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Differentiation of Patients With Unipolar Depression (UD) and Bipolar Disorder (BD) Based on the OPCRIT Test

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Abstract

Objective: The frequency of bipolar disorder (BD) is estimated at 2% in the global population, while unipolar disorder (UD) is estimated at 3.8%. Despite the prevalence of these disorders, the conversion rate from UD to BD is approximately 6.5%. The aim of the study was to use the OPCRIT (The Operational Criteria Diagnostic Checklist) questionnaire to identify additional elements beyond the diagnostic criteria that would allow for better differentiation between the two groups of patients.

Method: The responses of 587 people with BD and 250 people with UD were analyzed. The Mann-Whitney test, the χ^2 (chi-squared) test of independence, and the Fisher-Freeman-Halton exact test with Bonferroni correction were used for data analysis. A ROC analysis was also performed, the area under the ROC curve (AUC) was calculated, and the optimal cut-off point was determined along with sensitivity and specificity. The calculations were performed using PQStat (v. 1.8.6, PQStat Software) and Statistica (v. 13.3, TIBCO) software.

Results: Upon analyzing individual sections of the OPCRIT questionnaire, we identified those of its components that can be used to accurately diagnose BD. We also formulated questions that initially seemed less diagnostically relevant, but statistical analysis revealed significant differences in the responses of both patient groups.

Conclusions: The use of the OPCRIT questionnaire in the diagnostic process allows for precise differentiation between patients with BD and UD. The use of OPCRIT can directly contribute to an increase in the frequency of accurate BD diagnoses.

Keywords: bipolar disorder, unipolar depression, OPCRIT, diagnosis

Affective disorders are severe mental disorders, which include unipolar depression (UD) and bipolar disorder (BD). Despite numerous similarities, these two illnesses differ significantly in terms of their clinical course and epidemiological conditions. Cyclical relapses of depression are a characteristic feature of unipolar depression. In contrast, BD is additionally characterized by episodes of mania, hypomania, or mixed episodes, between which periods of symptom remission are observed (Cuellar, 2005). It is worth mentioning that mania is treated as a condition requiring urgent intervention, often hospitalization. Those affected may experience euphoric moods, increased irritability, and sometimes aggressive behavior (Halder, 2015). Furthermore, although depressive episodes occur in both UD and BD, their course may vary depending on the type of disorder and, in some cases, show signs of drug resistance (Sobów, 2005).

Aforementioned affective disorders occur in all climate zones, but depending on the form, they differ in epidemiological terms, especially with regard to the gender and age of patients (Wittchen, 2001). Potential relapses are also an important variable. The high probability of subsequent episodes leads to a significant reduction in the quality of life in patients, including their social, family, and professional functioning.

Despite significant differences in the course of unipolar and bipolar affective disorders, their diagnosis remains a major challenge. It is estimated that up to one-third of patients who actually suffer from bipolar disorder are misdiagnosed,

most often with unipolar depression. The frequency of such mistakes reaches about 60% (Gorostowicz, 2018). This may be due to the fact that the first episode in the course of BD is most often a depressive one (Philips, 2013). Delays in initiating optimal treatment affect patients' health and quality of life, contributing to more relapses, hospitalizations, and suicide attempts (Singh, 2006).

There are specific criteria for diagnosing or ruling out a particular type of mental disorder. The latest classifications used for this purpose are the DSM-V (Diagnostic and Statistical Manual of Mental Disorders) developed by the American Psychiatric Association and the ICD-11 (International Statistical Classification of Diseases and Related Health Problems) published by the WHO. However, in order to simplify and streamline the diagnostic process, numerous forms and questionnaires have been created that may also be useful for doctors in specialties other than psychiatry.

In the following study, we decided to analyze selected parts of the OPCRIT test, which is one such questionnaire, and identify elements that could be used to accurately diagnose BD. We also identified features that seemed less significant in terms of diagnosis (they did not result directly from the classification criteria), but whose statistical analysis revealed significant differences in responses between patient groups. These results may bring significant benefits both for a better understanding of affective disorder itself and for the development of new diagnostic and therapeutic strategies.

Method

Study Participants

The data used in the presented studies were obtained from patients in psychiatric wards and clinics in the Greater Poland region. Participants were included in the study after giving their informed and voluntary consent to participate, having been informed about its purpose, course, and the anonymity of the data obtained. Recruitment was voluntary.

The study included 587 patients diagnosed with bipolar disorder and 250 patients diagnosed with unipolar depression, including 534 women and 303 men. The average age of the participants was 45 years (Table 1, p. 142). Participants who had experienced only one depressive episode to date were classified as patients with unipolar depression.

People aged 18 to 85 with a diagnosis of bipolar disorder or unipolar depression, confirmed on the basis of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I), conducted by two independent psychiatrists, were qualified for the study. Only individuals who were in a stable mental and somatic state at the time of qualification were eligible to participate in the study. Individuals with diagnoses other than BD or UD and with comorbid conditions that could affect cognitive or emotional functioning were excluded from participation (Pawlak, 2013).

Table 1

Demographic data of the study populations

	BD		UD	
Age (*M* ± *SD*)	46 ± 14,31		45 ± 14,96	
Gender	women	men	women	men
	338 (57.6%)	249 (42.4%)	196 (78.4%)	54 (21.6%)

Measuring Tools

OPCRIT (*Operational Criteria Checklist for Psychotic Disorders*) is a tool for assessing psychopathological symptoms, developed by Peter McGuffin, Anne Farmer, and Ian Harvey in 1991. It was translated internally for research purposes as part of grants NN 402467140 and 2011/01/B/NZ5/02795 awarded by the National Science Centre (Poland). A paper version was created and the information obtained was digitized. Based on the data obtained with its help, it is possible to describe the occurrence and severity of clinical symptoms in psychotic and affective disorders. This form was chosen due to its high degree of accessibility, standardization, and objectivity, which enables the uniform collection of clinical data. This allows for reliable comparison of results between different studies and clinical centers. In addition, OPCRIT covers a wide range of affective, psychotic, and behavioral symptoms, allowing for an accurate description of the patient's condition. The form is completed by the physician based on an interview with the patient, rather than by the patient themselves, which further increases its reliability and objectivity. The results obtained using the OPCRIT form show good or very good agreement with diagnoses established on the basis of consensual procedures, considered the gold standard. (Craddock, 1996). What is more, the selected form is characterized by high Cohen's kappa coefficient (κ) values = 0.7 (Rucker, 2011). This means that independent researchers using the same data set obtain similar diagnostic results.

OPCRIT consists of 8 domains:

1. a set of preliminary issues (including the patient's gender, age at onset of the disease, clinical picture);
2. appearance and behavior (including bizarre behavior, catatonia, reduced need for sleep, agitation);
3. speech and formal thought disturbances (including speech distraction, verbosity, inhibition of thought flow);
4. affective symptoms (including blunted affect, inappropriate affect, irritable mood, depressed mood);
5. thought content disturbances (including persecutory disorders, delusions of grandeur, hallucinations, and delusions);
6. perceptual disturbances (including thought broadcasting, voices commenting, other auditory hallucinations);

7. psychoactive substance abuse or dependence (including addiction, history of alcohol/cannabis abuse);
8. overall assessment of the course of the disease (including lack of insight on the part of the patient, remission of psychotic symptoms after neuroleptic treatment).

Research Procedure

Medical interviews were conducted using the OPCRIT form and were carried out by psychiatrists during a personal examination of the patient. The final diagnosis was determined by consensus between two doctors in accordance with the DSM-IV and ICD-10 criteria. The research project received a positive opinion from the Bioethics Committee at the Poznan University of Medical Sciences (Resolution No. 421/11), issued at a meeting on June 16, 2011.

Data Analysis Methods

Most of the data from the questionnaire was treated as binary, with a value of 1 if the symptom occurred and 0 if it did not. For domains 2, 3, 5, 6, and 7, the scores obtained in individual questions were summed up and the entire domains were analyzed instead of individual questions. The decision to treat these areas as a whole was based on the fact that their questions referred to the same subject matter, and the individual items measured different aspects of the same construct, without being mutually exclusive. This approach allowed for a more accurate assessment of the severity of the analyzed phenomenon in individual domains. The normality of the distribution was tested using the Shapiro-Wilk test. The Mann-Whitney test was used to compare domains between patients with unipolar depression and bipolar disorder. The χ^2 test of independence or the Fisher-Freeman-Halton test with Bonferroni correction was used to analyze qualitative variables. A ROC analysis was performed to find the optimal cut-off point based on the Youden index. Sensitivity and specificity were given for this point. The area under the ROC curve (AUC) was calculated using the DeLong method. The calculations were performed using STATISTICA v. 13.3 (TIBCO, USA) and PQStat v.1.8.6 (PQStat Software, Poland).

Results

Domain 1

Analysis of the first question showed that in 93.93% of cases, the information collected in OPCRIT came partly or entirely from the patient interview – 11.48% exclusively, while in 82.45% other sources were also used. Responses

based solely on medical history concerned 2.84% of patients. Other sources included: medical history extract – 0.90%, interviews with relatives – 0.26%, and other sources without interviews – 2.06%.

The item "period of illness under investigation" was omitted because all participants were assessed in terms of symptoms occurring throughout the entire course of their illness to date.

The third question provided information on the gender distribution among the patient groups studied. In the male group, 82.18% had bipolar disorder and 17.82% had unipolar disorder. Among women, the percentages were 63.29% and 36.71%, respectively.

The fourth point concerned the age of the first episode of the disease, which allowed us to examine the differences in the age of onset of the diseases in question. The average age of onset was 30.25 years (median: 28) for BD and 38.12 years (median: 39) for UD. The Mann-Whitney U test confirmed significant differences in the age of onset ($p < .001$). Details are presented in Table 2.

Table 2

Analysis by age and duration of the longest episode

	BD						UD					
	M	*Mdn*	Min.	Max.	Q1	Q3	*M*	*Mdn*	Min.	Max.	Q1	Q3
Age of onset of the disease (in years)	30.25	28.0	10	63	21	38	38.12	39.0	17	72	26	48
Duration of the longest episode (in weeks)	24.32	20.0	1	208	12	28	23.08	18	2	208	9	27.5

The clinical picture of the onset of the disease was analyzed by combining responses regarding the gradual development of the disease (No. 4 "gradual development of the disease over 6 months" and No. 5 "slowly increasing symptoms over more than 6 months"). After modification, the following results were obtained: gradual or slow development of the disease was less common in patients with BD than in patients with UD. Patients with BD reported subacute onset of the disease (within a month) more often than patients with UD, as well as acute onset (within a week) and sudden onset (within hours or days).

The Bonferroni test showed significant differences between the "gradual or slow progression" category and the other categories, as well as between "subacute" onset and "acute" onset. The results are presented in Table 3 (p. 145).

Questions concerning marital status, employment, professional activity, social relationships, personality disorders, psychoactive substance use, occurrence of schizophrenia and other mental illnesses in the family, organic mental disorders, and stress factors during the first episode of the illness belonged to the first domain and were answered with a yes or no (found/not found). No significant differences were found between the diagnoses in terms of the marital status

of patients. Slightly more patients with UD than patients with BD remained married. Similarly, no significant differences in employment before the onset of the illness were found between the two groups of patients. Slightly fewer patients with BD were employed than patients with UD. In addition, a comparable number of patients with UD and BD reported continuous professional activity prior to the onset of the disease. Detailed data are presented in Table 4.

Table 3

The nature of the onset of the disease among patients with BD and UD

Nature of the onset of the disease	UD (%)	BD (%)
Gradual/slow progression of the disease (≥ 6 months)	52.66	31.0
Subacute onset (≤ 1 month)	37.23	42.0
Acute onset (≤ 1 week)	5.32	17.4
Sudden onset (hours-days)	4.79	9.6

Table 4

Summary of domain analysis results 1

Symptom	UD (occurrence %)	BD (occurrence %)	*p*
Marital status	67.65	65.01	.496
Employment before illness	87.13	85.92	.669
Continuous professional activity before the illness	92.27	91.03	.600
Healthy social relationships before illness	94.63	92.99	.415
No personality disorders prior to the illness	98.03	97.86	.883
Use of psychoactive substances one year prior to the onset of the disease	1.47	8.59	**< .001**
The occurrence of schizophrenia in the family	1.99	5.99	**.024**
Other mental illnesses in the family	41.29	53.43	**.003**
Organic mental disorders prior to illness	0.98	1.06	.919
Stress factor during the first episode of the disease	51.81	40.66	**.008**

Note. The table includes only those items from domain 1 of the OPCRIT questionnaire that are dichotomous variables. p – significance for the χ^2 test result.

The duration of the longest episode also did not differ significantly between patients with unipolar and bipolar disorder (p = .245). The mean duration was 24.32 weeks (median: 20) for BD and 23.08 weeks (median: 18) for UD. Details are presented in Table 2 (p. 144).

Patients with BD and UD did not differ in their ability to form normal social relationships before the onset of the illness. A comparable number of patients with BD and UD reported normal social relationships. In both groups, personality disorders before the onset of the illness were very rare ($p = .883$). Similarly, organic mental disorders were rare before the onset of the illness. These disorders were found in a comparable number of patients with BD and UD. More patients with BUD than with BD declared that they had not used psychoactive substances in the year prior to the illness. It was found that cases of schizophrenia and other mental illnesses were significantly more common in the family of patients with BD. The two groups studied did not differ in the frequency of organic mental disorders prior to the illness. These disorders were found in a comparable number of patients with BD and UD. The occurrence of stress factors during the first episode of the disease was significantly more frequently reported by patients with UD than with BD. Questions in domain 1, which are dichotomous variables, are presented in detail in Table 4 (p. 145).

Domains 2, 3, 5, 6, and 7

The second domain concerned appearance and behavior, including questions about bizarre behavior, catatonia, increased drive, reckless behavior, excessive distractibility, reduced need for sleep, agitation, decreased activity, and excessive fatigue. Statistical analysis showed significant differences between the total scores obtained by patients with BD and UD, with a higher median occurring in patients with BD.

The third domain contains questions about speech and thought disorders, such as incomprehensible speech, distraction, neologisms, inhibition of thought, verbosity, and accelerated thought (potentially occurring in both depressive and manic episodes). Statistical analysis showed significant differences between patients with BD and UD, with a higher median value recorded in the BD group.

The fifth domain of the OPCRIT test concerns thought content disorders, including persecutory, paranoid, grandiose, bizarre, influence and guilt delusions, as well as delusions accompanied by hallucinations and other thought disorders. Statistical analysis showed significant differences between patients with BD and UD, with higher scores again occurring in the BD group.

Domain six concerns perceptual disturbances, including thought broadcasting, hearing voices in the third person, voices commenting, insulting, or accusing the patient, and other hallucinations. Statistical analysis showed no significant differences between patients in the study groups ($p = .164$).

Domain seven concerns substance abuse and dependence, including alcohol, cannabinoids, and other substances, as well as mental disorders related to their use. Statistical analysis showed significant differences between patients with BD and UD ($p < .001$).

Based on the ROC curve analysis and Youden's index, the optimal cut-off point for predicting BD was determined. Detailed data for domains 2, 3, 5, 6, and 7 are presented in Table 5 (p. 147).

Table 5

Summary of domain analysis results: 2, 3, 5, 6, 7

Domain number	UD			BD			*p*	ROC analysis			
	Mdn	Min.; Max.	Q1; Q3	*Mdn*	Min.; Max.	Q1; Q3		AUC	cut-off point	sensitivity (%)	specificity (%)
2	2	0;7	2;2	6	0;9	6;7	**< .001**	0.98	4	97.99	95.07
3	0	0;3	0;1	2	0;6	2;3	**< .001**	0.96	2	93.81	96.57
5	0	0;9	0;0	1	0;11	1;2	**< .001**	0.87	1	83.14	87.62
6	0	0;3	0;0	0	0;6	0;0	.164	–	–	–	–
7	0	0;2	0;0	0	0;6	0;0	**< .001**	0.58	1	22.58	93.14

Note. The domain numbers correspond to the following assessment categories: 2 – appearance and behavior, 3 – speech and formal thought disturbances, 5 – thought content disturbances, 6 – perceptual disturbances, 7 – substance abuse or dependence.p-significance for the Mann-Whitney *U* test result.

Domain 4

In domain 4, concerning affective symptoms, statistically significant differences were found between the patient groups. The group of patients with UD, compared to the group of patients with BD, reported more often: reduced affect display, anhedonia, reduced sex drive, reduced ability to concentrate, and more frequent waking up at night. In contrast, patients with BD more often experienced, compared to the UD group: inappropriate affect, elevated mood, irritable mood, depressed mood, excessive sleepiness and excessive appetite, weight gain, co-occurrence of psychotic and affective symptoms, as well as increased interpersonal relationships.

No statistically significant differences were found in the occurrence of blunted affect, morning intensification of depression symptoms, guilt, suicidal thoughts, difficulty falling asleep, premature awakening, decreased appetite, and weight loss. Questions in domain 4 (affective symptoms) are presented in Table 6.

Table 6

Summary of the results of domain 4 analysis (affective symptoms)

Symptom	UD (occurrence %)	BD (occurrence %)	*p*
Reduced affect display	43.90	28.47	**< .001**
Blunted affect	10.73	8.72	.395
Inappropriate affect	0.97	5.18	**.009**

Continuation of Table 6

Symptom	UD (occurrence %)	BD (occurrence %)	*p*
Elevated mood	3.41	97.33	**< .001**
Irritable mood	14.22	73.84	**< .001**
Low mood	86.41	93.44	**.002**
Morning intensification of depression symptoms	74.74	75.43	.850
Anhedonia	98.04	85.96	**< .001**
Reduced sex drive	83.33	76.02	**.035**
Reduced ability to concentrate	97.56	93.96	**.044**
Guilt	78.16	73.66	.203
Suicidal thoughts	70.24	71.25	.786
Difficulty falling asleep	75.12	77.38	.513
Waking up at night	78.57	68.53	**.008**
Premature awakening	79.51	74.86	.182
Excessive sleepiness	17.48	29.70	**< .001**
Weakened appetite	73.79	70.71	.403
Weight loss	64.00	59.58	.276
Excessive appetite	6.83	17.52	**< .001**
Weight gain	7.35	15.65	**.003**
Co-occurrence of psychotic and affective symptoms	9.22	37.68	**< .001**
Improvement in interpersonal relationships	1.42	80.62	**< .001**

Note. p – significance for the χ^2 test result.

Domain 8

Information obtained from patients with BD was found to be significantly less reliable than that obtained from patients with UD significantly more often, and this group also reported a lack of patient insight and the inability to conduct an interview with the patient more frequently. Social functioning disorders in the course of the disease were also found more often in patients with BD than in patients with UD. Persistent functional impairment after the resolution of an acute episode was significantly less common in patients with UD. Questions in domain 8, which are dichotomous variables, are presented in Table 7 (p. 149).

The BD and UD patient groups also differed in terms of the clinical course of the disease ($p < .001$). The distribution of responses is presented in Table 8 (p. 149).

Table 7

Summary of domain 8 analysis results (overall assessment)

Symptom	UD (occurrence %)	BD (occurrence %)	*p*
Information from the patient not entirely reliable	2.93	17.97	**< .001**
Lack of patient insight	2.44	12.50	**< .001**
No interview due to lack of contact with the patient	0.00	1.95	**.044**
Social functioning disorders in the course of the disease	75.74	94.29	**< .001**
Persistent social functioning impairment following an acute episode	21.08	30.14	**.011**
Remission of psychotic symptoms after neuroleptics	16.44	55.94	**< .001**

Note. The table includes only those items from domain 8 of the OPCRIT questionnaire that are dichotomous variables.*p* – significance for the χ^2 test result.

Table 8

The course of the disease in patients with BD and UD

Type of disease progression	UD (%)	BD (%)
A single episode with complete remission	29.15	4.49
Multiple episodes of complete remission	50.75	65.53
Multiple episodes with incomplete remission	17.59	24.42
Chronic course	2.01	4.67
Chronic course with social withdrawal	0.50	0.90

Discussion

The aim of this study was to determine which elements of the OPCRIT questionnaire enable differentiation between patients with bipolar disorder and unipolar depression, even though they do not constitute direct diagnostic criteria. It was assumed that the analysis of selected OPCRIT domains could reveal symptom patterns and functional factors that complement the classic ICD-10 and DSM-IV criteria, increasing the accuracy of diagnosis and supporting the personalization of therapy.

Domain 1

The age of onset may be a stable indicator differentiating between BD and UD. Early onset of BD, typically before the age of 30, is consistent with previous reports (Baldessarini, 2012; Ho, 2000) and indicates potentially stronger genetic

determinants and a more dynamic course of the disease. Neuroimaging studies of BD confirm changes in the frontolimbic networks responsible for emotion regulation, which may explain its early and turbulent onset (Phillips, 2013). In turn, the higher prevalence of UD after the age of 35 seems to be associated with environmental stressors, psychosocial overload, and dysregulation of the hypothalamic-pituitary-adrenal axis (Gotlib & Joormann, 2010; Hosang, 2012). This indicates a greater contribution of reactive factors in the etiology of unipolar depression.

The finding of more frequent psychoactive substance use in BD confirms the importance of co-occurring addiction disorders. The literature indicates that impulsivity and behavioral control disorders increase the risk of substance abuse, which worsens the course of the disease and hinders the therapeutic process (Hunt, 2016; Lalli, 2021). For this reason, the integration of affective therapy and addiction treatment seems essential in clinical practice.

In addition, patients with BD were more likely to report schizophrenia and other mental disorders among their first-degree relatives. The results suggest that affective disorders and schizophrenia may share a partial genetic basis. This is confirmed by molecular studies, which have shown overlapping risk regions (loci) and common gene variants that promote the development of both disorders. (Cross-Disorder Group of the Psychiatric Genomics Consortium, 2013; Lichtenstein et al., 2009). These results emphasize the importance of family psychiatric history as a differentiating and prognostic factor. Including information about family history in diagnostic algorithms may increase the accuracy of differential diagnoses.

Domain 2

The second domain, covering behavioral symptoms and psychomotor activity, proved to be one of the most sensitive and specific in differentiating BD and UD. The results of this study confirm that reduced sleep need, increased activity, and impulsivity are characteristic features of manic and hypomanic episodes typical of the course of bipolar disorder. These symptoms, in line with earlier observations, reflect disturbances in circadian rhythm regulation and dopaminergic system activity (Harvey, 2008).

The relationship between circadian rhythm stability and the recurrence of affective episodes has been confirmed in prospective studies, which have shown that sleep-wake rhythm instability shortens the time to recurrence of episodes in BD (Esaki et al., 2021). In light of the data obtained in this study, it can be assumed that early identification of circadian rhythm disorders and reduced sleep in patients with unipolar depression may be a prognostic factor for conversion to bipolar disorder.

Domain 3

Formal thought disorders, including accelerated thought and verbosity, have been found to be one of the most characteristic indicators of manic episodes

(Phillips, 2013). These symptoms reflect increased dopaminergic activity and dysregulation of prefrontal functions.

In contrast, patients with BD predominantly exhibited the opposite phenomena – slowed speech and poverty of speech. The data obtained indicate that the cognitive impairments observed in BD and UD differ in severity rather than type, confirming their dimensional nature. The results suggest that the assessment of speech quality and dynamics may support differential diagnosis, especially in clinically ambiguous cases.

Domain 4

The domain of affective symptoms revealed clear differences between the groups. In BD, elevated or irritable mood, increased emotional expression, and increased interpersonal relationships were more common. In contrast, patients with UD predominantly experienced anhedonia, decreased affect, and psychomotor retardation. These results are consistent with the concept that unipolar depression is associated with decreased limbic system reactivity and the dominance of inhibitory processes (Cuellar, 2005).

The lack of significant differences in suicidal ideation may be due to the design of the OPCRIT tool, which does not distinguish between thoughts and suicide attempts. This is a significant limitation, as numerous meta-analyses confirm a higher risk of suicide in BD (Dome, 2019; Miller, 2020). Therefore, in future studies, it is recommended to supplement the assessment with tools dedicated to measuring suicidal behavior, which will allow for a more accurate analysis of this clinical aspect.

Domains 5 and 6

The higher frequency of productive symptoms in BD confirms their differential value. Psychotic symptoms occur in more than half of patients with BD, most often in manic or mixed phases, and may be associated with a more severe course of the disease and a higher risk of relapse (Chakrabarti, 2022). In UD, this phenomenon occurs sporadically, which is confirmed by population studies indicating that psychotic depression affects less than 1% of the general population (Ohayon & Schatzberg, 2002). The presence of productive symptoms in patients with unipolar depression should therefore prompt a re-evaluation of the diagnosis, as it may suggest the development of bipolar disorder or a different pathophysiological mechanism.

The lack of significant differences in perceptual disturbances (domain 6) confirms that they are not an optimal differentiating factor. Hallucinations appear to be a common feature of severe affective episodes, suggesting that they are an indicator of symptom severity rather than a distinct type of disorder. (Jääskeläinen, 2018).

Domain 7

The analysis showed that patients with BD were more likely to abuse psychoactive substances, which is consistent with previous studies confirming the highest rate of co-occurring addictions in this group (Hall et al., 2009; Hunt et al., 2016). This relationship can be explained by impulsivity and reward system dysregulation, which are more pronounced in people with BD (Goldstein & Levin, 2010).

The high specificity and low sensitivity of this domain suggest that the absence of substance abuse may indicate UD, while its presence, although non-specific, should prompt the diagnostician to consider a diagnosis of BD. The co-occurrence of addictions also has prognostic significance, as it is associated with a poorer response to treatment and an increased risk of suicide (Sublette et al., 2009).

Domain 8

Patients with BD more often showed reduced insight into their symptoms and less reliability of the information they provided (Regeer et al., 2015). This phenomenon reflects limited awareness of the disease during manic phases, which hinders the diagnostic process and requires the inclusion of observations from the patient's environment. In addition, this group was more likely to experience occupational and social dysfunction, as confirmed by numerous studies (Burdick et al., 2022; Judd et al., 2008). These dysfunctions are particularly severe in depressive phases (Rosa et al., 2010).

Analysis of the clinical course revealed that a single episode with full remission was more common in the unipolar affective disorder group. However, it should be noted that this result may be due to the inclusion criteria, according to which patients with a single depressive episode were assigned to the UD group. Despite this limitation, this observation is consistent with previous studies that indicate a less cyclical course of unipolar depression and greater recurrence and complexity of episodes in BD (Jo et al., 2022).

Limitations

The study was retrospective and based on the analysis of data from the OPCRIT questionnaire, which limited the ability to control clinical and environmental variables and the quality of source data. Some of the information was obtained from medical records and patient accounts, which may limit its reliability. The patient’s lack of critical thinking, tendency to downplay symptoms of mania, or focus exclusively on symptoms of depression may have distorted the objective clinical picture.

The OPCRIT questionnaire is a tool for the global description of the patient’s condition and, despite good validation, may only reflect the complexity

and variability of clinical symptoms to a limited extent. Furthermore, it does not take into account the temporal relationship between symptoms and episodes of the disease, nor its progression over time. The tool also does not cover the issue of multimorbidity and comorbid disorders, such as anxiety disorders, which may affect the interpretation of the results obtained.

The study focused exclusively on clinical data, without taking into account in-depth psychological or biological assessments that could increase the accuracy of differentiating between BD and UD. In addition, the impact of pharmacotherapy or disease duration on symptom severity was not analyzed.

The analysis also combined cases of BD type I and II, which limits the ability to capture the differences between these subtypes.

Conclusions

The results of the study highlight the effectiveness of the OPCRIT tool in the diagnosis of affective disorders. The test proved useful in differentiating bipolar disorder from unipolar depression. Data analysis revealed significant epidemiological, clinical, and demographic differences between BD and UD. An earlier onset of BD was observed, which may suggest the influence of neurodevelopmental disorders on the pathophysiology of the condition, especially in patients under 25 years of age. In addition, symptoms such as increased psychomotor drive, episodes of irritability, and the co-occurrence of psychotic and affective symptoms were found to be more common in BD, as was the use of psychoactive substances. In summary, the results obtained indicate clear differences in selected aspects of both diseases. The use of the OPCRIT questionnaire, especially when considering the designated cut-off thresholds, allows these differences to be used to obtain a more precise diagnosis. This then translates into better personalization of therapy and, consequently, an improvement in patients' quality of life.

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