BIPOLAR DISORDERS Factsheet

September 2021

What is bipolar depression?

Bipolar disorder is characterised by recurrent episodes of depression and mania, hypomania, or mixed symptoms. A major depressive episode is a period of at least two weeks in which a person has at least five of the following symptoms (including one of the first two): intense sadness or despair; feelings of helplessness, hopelessness or worthlessness; loss of interest in activities once enjoyed; feelings of guilt, restlessness or agitation; sleeping too little or too much; slowed speech or movements; changes in appetite; loss of energy; difficulty concentrating, remembering or making decisions; and/or thoughts of death or suicide. Long-term studies have found that depressive symptoms are usually more pervasive than mood elevation or mixed symptoms. Depressive symptoms have also been consistently associated with greatest impairments in social and occupational functioning.

What is the evidence for bipolar depression?

High quality evidence shows an earlier age of illness onset of bipolar disorder is associated with increased severity of depression. Moderate to high quality evidence shows depression episodes are around three times more common than mania, elevated, or mixed episodes over the course of bipolar disorder. Factors associated with depression predominance are; type II bipolar disorder, melancholia symptoms, a depressive onset of illness, suicide attempts, mixed episodes, and delayed diagnosis of bipolar disorder.

Moderate quality evidence suggests the factors associated with bipolar depression rather than unipolar depression in children or youth include; more psychiatric comorbidities and behavioural problems (oppositional disorder, conduct disorder, anxiety disorders, irritability, suicidal/self-harm, social impairment, and substance use); earlier onset of mood symptoms; more severe depression; and having a family history of psychiatric illness.

Moderate to low quality evidence suggests the *cumulative rate* of conversion from unipolar depression to bipolar disorder increases from 3.78% at 1 year assessment to 12.87% at 10 year assessment. However, the *yearly rate* of conversion from unipolar depression to bipolar disorder decreases from 3.83% at 1 year assessment to 0.78% at 10 year assessment.

Moderate quality evidence finds no differences in levels of anhedonia (reduced capacity for pleasure) between people with bipolar disorder and people without a mental illness. Levels of anhedonia were higher only in people with schizophrenia, major depression (not remitted), substance use, and Parkinson's disease when compared to people without a mental illness.

For more information see the technical table

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NeuRA (Neuroscience Research Australia) is one of the largest independent medical and clinical research institutes in Australia and an international leader in neurological research.

Diseases of the brain and nervous system pose the greatest health, economic and social burden of any disease group because they are chronic, debilitating and have no known cures.

Medical research is the cornerstone of efforts to advance the health and wellbeing of families and the community. Our dedicated scientists are focussed on transforming their research into significant and practical enefits for all patients.

While we hope you find this information useful, it is always important to discuss any questions about bipolar disorder or its treatment with your doctor or other health care provider.

HOW YOUR SUPPORT HELPS

We are able to make significant advances due to the generosity of countless people. Your donation allows us to continue to work towards transforming lives. For information on how you can support our research, phone **1300 888 019** or make a secure donation at **neura.edu.au**.

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