Impact of Childhood Trauma Histories Versus Recent Trauma Symptoms on Affective Lability in Adult Bipolar Disorder

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Early life adversity is a recognized predictor of poor outcome in mood disorders. Additionally, genetic factors may contribute to affective instability and emotional lability as a dimension across psychiatric conditions.[1] A recent large study reported that affective instability and mood lability may be an indicator of a bipolar diathesis, as shown in the BRIDGE-MIX-II study.[2] It remains unclear whether *recency* of trauma symptoms differentially impacts mood episodes or affective ability in adult bipolar patients.[3–5] We therefore examined childhood trauma and current traumatic stress ratings in bipolar and unipolar inpatients, hypothesizing that higher levels of both childhood trauma and current trauma symptoms would be associated with more severe affective lability.

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Methods

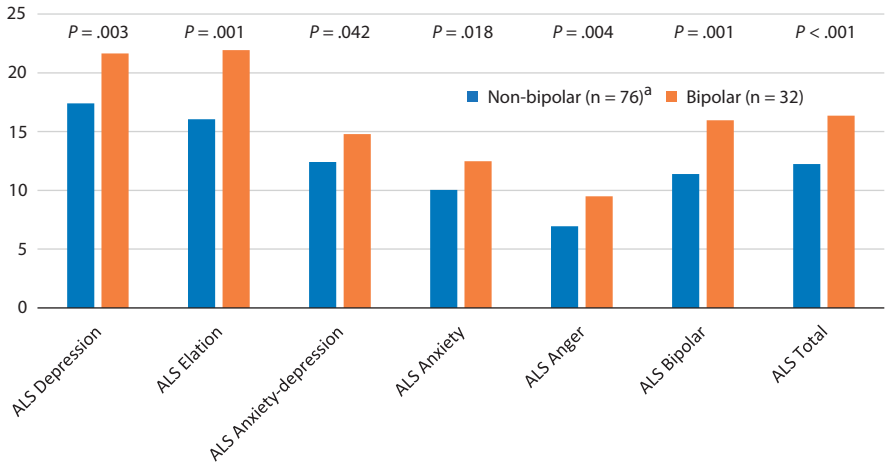
Participants (N = 109) were consecutive, voluntary, English-speaking, non-intoxicated adult inpatients at a private psychiatric facility who provided written informed consent. Analyses were a post hoc exploratory investigation in this previously described cohort.[6,7] Procedures complied with ethical standards on human experimentation and the 1975 Helsinki Declaration. The protocol was approved by the Western Institutional Review Board (Olympia, Washington). Diagnostic assessments included a modified semistructured interview version[7] of the Mood Disorders Questionnaire, itself a bipolar disorder screening tool[8]; other ratings included the Quick Inventory for Depressive Symptomatology-Self Report (QIDS-SR),[9] the 54-item Affective Lability Scale (ALS),[10] the PTSD Checklist-Civilian (PCL-C),[11] and the 28-item Childhood Trauma Questionnaire (CTQ).[12]

Results

Figure 1 reveals significantly and uniformly higher ALS subcomponent scores in bipolar than nonbipolar subjects.

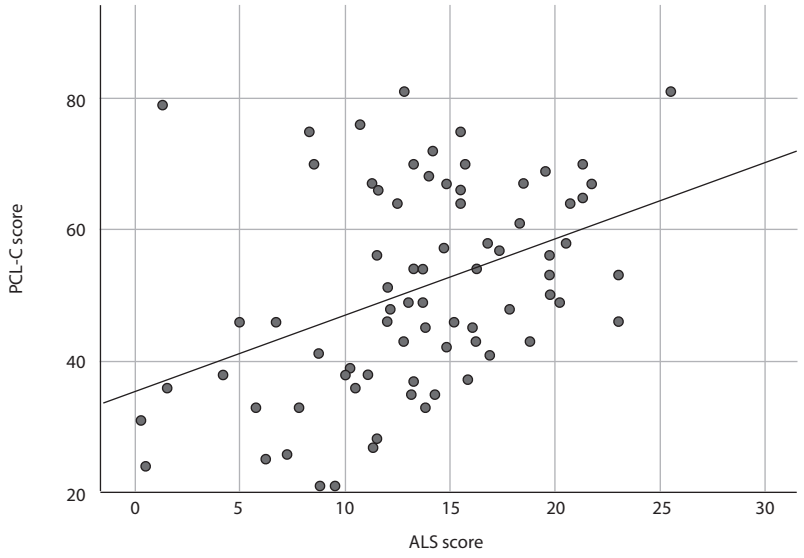
Linear regression examined associations between ALS (the dependent variable) and PCL-C scores, while controlling for CTQ subscales (sexual abuse, emotional neglect, physical abuse, emotional abuse), bipolar/unipolar diagnoses, QIDS-SR scores, and age at onset. The model was significant ($R^2 = 0.504$, $F_{9, 38} = 3.279$, $P = .007$). Bipolar diagnoses ($P = .035$) and PCL-C scores ($P = .047$)

Figure 1. Mean Affective Lability Scale (ALS) Scores Among Bipolar and Non-Bipolar Mood Disordered Subjects



[a]One non-bipolar patient had incomplete ALS data.

Figure 2. Regression Plot of PTSD Checklist-Civilian (PCL-C) Scores by Affective Lability Scale (ALS) Scores



significantly predicted ALS total scores while controlling for age at onset ($P = .036$). QIDS-SR total scores were significantly associated with ALS scores in univariate analyses but not when controlled for in the regression. No individual CTQ scores in the model were significantly associated with ALS scores. Current substance misuse did not significantly correlate with ALS scores or improve the explanatory power of the model. Figure 2 depicts the regression plot between PCL-C scores and ALS scores.

The present findings indicate a strong link between current distress about trauma symptoms and affective lability among inpatients with bipolar (but not unipolar) disorder, while controlling for current depressive symptoms or age at onset. Unexpectedly, self-reported histories of childhood trauma per se did not contribute significantly to ALS scores, despite prior literature linking childhood trauma with affective lability in adult bipolar disorder.[1–3,13] These provisional findings require corroboration with larger sample sizes and longitudinal assessment, direct evaluation of adult trauma, and closer evaluation of the timing of adult versus early life trauma vis-à-vis current affective symptoms. While the PCL-C is used to screen for PTSD, formal *DSM-5* PTSD diagnoses were not ascertained. The study also did not directly compare childhood vs adult trauma and instead focused on childhood trauma versus recent distress about trauma (using the PCL-C), as we did not include measures of adult trauma. Study subjects were self-selected for seeking treatment at a private psychiatric hospital, limiting generalizability. Most participants had comorbid substance use disorders. There is also the possibility that the presence of symptomatic bipolar or mood disorders would impact scores on the ALS and PCL-C and be a source of bias. Other limitations include potential recall biases and the impossibility to establish causality.

Future studies to discriminate the proximity and nature of childhood versus adult trauma, directly measuring both childhood and adult trauma, using validated scales and instruments, relative to BD mood episodes may help to shed further light on possible catalysts for affective lability and episodes within the kindling model.[14]

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