Unipolar versus Bipolar Depression

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Objectives

• Define Unipolar depression
• Define Bipolar Disorder and Bipolar Depression
• Differentiate between bipolar depression and unipolar depression
• Discuss basic treatment options for Unipolar and Bipolar Depression
If you are physically sick, you can elicit the interest of a battery of physicians; but if you are mentally sick, you are lucky if the janitor comes round.

~Martin H. Fischer
Unipolar Depression

• Consists of
  ▫ Major depressive disorder
  ▫ Dysthymic Disorder
  ▫ Mixed Depressive Disorder (new to DSM V)
  ▫ Adjustment disorder with depressed mood
  ▫ Depression NOS
How Common is Depression?

Current depression: 9% of adults in the United States¹

Lifetime prevalence of depression: 35.7 million²
Projected increase in lifetime prevalence: 35%
increase from 2005 to 2050
46 million adults in the United States
expected to have a diagnosis of depression by
2050

Economic Burden of Depression

• According to the World Health Organization, unipolar depression was the third most important cause of disease burden worldwide in 2004. Unipolar depression was in “eighth place in low-income countries, but at first place in middle- and high-income countries.”¹

• In a nationally representative face-to-face household survey, 6.7% of U.S. adults experienced a major depressive episode in the past 12 months.²

• Significantly greater percentages of lifetime major depression have been reported among women (11.7%) than men (5.6%).³

• Examining ethnic differences reveals lifetime percentages of depression of 6.52% among whites and 4.57% among blacks and 5.17% among Hispanics.⁴

DSM IV Criteria for Depression

For 2 weeks or more five or more symptoms:
Feeling depressed mood most of the day nearly every day
Markedly diminished interest or pleasure in all or almost all activities
Significant weight loss or decreased appetite
Insomnia or hypersomnia
Psychomotor agitation or retardation
Fatigue or loss of energy
Feelings of worthlessness or excessive guilt
Diminished ability to think or concentrate or indecisiveness
Recurrent thoughts of death
Dysthymic Disorder DSM IV Criteria

- dysthymia is characterized by an overwhelming yet **chronic** state of depression, exhibited by a depressed mood for most of the days, for more days than not, for at least 2 years. (In children and adolescents, mood can be irritable and duration must be at least 1 year.) The person who suffers from this disorder must not have gone for more than 2 months without experiencing two or more of the following symptoms:
  - poor appetite or overeating
  - insomnia or hypersomnia
  - low energy or fatigue
  - low self-esteem
  - poor concentration or difficulty making decisions
  - feelings of hopelessness
Diagnosis of Depression in Primary Care

Use screening tools to help with identifying who needs further screening but don’t ignore your skills as a clinician

PHQ 9

Scores of 12 and above have an 88% specificity and sensitivity for moderate depression, free on line

Beck Depression Inventory

Good validity, must pay for use

Hamilton Depression Scale

Available online for free use, longer and more complicated to perform, considered gold standard but recently has shown to have poor inter-rater reliability
Bipolar Disorder

- Bipolar I disorder
- Bipolar II Disorder
- Mood Disorder NOS
Criteria For Bipolar I Disorder

- Currently or recent manic, hypomanic, mixed or depressed phase
- At least one manic episode
- Symptoms cause significant distress or impairment
- The mood cannot be better explained by another mood disorder or by the use of drugs or a medical disorder
Criteria for Bipolar II Disorder

- One or more depressive episodes
- One or more hypomanic episodes
- Never had a manic episode
- The mood symptoms are not better explained by another mood disorder
- The symptoms cause significant distress or impairment
Depressed Phase

- Depressed most of the day, nearly every day
- Decreased interest or pleasure in all or almost all activities
- Weight loss when not dieting or weight gain (more that 5% in one month) or increase or decrease in appetite
- Insomnia or hypersomnia
- Agitated or slowed movement
- Fatigue or loss of energy
- Feelings of worthlessness or excessive inappropriate guilt
- Diminished ability to think or concentrate or indecisiveness
- Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
Manic Phase

• Period of abnormally elevated, expansive, or irritable mood that lasts at least one week or any length of time if hospitalization is required
• During the period of mood disturbance three of the following symptoms have been present to a significant degree:
  ▫ Inflated or grandiose
  ▫ Decreased need for sleep
  ▫ Increasingly talkative or pressured
  ▫ Thought racing
  ▫ Distractibility
  ▫ Increase in goal directed activity
  ▫ Excessive involvement in pleasurable activities that have high potential for painful consequences
Hypomanic Phase

- A period of persistent elevated, expansive or irritable mood that lasts throughout at least 4 days and that is clearly different from the usual nondepressed mood
Bipolar I Disorder VS Bipolar II Disorder

Bipolar I Disorder
- Manic Phase
- Depressed Phase
- Mixed Manic
- Hypomanic Phase

Bipolar II Disorder
- Hypomanic Phase
- Depressed Phase
Bipolar Disorder NOS Criteria

- Bipolar disorder NOS is more of a catch-all category than an actual type of this disorder. This diagnosis is used when one has symptoms of bipolar disorder, but does symptoms do not meet the requirements for a diagnosis of bipolar 1 disorder, bipolar 2 disorder or cyclothymic disorder.
  - The DSM gives a few examples for when you may be given this diagnosis:
    - You are having symptoms of mania and depression but the episodes are too short to qualify as an actual episode.
    - You’ve had many episodes of hypomania, but you’ve not had a depressive episode.
    - You are having a manic or mixed episode but you were previously diagnosed with a psychotic disorder or schizophrenia.
    - You’ve had symptoms of hypomania and depression, but they don’t last long enough to qualify as cyclothymic disorder.
    - It looks like you have bipolar disorder but your doctor thinks your symptoms might be caused by drugs, alcohol or a general medical condition.
Cyclothymic Disorder

- Cyclothymia disorder - is "a chronic, fluctuating mood disturbance involving numerous periods of hypomanic symptoms and numerous periods of depressive symptoms. Here's what goes into a diagnosis of cyclothymia:
  - All the criteria are met for a hypomanic episode
  - Symptoms do not qualify as manic or major depressive episodes
  - Symptoms never ease up for more than two months
  - There hasn't been a manic, mixed or major depressive episode in the first two years of symptoms
  - Another disorder is not responsible for symptoms
  - Symptoms are not caused by a drug or general medical condition
Economic Burden: Direct Costs/$7.6 Billion

- Inpatient: 2% of $7.6 Billion
- Outpatient: 1% of $7.6 Billion
- Nursing Home: 26% of $7.6 Billion
- Medication: 3% of $7.6 Billion
- Substance Abuse: 33% of $7.6 Billion
- Shelters: 1% of $7.6 Billion
- Crime: 8% of $7.6 Billion

*J Clin Psychiatry* 2000;61[suppl 13]:38-41
Overall Financial Burden of Bipolar Disorder

- Bipolar disorder has been deemed the most expensive behavioral health care diagnosis, costing more than twice as much as depression per affected individual.

- Total costs largely arise from indirect costs and are attributable to lost productivity, in turn arising from absenteeism and presenteeism.

- For every dollar allocated to outpatient care for persons with bipolar disorder, $1.80 is spent on inpatient care, suggesting early intervention and improved prevention management could decrease the financial impact of this illness.

References:
Evolution of Bipolar Disorder

- Pseudounipolar
- Kinding/Sensitization
- Recurrent Depression
- Mania/Hypomania
- Rapid Cycling

Character Traits
Substance Abuse
### Table 1. Essential Features of Bipolar Disorders

<table>
<thead>
<tr>
<th>Diagnostic Features</th>
<th>Bipolar I Disorder</th>
<th>Bipolar II Disorder</th>
<th>Cyclothymia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mania/hypomania</td>
<td>At least 1 manic or mixed episode</td>
<td>At least 1 hypomanic episode; no history of manic or mixed episodes</td>
<td>2 years of numerous periods of hypomanic symptoms that do not meet full criteria for manic, hypomanic, or mixed episodes</td>
</tr>
<tr>
<td>Major depressive episode</td>
<td>Optional</td>
<td>Necessary</td>
<td>2 years of numerous periods of depressive symptoms that do not meet full criteria for a major depressive episode</td>
</tr>
</tbody>
</table>

*Source: Reference 3.*

A cutoff point of 7 or more was selected for a positive screen, which provided good sensitivity (73%) and very good specificity (90%). By using this threshold, 7 of 10 people with bipolar spectrum disorder would be correctly identified by the MDQ, and 9 of 10 people who do not have bipolar disorder would be accurately screened out.
Issues with MDQ

• “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 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.”

1. Has there ever been a period of time when you were not your usual self and...
   ...you felt so good or so hyper that other people thought you were not your
   normal self or you were so hyper that you got into trouble?
   ...you were so irritable that you shouted at people or started fights or arguments?
   ...you felt much more self-confident than usual?
   ...you got much less sleep than usual and found you didn’t really miss it?
   ...you were much more talkative or spoke much faster than usual?
   ...thoughts raced through your head or you couldn’t slow your mind down?
   ...you were so easily distracted by things around you that you had trouble
   concentrating or staying on track?
   ...you had much more energy than usual?
   ...you were much more active or did many more things than usual?
   ...you were much more social or outgoing than usual, for example, you
   telephoned friends in the middle of the night?
   ...you were much more interested in sex than usual?
   ...you did things that were unusual for you or that other people might have
   thought were excessive, foolish, or risky?
   ...spending money got you or your family into trouble?
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please circle one response only.
   No Problem         Minor Problem             Moderate Problem             Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?
So How Do We Differentiate Bipolar Depression from Unipolar Depression

• History
  ▫ There is no screening tool that takes the place of a good history
  ▫ Screening tools can complement the practice to help guide you but don’t rely on them to give you the answer
Case Study 1-Brian

• Brian is a 22 year old male who presents with symptoms of lack of energy, increased sleep, increased appetite with 5 lb weight gain in the last month. He also is anhedonic. He denies suicidal ideation. He often feels irritable. This has been ongoing for 3 weeks and is the 2nd time he has felt this way for a several week period.

• What more do you want to know?
Brian Continued

- PHQ 9 score is 17
- His GAD 7 is 16
- MDQ score is 7 with moderate difficulties and no family history of bipolar disorder
  - He endorsed increased irritability, racing thoughts, problems sleeping, spending money, hypersexuality, pressured speech, and increased energy

- What else might be helpful?
Questions That Help to Clarify

• When you had the symptoms listed above did they all happen at the same time?
• If so did you do anything totally out character for yourself or get into any trouble?
• How long did this time last?
• If less than a week did you go to the hospital?
• Is there anyone in your family with drug/alcohol issues, legal problems, depression or schizophrenia?
Brian continued

• Brian states that he has had all those symptoms at the same time for a day at the most. He denies doing anything that would be out of character for him. He has trouble with money when he is not feeling that way.
• He has never been to a hospital for any of his symptoms
• He does have an uncle with alcohol issues and an aunt with schizophrenia
Potential Diagnosis

- Major Depression
- Anxiety Disorder
- Mood Disorder NOS
- Can we rule in or out Bipolar I or II Disorder yet?
Plan

• At this time the diagnosis most likely would be depression and possibly anxiety.
• We can not rule out or in any other mood disorders yet per the current diagnostic manual.
• He could be tried cautiously on an antidepressant but should be seen back within 2 weeks due to his age.
Discussion

• This is a difficult case as he is still young enough to have a first manic episode and has some mood lability but not long enough to meet the criteria for a manic episode.
• This would be a case that I would approach with caution but not necessarily diagnose with a Bipolar Type illness.
• Possibly this is one to refer on to a specialist who can sit down and spend more time with whittling away at the diagnosis.
Case Study - Janet

- Janet is a 43 year old female new to your practice with many years of depressive episodes. She reports she has been on numerous antidepressants and says that nothing works. She currently complains of decreased appetite, disrupted sleep, racing thoughts, irritability, sadness, feelings of guilt and anhedonia.
- She is not currently suicidal but has had 3 attempts in the past with the last one being a year ago via overdose.
Janet Continued

• Her PHQ 9 score is 16
• Her MDQ is 6 with moderate difficulties and a family history of bipolar disorder
  □ She endorses increased energy, decreased need for sleep racing thoughts, pressured speech, spending money, feeling extremely good.
• Her GAD7 is 14
Clarifying Questions

• All of the above symptoms happened at the same time and lasted at the most 10 days.
• During one episode she drove to her sisters house in California without telling her husband
• She has never been hospitalized during one of these episodes
• While no one in the family has a history of substance abuse she has a history of methamphetamine abuse when she was younger
Potential Diagnosis

- Bipolar I Disorder
- Bipolar II Disorder
- Major Depression
- Anxiety Disorder
Plan

- I would diagnose this patient with Bipolar I Disorder and start her on a mood stabilizer.
- She should be monitored closely for her response to the mood stabilizers and for side effects to ensure she is compliant.
Discussion

• We can not assume that someone in their 40’s with depression has been adequately screened for bipolar disorders.
• It is often helpful to get collateral information as these patients are often poor historians.
Case Study - Casey

• Casey is a 29 year old female who presents complaining of issues with sleep, irritability, racing thoughts, poor energy, feelings of guilt, lack of motivation, and anger outbursts.
• She has never been diagnosed or treated for any psychiatric issues in the past.
• She does have a history of marijuana use that is on and off currently.
• She also uses alcohol almost every weekend.
Casey continued

- Casey’s PHQ 9 is 14
- Her GAD 7 is 13
- Her MDQ is 5 with a moderate score and no family history of bipolar disorder
  - She endorses increased energy, racing thoughts, irritability, pressured speech, decreased concentration.
Clarifying questions

- She always has the racing thoughts even when she feels sad and hopeless.
- Her racing thoughts are usually about negative thoughts.
- She has a family history of depression and anxiety in her maternal family and anxiety in her paternal family.
- She has a history of cutting and suicide attempts though has avoided hospitalization.
Potential Diagnosis

- Major Depression
- Anxiety Disorder
- Borderline Personality Disorder
- Bipolar II Disorder
Plan

• At this time I would diagnose this patient with Major Depression, Generalized Anxiety Disorder and Borderline Personality Traits.
• I would start an antidepressant that helps treat anxiety such as an SSRI. I would also treat sleep if she is having trouble sleeping.
• I would see her back in 2 weeks and follow her closely as she is unpredictable.
Discussion

- This is a common presentation to my office.
- While this could be a young lady with Bipolar Disorder I would likely lean more toward Major Depression, Anxiety Disorder and Borderline Personality Traits just based on the information that is currently present.
- What more would be helpful to know?
- How would you proceed from here?
Summary

• There is no easy test to differentiate between Bipolar Depression and Major Depression.
• Screening tests can be helpful but the best way to diagnose is through a thorough history.
• If possible talk with family members to collaborate history.
• Treat cautiously and see the patient often at least until stable. Refer out if not sure where to start.