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Research report

A downscaled practical measure of mood lability as a screening tool for bipolar II

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Abstract

Background: Current data indicate a strong association between Cyclothymic temperament (and its more ultradian counterpart of mood lability) and Bipolar II (BPII). Administration of elaborate measures of temperament are cumbersome in routine practice. Accordingly, the aim of the present analyses was to test if a practical measure of mood lability was unique to BPII, in comparison with major depressive disorder (MDD). *Methods*: Using the Structured Clinical Interview for DSM-IV Axis I Disorders, Clinician Version as modified by us [J. Affect. Disord. 73 (2003) 33; Curr. Opin. Psychiatry 16 (2003) S71], we interviewed 62 consecutive BPII outpatients, as well as their 59 MDD counterparts during a major depressive episode (MDE). Hypomanic symptoms *during* MDE were systematically assessed: three or more such symptoms defined depressive mixed state (DMX3) on the basis of previous work by us [J. Affect. Disord. 73 (2003) 113]. A downscaled definition of trait mood lability was adapted from Akiskal et al. [Arch. Gen. Psychiatry 52 (1995) 114] and Angst et al. [J. Affect. Disord. 73 (2003) 133], requiring a positive response to one of two queries on whether one is a person with frequent "ups and downs" in mood, and whether such mood swings occur for no reason. The patients selected for inclusion had not received neuroleptics and antidepressants for at least 2 weeks prior to the index episode, they were free of substance and alcohol abuse, and did not meet the DSM-IV criteria for borderline personality disorder (BPD). Associations between mood swings and clinical variables were tested by logistic regression (STATA 7). *Results*: Mood swings were endorsed by 50.4% of the entire sample: 62.9% of BPII and 37.2% of MDD ($p = 0.0047$). This practical measure of mood lability was significantly associated with BPII, lower age at onset, high depressive recurrences, atypical features, and DMX3. When controlled for number of major affective episodes, mood swings were still significantly associated with BP-II. Sensitivity and specificity of mood swings for predicting BPII were 62.9% and 62.7%, respectively. *Limitation*: The low specificity of trait mood lability for BPII diagnosis is probably due to the fact that we used a downscaled simplified measure of this trait. *Conclusions*: On the other hand, the relatively high sensitivity of our downscaled measure of mood lability for predicting BPII supports its usefulness as a screening tool for this diagnosis. The lack of association between self-reported mood lability and number of major mood episodes indicates that such lability does not reflect the perception of history of frequent episodes, and that it has some validity as a trait indicator. Given that our sample excluded patients meeting the DSM-IV criteria for BPD, contradicts the opinion of the latter manual that such mood lability represents its pathognomonic characteristic that distinguishes it from BPII. The bipolar nature of mood lability is further

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supported by significant associations with external validating criteria for bipolarity. Overall, these data indicate that in the differential diagnosis between MDD and BPII, trait mood lability favors the latter at a significant statistical level.

Keywords: Mood lability; Mood swings; Bipolar II disorder; Major depressive disorder; Depressive mixed state; Borderline personality disorder

1. Introduction

The diagnosis of bipolar II (BPII) is not easy at first clinical presentation (Dunner and Tay, 1993; Hantouche et al., 1998). The instability of the course of this bipolar subtype involves a tempestuous biographical background (Akiskal et al., 1995), which is often confused with borderline personality disorder (BPD) and other erratic personality disorders (Akiskal, 1981; Deltito et al., 2001). Diagnostic confusion may be even greater when BPII presents as a depressive mixed state, i.e. hypomanic signs and symptoms intruding into the depressive phase of BPII.

DMX is defined as a major depressive episode (MDE) with few simultaneously occuring intra-episode manic or hypomanic symptoms. It was first systematically described by Weygandt (1899; translation into English by Marneros, 2001) and by Kraepelin (1889) in their hospitalized, typically psychotic, patients with affective disorder. Recent studies have focused beyond bipolar I DMX—a usually psychotic MDE with few intra-episode manic symptoms (Perugi et al., 1997, 2001)—to include BPII DMX, which is a non-psychotic MDE with few intra-episode hypomanic symptoms (Akiskal and Mallya, 1987; Akiskal, 1996; Akiskal and Pinto, 1999; Benazzi and Akiskal, 2001, 2003b; Benazzi, 2001a; Akiskal and Benazzi, 2003). The definition of BPII DMX used in these studies was a dimensional one, like that for non-DSM-IV mixed mania (Akiskal et al., 1998). BPII DMX was found to be very common among MDE outpatients (up to 60%) in a non-tertiary care setting, and in about half that in major depressive disorder (MDD) outpatients (Akiskal and Benazzi, 2003). In this setting, its most common hypomanic symptoms were found to be irritability, racing/crowded thoughts, distractibility, psychomotor agitation and more talkativeness. In university outpatient settings mood lability and increased sexual arousal have also been reported (Akiskal and Mallya, 1987; Akiskal and Pinto, 1999). Related studies (Akiskal, 1996; Akiskal and Pinto, 1999) suggested that BPII DMX could be related to cyclothymic or hyperthymic temperaments, which facilitate the intrusion of hypomanic features into the MDE. Hantouche et al. (1998) found that the cyclothymic temperament was significantly much more common in BPII vs. MDD patients (44.4% vs. 4.4%), while hyperthymic temperament was not more common in BPII vs. MDD patients (15.1% vs. 17.1%). The relationship between cyclothymic temperament and BPII DMX therefore deserves further study.

Cyclothymic temperament was contemporaneously described in Tennessee studies (Akiskal et al., 1979, 1998; Akiskal and Mallya, 1987). Its main features are instability of mood, behavior, thinking, energy, and sleep, usually changing every few days. There is considerable similarity between the cyclothymic temperament definition and the mood lability trait uncovered in the NIMH collaborative study (Akiskal et al., 1995); the latter was found to be a strong predictor of switching from MDD to BPII. Its main features are the *ultradian* instability of mood, with frequent ups and downs, being easily hurt, frequent dips into pessimism and disgruntled mood, and racing thoughts. It can be seen that trait mood lability shares with the cyclothymic temperament a very important feature, namely the high instability of mood, which could be the basic feature of both temperament constructs. The baseline instability of mood could, in turn, lead to the appearance of opposite (hypomanic) symptoms during MDE.

According to DSM-IV (American Psychiatric Association, 1994), mood lability is the pathognomonic symptom in distinguishing BPD from BPII. We reasoned that if this were true, then an MDE sample without BPD should have a low prevalence of mood lability. As existing data (Akiskal et al., 1995; Henry et al., 2001) contradict the DSM-IV position, we