

Bipolar Depression: Screening, Diagnostic Delay, and Clinical Considerations

Possible Clinical Probes for Manic and Depressive Symptoms

Using this framework alongside clinical judgment may help reduce the delay in accurately identifying bipolar depression.

STEP 1

PROBE FOR MANIC SYMPTOMS¹

Sample probes for essential criteria

Elevated mood: “Has there ever been a period of abnormally elevated, expansive, or irritable mood lasting several days that felt different from your usual self?”

Increased energy: “Did you feel unusually ‘wired’ or restless, take on more than usual, or find yourself unable to sit still or slow down?”

If yes, probe for additional symptom criteria individually, such as

Sleep: “Did you need less sleep than usual and still feel rested or energized, not just tired and pushing through?”

Distractibility: “Did you have trouble staying focused on one thing, even during conversations or tasks that don’t usually pull your attention away?”

STEP 2

PROBE FOR FAMILY HISTORY²

Sample probe: “Do you have a family history of psychiatric illness, such as depression or bipolar disorder?”

STEP 3

LEVERAGE SCREENING TOOLS

The Mood Disorder Questionnaire (MDQ) and Rapid Mood Screener (RMS) are screening tools that can help supplement the standard clinical interview.^{3,4}

The MDQ is a brief screening tool that can be completed either by the patient or together with the patient and their provider, with three components³:

13 yes-or-no questions about past manic or hypomanic symptoms

1 yes-or-no question about whether the symptoms occurred during the same period

1 question assessing the extent to which the symptoms affected the patient’s life on a 4-point scale (none, minor, moderate, or serious)

A positive MDQ screen requires endorsement of at least 7 of the 13 symptom items, a yes response indicating that the symptoms occurred during the same period, and a functional impact rating of moderate or serious. Meeting all three criteria warrants further evaluation to determine whether bipolar disorder is present.^{1,3}

- The MDQ is less sensitive for detecting bipolar II (0.3) versus bipolar I (0.69), meaning that standard MDQ scoring may miss approximately 7 in 10 patients with bipolar II.⁵
- A negative screen does not rule out bipolar II and should be interpreted alongside the clinical interview.⁵

The RMS is a screening tool that helps differentiate bipolar disorder from major depressive disorder (MDD) in patients presenting with depressive symptoms. Validated for detecting bipolar I, the RMS includes six questions assessing both depressive and manic symptoms.⁴

Consequences of Diagnostic Delay in Bipolar Depression



patients experienced a **>5-year delay in receiving an accurate diagnosis** after initially seeking treatment.^{6*}

Of patients who were misdiagnosed, **the most common misdiagnosis (60% of patients) was MDD.**^{6*}

*Based on responses to a national survey of patients with bipolar disorder in 2000.

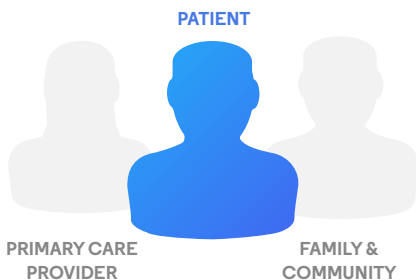
Patients with bipolar disorder typically present for care during a depressive episode. Manic episodes in bipolar I or hypomanic episodes in bipolar II, which distinguish bipolar disorder from MDD, are often underrecognized or may not be perceived by the patient as impairing. This may complicate accurate diagnosis based on self-report alone.¹

Depressive symptoms account for a large share of total time spent unwell in bipolar II (81%) and in bipolar I (70%), and diagnostic delay is a particular concern for women with bipolar II.^{7,8}

BIPOLAR II	81%
BIPOLAR I	70%

Certain clinical characteristics may increase the likelihood of a bipolar depression diagnosis rather than MDD. These can include²:

- Onset of the first depressive episode before age 25 years
- Five or more lifetime depressive episodes
- Psychotic features during a depressive episode
- A family history of bipolar disorder



Clinical Considerations for Bipolar Depression Screening

If a patient screens positive on the MDQ, the next step is a full clinical evaluation. The MDQ itself is not a diagnostic tool.³

Self-report accuracy depends on patient insight; some patients may underreport symptoms and have a negative screen despite a clinician-confirmed diagnosis of bipolar disorder, **underscoring the value of collateral information from family members, health care providers, or others close to the patient.**^{1,5}

Patient Care Impact

Diagnostic accuracy has direct treatment implications. According to guidelines, **antidepressant monotherapy is not recommended for the treatment of patients with bipolar depression due to the potential for precipitating a switch to a manic episode.** Probabilistic indicators and screening tools support—but should not replace—a comprehensive clinical evaluation before treatment decisions are made.^{1,8}

References

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