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Differences in Symptom Severity, Course of Illness, and Psychological Well-Being Between Unipolar and Bipolar Depression

Sartaj Vallisaheb Bagwan*

Assistant Professor, Department of Psychiatry, SSPM medical college and lifeline hospital, Padve, Sindhudurga, Maharashtra, India

***Address for Correspondence:** Dr. Sartaj Vallisaheb Bagwan, Assistant Professor, Department of Psychiatry, SSPM medical college and lifeline hospital, Padve, Sindhudurga, Maharashtra- 416534, India
E-mail: sartaj0307@gmail.com

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ABSTRACT

Background: Unipolar and bipolar depression share many depressive symptoms, often leading to diagnostic difficulties and delays in appropriate treatment. However, differences in symptom severity, illness progression, and psychological well-being have important implications for clinical management and outcomes.

Methods: This comparative study was conducted at SSPM Medical College, Sindhudurg, Maharashtra, from December 2024 to November 2025 after obtaining ethical approval. Fifty patients aged 18–65 years were enrolled, including 25 patients with unipolar depression and 25 with bipolar depression, diagnosed according to DSM-5 criteria. Socio-demographic and clinical details were collected. Assessment tools included the Hamilton Depression Rating Scale (HDRS), the Brief Psychiatric Rating Scale (BPRS), the WHO Quality of Life-BREF (WHOQOL-BREF), the Alcohol Use Disorders Identification Test (AUDIT), and the Fagerström Test of Nicotine Dependence. Data were analyzed using descriptive and inferential statistical methods.

Results: Patients with bipolar depression showed an earlier age of onset, longer illness duration, more frequent and prolonged depressive episodes, and higher rates of hospitalization compared to those with unipolar depression. Bipolar depression was associated with significantly greater psychotic symptoms, including delusions, and higher severity of depressive symptoms and overall psychopathology. Psychological quality of life was significantly poorer in the bipolar group, while other quality-of-life domains and substance use patterns did not differ significantly.

Conclusion: Bipolar depression differs substantially from unipolar depression, with a more severe and recurrent course, greater psychopathology, increased psychotic symptoms, and poorer psychological quality of life, highlighting the need for accurate diagnosis and targeted treatment strategies.

Key-words: Unipolar depression, Bipolar depression, Psychopathology, Quality of life, Clinical differentiation

INTRODUCTION

Major depressive disorder (MDD) is the most common mental condition, characterised by a consistent low and depressive mood, along with changes with respect to cognitive and behavioural patterns of responses. These depressive events are categorised into unipolar and bipolar depression and depend on the hypomanic events.

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Bipolar disorder is complex and challenging for early detection, 20% of individuals have received a diagnosis in the initial year of treatment. At the same time, the average delay in diagnosis is 5 to 10 years [1]. Specifically, patients with bipolar disorder are often treated with antidepressants, with a risk of shifting towards manic events along with a high risk of suicide, highlighting the significance of early diagnosis [2]. Certain depressive characteristics differentiate bipolar and unipolar depression. High prevalence of atypical characters is seen in bipolar depression, including gain of weight and lethargy; psychotic symptoms are commonly seen along with agitation and psychomotor disturbances. Suicidal tendency is common in bipolar depression. At the same time, a high rate of anxiety problems is seen among

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individuals with unipolar depression, along with insomnia, loss of appetite, and other somatic complications [3]. Mood disorders have been differentiated into mania and depressive syndrome and significantly categorized under certain subtypes like recurrent mania, recurrent periods of depression, and recurrent events of both mania and depression.

Several studies have reported that unipolar depression consisted of more vegetative or psychomotor signs and symptoms compared to bipolar disorder, including loss of body weight and typical insomnia [4]. More atypical symptoms were observed in bipolar depression, including hypersomnia. At the same time, feelings of anxiety, anger and agitation were the common symptoms associated with unipolar depression rather than bipolar depression [5]. In the case of cognitive assessment, a negative cognitive style was observed in bipolar rather than unipolar depression. At the same time, attribution to failure is interrelated with the severity of depression for both depressive disorder [6]. Psychosocial treatment strategies are effective for both types of depression due to the similarities in cognitive and personality. Mood stabilisers are significant for treating mania. The interventional study by Frank *et al.* has demonstrated that family and interpersonal psychotherapies reduce depressive symptoms, not mania [7]. A study revealed that bipolar depression is shorter than unipolar depression. At the same time, bipolar depression is characterised by the onset at a young age, with more frequent events and variation of mood for the short term [8]. The study aims to conduct a comparative analysis of both unipolar and bipolar depression based on the severity of the symptoms, course of illness and different associated psychological statuses. This aids in differentiating clinical and psychosocial parameters to improve outcomes and support effective diagnosis and management strategies.

MATERIALS AND METHODS

Study design- The study was a cross-sectional study conducted at SSPM Medical College, Sindhudurg district, Maharashtra, with ethics committee approval from December 2024 to November 2025. The study compared the clinical characteristics, course of illness, substance use patterns and quality of life between patients with unipolar and bipolar depression diagnosed according to DSM-5 criteria. A total of 50 patients aged 18-65 years were recruited from the outpatient and inpatient psychiatry units.

Socio-demographic and clinical data were obtained from clinical history, including age of onset, frequency of episodes, hospitalisations, psychotic symptoms, and family history. They were Standardized assessment tools, Hamilton Depression Rating Scale (HDRS) and Brief Psychiatric Rating Scale (BPRS) to assess the severity of depression and psychiatric symptoms, WHO Quality of Life-BREF (WHOQOL-BREF) to assess the quality of life, as well as alcohol dependence and nicotine dependence, respectively, using the Alcohol Use Disorders Identification Test (AUDIT) and Fagerstrom Test. There was consistency across all the assessment scales, as each was administered at the same time.

Inclusion criteria

- Patients aged 18–65 years.
- Diagnosis of unipolar depression or bipolar depression as per DSM-5 criteria.
- Patients attending outpatient or inpatient psychiatry services.
- Willingness to participate in the study.
- Provision of written informed consent.

Exclusion criteria

- Refusal or inability to provide informed consent.
- Presence of major psychiatric disorders other than unipolar or bipolar depression.
- Significant cognitive impairment or intellectual disability.
- Severe neurological illness interfering with clinical assessment.

Statistical Analysis- The statistical analysis was performed using SPSS 27, with descriptive and inferential tests conducted, including independent t-tests and chi-square tests to compare groups and correlation tests to evaluate relationships between clinical symptoms and quality of life. For categorical data, Pearson's chi-square was used, while for continuous data, t-test was conducted. $p<0.05$ was considered to be significant.

Ethical Approval- Institutional Ethics Committee provided ethical approval, and informed consent was obtained from all participants, with assurances of confidentiality and voluntary participation.

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RESULTS

The study involved 50 participants (25 each). More females were affected in both groups, as there were 15 cases (60%) in Unipolar Depression (UD) and 14 cases (56%) in Bipolar Depression.

Table 1 provides a comparative study of the clinical features between patients with unipolar and bipolar depression, which identifies similarities in the clinical features and differences in the symptom profiles. There were no significant differences between the unipolar and bipolar depression in the symptoms of fatigue, insomnia, anhedonia, appetite disturbances, hypersomnia, inability to concentrate, psychomotor changes, feelings of guilt, deliberate self-harm, postpartum, and hallucinations (all $p>0.05$). A major distinguishing aspect was psychotic features. The most common psychotic symptoms were found to be higher in bipolar than in unipolar depression (64 vs. 36; $p=0.002$). Consistent with this, bipolar depressed patients (56% vs. 32; $p=0.01$) had significantly higher rates of delusions as well, which supports the relationship between bipolar depression and more severe psychotics. Further, higher levels of appetite were found significantly more comparable in the case of bipolar than unipolar depression (16% vs. 8; $p=0.03$). Suicidal ideation was found more in bipolar (60%) than unipolar (44%), which was not found to be statistically significant ($p=0.09$). This showed that there is a tendency that needs to be further explored in larger populations.

Table 1: Clinical Characteristics Comparison in Unipolar and Bipolar Depressed Patients.

Clinical characteristics	Unipolar depression	Bipolar depression	Test	p-value
Fatigue	14 (56%)	11 (44%)	$X^2=1.15$	0.28
Insomnia	13 (52%)	17 (68%)	$X^2=1.94$	0.16
Psychotic symptoms	9 (36%)	16 (64%)	$X^2=9.94$	0.002
Decreased appetite	11 (44%)	13 (52%)	$X^2=0.76$	0.40
Increased appetite	2 (8%)	4 (16%)	Fischer's exact test	0.03
Deliberate self-harm	5 (24%)	4 (16%)	$X^2=0.75$	0.39
Anhedonia	14 (56%)	12 (48%)	$X^2=1.05$	0.31
Hypersomnia	4 (16%)	3 (12%)	$X^2=0.58$	0.465
Difficulty in concentration	13 (52%)	14 (56%)	$X^2=0.38$	0.550
Increased Psychomotor activity	2 (8%)	4 (16%)	$X^2=1.68$	0.198
Decreased Psychomotor activity	11 (44%)	13 (52%)	$X^2=0.54$	0.48
Delusions	8 (32%)	14 (56%)	$X^2=6.65$	0.01
Postpartum onset	2 (8%)	3 (12%)	Fischer's exact test	0.23
Feelings of guilt	10 (40%)	12 (48%)	$X^2=0.81$	0.37
Suicidal thoughts/ideations	11 (44%)	15 (60%)	$X^2=2.80$	0.09
Hallucinations	1 (4%)	2 (8%)	Fischer's exact test	0.13

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Table 2 indicates that there were significant differences in the course of illness in patients with unipolar and bipolar depression and that these differences were statistically significant. The onset of bipolar depression was also considerably earlier (40% of patients had become ill before 20 years of age versus 16% in unipolar depression), and unipolar depression tended to start later in life (40 - 60 years: 36% vs. 8%; p<0.001). Bipolar depression was more recurrent in the course of illness since more patients had 5–10 episodes (56% vs. 36%), and more than 10 episodes (16% vs. 4%). In contrast, fewer than five episodes were more typical of unipolar depression (60% vs. 28, p=0.0004). Similarly, bipolar depression hospitalization was significantly lower, with only 32% having none to five hospitalizations compared to 76% of unipolar patients, and a significantly higher percentage of bipolar patients having 5 -10 or more than 10 hospitalizations (p<0.001), which indicates a more severe illness. Regarding the length of the episode, bipolar depression more commonly lasted 3-6 months (56 vs. 36; p=0.03) and had a significantly longer average episode of depression than unipolar depression (145.09 vs. 92.12 days; p=0.009).

Table 2: Course of Illness in Unipolar and Bipolar Depression Patients

Category	Unipolar depression (N=25)	Bipolar depression (N=25)	Test	p-value
Age of onset <20 years	4 (16%)	10 (40%)	X^2= 13.89	<0.001
Age of onset 20-40 years	12 (48%)	13 (52%)		
Age of onset 40-60 years	9 (36%)	2 (8%)		
Episodes <5	15 (60%)	7 (28%)	X^2=15.56	0.0004
Episodes 5-10	9 (36%)	14 (56%)		
Episodes >10	1 (4%)	4 (16%)		
Hospitalizations 0-5	19 (76%)	8 (32%)	X^2=30.65	<0.001
Hospitalizations 5-10	5 (20%)	14 (56%)		
Hospitalizations >10	1 (4%)	3 (12%)		
Duration 3-6 months	9 (36%)	14 (56%)	X^2=4.32	0.039
Duration >6 months	3 (12%)	4 (16%)		
Mean durations of depression	92.12 days	145.09 days	t=2.72	0.009

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Table 3 shows that there are substantial variations in clinical severity and psychological quality of life between unipolar and bipolar depression. In contrast, the use of substances and most quality-of-life domains are similar. Compared to unipolar depression, patients with bipolar depression displayed much more depressive severity, based on higher HDRS scores (21.65±5.12 vs. 17.12±4.54; p<0.001), and overall psychopathology, which was more extreme based on higher BPRS scores (44.21±8.02 vs. 37.98±8.63; p<0.001). There was a slight difference in the severity of alcohol use identified by AUDIT that approached borderline statistical significance (p=0.05) in the bipolar group as compared with the control, but no statistical difference in nicotine dependence characterized by the Fagerström score (p=0.354). Psychological well-being was much worse in bipolar depression (41.78±13.56) than in unipolar depression (48.87±13.45), with the latter indicating more psychological distress in patients with bipolar disorders. Nevertheless, there were no significant differences in the environmental, physical, or social domains of quality of life (p>0.05), indicating that these functional areas were equally impaired in the two groups.

Table 3: Comparison of Clinical Scales and Quality of Life of mean scores

Measure	Unipolar (mean±SD)	Bipolar (mean±SD)	t-value	p-value
AUDIT	3.91±2.34	4.82±2.61	1.99	0.050
HDRS	17.12±4.54	21.65±5.12	4.82	< 0.001
Fagerstrom	1.98±1.68	2.34±1.97	0.95	0.354
BPRS	37.98±8.63	44.21±8.02	4.36	< 0.001
QOL - Environmental	58.34±13.45	56.12±13.45	1.16	0.253
QOL - Physical	52.54±13.92	50.25±12.78	0.98	0.334
QOL - Social	52.65±17.56	50.78±16.76	0.64	0.532
QOL - Psychological	48.87±13.45	41.78±13.56	2.94	0.004

AUDIT: Alcohol Use Disorders Identification Test; HDRS: Hamilton Depression Rating Scale; Fagerstrom: Fagerström Test for Nicotine Dependence; BPRS: Brief Psychiatric Rating Scale; QOL– Environmental: World Health Organization Quality of Life – Environmental Domain; QOL– Physical: World Health Organization Quality of Life – Physical Health Domain; QOL– Social: World Health Organization Quality of Life – Social Relationships Domain; QOL– Psychological: World Health Organization Quality of Life – Psychological Domain.

Table 4 shows the pattern of relations between the clinical severity and quality-of-life domains in unipolar and bipolar depression, which can show similar and differentiated associations. There was a positive, strong correlation of depressive severity (HDRS) with overall psychopathology (BPRS) in both groups, which was marginally stronger with unipolar depression (r=0.65, p<0.001) than with bipolar depression (r=0.56, p<0.001), meaning that with an increased number of depressive symptoms, the psychiatric burden of symptoms increases in both cases. Nevertheless, the effect of the severity of the symptoms on the quality of life was stronger in the case of bipolar depression. The Hamilton Depression Rating Scale (HDRS) scores in the bipolar group had a significant negative correlation with psychological health (r=-0.37, p=0.009) and environmental quality of life (r=-0.32, p=0.03). Still, in the case of unipolar depression, the relationship between HDRS scores and environmental quality of life (r=-0.28, p=0.04) was less strong and mostly non-

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significant. The HDRS scores did not show a significant relationship with physical health or social relationships in both groups. In the same vein, the Brief Psychiatric Rating Scale (BPRS) scores had better and higher negative associations with quality-of-life domains in bipolar depression, such as psychological health (r=-0.42, p=0.002), environment (r=-0.36, p=0.007), and social relationships (r=-0.26, p=0.04). Conversely, in unipolar depression, only BPRS was largely related to the psychological health (r=-0.33, p=0.02), and there was a tendency toward significance with the environmental domain.

Table 4: Correlation Under Clinical Variables and Quality of Life

Correlation	Unipolar depression (r, p)	Bipolar depression (r, p)
HDRS & BPRS	0.65, <0.001	0.56, <0.001
HDRS & Psychological Health	-0.23, 0.09	-0.37, 0.009
HDRS & Environment	-0.28, 0.04	-0.32, 0.03
HDRS & Physical Health	-0.19, 0.21	-0.25, 0.11
HDRS & Social Relationships	-0.11, 0.53	-0.21, 0.16
BPRS & Psychological Health	-0.33, 0.02	-0.42, 0.002
BPRS & Environment	-0.25, 0.05	-0.36, 0.007
BPRS & Social Relationships	-0.17, 0.23	-0.26, 0.04

HDRS: Hamilton Depression Rating Scale; BPRS: Brief Psychiatric Rating Scale; Psychological health: World Health Organization Quality of Life – Psychological Domain; Environment: World Health Organization Quality of Life – Environmental Domain; Physical health: World Health Organization Quality of Life – Physical Health Domain; Social Relationships: World Health Organization Quality of Life – Social Relationships Domain.

DISCUSSION

A study was done to assess and compare the impact of disease on quality of life in patients with bipolar and unipolar depression. Patients attended the hospital and completed the Beck Depression Inventory and QOL Instrument-Short Version. The study reported significantly low scores of QOL in bipolar depression patients. The study concluded that unipolar and bipolar depression patients show different QOL profiles; this difference is independent of the severity of mood disturbance and may be related to higher suicidal rates [9].

A study examined the association between functional outcome and life satisfaction in patients with bipolar a dunipolar disorders. The study concluded that recurrent depression leads to poor life satisfaction among different subtypes of disorders. Patients with bipolar and unipolar psychotic depression may have a subjective quality of life (QOL) that does not adequately represent their objective functional outcome status, possibly because of reduced insight, demoralisation, or changing life expectations over time [10].

A study applied techniques derived using the item response theory (IRT) to investigate whether, in controlling the level of depression severity, there are dissimilarities in the possibility of reporting the symptoms of major depressive episode (MDE) in the DSM-IV in individuals with and without a history of manic symptoms. Some significant differences may exist in the clinical manifestation of depressive symptoms in individuals with and without a lifetime history of manic symptoms. The study reported unusual symptomatic presentations among individuals with co-occurring symptoms [11].

A study compared clinical features, the course of illness, the use of substances, and the quality of life of patients with unipolar and bipolar depression. There was a cross-sectional study of 140 patients with a diagnosis of unipolar or bipolar depression according to the DSM-5

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criteria. Bipolar depression is worse, recurrent, and has psychotic symptoms that affect the general psychological well-being [12].

An investigation was done on the clinical features, course of illness, patterns of substance use, and quality of life of patients with unipolar and bipolar depression. Participants were assessed using the Hamilton Depression Rating Scale (HDRS), Brief Psychiatric Rating Scale (BPRS), WHO Quality of Life-BREF (WHOQOL-BREF), Alcohol Use Disorders Identification Test (AUDIT), and the Fagerstrom Test of Nicotine Dependence. Descriptive and inferential statistics were used to analyse the socio-demographic and clinical data. Compared to unipolar depression, bipolar depression has more severe symptoms, recurrence, and psychotic symptoms, which affect general psychological health [13].

The objectives of the study were as follows: to make psychological well-being an empirical subject of study within the framework of bipolar disorder; to compare psychological well-being among a group of patients with bipolar disorder with that of a normative sample; and to determine whether common measures of psychological well-being and mood empirically assess different phenomena. The Psychological Well-Being Scale (PWBS) was applied to measure psychological well-being. Remitted outpatients of bipolar disorder exhibited psychological well-being significantly impaired, although having low rates of depressive symptoms, in comparison with a normative community sample [14].

A study was conducted to compare quality of life (QOL) in remitted patients with major depressive disorder (MDD) and bipolar disorder (BD) and to investigate the association between quality of life (QOL) and demographic, clinical, and cognitive factors. Symptoms of depression, anxiety, and mania were assessed with the help of the Hamilton Depression Rating Scale (HAMD-17), Hamilton Anxiety Rating Scale (HAMA), and Young Mania Rating Scale (YMRS), respectively. Patients with MDD and BD in remission have a poor quality of life compared to the normal population. QOL of MDD is worse compared to that of BD. MDD, but not BD, had an association with increased QOL based on marital status. Remaining symptoms of depression or anxiety reduced the QOL in both MDD and BD [15].

CONCLUSIONS

The study concludes that bipolar depression is significantly differentiated as compared to unipolar depression in terms of severity, course of illness, and psychological impact, whereby the former presents earlier, recurring, and increased in duration and associated with higher psychopathology, high levels of psychotic symptoms and lower psychological quality of life, thus stating a compelling need to recognize the critical importance of making early and accurate differentiation of unipolar and bipolar depression in terms of diagnosis, proper treatment planning, and patient outcome. A more serious and recurrent course of illness, high psychopathology, and worse psychological well-being are linked with bipolar depression than with unipolar depression. These results highlight the significance of early and accurate diagnosis of unipolar and bipolar depression to ascertain the relevant treatment plans, prevent negative consequences, and improve the overall quality of life among the concerned patients..

CONTRIBUTION OF AUTHORS

One author has only contributed to this article.

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