Journal of Affective Disorders 169 S1 (2014) S3–S11

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Review

The prevalence and burden of bipolar depression

Shefali Miller[a,b,*], Bernardo Dell'Osso[a,c], Terence A. Ketter[a]

[a] Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Stanford, CA, USA
[b] Sierra Pacific Mental Illness Research Education and Clinical Centers, Palo Alto VA Health Care System, Palo Alto, CA, USA
[c] Department of Psychiatry, University of Milan; Fondazione IRCCS Cà Granda, Ospedale Maggiore Policlinico, Via F. Sforza 35, 20122, Milan, Italy

ARTICLE INFO

Article history:
Received 15 May 2014
Received in revised form 8 August 2014
Accepted 3 September 2014

Keywords:
Bipolar disorder
Depression
Prevalence
Burden
Cost
Functioning

ABSTRACT

Background: Bipolar disorder is characterized by debilitating episodes of depression and mood elevation (mania or hypomania). For most patients, depressive symptoms are more pervasive than mood elevation or mixed symptoms, and thus have been reported in individual studies to impose a greater burden on affected individuals, caregivers, and society. This article reviews and compiles the literature on the prevalence and burden of syndromal as well as subsyndromal presentations of depression in bipolar disorder patients.
Methods: The PubMed database was searched for English-language articles using the search terms "bipolar disorder," "bipolar depression," "burden," "caregiver burden," "cost," "costs," "economic," "epidemiology," "prevalence," "quality of life," and "suicide." Search results were manually reviewed, and relevant studies were selected for inclusion as appropriate. Additional references were obtained manually from reviewing the reference lists of selected articles found by computerized search.
Results: In aggregate, the findings support the predominance of depressive symptoms compared with mood elevation/mixed symptoms in the course of bipolar illness, and thus an overall greater burden in terms of economic costs, functioning, caregiver burden, and suicide.
Limitations: This review, although comprehensive, provides a study-wise aggregate (rather than a patient-wise meta-analytic) summary of the relevant literature on this topic.
Conclusions: In light of its pervasiveness and prevalence, more effective and aggressive treatments for bipolar depression are warranted to mitigate its profound impact upon individuals and society. Such studies could benefit by including metrics not only for mood outcomes, but also for illness burden.

© 2014 Elsevier B.V. All rights reserved.

Contents

* Corresponding author at: 401 Quarry Road, Stanford, CA 94305-5723, USA.
Tel.: +1 650 725 8203; fax: +1 650 724 9900.
E-mail address: shefalis@stanford.edu (S. Miller).

0165-0327/© 2014 Elsevier B.V. All rights reserved.

1. Introduction

Bipolar disorder (BD) is a serious, commonly disabling psychiatric condition that is tragically, on occasion, fatal. It is characterized by recurrent episodes of depression and mood elevation (mania or hypomania). Bipolar spectrum illness (comprising BD in its broadest sense), including bipolar I disorder (BDI, requiring a lifetime history of at least one manic episode), bipolar II disorder (BDII, requiring a lifetime history of major depressive and hypomanic episodes, without any history of mania), and BD not otherwise specified (BDNOS, including subthreshold bipolar presentations), may affect as much as 4.4% of the US population (Merikangas et al., 2007). Despite its lower prevalence compared with some other mental disorders, such as unipolar major depressive disorder (MDD, which has an approximately 3-fold higher lifetime prevalence) and anxiety disorders (which in aggregate have an approximately 6-fold higher lifetime prevalence) (Kessler et al., 2005), BD causes more marked functional impairment (Shippee et al., 2011; Solé et al., 2012) and greater reduction in quality of life (QOL) (Gutierrez-Rojas et al., 2008; Sierra et al., 2005). As a result, BD imposes a greater economic burden to society (i.e., higher costs) than other mental disorders (Kleinman et al., 2005; Peele et al., 2003) and constitutes the 12th leading cause of disability worldwide across all age groups (World Health Organization, 2008).

The course of bipolar illness is characterized by the predominance of depressive symptoms, which are more pervasive than mood elevation or mixed symptoms. Prospective studies consistently show that BD patients spend more time with depressive symptoms than with mood elevation/mixed symptoms (Judd et al., 2003; Judd et al., 2002; Kupka et al., 2007). Consequently, depressive symptoms compared with mood elevation/mixed symptoms have been consistently associated with greater (or at least equal) impairments of social and occupational functioning (Bonnin et al., 2010; Calabrese et al., 2004; Gitlin et al., 2011) and QOL (Gutierrez-Rojas et al., 2008; Revicki et al., 2005; Zhang et al., 2006). The present article aims to review the prevalence of bipolar depression and discuss the impact of depressive symptoms on the overall burden of BD.

2. Methods

The PubMed database was searched in February 2013 for English-language articles using the following search terms: "bipolar disorder," "bipolar depression," "burden," "caregiver burden," "cost," "costs," "economic," "epidemiology," "prevalence," "quality of life," and "suicide." The search results were reviewed, and studies related to the epidemiology and burden of BD and bipolar depression were manually selected for inclusion as appropriate. Additional references were obtained manually by reviewing the reference lists of relevant articles found by computerized search.

3. Prevalence and epidemiology of bipolar disorder

BD affected an estimated 29.5 million individuals worldwide in 2004, according to the World Health Organization (World Health Organization, 2008). A more recent (2011) study involving a combined sample of 61,392 community-dwelling individuals in 11 countries, mainly in the Americas, Europe, and Asia, found an aggregate lifetime BD prevalence of 2.4% (0.6% BDI, 0.4% BDII, and 1.4% subthreshold BD) (Merikangas et al., 2011). Of the 11 countries examined in this study, the United States had the highest lifetime prevalence of bipolar spectrum illness (combined BDI, BDII, and subthreshold BD) at 4.4%, while India had the lowest prevalence of bipolar spectrum illness at 0.1% (Merikangas et al., 2011).

In the United States, the estimated 12-month prevalence rates of BDI, BDII, and subthreshold BD were 0.6%, 0.8%, and 1.4%, respectively (Merikangas et al., 2007). BD prevalence decreased with increasing age and education level and was higher in unemployed/disabled individuals compared with employed individuals, but did not appear to be consistently related to gender, race/ethnicity, or income (Merikangas et al., 2007). Typical age at onset of BD was late adolescence to young adulthood (Merikangas et al., 2007). Childhood-onset BD occurs with prevalence estimates of 0.1% to 2.5% in pediatric samples, and there is some potentially substantive geographic variation (Merikangas et al., 2012; Stringaris et al., 2010). For example, childhood-onset BD may be more common in the United States than in Europe (Post et al., 2008). Indeed, among the first 1000 participants in the US-based Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD), 27.7% had childhood onset (age <13 years), which was associated with greater number of lifetime depressive and manic episodes, and greater likelihood of past suicide attempt, compared with adolescent onset (age 13–18 years) and adult onset (age >18 years) (Perlis et al., 2004). Thus, childhood-onset BD, which may entail greater genetic vulnerability (offspring of parents with BD may be at particular risk for this form of BD) (Goodwin and Jamison, 2007), could represent one of the more costly forms of BD.

BD has been consistently associated with significant medical and psychiatric comorbidity. For example, in the National Comorbidity Survey Replication (NCS-R), 94.6% of patients with BD reported having at least one comorbid disorder, with a mean of 4.6 medical and/or psychiatric comorbidities reported by such individuals (Gadermann et al., 2012). Moreover, in a Stanley Foundation Bipolar Treatment Outcome Network (SFBN) study, among 288 BD patients assessed by structured diagnostic interview, 65% had at least one comorbid Axis I disorder, with anxiety and substance use disorders being the predominant comorbidities (McElroy et al., 2001). In STEP-BD, 58.8% of BD patients had at least one medical comorbidity, and the prevalence was significantly higher in those with lifetime anxiety and substance use disorders (Magalhaes et al., 2012). In addition, analysis of the National Hospital Discharge Survey showed that among patients discharged with a primary diagnosis of BD, 74.6% had at least one comorbid condition, and patients with a primary diagnosis of BD had a greater burden of most psychiatric and some general medical comorbidities, compared with those without a BD diagnosis (Weber et al., 2011).

With regard to medical comorbidities, cardiovascular and metabolic diseases are particularly prevalent among BD patients, who have shown elevated rates of hypertension, obesity, metabolic syndrome, and diabetes (Fiedorowicz et al., 2008; Goldstein et al., 2011; McIntyre et al., 2005; Vancampfort et al., 2013). A large population-based cohort study in Sweden found that patients with BD had increased mortality rates due to cardiovascular and other medical illnesses, dying of cardiovascular disease, on average, 10 years earlier than the general population (Westman et al., 2013); these results are consistent with findings from a recent review of the literature (Roshanaei-Moghaddam and Katon, 2009). Medical illness burden may have important implications for BD mood outcomes. For example, in post hoc analyses of two clinical trials involving 225 rapid-cycling BDI and BDII participants, endocrine/metabolic illness burden was inversely correlated with remission from depression, and higher body mass index was associated with lower likelihood of response or remission (Kemp et al., 2010). Moreover, results from a Canadian population-based study associated chronic medical conditions with more severe bipolar illness course, poorer functioning, and increased medical service utilization among BD patients (McIntyre et al., 2006).

As noted above, psychiatric comorbidities are also particularly prevalent in BD patients; more than 90% of BDI and BDII patients

Download English Version:

https://daneshyari.com/en/article/4185972

Download Persian Version:

https://daneshyari.com/article/4185972

Daneshyari.com