Student's Journal of Health Research Africa
Vol. 4 No. 9 (2023): September 2023 Issue
https://doi.org/10.51168/sjhrafrica.v4i9.694
Original article

A STUDY COMPARING SOCIO-DEMOGRAPHIC AND CLINICAL PROFILE OF PATIENTS OF UNIPOLAR AND BIPOLAR DEPRESSION.

Farheen Fatma[a], Dhruv[b,*]

[a] *Assistant Professor, Department of Psychiatry, Netaji Subhas Medical College and Hospital, Amhara, Bihta, Bihar, India*
[b] *Tutor, Department of Anatomy, All India Institute of Medical Sciences, Patna, Bihar, India*

Abstract.

Background:

Unipolar and bipolar depression distinguishes very distantly, in symptoms, diagnosis, prognosis, course of treatment, neurobiology and genetics. The study's main goal is to compare the subjective variables linked to bipolar and unipolar depression in inpatients. This study also aimed to investigate the psychosocial and demographic factors that affect bipolar and unipolar depression.

Materials and Methods:

152 patients both males and females classified, group I (unipolar) and group II (bipolar). Clinical profile and socio demographic profile of both were recorded. The collected data was analyzed statistically. Patients who fulfilled the inclusion criteria were included in this study.

Results:

The difference was significant between the two groups i.e., unipolar and bipolar depression. Value for P less than 0.05 is considered significant. 60% of the unipolar group reported severe depression without psychotic symptoms compared to 80% of the bipolar group who had severe depression with psychotic symptoms. parameters of Group I & II are relatively differing as Delusions were seen in 30 and 2, panic symptoms in 22 and 14, anhedonia in 42 and 26, suicidal thoughts in 2 and 5, pseudodementia in 6 and 2, depressive cognitions in 10 and 6 respectively.

Conclusion:

Authors found that patients with bipolar and unipolar depressions have different QOL profiles. With the introduction of bipolar spectrum, Adequate measures should be taken to understand the clinical markers of bipolarity. It is important to understand signs of disorder and to determine the precise neurobiology of bipolarity and to forecast its course, more research is required.

Recommendation:

A second drug is recommended if the patient presents while the condition is already managed with lithium monotherapy.

Keywords: Bipolar depression, comparative study, unipolar depression, Submitted: 2023-09-22, Accepted: 2023-09-25Bipolar depression, comparative study, unipolar depression

1. Introduction.

With an estimated 350 million sufferers worldwide, depression is a prevalent mental illness [1].

* Corresponding author.
Email addresses: farheenfatma77@gmail.com (Farheen Fatma), dhruvs958@gmail.com (Dhruv)

The range of lifetime rates of prevalence ranges from 3% to 16.9%, with most nations ranging between 8% and 12% [2]. When a patient exhibits low mood, disinterest and enjoyment, and dropped stamina for at least a week, in addition to other typical symptoms like insomnia, decreased appetite, feeling of worthlessness, empty negative views for future, weakened self-confidence, and diminished confidence and self-worth, a depressive disorder is suspected. A person is diagnosed with bipolar depression if they had at least one hypomanic episode in their past, manic, or mixed affective episode. Along with relapse and remission, psychotic symptoms can appear in either kind of depression [3, 4]. In 2004, the WHO estimated about 29.5 million people (about the population of Texas) worldwide suffered from bipolar illness [5]. According to projections, if current demographic and epidemiologic trends continue, by 2020 depressive disorders will rank as the second-leading cause of lifelong disabilities, accounting for 5.7% of all sickness burden [6, 7].

Even when bipolar patients come into depression and can be easily confused with unipolar depression, distinguishing remains a difficult clinical problem [8-10]. Different approaches to these conditions' best management exist. When bipolar depression patients are treated as if it were unipolar depression, a manic transition or cycle acceleration is more likely [11, 12]. The diagnosis and management of such illnesses can be much improved with more appropriate treatment options, which will aid in the long-term care of these populations of people, if steps are taken to clinically detect or at least suspect the type of disorder in the early stages. Important bipolar disorder indicators include depressive episodes with abrupt start, diurnal mood variation, psychomotor slowness, anhedonia, feelings of worthlessness, psychotic symptoms, suicidal thoughts, pathological guilt, unusual features, and labile mood. The aim of this research is to compare sociodemographic and clinical characteristics of patients with unipolar and bipolar depression.

2. Materials and Methods.

2.1. Study Design and Sample.

This comparative research was performed in the psychiatry department in a tertiary care hospital in Bihar. Patients who sought inpatient treatment for unipolar or bipolar depression met inclusion criteria compromised 152 patients. All had given their consent for participation in this study.

2.2. Inclusion criteria.

Patients who fulfilled diagnostic criteria, admitted with moderate depression, with or without symptoms were included. Patients who had stopped taking their medications two weeks or less prior to the start of the recent episode and informants who provided written informed consent were included in the study.

2.3. Exclusion criteria.

Patients having a past of seizures, mental disability, cognitive impairment, irreversible neurological deficits and affective disease due to a general health issue or drug use were disqualified. Individuals in poor health, those whose sources were unable to offer enough information, and unipolar sufferers who had first- or second-degree relatives with Bipolar affective disorder (BPAD) or psychotic illnesses were also excluded from the study.

2.4. Data Collection and Analysis.

Names, ages, genders, and other information were recorded. Both bipolar and unipolar patients were categorized in groups I and II, respectively. Bipolar and unipolar patients' sociodemographic and clinical profiles were taken. The collected data was analyzed statistically. Value for P less than 0.05 was deemed significant.

3. Results.

Among 152 patients, 92 were male and 60 were females. At the initial stage a number of 200 patients were examined for eligibility, however 48 patients were excluded from this study due to not being eligible. Regarding the current study, 60% of the unipolar group reported severe depression

without psychotic symptoms compared to 80% of the bipolar group who had severe depression with psychotic symptoms. There were no discernible variations between the two groups' educational levels. In the unipolar group, 80% were married, compared to 63.3% in the bipolar group. Manual laborers and other skilled employees made up the BP group, whereas housewives and skilled workers comprised the unipolar group. Both categories were composed of more than half members of lower middle-class families. Nuclear families made up 60% of unipolar group and 53.3% of the group II.

Compared to 10% of the unipolar group, 16.7% of the bipolar group had an alcohol dependence diagnosis. 20% of the bipolar group and 13.3% of unipolar group (P = 0.054) both had cigarette dependency. 33.3% of the unipolar group had a family history, compared to 53.3% of the bipolar group who had a BPAD. Compared to 36.7% of bipolar group patients, 46.7% of unipolar group patients' relatives reported suicides.

Table 1 shows total duration (years) was 27 & 34.5, age of onset was 29.4 and 20.5, number of episodes was 6.8 and 15.2, number of hospitalizations were 4.6 and 10.8, delusions were seen in 30 and 2, panic symptoms in 22 and 14, anhedonia in 42 and 26, suicidal thoughts in 2 and 5, pseudodementia in 6 and 2, depressive cognitions in 10 and 6.

4. Discussion.

Out of 152 patients, 92 of them were men and 60 were women. Regarding the overall worldwide burden of diseases, unipolar depressive disorders were placed fourth in 2004 and will move up to first place by 2030 [13]. In 2004, the World Health Organization estimated that 29.5 million people (about the population of Texas) worldwide suffered from bipolar illness [14]. According to projections, from 2020 depressive disorders ranked as the second-leading cause of lifelong disabilities, accounting for 5.7% of all sickness burden if present demographic and epidemiologic trends continue [15]. The sociodemographic and clinical characteristics of patients with unipolar and bipolar depression were compared in the current study.

A total of 330 respondents were included in Kalita et al.'s study [16], which used a purposive sample technique. Beck Depression Inventory and the Mini-International Neuropsychiatric Interview version 6.0 were used. In the bipolar group, the illness began at a substantially younger age and was more chronic (32.85 ± 11.084). The unipolar depression group had a considerably higher mean BDI score. Early detection of bipolar depression may benefit from a careful approach to minimize symptoms severity and related sociodemographic profiles in depressed patients. To examine the socioeconomic background and depressive illness in a private mental hospital setting in Ranchi, Chopra et al. [17] concluded that this population had a higher proportion of middle-class individuals. More patients in both groups indicated living in nuclear households, which would add to the load on caretakers. Analyses by Berlim et al [18] Bipolar depression patients reported considerably worse results than those with unipolar depression in the psychological QOL component (p=.013). Social and demographic factors, the other QOL domains evaluated, and the severity of depression indications did not significantly differ between the study groups.

5. Conclusion.

Compared to Rural Development Department, Bipolar affective disorder (BPAD) episodes are more severe and incapacitating. With the introduction of the bipolar spectrum idea, it is now even more crucial to detect levels of bipolarity in patients who have just experienced their first episode of depression. It is important to understand the clinical signs of bipolar disorder. It is necessary to create newer rating scales that can measure bipolarity. To determine the precise neurobiology of bipolarity and to forecast its course, more research is required. Researchers discovered that the QOL profiles of patients with unipolar and bipolar depressions varied.

Table 1: **Comparison of parameters**

Parameters	Group I (76)	Group II (76)	P value
Age of onset	29.4	20.5	0.05
Total duration	27	34.5	0.02
Number of episodes	6.8	15.2	0.04
Number of hospitalizations	4.6	10.8	0.01
Delusions	30	2	
Panic symptoms	22	14	
Anhedonia	42	26	
Pseudodementia	12	4	0.05
Depressive cognitions	10	6	
Catatonic features	20	8	
Suicidal thoughts	4	10	

6. Limitations.

The study's sample size is one of its limitations. In patients who were different from the general population made up the sample. A bigger sample size would have improved the results' generalizability. The entire concentration was on only a few carefully chosen variables. Even if the examination was performed after making sure the patient was not in a drunken condition, in individuals who use psychotropic drugs, they could not be prevented from having an unintentional impact on psychosis.

7. Recommendation

A second drug is recommended if the patient is present while the condition is already managed with lithium monotherapy.

8. Acknowledgment.

We are thankful to the patients; without them the study could not have been done. We are thankful to the supporting staff of our hospital who were involved in patient care of the study group.

9. List of abbreviations.

QOL- Quality of Life
WHO- World Health Organisation
BPAD- Bipolar affective disorder
BP- Bipolar
BDI- Beck Depression Inventory

10. Source of Funding.

The study was not funded.

11. Conflict of interest.

The authors report no conflicts of interest in this work.

12. Publisher details.

Publisher: Student's Journal of Health Research (SJHR)
(ISSN 2709-9997) Online
Category: Non-Governmental & Non-profit Organization
Email: studentsjournal2020@gmail.com
WhatsApp: +256775434261
Location: Wisdom Centre, P.O.BOX. 148, Uganda, East Africa.

13. References.

1. World Health Organization. Depression a Global Public Health Concern. 2012. [cited 2023 Feb 22].
2. Andrade L, Caraveo-Anduaga JJ, Berglund P, Bijl RV, De Graaf R, Vollebergh W, et al. The epidemiology of major depres- sive episodes: Results from the Interna- tional Consortium of Psychiatric Epidemiol- ogy (ICPE) Surveys. Int J Methods Psychi- atr Res. 2003; 12:3–21.
3. World Health Organization. ICD-10 International Statistical Classification of Diseases and Related Health Problem. 10th Revision. 4th ed. Geneva, Switzerland: World Health Organization; 2011.
4. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders [DSM-IV]. Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association; 2000.
5. World Health Organization. The Global Burden of Disease: 2004 Update. Geneva: World Health Organization; 2008. [cited 2023 Apr 02].
6. Doris A, Ebmeier K, Shajahan P. Depressive illness. Lancet. 1999; 354:1369–75.
7. Lopez AD, Mathers CD, Ezzati M, Jamison DT, Murray CJ. Global Burden of Disease and Risk Factors. Washington, DC: The World Bank; 2006.
8. Benazzi F. Misdiagnosis of bipolar II disorder as major depressive disorder. J Clin Psychiatry. 2008; 69:501–2.
9. Ghaemi SN, Ko JY, Goodwin FK. "Cade's disease" and beyond: Misdiagnosis, antidepressant use, and a proposed definition for bipolar spectrum disorder. Can J Psychiatry. 2002; 47:125–34.
10. Hirschfeld RM, Lewis L, Vornik LA. Perceptions and impact of bipolar disorder: How far have we really come. Results of the national depressive and manic-depressive association 2000 survey of individuals with bipolar disorder? J Clin Psychiatry. 2003; 64:161–74.
11. Bowden CL. Strategies to reduce misdiagnosis of bipolar depression. Psychiatr Serv. 2001; 52:51–5.
12. Ghaemi SN, Boiman EE, Goodwin FK. Diagnosing bipolar disorder and the effect of antidepressants: A naturalistic study. J Clin Psychiatry. 2000; 61:804–8.
13. Angst J, Adolfsson R, Benazzi F, Gamma A, Hantouche E, Meyer TD, et al. The HCL-32: Towards a self-assessment tool for hypomanic symptoms in outpatients. J Affect Disord. 2005; 88:217–33.
14. World Health Organization. The Global Burden of Disease: 2004 Update. Geneva: World Health Organization; 2008. [cited 2023 Apr 02].
15. Weissman MM, Bland RC, Canino GJ, Faravelli C, Greenwald S, Hwu HG, et al. Cross-national epidemiology of major depres- sion and bipolar disorder. JAMA. 1996; 276:293–9.
16. Kalita KN, Hazarika J, Sharma M, Saikia S, Patangia P, Hazarika P, et al. Sociodemographic correlates of unipolar and bipolar depression in North-East India: A cross-sectional study. Indian J Psychol Med. 2017; 39:46-51.
17. Chopra HD, Bhaskaran K, Verma IP. Socioeconomic status and manic-depressive psychosis (a study based on hospital cases). Indian J Psychiatry. 1972; 12:40–7.
18. Berlim MT, Pargendler J, Caldieraro MA, Almeida EA, Fleck MP, Joiner TE. Quality of life in unipolar and bipolar depression: Are there significant differences? J Nerv Ment Dis. 2004; 192:792-5.

Author biography

Farheen Fatma Assistant Professor, Department of Psychiatry, Netaji Subhas Medical College and Hospital, Amhara, Bihta, Bihar, India

Dhruv Tutor, Department of Anatomy, All India Institute of Medical Sciences, Patna, Bihar, India