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Original article

Bipolar I and II versus unipolar depression: Clinical differences and impulsivity/aggression traits

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ABSTRACT

Objective: To investigate distinguishing features between bipolar I, II and unipolar depression, and impulsivity/aggression traits in particular.
Methods: Six hundred and eighty-five ($n = 685$) patients in a major depressive episode with lifetime Unipolar (UP) depression ($n = 455$), Bipolar I (BP-I) disorder ($n = 151$), and Bipolar II (BP-II) ($n = 79$) disorder were compared in terms of their socio-demographic and clinical characteristics.
Results: Compared to unipolar patients, BP-I and BP-II depressed patients were significantly younger at onset of their first depressive episode, and were more likely to experience their first depressive episode before/at age of 15. They also had more previous affective episodes, more first- and second-degree relatives with history of mania, more current psychotic and subsyndromal manic symptoms, and received psychopharmacological and psychotherapy treatment at an earlier age. Furthermore, BP-I and BP-II depressed patients had higher lifetime impulsivity, aggression, and hostility scores. With regard to bipolar subtypes, BP-I patients had more trait-impulsivity and lifetime aggression than BP-II patients whereas the latter had more hostility than BP-I patients. As for co-morbid disorders, Cluster A and B Personality Disorders, alcohol and substance abuse/dependence and anxiety disorders were more prevalent in BP-I and BP-II than in unipolar patients. Whereas the three groups did not differ on other socio-demographic variables, BP-I patients were significantly more often unemployed that UP patients.
Conclusion: Our findings comport with major previous findings on differences between bipolar and unipolar depression. As for trait characteristics, bipolar I and II depressed patients had more life-time impulsivity and aggression/hostility than unipolar patients. In addition, bipolar I and II patients also differed on these trait characteristics.

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1. Introduction

Differences and similarities in the phenomenology of depression in Major Depressive Disorder (MDD) and Bipolar Disorder (BP) have remained a subject of continuous research interest [5,80,96]. Indeed, some suggest that eliciting specific features of the depressive episode itself (i.e. the quality of depressed mood) may assist in differentiating bipolar from unipolar disorder [91] early in the course of illness. Making this distinction is critical because initiating antidepressants without a mood stabilizer in BP can have negative sequelae [39,92].

Bipolar depression may be distinguished from unipolar depression by more frequent family history of bipolar disorders; [7,63,93] more lifetime affective episodes; [7,28,96] earlier age of onset; [18,63,79] and psychotic features [42,62,91]. Furthermore, pharmacologically induced hypomania [3,7,33] (now considered a criterion for bipolar disorder in DSM-5) [4]; poorer response to antidepressants; [57,84] atypical depressive symptoms; [46,62]

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subsyndromal (hypo)manic symptoms, [15,54,72] postpartum depressive episodes, [25,55] rapid onset of a depressive episode (within one week and in absence of acute critical life events) [47] and a greater number of hospitalizations [73] are associated with bipolar depression.

As Smith & Craddock (2011) [90] stated, it is still unclear whether major mood disorders are better conceptualized as existing on a continuum or as a set of overlapping pathological processes. The use of both dimensional and categorical approach to psychopathology [90], and taking in account premorbid personality can contribute to optimal assessment and intervention. In this context, research on trait-like personality characteristics in bipolar vs. unipolar depressed patients is relatively scarce. It is worth noting that in DSM-5 [4] nosology, the presence of hypomanic or manic symptoms during a depressive episode does not in and of itself constitute evidence for bipolar disorder, when they occur in the absence of a history of manic or hypomanic episodes. These considerations underscore the importance of assessing trait-like characteristics related to personality/temperament (e.g. impulsivity/aggression) during depressive episodes as they could underlie mixed symptomatology, [37,89] and may also be associated with treatment response [27]. On the other hand, traits correlate significantly with self-reported symptoms in patients with affective disorders possibly contributing to over-reporting of mood symptoms [32].

Comparison studies of bipolar and unipolar patients revealed higher impulsiveness [83] and higher lifetime aggression [9,81] in bipolar than unipolar patients. However, bipolar I and II subtypes have rarely been differentiated in terms of trait characteristics. Of interest, a recent review [78] on distinguishing characteristics between BP-I and BP-II individuals found no differences in temperament and personality [37].

In order to further expand our knowledge on trait-like characteristics and their associations with mood disorders, we investigated in a large clinical sample 1) whether impulsive/aggressive traits are higher in currently depressed bipolar patients (BP-I and BP-II) compared with unipolar depression patients; and 2) whether there is a difference in these trait characteristics between BP-I and BP-II patients. Furthermore, we compared currently depressed BP-I, BP-II and MDD patients in terms of 3) course of illness, family history and treatment history; and 4) clinical characteristics and comorbid disorders.

2. Subjects and methods

2.1. Subjects

Six hundred and eighty-five ($n = 685$) individuals in a Major Depressive Episode (151 with Bipolar I disorder, 79 with Bipolar II disorder and 455 with Major Depressive Disorder) were recruited by advertisement or clinical referral for participation in the study. The mean age of the sample was 37.3 ($\pm$ 13.0; range 17–85) years, 60.9% ($n = 417$) were female, 79.4% ($n = 505$) were white, and 39.5% ($n = 266$) currently employed. Mean education of the sample was 14.8 ($\pm$ 2.9) years. Furthermore, 50.2% ($n = 344$) of the sample was currently married, and 40.6% ($n = 264$) had children. The research was conducted at the New York Psychiatric State Institute (NYSPI), and the Western Psychiatric Institute and Clinic and St. Francis Hospital in Pittsburgh. At the time of the assessment, 49% ($n = 336$) were inpatients and 51% ($n = 349$) were outpatients. Inclusion criteria included a 17-item-Hamilton Depression Rating Scale (HAM-D-17) [45] scores greater than 15 points and, for the NYSPI campus, willingness to participate in biological studies. Patients provided written informed consent and protocols were approved by the Institutional Review Board affiliated with each site. Exclusion criteria were comorbid substance abuse disorder in the past 2 months, substance dependence disorders in the past 6 months, IQ < 80, cognitive disorders, or neurological or medical conditions that could impede accurate diagnosis. Furthermore, 1.16% of all patients who met criteria for a Major Depressive Episode were excluded based on low HAMD scores.

2.2. Instruments and measures

Lifetime and current DSM-IV Axis I psychiatric disorders were diagnosed based on the Structured Clinical Interview for DSM-III-R (SCID) [92] and confirmed by a consensus conference led by experienced MD or PhD-level research clinicians. Presence or absence of Axis II personality pathology was assessed with the Structured Clinical Interview for DSM-III-R (SCID-II) [36]. Clinically rated depression was assessed with the 17-item Hamilton Depression Rating Scale (HAM17) [45]. Patients' subjective perception of severity of depression was assessed by self-report using the Beck Depression Inventory (BDI), [12] and hopelessness was assessed by self-report with the Beck Hopelessness Scale (BHS) [13]. Global psychopathology was evaluated by using the Brief Psychiatric Rating Scale (BPRS), [76] and manic symptoms with Young Mania Rating Scale (YMRS) [98]. Trait-like characteristics such as impulsivity, aggression and hostility were assessed by Barratt Impulsivity Scale (BIS), [10] the Brown-Goodwin Aggression Inventory (BGAI), [20] and the Buss-Durkee Hostility Inventory (BDHI), [21] respectively. The highest level of suicidal ideation in the two weeks prior to baseline assessment was measured using the Scale for Suicidal Ideation (SSI) [14]. Lifetime history of suicide attempts was obtained using the Columbia Suicide History Form [74]. The presence or absence of physical or sexual childhood abuse before the age of 15 was determined by patient's responses to three direct questions from the Columbia Demographic and Treatment History Interview [19]: "Any history of physical and/or sexual abuse over lifetime" (yes/no); "If yes, describe and code: physical/sexual/both/not applicable"; "If yes, did abuse take place before age 15 years?" (yes/no/not applicable). Family history of DSM-IV affective disorders of first and second relatives was assessed using a structured family history approach with the Family Interview for Genetic Studies (FIGS) [70].

2.3. Diagnostic procedures

Interviews were conducted by masters-level and doctoral-level clinicians or psychiatric nurses who received didactic training in the administration of semi-structured interviews and attended weekly inter-rater reliability meetings. The assessment was done in one session which took a total of approximately 5 hours. Upon patient request, it was also possible to administer interviews in two sessions. Best-estimate diagnoses were made by consensus on the basis of all available data sources at diagnostic consensus conferences attended by research clinical staff, including senior diagnosticians. All instruments evidenced inter-rater reliability of .70 or greater.

2.4. Statistical analysis

Sociodemographic and clinical variables were compared in Bipolar I (BP-I), Bipolar II (BP-II), and Major Depressive Disorder (MDD) patients using Anova (with Bonferroni correction) for continuous variables and the chi-square test for categorical variables. Pearson correlations were performed in order to test correlations between impulsivity/aggression traits and scores on YMRS. Statistical analyses were performed with Statistical Package for Social Sciences, version 19 (SPSS 19.0).

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