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Distinctions between bipolar and unipolar depression

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Abstract

This is a review of the studies comparing unipolar and bipolar depression, with focus on the course, symptomatology, neurobiology, and psychosocial literatures. These are reviewed with one question in mind: does the evidence support diagnosing bipolar and unipolar depressions as the same disorder or different? The current nomenclature of bipolar and unipolar disorders has resulted in research that compares these disorders as a whole, without considering depression separately from mania within bipolar disorder. Future research should investigate two broad categories of depression and mania as separate disease processes that are highly comorbid.

Keywords: Bipolar disorder; Major depression; Diagnostic; Nomenclature

1. Distinctions between bipolar and unipolar depression

This review focuses on depression within bipolar disorder and the evidence concerning whether bipolar depression and unipolar depression appear unique or parallel in their etiology, symptoms, and course. Over the past 100 years, conceptions of depression within bipolar disorder have varied widely, and the changes in conceptualization have been reflected in fundamental changes in the diagnostic nomenclature.

Mania and depression have been seen as distinct, yet related, phenomena since ancient Greece (Angst & Marneros, 2001). Only in recent history have mood disorders been divided into syndromes of mania

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and depression. As the father of current psychiatric nosology, Kraeplin was one of the first to distinguish individuals with mania into those with and without depression. From Kraeplin through DSM-II (APA, 1968), the syndromes were labeled as mood disorders with the subtypes of recurrent mania, recurrent depression, recurrent mania and depression, and affective disorders with mixed states. Of note, recurrent mania was differentiated from recurrent mania with depression. Early descriptions of affective disorders conceptualized monopolar mania as separate from other mood disorders (Leonard, 1957). Psychiatric nosology since the DSM-III has classified major depressive disorder separately from bipolar disorder, defined by the presence of mania. Several issues guided the move to label bipolar disorder and unipolar disorder as distinct illnesses. Among these, increasing evidence supported the biological etiology and more severe lifetime course of mania compared to depression.

With the move to distinguish bipolar disorder from unipolar depression, substantial changes were made in the categorization of depression that accompanied mania. Depression and mania within bipolar disorder were viewed as part of a unitary illness, reflecting dysregulation along a single dimension. Indeed, the presence or absence of a history of depression within bipolar disorder was no longer included in the diagnostic subtypes. This unitarian view of bipolar disorder codified a distinction between bipolar depression and unipolar depression, even though episodes of depression are common to bipolar and unipolar disorders. This assumption that bipolar and unipolar depressions are distinct has continued to guide research for almost 30 years. At this point it is easy to forget the controversy surrounding the creation of a separate bipolar classification. Hoche, one of Kraepelin's critics, pointed out, "If the term 'manic–depressive' is meant as a theoretical expression of the close internal relationship of the two opposite poles of affectivity, then there are no objections to raise against it. But the name is to be rejected as a disease-entity and consequently as a designation of diagnostic and prognostic value." (p. 273, in Jackson, 1986).

Given the increase in available evidence, it appears wise to question whether this bipolar–unipolar distinction, as it applies to *depressive* episodes, continues to garner support. That is, do depressions within bipolar disorder reflect unique disease processes compared to depressions within unipolar disorder? Indeed, a recent biological review has suggested that it may be more fruitful to consider conceptualizing bipolar and unipolar depression as the same illness (Joffe, Young, & MacQueen, 1999). This review, however, was focused on simply the biological evidence. Here, we broaden the question to include the evidence from studies of course and of psychosocial triggers. We believe that this broader focus is important, given the burgeoning literature on psychosocial antecedents and correlates of episodes of bipolar disorder.

Before continuing with the review of bipolar depression, it is worth noting that bipolar disorder does not necessarily imply a history of depression. Diagnostic criteria for bipolar I disorder require only one lifetime manic episode, but do not require an episode of depression (APA, 1994). Current research appears to support the existence of monopolar mania. Twenty-five to 33% of individuals with bipolar disorder in nontreatment samples do not report ever having a major depressive episode (Depue & Monroe, 1978; Karkowski & Kendler, 1997; Kessler, Rubinow, Holmes, Abelson, & Zhao, 1997; Weissman & Myers, 1978). In addition, a long-term study demonstrated that seven cases of unipolar mania remained free of depressive episodes during a 20-year follow-up (Solomon et al., 2003). Because depression may be more strongly related to treatment-seeking than mania (Johnson, in preparation), treatment samples tend to underestimate the prevalence of monopolar mania.

There is also evidence that mania and depression can be viewed as two separate continuums, rather than opposite ends of the same dimension. Perhaps the strongest evidence on this front stems from the