The Mood Disorder Questionnaire in Primary Care: (Not) Ready for Prime Time?

In this issue of the *Companion*, we alert you to a recently developed and validated instrument for the recognition of bipolar disorder—the Mood Disorder Questionnaire (MDQ). The development of this instrument by Hirschfeld and colleagues underscores 2 important aspects of depression management that cannot be overemphasized. First, bipolar depression is an all-too-common and overlooked phenomenon in clinical practice. There is direct evidence of a higher-than-appreciated prevalence in both psychiatric and primary care settings. There is supportive indirect evidence for the primary care prevalence when one considers the fact that current estimates of bipolarity in the general population are in the 5% range, with only one third of mood disorder patients treated in psychiatric settings. This leaves the remaining two thirds treated elsewhere with—you guessed it—primary care settings the most likely recipient of these patients. The vast majority of those with bipolar illness are misdiagnosed at presentation (repeatedly) because bipolar depression is not considered. Patients with bipolar disorder often suffer noxious effects from antidepressant monotherapies (treatment-emergent hypomania/mania, mixed states, cycle acceleration). Since there is potential harm involved in misdiagnosis, an essential question for all clinicians contemplating an antidepressant prescription for a patient presenting in a depressed state is, "Is this person suffering from a bipolar depression?" Our primary care observations suggest that the answer will be in the affirmative 25% to 30% of the time!

The prevalence issue begets another important question: "How do I diagnose bipolar disorder?" The answer is to apply the diagnostic criteria, but the current standard, the DSM-IV, is, on the basis of the scientific literature, insensitive to bipolar II disorder, because 4 days of expanded mood are required to establish the diagnosis, whereas the mean modal duration of hypomania is 1 to 3 days. To make matters worse, no biological markers currently exist, so we are left with careful interviews and close longitudinal observation (a radical concept) to make an accurate diagnosis. This is time consuming, and limitations on time drive the search for shortcuts, which is what the MDQ is. I say this not to deride shortcuts per se—I have my own set of treasured time-savers—but shortcuts are approximations based on and limited by inherent presuppositions.

The MDQ was validated in tertiary outpatient psychiatric settings in a population of patients with predominantly bipolar I disorder (mania). Most patients with bipolar disorder have bipolar II disorder. This is particularly true in primary care settings. Also, the MDQ asks about periods of abnormally expansive mood. Since most patients with bipolar II disorder view their hypomanic episodes as periods when they feel normal and productive, many may fail to endorse such statements, leading to false negative

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screens and a false sense of security about having ruled out the diagnosis. The MDQ asks about a family history of bipolar disorder, but such histories are often couched in shame, secrecy, and comorbidities such as alcoholism, drug abuse, and antisocial behavior. Sometimes in my practice, the only indication I get of a bipolar pedigree is in the gestalt of a "loaded" or "ugly" genogram, where everyone is either depressed, anxious, addicted, or acting out. The MDQ does not approach the issue of treatment-emergent hypomania/mania in the diagnosis of bipolar illness, a controversial area of evidence not embraced by the DSM-IV, although increasingly viewed as diagnostic.

We believe that the MDQ represents a step in the right direction, but a strong endorsement must await validation studies in our setting and in patients likely to present here. That means populations consisting largely of individuals with bipolar II disorder or even subthreshold bipolar symptoms, since the DSM-IV is an insensitive standard. Longitudinal studies suggest that temperamental traits (mood lability, energy and activity, intense fantasy, and social anxiety) and comorbidities may offer the best clues to accurate and early diagnosis of bipolar II disorder. Primary care is about early identification and risk assessment. The MDQ may yet serve clinicians in this ongoing process. Perhaps lower scoring thresholds will be found sufficient. However, this question must be rigorously tested in primary care populations.

—J.S.M.