# THE SIGNIFICANCE OF DISTINGUISHING UNIPOLAR DEPRESSION AND DEPRESSIVE EPISODES IN BIPOLAR AFFECTIVE DISORDER - CASE REPORT

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**Summary: Introduction.** Mood disorders are the most prevalent mental disorders, divided into unipolar depression and bipolar affective disorders. Bipolar affective disorders manifest as mania, hypomania, mixed episodes, and depressive episodes, with depressive episodes occurring much more frequently. Hypomanic/ manic episodes often remain unrecognized by patients, their families, and even physicians due to insufficiently available heteroanamnestic data. It is crucial to raise awareness of the importance of thorough history taking, as therapy differs significantly between unipolar depression and bipolar affective disorder. The aim of this study is to emphasize the importance of distinguishing unipolar depression from depressive episodes in bipolar affective disorder and establishing an accurate diagnosis. Case presentation: We present a case of a 73-year-old female patient who has been undergoing outpatient psychiatric treatment for the past twenty years, diagnosed with recurrent depression. During her last hospitalization, she presented to the clinic accompanied by her children, who reported significant changes in her emotions and behavior, accompanied by paranoid-interpretative delusional ideas. Overall, this description corresponds to a manic psychotic episode within the framework of bipolar affective disorder. Further heteroanamnestic data revealed the patient's history of regularly seeking medical help when experiencing low mood and impaired functioning on a daily basis. However, episodes of hypomania, characterized by elevated mood, logorrhea, increased activity, decreased need for sleep, and the absence of accompanying fatigue, were perceived simply as her good mood by both her family members and herself. Consequently, the patient was perceived as having a recurrent depressive disorder, leading to therapy with antidepressants only, while in fact, the lack of data led to the oversight of bipolar affective disorder. Conclusion: From the presented case, we conclude that timely distinction and accurate diagnosis of these two disorders are crucial for prescribing appropriate therapy and preventing the occurrence of "switching" into mania.

**Keywords:** bipolar affective disorder, unipolar depression, recognition of hypomania, psychopharmacotherapy

## INTRODUCTION

The most prevalent mental disorders are mood disorders. They often occur in association with other illnesses, which complicates the accurate diagnosis. Normal mood, such as feelings of happiness, sadness, or melancholy, differs from pathological mood by its duration, intensity, disturbance of sleep, appetite, altered perception of reality, and frequent suicidal attempts.

Mood disorders are divided into depressive disorders, which manifest solely with symptoms of depressive syndrome—unipolar depression, and bipolar disorders, which occur within the framework of bipolar affective disorder. Depressive disorders can occur at any age and are known to be twice as common in women. Approximately 350 million people worldwide suffer from depression.

Bipolar affective disorders are more common in younger age groups and occur equally in both men and women. Bipolar affective disorder is a progressive disease with a significant burden and complicated consequences, with depressive symptoms much more common than manic symptoms and responsible for most of the time during which patients experience symptoms of their illness.

Timely diagnosis and early initiation of appropriate treatment lead to a good prognosis. Patients with depressive disorders often complain of nonspecific somatic symptoms such as general weakness, body aches, and insomnia. They also mention feelings of emotional emptiness, sadness, tearfulness, and hypersensitivity. Thoughts of suicide are common because depressed individuals see no other way out of their condition.

It is essential to determine whether the patient has recurrent depressive disorder or a depressive episode within the framework of bipolar affective disorder. Typical symptoms of a depressive episode include depressed mood, loss of interest, and decreased energy. Other symptoms include decreased concentration and attention, reduced self-confidence, a pessimistic outlook on the future, disrupted sleep, decreased appetite, and suicidal thoughts. A depressive episode can be mild, moderately severe, or severe.

Depressive disorders must be distinguished from bipolar affective disorder, anxiety disorders, adjustment disorders, disorders due to harmful substance use, schizoaffective disorder depressive type, dementia, and personality disorders. Additionally, depressive syndrome should be differentiated from endocrine disorders, autoimmune diseases, neurological, and malignant diseases.

Bipolar disorders manifest as mania, hypomania, mixed episodes, and depressive episodes. What is characteristic of mood disorders is their episodic nature, meaning that after one depressive, manic, or hypomanic episode, a period of remission and recovery ensues, followed by the next episode. The risk of suicide and attempts is particularly high in the days following discharge from psychiatric hospitalization, associated with the delay or lack of appropriate care thereafter.

*Distinguishing Unipolar from Bipolar Disorder*

The most important thing is to recognize the depressive episode and determine whether it is recurrent depressive disorder or a depressive episode within bipolar disorder. The term unipolar depression is used in the literature to describe a condition where a person is solely depressed, without periods of mania or hypomania. Proper diagnosis (distinguishing between bipolar and unipolar disorder) is crucial for assessing the therapy needed for treatment.

The main challenge in diagnosing whether depression belongs to bipolar or unipolar disorder lies in the rare episodes of mania and hypomania in bipolar affective disorder compared to longer and more frequent periods of depression. In most patients diagnosed with bipolar affective disorder, the illness started with a depressive episode rather than mania. The aim of this study is to highlight the importance of distinguishing unipolar depression from a depressive episode in bipolar affective disorder and establishing an appropriate diagnosis.

## CASE REPORT

The patient is a 73-year-old female, widowed, with two children she lives with, and holds a middle-level education as an accountant. She has been unemployed for thirty years since relocating from Croatia to Novi Sad as a refugee in 1991. She has not experienced any significant somatic illnesses aside from controlled hypertension with antihypertensive medication. There is no relevant psychiatric heredity data available. She does not consume alcohol or psychoactive substances. The patient has been receiving outpatient psychiatric treatment for the past twenty years, diagnosed with recurrent depression.

Currently, she presents at the clinic accompanied by her son and daughter, reporting significant behavioral changes. She exhibited accelerated speech, disturbed sleep-wake rhythm, spending sprees, and making unrealistic plans to earn additional money. Primarily, she displayed elevated mood, occasional irritability, and hostility towards family members, accompanied by paranoid delusions regarding her children stealing money from her. These symptoms persisted for approximately two months before culminating in hospitalization. Initially, the symptoms manifested as reduced sleep and increased activity without fatigue, along with persistent heightened mood and impulsive spending. Subsequently, paranoid ideation emerged towards her children, accusing them of stealing her savings left after her husband's death. Even after the money was returned, her symptoms worsened, demanding her daughter to evict her tenants because they were "taking her money." She also believed her family wanted to "institutionalize her" and exploit her finances during her hospital stay. The patient lacked insight into her condition. After three weeks of appropriate psychopharmacological therapy, including antipsychotics, mood stabilizers, and anxiolytics, her symptoms subsided, leading to behavioral and emotional stabilization.

Further details obtained from heteroanamnestic data revealed the patient's previous functioning. She regularly attended outpatient visits whenever she felt a lowered mood, experiencing difficulties in daily functioning, accompanied by fatigue, malaise, moodiness, and reluctance to perform daily tasks. She complained of sleep disturbances, decreased appetite, and forgetfulness. Loss of self-confidence with withdrawal tendencies was also common. Following the administration of psychopharmacotherapy and relief of depressive symptoms, the patient exhibited periods of elevated mood, sometimes excessive

cheerfulness, functioning with minimal sleep, and excessive movement. She became talkative, accelerated, and difficult to restrain, attributes attributed to her personality. Additionally, she always attended psychiatric appointments alone, refusing accompaniment, and since she did not perceive her elevated mood and acceleration as problematic but rather as excellent functioning, likely resulting in an inadequate description of her functioning between depressive episodes.

Consequently, the patient was initially considered to have recurrent depressive disorder, resulting in the prescription of antidepressant therapy alone. However, due to the lack of auto and heteroanamnestic data, the possibility of bipolar affective disorder was overlooked, specifically a manic psychotic episode within bipolar affective disorder, as described above..

## DISCUSSION

As we can see from the presented case, this patient has been treated for twenty years under the diagnosis of unipolar depression, which, based on the current clinical picture and additional detailed heteroanamnestic data, leads us to the conclusion of previously unrecognized episodes of hypomania/mania. The clinical presentation of depressive episodes manifested through feelings of emptiness, sadness, tearfulness, and hypersensitivity. She responded slowly and quietly to questions, accompanied by limited facial expressions.

Typical symptoms of unipolar depression are classified into psychological, behavioral, and somatovegetative categories. Each diagnosis is primarily based on historical data, observed psychopathological phenomena, and disorder course. In this case, it was necessary to determine whether it was a recurrent depressive disorder or a depressive episode within bipolar affective disorder. Typical symptoms of a depressive episode include depressed mood, loss of interest, and decreased energy. Other symptoms include reduced self-confidence, feelings of guilt, a pessimistic view of the future, and suicidal ideation.

The primary symptoms of manic syndrome include emotional disturbances (euphoric or irritable mood), psychomotor symptoms and signs (hyperactivity), and increased self-confidence. In hypomania, symptoms are similar to mania but milder and shorter in duration. Delusions and hallucinations are absent in hypomanic states. Hypomanic episodes occur more frequently than diagnosed.

For these patients, obtaining information about previous hypomanic episodes during adolescence is essential (which was absent in the aforementioned patient) because, in that case, the diagnosis would not be recurrent depression but bipolar affective disorder. The treatment concept differs significantly in such cases. Treatment for unipolar depression involves a combination of antidepressant pharmacotherapy and psychotherapy, while bipolar affective disorder treatment involves a combination of several medications as it is divided into several phases: treatment of acute manic/hypomanic episodes, treatment of depressive episodes, maintenance phase, and prophylactic phase.

Medication treatment for acute mania involves the use of mood stabilizers and antipsychotics. Benzodiazepines are sometimes necessary in the initial days. The treatment of depressive episodes in bipolar disorder includes mood stabilizers and antidepressants. Antidepressants should not be used as monotherapy due to the risk of switching to mania. Moreover, prescribing antidepressants in bipolar disorder cases is often associated with mood destabilization, especially during maintenance therapy. Unfortunately, effective pharmacological treatments for bipolar affective disorders are not universally available, especially in countries with low to middle levels of healthcare.

Regarding mood stabilizers, lithium treatment requires careful monitoring of patients compared to most other mood stabilizing drugs. This facilitates the identification of new symptoms associated with suicidal behavior, including thoughts and suicidal ideation, early agitation, dysphoric mood, anger, and disrupted circadian rhythms. Antidepressants may not produce the desired effect or may even increase agitation and suicide risk. In contrast, with the use of mood stabilizers, especially long-term maintenance of lithium salts, greater effectiveness is expected in comprehensive treatment aimed at suicide prevention.

One treatment option is electroconvulsive therapy, which is applied in treatment-resistant or psychotic depressive episodes, severe psychotic or treatment-resistant mania. It is also the therapy of choice for bipolar affective disorder during pregnancy.

For such patients, it is crucial to differentiate between unipolar depression and depressive episodes of bipolar affective disorder. Incorrectly diagnosing unipolar depression in patients with bipolar depression has many harmful consequences, including the use of inadequate psychopharmacotherapy, the

possibility of switching to mania, and increased suicidal risk. Bipolar and unipolar disorders are also associated with increased impulsivity, although it is more common in bipolar disorders. Approximately one million people die by suicide each year. It is essential to effectively treat depression, as many people suffer from it, and only half achieve complete remission with treatments such as pharmacotherapy and psychotherapy within two years of starting treatment. Some patients may experience reduced effectiveness of antidepressant therapy because a significant number of patients do not adhere to prescribed treatment. There is also no evidence that adjunctive antidepressants improve response rates or depressive symptoms in acute bipolar depression. Depression in patients with bipolar affective disorder is a significant clinical challenge as it is associated with higher morbidity, mortality, and a high risk of suicide.

In bipolar depression, the risks of diabetes mellitus, cardiovascular disorders, and metabolic syndrome are several times higher than those in the general population or patients with other psychiatric disorders.

## CONCLUSION

Depression can occur as a symptom within various psychiatric disorders or as an independent entity. Symptoms of depression encompass combinations of psychological, psychomotor, and somatic symptoms that manifest with varying intensity. Depression affects all aspects of life. Unipolar and bipolar depressive episodes entail differences in etiology, phenomenology, as well as in the course and treatment process. Bipolar depression is more strongly associated with mood lability, psychomotor retardation, and hypersomnia. In these patients, symptoms manifest early, there is a higher frequency of depressive episodes, and the presence of bipolar disorder in the family is more common. Diagnosing bipolar disorder is nonspecific and lengthy, often being diagnosed and treated as unipolar depression. One reason for this is the failure to recognize hypomanic or manic symptoms by the patient or family members who attribute them to good mood or the patient's personality. It may take more than ten years to establish the correct diagnosis. For such patients, it is crucial to identify the presence of manic or hypomanic episodes. Depression in patients with bipolar affective disorder is a significant clinical challenge because in such patients, depression is associated with more frequent morbidities, as well as mortality and a high risk of suicide. Above all, it is essential to consider the specificities of each patient to achieve the full effect of treatment.

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