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A COMPARATIVE STUDY OF SEVERITY OF ANXIETY & DEPRESSION & QUALITY OF LIFE BETWEEN PATIENTS WITH MAJOR DEPRESSIVE DISORDER & BIPOLAR DEPRESSION.

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ABSTRACT

Introduction: Major Depressive Disorder (MDD) and bipolar disorder (BD) are both characterized by depressive episodes that can be clinically indistinguishable in their initial stages. Although they may appear similar, these disorders differ greatly in their underlying pathophysiology, progression over time, treatment strategies, and notably, their impact on quality of life (QoL). Recognizing the subtle differences is increasingly considered a vital dimension of mental health care, reflecting not just symptom control but overall well-being and functional status.

Objectives:

1. To study difference in severity of anxiety and depression between patients of Bipolar depression and Major Depressive disorder
2. To study difference in overall quality of life between patients of Bipolar depression and Major Depressive disorder

Materials & Methods: 100 patients (50 each for major depressive disorder and bipolar depression) according to ICD-10 criteria included in this study from outpatient department of Psychiatry, of Saraswathi Institute of Medical Sciences, Hapur, U.P. during the period of 2 years. Detailed clinical interview was done and HAM-A, HAM-D, Suicide intent scale and WHOQOL BREF were filled. Data was entered in excel sheet and analysed using SPSS software v29. **Results:** Amount of 100 subjects were analysed in this study, and it was found that Bipolar depression patients had a mean HAM-A score of 11.74 ± 2.37, whereas major depressive disorder patients had a mean score of 16.34 ± 2.36 ($t = -9.61438$, $p < 0.00001$). The Hamilton Depression Rating Scale (HAM-D) scores revealed mean scores of 21.44 ± 4.057 for bipolar depression and 23.24 ± 3.982 for major depressive disorder ($t = -2.239$, $p = 0.014$). Quality of life interpretation categorization showed 13 subjects (13%) with good quality of life (3 bipolar, 10 MDD) and 87 subjects (87%) with poor quality of life (47 bipolar, 40 MDD). Overall quality of life interpretation differed significantly between groups ($\chi^2 = 4.332$, $p = 0.037$). **Conclusion:** This study highlights the substantial clinical overlap between bipolar depression and major depressive disorder, while emphasizing the importance of distinguishing between them. Accurate diagnosis is fundamental to individualized treatment planning, improved quality of care and favourable prognostic outcomes

KEYWORDS : Bipolar Affective Disorder, Major Depressive Disorder, Quality of life, Unipolar Depression, Bipolar Depression.

INTRODUCTION

Mood disorders pose a major public health issue globally, significantly affecting individual capabilities, societal productivity, and healthcare systems. Major Depressive Disorder (MDD) and bipolar disorder (BD) are among the most common mood disorders, both characterized by depressive episodes that can be clinically indistinguishable in their initial stages. [1,2,3] Although they may appear similar, these disorders differ greatly in their underlying pathophysiology, progression over time, treatment strategies, and notably, their impact on quality of life (QoL). Recognizing the subtle differences in clinical features and QoL outcomes between individuals with MDD and those experiencing bipolar depression is essential for accurate and timely diagnosis, effective treatment planning, and enhanced patient outcomes. [4].

This study aims to provide a comparative analysis of clinical characteristics & QoL in patients with MDD and bipolar depression, using standardized diagnostic tools and QoL instruments. The goal is to elucidate differences and similarities that can inform clinical practice, contribute to more accurate diagnostics, and improve long-term outcomes.

Objectives

1. To study difference in severity of anxiety and depression between patients of Bipolar depression and Major Depressive disorder
2. To study difference in overall quality of life between patients of Bipolar depression and Major Depressive disorder

MATERIALS & METHODS

Source of Data: Subjects attending the outpatient clinic of psychiatry department in a tertiary care Centre, SIMS, Hapur, Uttar Pradesh
Study Design: Prospective observational study
Study Period: March 2024- February 2026
Sample Size and Basis of Calculation: 100

A sample of 100 subjects (50 each for major depression and bipolar depression) according to ICD-10 criteria.

Criteria for Selection of Study Group:

Inclusion Criteria:

- Subjects with diagnosis of Major Depressive disorder and Bipolar depression as per ICD-10 Criteria attending psychiatry outpatient clinic.
- Subjects who provided a written informed consent.

Exclusion Criteria:

- Subjects with any Drug history, any other psychiatric disorder or any other medical illnesses presenting with symptoms of MDD or BD.
- Subjects who refused to participate in the research.

METHODOLOGY

This study and its methodology were discussed and approved by ethical committee of research panel of SIMS, Hapur. Informed consent obtained from patients. Participation or non-participation did not affect the services offered to patients. Information gathered during the study was kept confidential. Patients were interviewed in the Outpatient Department of SIMS. Relatives were also required for the purpose of interviewing.

Information regarding name, age, sex, education, occupation, income, marital status, family type, type of depression, pre-morbid personality, physical illness, co-morbid psychiatric disorder, course of illness, previous treatments and treatment response were obtained in the patients attending outpatient Psychiatry department of SIMS, Hapur.

Clinical interview for the diagnosis of type of depression was conducted fulfilling ICD-10 criteria.

1. Hamilton depression rating scale (HDRS)
2. Hamilton Anxiety Rating Scale.
3. Suicide Intent Scale
4. World health organization quality of life scale (WHO QOL) BREF

Patients were required to come for the follow-up after 2-3 months so that we can assess the QoL with the progression of disease. Patients

were given full right to withdraw themselves from the study without affecting the course of treatment.

Statistical Analysis

Data entered in Microsoft Excel and was analysed in IBM SPSS (v29.0). The collected data was analysed by statistical tests and techniques such as mean + SD, graphical representation of data, frequency distribution, chi-square test or paired t-test, correlation etc. A $p < 0.05$ was considered as statistically significant. Data obtained was analysed and discussed for comparison of clinical characteristics and quality of life between patients of major depression and bipolar depression.

RESULTS

A total of 100 subjects were analysed in this study.

Depression Severity (Hamilton Depression Rating Scale - HAM-D)

1. Bipolar depression: 21.44 ± 4.057 (moderate depression)
2. Major depressive disorder: 23.24 ± 3.982 (moderate-severe depression)

Difference: MDD shows 1.8 points higher depression score ($p = 0.014$, significant). Clinical implication: MDD presents with slightly greater depression severity on objective scale.

Anxiety Severity (Hamilton Anxiety Rating Scale - HAM-A)

1. Bipolar depression: 11.74 ± 2.37 (mild anxiety)
2. Major depressive disorder: 16.34 ± 2.36 (moderate anxiety)

Difference: MDD shows 39% higher anxiety scores ($p < 0.00001$, highly significant). Critical finding: MDD has substantially greater anxiety burden; requires anxiety-focused treatment.

Quality of Life (WHOQOL) Status

1. Bipolar depression: 94% poor quality of life, 6% good quality
2. Major depressive disorder: 80% poor quality of life, 20% good quality

Clinical significance: Both groups severely impaired; bipolar more universally affected ($p = 0.037$).

DISCUSSION

Study examined clinical characteristics and quality of life outcomes in patients with MDD & BD, providing important information into distinction between these frequently misdiagnosed conditions. The findings revealed variations across clinical presentations, symptomatology, and QoL domains, with clinical implications & patient management in resource-limited Indian healthcare settings.

Anxiety and Depression Severity

HAMA scale scores when applied to subjects participating in the study were significantly higher in MDD (16.3) compared to BD (11.7), a statistically significant difference. This counter-intuitive finding points that MDD patients experience more prominent anxiety symptoms during depressive episodes, despite traditional associations of anxiety with bipolar illness. Johnson & Mitchell found that anxiety, increased activity, and somatization were more prevalent in unipolar depression when methodologically rigorous medication controls were implemented.[5] The higher anxiety in MDD may drive functional impairment through anxious rumination and worry, distinct from the agitation or dysphoria of bipolar depression.

Depression severity when measured in the subjects by HAMD scale showed minimal group differences, with MDD slightly elevated (23.2) versus BD (21.4), not reaching clinical significance. This finding in way with Kumar et al. (2025), who reported higher HDRS scores in bipolar depression (21.59) versus unipolar (17.64), though notably in opposite direction to our data.[6] The similarity in overall depression severity between groups when measured by standardized scales suggests symptom severity alone cannot distinguish these conditions; rather, symptom quality and associated features prove more discriminative.

Quality of Life Impairments

A critical finding in results was the substantially greater proportion of bipolar depression patients rating quality of life as poor/very poor (74%) compared to MDD (32%). This marked impairment in QOL in bipolar depression represents significant patient-cantered outcome differences. Zhang et al. (2019) reported that while both MDD and BD patients showed impaired quality of life, MDD patients demonstrated lower psychological domain scores, whereas our study found overall greater impairment in bipolar patients. [10] The discrepancy may reflect severity differences in study samples or cultural differences in quality-of-life perception.

CONCLUSION

This study contributes to the growing evidence advocating for dimensional assessment of mood psychopathology while maintaining categorical diagnostic distinctions that were clinically meaningful. Future research employs longitudinal designs examining illness trajectory, incorporate neurobiological biomarkers, and examine treatment response patterns to further refine understanding of the bipolar-unipolar distinction and optimize therapeutic approaches for improved patient outcomes in diverse cultural and healthcare contexts.

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