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Research report

Bipolar II vs. unipolar depression: psychopathologic differentiation by dimensional measures

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Abstract

Background: Clinical presentations of depression in bipolar disorder are varied, inconsistent and often confusing. Most previous studies have focused on bipolar I (BP-I). Given that bipolar II (BP-II) is the more common bipolar phenotype, which is often confused with unipolar (UP), the aim of the current analyses is to delineate the symptomalogic differences between BP II vs. UP MDD in a large national sample. *Methods*: The data derived from the French National EPIDEP study ($n=452$ DSM-IV major depressives), subdivided into BP-II ($n=196$) and UP ($n=256$). The BP II group included major depressives with both spontaneous and antidepressant-associated hypomania based on our finding of similarity in rates of familial bipolarity in the two subgroups. At index presentation, depression was assessed by the clinician (using HAM-D and the Rosenthal Atypical Depression Scale) and by the patient (using the Multi-Visual Analog Scale of Bipolarity, MVAS-BP). Principal component analyses (PCA with varimax rotation) were conducted on HAM-D and MVAS-BP in the total population and separately in BP-II and UP. We performed inter-group comparative tests (UP vs. BP-II) on factorial scores derived from PCAs and correlation tests between these factorial scores. *Results*: The PCA on "HAM-D + Rosenthal scale" showed the presence of nine major factors: F1-2 "weight changes", F3-4 "sleep disturbances", F5 "sadness–guilt", F6 "retardation–fatigue", F7 "somatic", F8 "diurnal variation" and F9 "insight–delusion". The PCA on MVAS-BP revealed the presence of eight principal components: F1 "psychomotor retardation", F2 "central pain", F3 "somatic", F4 "social contact", F5 "worry", F6 "loss of interest", F7 "guilt" and F8 "anger". Despite uniformity in global intensity of depression, significant differences were observed as follows: higher score on "psychomotor retardation" ($p=0.03$), "loss of interest" ($p=0.057$) and "insomnia" ($p=0.05$) in the UP group, and higher score on "hypersomnia" ($p=0.008$) in the BP-II group. Correlation analyses between clinician- and self-rating revealed the presence of higher number of significant coefficients in the UP vs. BP-II group ($p\leq 0.001$). *Limitation*: A three-way comparison between BP-I, BP-II and UP may have yielded somewhat different results. *Conclusion*: Our data indicate greater psychomotor retardation, stability and uniformity in the clinical picture of strictly defined UP depression. By contrast, bipolar II depression appeared to be characterized, despite the hypersomnic tendency, by psychomotor activation. This would indicate greater mixed features than those observed in UP. Moreover, in BP-II, there was less agreement between clinician vs. self-rating on the presence of various features of depression. Taken together, these findings explain why BP-II depression is missed by clinicians as a genuine depression.

Keywords: Bipolar II depression; Unipolar depression; Psychopathologic differentiation

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1. Introduction

The debate on the clinical picture of bipolar depression is ongoing. For some, there is no difference between unipolar (UP) and bipolar (BP) depressions (Joffe et al., 1999). Previous studies, which have largely focused on bipolar I (BI-I), have suggested that psychomotor retardation is pathognomonic in comparison with UP (Akiskal, 1981, 1983; Akiskal and Mallya, 1987; Mitchell et al., 2001). Other studies, which have largely derived from bipolar II (BP-II) samples, have concluded that bipolar depression has a distinct phenomenology with anxious, agitated, impulsive, irritable, and mixed features, as well as greater atypical manifestations such as reverse vegetative symptoms (Perugi et al., 1998; Benazzi and Akiskal, 2003). In addition, hypersomnia is often considered the main sleep pathology in bipolar disorder (Detre et al., 1972; Akiskal, 1983). The debate on these issues cannot be resolved unless bipolar I and II are considered separately (Akiskal, 1983;Akiskal et al., 1995); and the unipolar group is "cleansed" by excluding depressives with antidepressant associated-hypomania, because the latter are familially bipolar (Akiskal et al., 2003a).

The EPIDEP French study showed that the rate of BP-II disorder nearly doubled from 21% at intake to 39.7% in a month's time, after systematic search for hypomania according to DSMIV criteria (Hantouche et al., 1998; Allilaire et al., 2001). Without this prospective assessment of BP-II on at least two points in time, nearly 50% of all BP-II would have been misclassified as UP. In line with the reason given above, we also subsumed depressions with antidepressant-associated hypomania under BP-II. In the present analyses, we thereby succeeded to constitute appropriately defined groups of BP-II and UP patients, which enabled us to compare these groups on psychometric and phenomenological grounds.

2. Methodology

The EPIDEP is a national French multi-site study (15 sites and 48 trained investigators) conducted in a cohort of 537 patients with major depression (DSM-IV criteria). The aim of EPIDEP is to show the feasibility of validating the spectrum of BP-II. The full methodology can be found elsewhere (Hantouche et al., 1998; Akiskal et al., 2003b; Allilaire et al., 2001). From a total inclusion of 537 patients presenting a major depressive episode (DSM-IV), 493 (91,8%) completed the study (at least two visits 1 month apart). Cases presenting with BP-I disorder, with at least one manic episode ($N=41$) were excluded from the present analyses. Thus, the size of the current validated sample (UP + BP-II) was 452.

During the two visits, depression was assessed by the Hamilton Depression Rating Scale (21 items) plus additive Rosenthal Scale (8 items) for atypical features, and the multiple VAS of Bipolarity (MVAS-B; Ahearn and Carroll, 1996), which were filled out by patients. The definite categorization of mood disorder was obtained at the second visit according to a systematic screening of hypomania: 196 patients were ranked in the "BP-II" group (all cases with hypomania according to DSM-IV criteria; hypomania associated with antidepressant were also subsumed in this subpopulation), and 256 in the "UP" sub-group, which included all the remaining patients.

Psychometric data on depression were obtained during intake (in other words, during the acute current depression). Principal component analyses (PCA) were separately conducted on the HAM-D (29 items) and the MVAS-BP (26 items), by using the varimax rotation method. Comparative tests of factorial scores of HAM-D and those of MVAS-BP were applied in UP vs. BP-II sub-groups (with a significance level at $p \leq 0.05$). Correlation tests (Pearson method) between the factorial scores of HAM-D and those of MVAS-BP were performed in the total sample, then separately in UP, and BP-II sub-populations (with significance level set at $p \leq 0.001$).

3. Results

The PCA conducted on "HAM-D + Rosenthal scale" (29 items) showed the presence of nine major factors: F1"weight loss" (two items: gastro-intestinal (GI) symptoms, weight loss), F2 "hyperphagia" (four items: weight gain, augmented appetite, hyperphagia, craving for carbohydrates), F3 "insomnia" (three items: initial, midnight and late insomnias), F4 "hypersomnia" (one item: hypersomnia), F5 "sadness–guilt" (five items: depressed mood, GI symptoms, guilt feel-