

Michael R. Lyles, M.D.

Diplomate of the
American Board of
Psychiatry and Neurology



Mark E. Crawford, Ph.D.

Licensed Psychologist

Bipolar Depression Michael Lyles M.D.

Bipolar disorder affects approximately 3.7% of the population, with the highest impact in the 18-24 year age range. Most of us were trained to recognize mania as the signature symptom of bipolar disorder but research has proven this to be incorrect. Over a 12 year time frame, bipolar patients were ill 47% of the time – with depression as the prominent symptom 67% of the symptomatic time (compared to 20% for mania). Even if the patient was currently manic, there is a 43% chance that the next episode will be depression over an 18 month study period. Moreover if the patient presented in the depressed phase of the illness, the odds of the next episode being depression was 71%. Depression is the initial symptomatic event in 35-60% of bipolar patients. Thus it is more accurate to view depression as the most common symptom in bipolar disorder – not mania. Thus it is not surprising that 69% of bipolar patients are initially misdiagnosed – usually as major depression- over their first five years of seeking help. This is a huge error as the treatments for depression can trigger mania and worsen the symptoms of the depressed phase of bipolar disorder aka bipolar depression. Therefore it is critical to recognize the clinical diagnostic differences between bipolar depression and primary depressive disorders. This is less difficult if a clear history of mania exists, but often this is not the case or the patient fails to report or is unaware of it. Thus the following is a list of clinical clues that should raise the index of suspicion for the possibility of some level of “bipolarity” in a patient that is presenting with significant problems with depressed mood.

1. History of severe depression in childhood or adolescence, especially if accompanied by suicidal ideation or self-mutilation (e.g. cutting)..
2. History of multiple depressive episodes of a moderate to severe intensity.
3. Postpartum onset of clinically significant depression, especially if psychotic features are present
4. Presence of atypical symptoms such as increased sleep or overeating while depressed.
5. Abrupt onset of depression – like a light switch was flipped.

11111 Houze Road | Suite 320 | Roswell, GA 30076
(O) 770.993.0051 | (F) 770.993.0052

6. Seasonal onset usually of depression in the winter and agitated states in the spring- especially with shifts such as daylight savings time.
7. History of agitated responses to antidepressants
8. History of "treatment resistant" depression – i.e. failure to respond to 2 or more antidepressants
9. Depression with dramatic premenstrual worsening of symptoms
10. Depression with binge drinking pattern of alcohol abuse
11. History of multiple suicide attempts
12. Severe and prolonged depressive episodes
13. Family history of mania or severe prolonged psychiatric illness that required multiple hospitalizations.
14. "Two speed" depressions – agitated (like electricity in the bloodstream) and then psychomotor retarded (like molasses are in the bloodstream).
15. History of agitated depression at any stage of life.
16. History of psychotic depression, especially in childhood or adolescence.
17. Depressed patient with ADHD child (27% of children of bipolar patients may have ADHD).
18. History of a positive mood response to a moodstabilizer (lithium, anticonvulsant, or atypical neuroleptic).
19. Worsening of mood symptoms with ADHD medications.
20. Family history of binge drinking alcoholics.
21. Family history of multiple suicide attempts
22. severe worsening of symptoms with sleep deprivation (e.g. jet lag)
23. Induction of mania by steroids or weight loss medications.
24. Worsening of symptoms with St. John's Wort or SAMe
25. Depression with a history of severe ADHD diagnosis that did not respond to medications for ADHD.