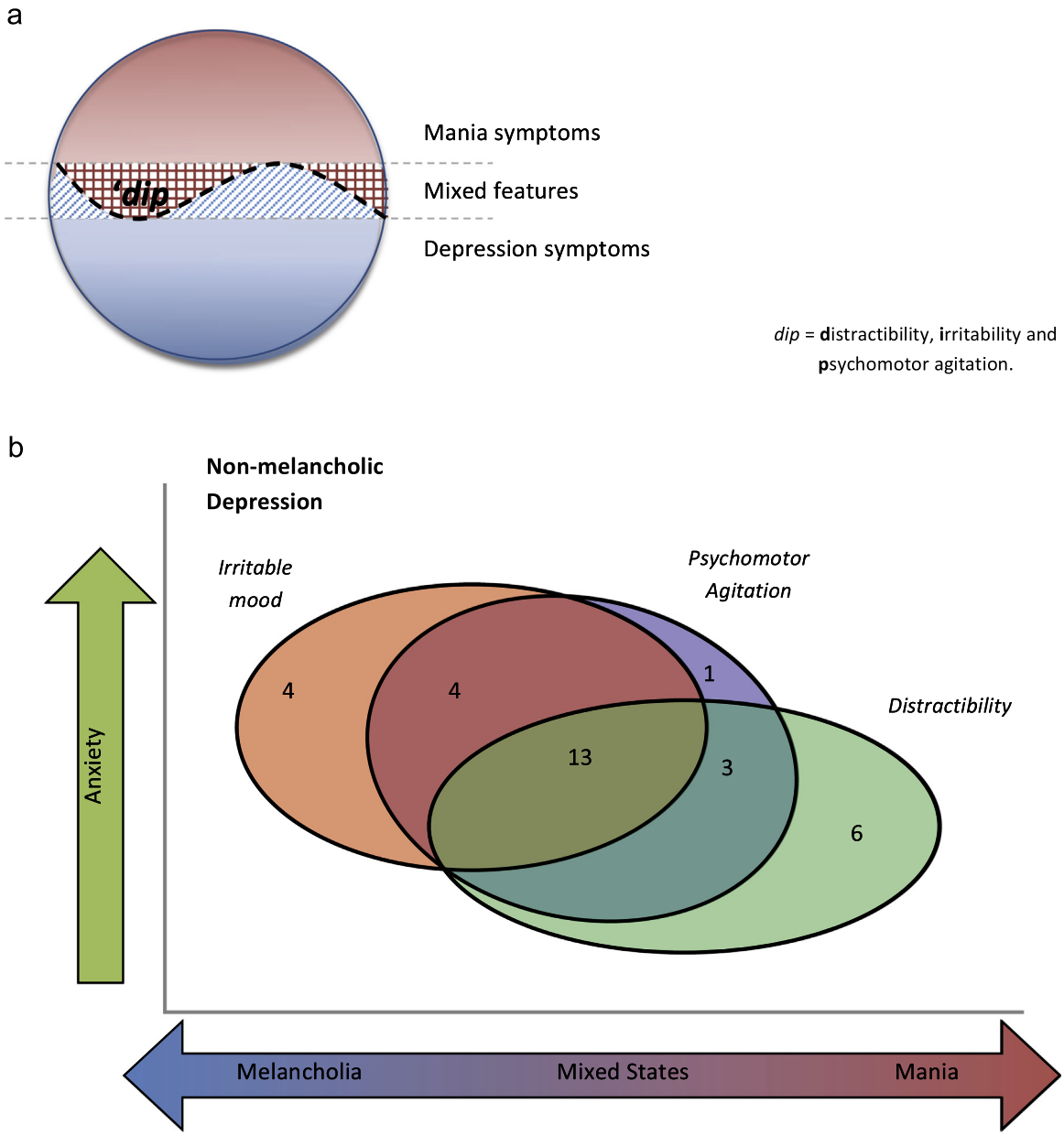

Fig. 1. (a) Schematic of mixed features that form interface between depression (blue) and mania (red). Mixed features that '*dip*' into depression are shown to lie within the mixed features that originate from mania (red checked pattern). (b) Numbers of patients experiencing *dip* mixed features symptoms schematically represented in relation to spectrum of mood disorders diagnoses and anxiety. (For interpretation of the references to colour in this figure legend, the reader is referred to the web version of this article.)