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ORIGINAL PAPER

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Is 4 days the minimum duration of hypomania in bipolar II disorder?

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Abstract DSM-IV requires that bipolar II disorder has hypomania with a minimum duration of 4 days, a cutoff not based on data. The study aim was to test if hypomania lasting 2 to 3 days could identify a group of bipolar II with typical clinical features of bipolar disorders. Consecutively, 65 unipolar and 103 bipolar II major depressive episode (MDE) outpatients were interviewed with the Structured Clinical Interview for DSM-IV. Almost all had had 2 to 3 days of hypomania, and all had had more than one hypomania. Typical clinical variables distinguishing bipolar from unipolar disorders (age at onset, atypical features, and recurrences) were compared. Bipolar II had significantly lower age at onset, more recurrences, and more atypical features. Findings suggest that hypomania lasting 2 to 3 days may identify a bipolar II group having typical features of bipolar disorders.

Key words Hypomania · Unipolar · Bipolar

Introduction

According to Dunner (1998), a member of the DSM-IV Mood Disorders Working Group, the DSM-IV (American Psychiatric Association 1994) minimum duration of hypomania of 4 days for the diagnosis of bipolar II disorder was not based on data. The validity of bipolar II with hypomania lasting 1 to 3 days (Angst 1998; Akiskal et al. 1977) was supported by a positive family history for bipolar disorder. As the prevalence of bipolar II disorder in outpatient depression may be 30–50 % (Akiskal 2000; Benazzi 1997; Benazzi 1999; Benazzi 2000) the study of bipolar II depression is important because its psychopharmacological treatment may be different from that of unipolar depression (Akiskal 2000). Study aim was to test if bipolar II with hypomania lasting 2 to 3 days could identify a group of bipolar II with typical clinical features of bipolar (I / II) disorders (Akiskal 2000; Baldessarini 2000; Dunner 1996): younger age at onset, more depressions with atypical features, and more recurrences, than unipolar depression.

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Materials and methods

The study was conducted by a senior clinical (16 years in psychiatry practice, more than 4000 mood disorder visits per year, more than 400 new mood disorder patients per year) and mood disorder research (search "Benazzi F" on PubMed / Medline) psychiatrist of the Department of Psychiatry, National Health Service, Forlý, Italy. The study was conducted in his outpatient private practice. Private practice was chosen because it is more representative of mood disorder patients spontaneously seeking psychiatric treatment in Italy, where it is the first (or the second, after family doctors) line of treatment of mood disorders, and where the most severe mood patients are usually treated in national psychiatric health services or in university centers. Mood disorder patients in academic centers may not be representative of typical mood disorder patients (Goldberg and Kocsis 1999), and the literature-studied bipolar patients are not representative of the larger universe of patients seen in clinical practice (Akiskal and Pinto 1999).

Consecutively, 65 unipolar (major depressive disorder, dysthymic disorder) and 103 bipolar II outpatients, presenting spontaneously for major depressive episode (MDE) treatment, were included in the last year. Substance and severe personality disorder patients (diagnosed by clinical interview following DSM-IV criteria) were not included, because they may confound the diagnosis of bipolar II (Akiskal 2000). Patients were interviewed by the author during the first visit (when they had minimal or no psychopharmacotherapy) with the Structured Clinical Interview for DSM-IV Axis I Disorders-Clinician Version, Mood Disorder module (SCID-CV) (First et al. 1997), and the Global Assessment of Functioning (GAF) scale (American Psychiatric Association 1994). All patients were SCID-CV interviewed for history of manic / hypomanic episodes. Nearly all bipolar II patients had had 2 to 3 days of hypomania, and all had had more than one hypomania (increasing the reliability of bipolar II diagnosis). Often, family members or close friends supplemented the clinical information during the interview.

The variables studied were age, female gender, GAF, age at onset of the first MDE [as age at onset of the first hypomania is difficult to assess reliably (Dunner and Tay 1993; Dunner 1996), while age at onset of the first MDE can be assessed retrospectively with high reliability (McMahon et al. 1994)], MDE with DSM-IV atypical features,

and recurrences (more than 3 MDEs). As age at onset was not normally distributed (Skewness and Kurtosis test, P=0.0000), the comparison of age at onset using means and medians would have been misleading (Goodwin and Jamison 1990; McMahon et al. 1994). Comparison of age at onset distribution was a better estimate of difference (McMahon et al. 1994). Age at onset distributions were compared with the two-sample Kolmogorov-Smirnov test for equality of distribution (D) (McMahon et al. 1994). Mean and median ages at onset were also compared to present a complete picture of age at onset. Means were compared with t test (T), medians were compared with Mann-Whitney test (Z), and proportions with the two-sample test of proportion (Z). Significance level was two-tailed $P < 0.05$. STATA 5 statistical software (Stata Corporation, College Station, Texas, USA, 1997) was used.

The study was approved by the ethics committee, and it was performed in accordance with the 1964 Declaration of Helsinki. All persons gave informed consent prior to inclusion in the study.

Results

Comparisons between unipolar and bipolar II are presented in table 1. Bipolar II had a significantly lower age, lower age at onset, more recurrences, and more MDEs with atypical features.

Discussion

Findings suggest that hypomania lasting 2 to 3 days may identify a bipolar II group having typical clinical features of bipolar disorders (lower age at onset, more MDEs with atypical features, and more recurrences, than unipolar depression) (Akiskal 2000; Baldessarini 2000; Dunner 1996). The DSM-IV minimum duration of hypomania of 4 days could be reduced to 2 to 3 days, as it would still identify bipolar II with typical clinical features of bipolar disorders. The reported positive family history for bipolar disorder in bipolar II with hypomania lasting 1 to 3 days supports the present findings (Angst 1998; Akiskal et al. 1977).

Limitations include single interviewer, non-blind cross-sectional assessment, reliability of bipolar II diagnosis based on history of hypomania, no clear boundaries between the clinical pictures of DSM-IV mania and hypomania (Akiskal 2000; Dunner 1996). A validated structured interview, a senior clinical and research psychiatrist, family members or close friends supplementing clinical information, standard assessment of all consecutive patients, and systematic questioning about past hypomania may have reduced these limitations (Akiskal 2000; Goodwin and Jamison 1990).

Advantages include inclusion of outpatients only, no substance and severe personality disorders, large sample of bipolar II patients, and a non-academic setting. Because a non-academic sample, like the present one, may be more representative of typical mood disorder patients, and of the larger universe of bipolar patients seen in clinical practice, results may have more general validity (Goldberg and Kocsis 1999; Akiskal and Pinto 1999).

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Tab. 1 Comparisons between Unipolar (UP) and Bipolar II (BP)

Variable	UP (n = 65)	BP (n = 103)	T/Z/D	DF	P
Age (years), mean (SD)	47.7 (15.7)	42.0 (14.3)	2.4	166	0.0165
GAF, mean (SD)	51.0 (9.0)	49.9 (7.9)	0.8	166	0.4063
Female gender, %	60.0	66.0	0.7		0.4309
More than 3 MDEs, %	60.0	78.6	2.5		0.0094
DSM-IV atypical features, %	16.9	47.5	4.0		0.0000
Age at onset (years):					
Mean (SD)	30.3 (13.0)	25.5 (12.9)	2.3	166	0.0204
Median	27	22	2.8		0.0050
Kolmogorov-Smirnov			0.2		0.009

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