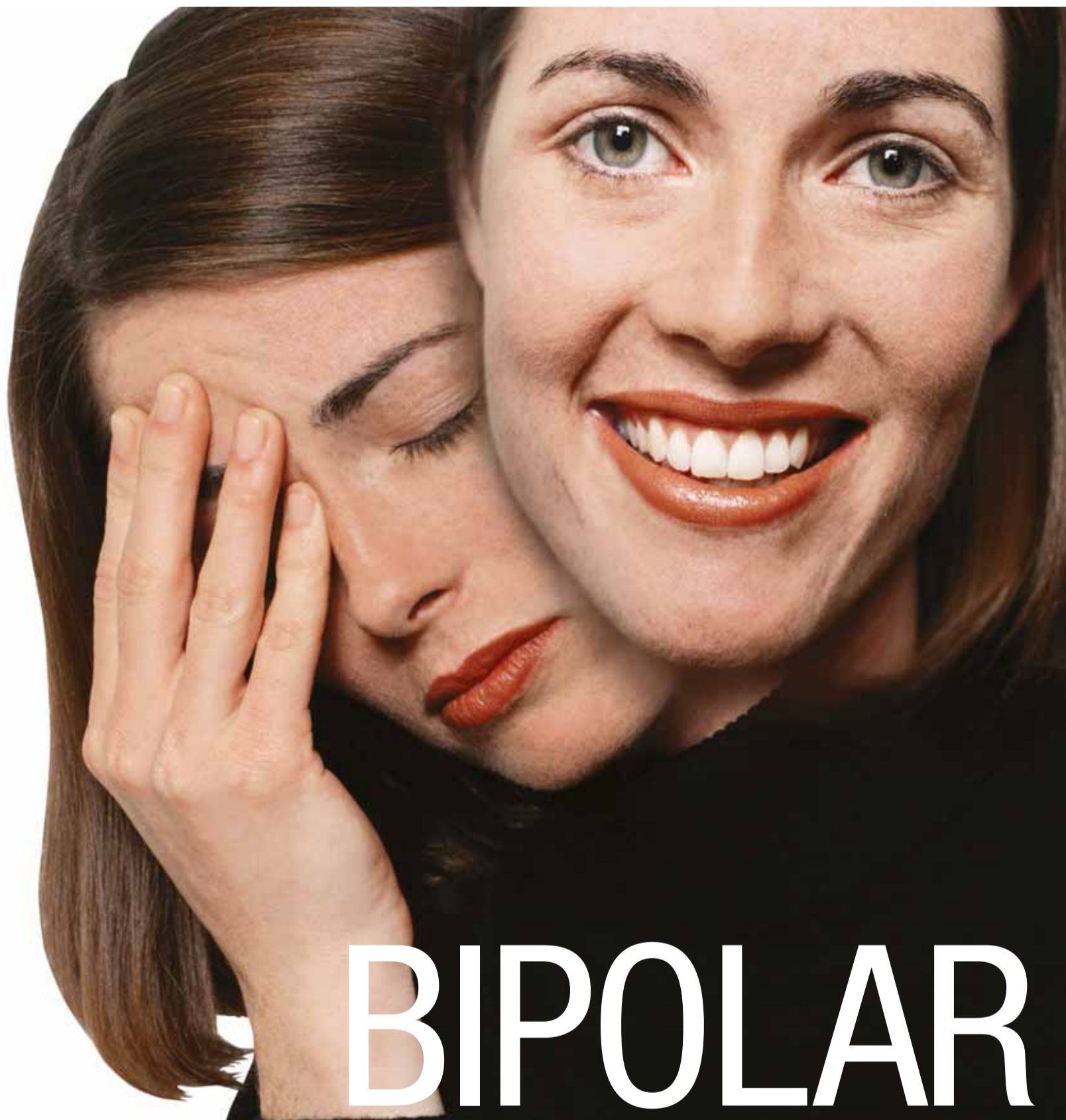


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BIPOLAR disorder

Defining bipolar disorder

A new name for an old illness

DESCRIPTIONS of mood changes suggestive of depression and mania can be traced to ancient Persian and Greek writings. In the second century AD, Arateus described individuals who at times danced throughout the night, were excessively talkative and overly confident, yet at other times very sad and sorrowful for no

obvious reason.

In the 19th century, Jules Baillarger (1809-1890) and Jean-Pierre Falret (1794-1870) independently suggested that a single illness could perhaps present with both manic and depressive symptoms. Falret described this as 'circular insanity'.

Following on from this work, Emil Kraepelin meticulously detailed the

occurrence of both mania and depression as part of one illness and named this manic-depressive insanity. Hence, until recently the term manic-depression has been widely used to describe what is now called bipolar disorder.

The first and greatest difficulty any clinician faces with any illness is that of detection and diagnosis. There-

fore, a significant proportion of this article focuses on describing the signs and symptoms of bipolar disorder in relation to its clinical phases and diagnostic subtypes.

Having reliably diagnosed bipolar disorder, certain issues arise in terms of management, and the remainder of this article discusses the

cont'd page 27

inside

Mania and hypomania

Bipolar depression

Pharmacological treatment

Psychological treatment

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from page 25

approaches currently available, in particular, some of the recommended treatment strategies.

It is important to state that several aspects of the treatment of bipolar disorder are contentious, and further research is awaited. Therefore in this article we have attempted to adhere to common and widely accepted practices.

Bipolar disorder — an episodic illness?

Bipolar disorder is a complex illness and is divided into subtypes such as bipolar I and II (figure 1). It is considered to be an episodic illness with highs and lows that are described as mania (or hypomania) and depression respectively, and these are defined below.

However, it is worthwhile noting that not all individuals with bipolar disorder experience discrete episodes of illness and that individual bipolar episodes can comprise admixtures of both depressive and manic symptoms.

These mixed episodes, in which symptoms from both poles of illness manifest, overlap with rapid-cycling bipolar disorder, in which episodes of depression and mania alternate in quick succession.

Clinically, such complex presentations are important, as they are relatively common and difficult to treat. However, management of mixed presentations and rapid-cycling bipolar disorder usually necessitates involvement of a specialist, so in this article these are not dealt with in detail.

What are mania and hypomania?

Mania is defined on the basis of symptoms and signs that are out of character for the individual and usually occur in discrete episodes (table 1). In the *DSM-IV* the diagnosis of mania requires the persistence of euphoric mood for a period of at least seven days, during which a minimum of three additional symptoms (four if mood is mainly that of irritability) are present.

Technically, the predominant mood is either that of excessive happiness, described as euphoria, or, alternatively, feelings of irritability. In practice, individuals will often describe feeling “pumped up” and “energised” or “wired”, with a notable increase in drive and goal-directed activity that often results in increased pleasure-seeking behaviour.

Other features include a decreased need for sleep, racing thoughts and distractibility. Not surprisingly, many of these symptoms, and risk-taking behaviour in

Figure 1: Diagnostic criteria and clinical patterns of bipolar disorder.

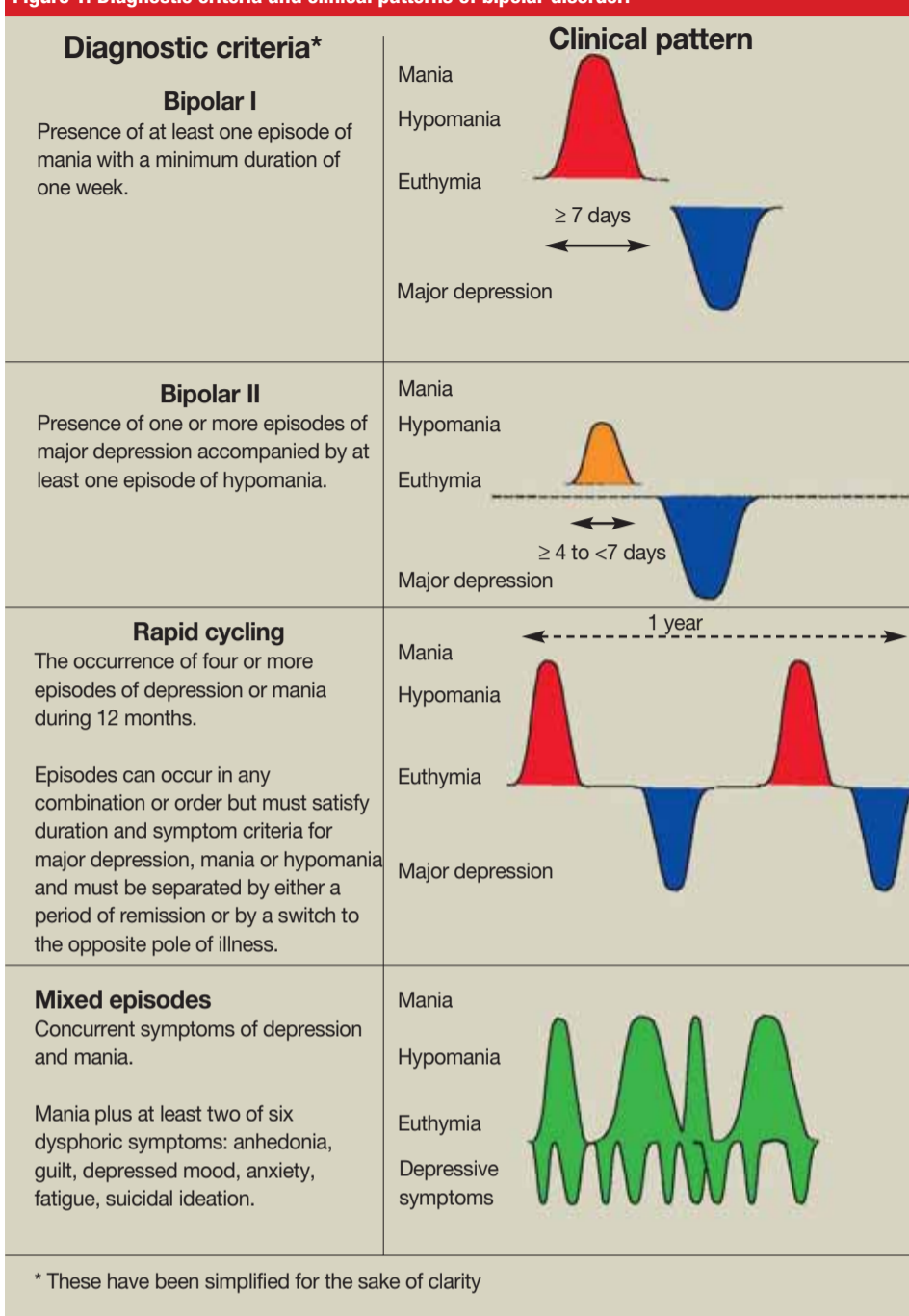


Table 1: A comparison of common signs and symptoms of mania and bipolar depression

Mania	SIGN/SYMPTOM	Bipolar depression
<ul style="list-style-type: none"> Unusual, garish or strange dress style 	APPEARANCE	<ul style="list-style-type: none"> Less attention is paid to personal hygiene and in physical appearance or grooming
<ul style="list-style-type: none"> Loud, pressured speech Difficult to interrupt Shifting from topic to topic Diminished need for sleep 	SPEECH	<ul style="list-style-type: none"> Slowed speech Monotonous
<ul style="list-style-type: none"> Undertake tasks for prolonged periods of time Tendency to engage in impulsive and risk-taking behaviours (use of illicit substances, gambling) 	GENERAL ACTIVITY	<ul style="list-style-type: none"> Either insomnia and early morning waking, or hypersomnia with daytime napping Diminished interest in pleasurable activities Difficulty with initiating actions
<ul style="list-style-type: none"> Increased, often with noticeable restlessness Increased levels of energy Engage in activities for extended periods of time seemingly without tiring or experiencing fatigue 	PSYCHOMOTOR ACTIVITY ENERGY	<ul style="list-style-type: none"> Usually diminished but can be heightened, resulting in agitation Diminished energy Tire easily Feel lethargic and listless
<ul style="list-style-type: none"> Sustained elation (euphoria) Heightened cheerfulness and optimism Increased irritability 	MOOD	<ul style="list-style-type: none"> Feelings of sadness or flatness Thoughts of hopelessness and pessimism Suicidal ideation
<ul style="list-style-type: none"> Inflated self-confidence Grandiose ideation 	SELF-PERCEPTION	<ul style="list-style-type: none"> Diminished self-esteem Feelings of guilt, self-blame or worthlessness
<ul style="list-style-type: none"> Diminished capacity to make sound decisions — judgment is more likely to be compromised Thoughts are often incomplete and described as ‘racing’ Difficulty with reasoning and planning Distractible, with a heightened focus on irrelevant details 	COGNITION	<ul style="list-style-type: none"> Difficulty in decision-making Diminished concentration and memory

Table 2: Symptoms and signs of mania (FIDGETS)

Symptom/sign	Description by individual
Flight of ideas	Experiences racing thoughts
Insomnia	Reduced need for sleep. Despite sleeping less, energy levels are sustained
Distractibility	Unable to maintain concentration
Grandiosity	Sense of inflated self-esteem
Energetic and increased activities	Increased goal-directed activities in social and professional context
Talkativeness	Increased talkativeness resulting in pressured speech
Socially inappropriate behaviour (thoughtlessness and risk taking)	Desire to engage in pleasurable activities that may have painful consequences such as over-spending and inappropriate sexual behaviour

Table 3: Characteristics of bipolar depression versus major (unipolar) depression

Features more likely in bipolar compared with unipolar depression	
Phenomenology	<ul style="list-style-type: none"> Irritability Psychosis Atypical symptoms Psychomotor retardation/agitation Melancholia Flat mood
Course of illness	<ul style="list-style-type: none"> Early age of onset (teens) Recurrence/rapid cycling Brief episodes of depression Abrupt onset of episodes Seasonal and postpartum patterns
Response to antidepressants	<ul style="list-style-type: none"> Treatment-induced mania Development of rapid cycling Development of mixed state Non-response/tolerance

particular, can result in significant social or occupational impairment, with potentially painful consequences such as risk to health, livelihood or reputation.

The symptoms and signs of mania can be conveniently remembered using the mnemonic FIDGETS (table 2).

Hypomania is defined along the same lines as mania with regard to signs and symptoms, but the term is usually used to describe briefer periods of mood disturbance that generally incur less functional impairment than in mania. The *DSM-IV* employs a somewhat arbitrary cut-off of four days’ duration to define hypomania, but in practice this is often difficult to apply.

In practice the diagnosis of hypomania is less reliable than that of mania or depression and it is seldom spontaneously reported because it is usually mild and transient and construed as a pleasant experience. People with bipolar disorder often consider periods of hypomania to be ‘normal’ and understandably regard them as desirable, and rarely present clinically with such symptoms.

However, it is important to remember that hypomanic symptoms are, more often than not, functionally disabling and that it is critical

to screen for manic or hypomanic symptoms even in patients presenting with depression. This is important because identifying previous hypomania distinguishes a subsequent depressive episode as bipolar rather than unipolar.

It is therefore critical to inquire as to the presence of past hypomania in every patient presenting with depression, otherwise the possibility of a bipolar diathesis is easily missed.

What is bipolar depression?

Although mania is the hallmark of bipolar disorder, it is the depressive phase of bipolar illness that is the predominant component of this illness both in terms of time spent unwell and the associated functional disability. This bias in morbidity towards depression is even more pronounced in bipolar II disorder compared with bipolar I disorder.

Like unipolar depression, bipolar depression is associated with an increased risk of suicide. However, bipolar depression differs from its unipolar counterpart in several ways. An abrupt, earlier age of onset is more likely in bipolar depression, compared with a more gradual onset and offset in unipolar depression.

A family history of bipolar *cont’d next page*

from previous page

disorder and a highly recurrent pattern of depression are also suggestive of a bipolar depressive episode as opposed to major depression. In terms of symptom profile, increased sleep and appetite, psychomotor retardation, mood lability and psychosis are thought to be more common in bipolar depression (table 3, page 27).

How do you diagnose bipolar disorder?

The diagnosis of bipolar disorder is complex, and an incorrect or delayed diagnosis is not uncommon. In Australia there is an average delay of 12.5 years from symptom onset to diagnosis.

In the natural evolution of bipolar disorder, depressive episodes usually precede any episodes of mania or hypomania by several years, so usually the most common initial diagnosis is that of major depression. This then undergoes subsequent revision when symptoms of the opposite pole eventually emerge.

The symptoms and signs of bipolar disorder can vary considerably and incorporate those not usually regarded as typical of depression or mania. Changes in energy level, engaging in substance misuse and manifesting impulsive behaviour are not uncommon, and often these are mistakenly attributed to other disorders (table 4).

The diagnosis of bipolar disorder

Table 4: Differential diagnosis of bipolar disorder

Disorder	Common features
Unipolar depression	No history of mania or hypomania; psychotic features are comparatively rare; psychosocial precipitants common
Anxiety disorders*	Usually longstanding but may be situation-specific; associated with specific phobias (eg, social phobia, agoraphobia); may experience panic attacks
Substance abuse*	History of substance abuse; often comorbid with bipolar disorder, unipolar depression, anxiety disorders and psychosis; may be primary, or secondary to comorbidity
Schizophrenia and related disorders	Negative symptoms, cognitive dysfunction and psychotic symptoms often prominent; marked psychosocial decline is common; often chronic rather than episodic, with marked loss of insight
Borderline personality disorder	Chronic affective instability; dysphoria, emptiness and feelings of abandonment rather than depression; cutting and other forms of self-harm; history of childhood sexual or physical abuse
ADHD or conduct disorder (adolescents)	ADHD: early onset; inability to focus attention; affects a number of social domains (school, home, etc). Conduct disorder: early onset; lack of remorse; non-conformity to social norms
Organic brain syndromes (older patients)	Acute onset; suspicion of underlying 'organic' cause; may have subtle confusion

*Commonly occurs as a comorbid condition in bipolar disorder

der is further complicated when periods of illness lack distinction, and affected individuals fail to recognise or acknowledge their symptoms as unusual or undesirable.

While depression and mania are usually listed as separate entities, in practice it is common for people with depression to have some manic symptoms at the same time, such as racing thoughts, or agitation, and to have depressive symptoms such as suicidal thoughts and dysphoric mood when manic. These mixed states

are important to recognise.

For the purposes of classification bipolar disorder is divided into bipolar I, bipolar II, cyclothymia and a residual 'category' called bipolar disorder not otherwise specified, which includes individuals who have clear bipolar features but do not meet threshold criteria for diagnosis. This last group is sometimes described as being part of the bipolar spectrum. In this article we consider a simpler view with bipolar disorder divided into two subtypes — bipolar I and bipolar II (figure 1, page 27).

How common is bipolar disorder?

The lifetime prevalence of bipolar disorder is between 1% and 4% and in any one year about one in 200 Australians can expect to experience an episode of either bipolar depression or mania.

More important than the exact percentage of the population that has bipolar disorder is the possibility that almost half remain undetected and undiagnosed and almost one-third are incorrectly diagnosed as having unipolar major depression. Consequently there is often a considerable delay in diagnosis, sometimes up to a decade or more.

Women and men are equally likely to develop bipolar I disorder, in contrast with major depression, when women are twice as likely as men to become depressed. However, as women are more likely to report symptoms of depression than men, they have a greater likelihood of being diagnosed with bipolar II disorder.

Recent studies suggest that symptoms and signs in keeping with bipolar disorder are common in adolescence and that the onset of bipolar disorder (at about age 17), like that of depression, appears to be getting younger. The early onset of bipolar disorder is generally associated with a poorer outcome, including a greater likelihood of developing rapid cycling or mixed states.

How to treat bipolar disorder

Approaches to treatment

THE management of bipolar disorder is best considered in stages (figure 2). The first stage (acute phase) is the effective treatment of acute episodes of depression and mania, in which the objective is symptom remission.

Having achieved remission the next objective (maintenance phase) is to prevent any relapse and achieve full recovery. The latter involves resuming function, both with respect to social interactions and occupational role. An additional ongoing objective throughout treatment is that of ensuring safety and, specifically, reducing the risk of suicide.

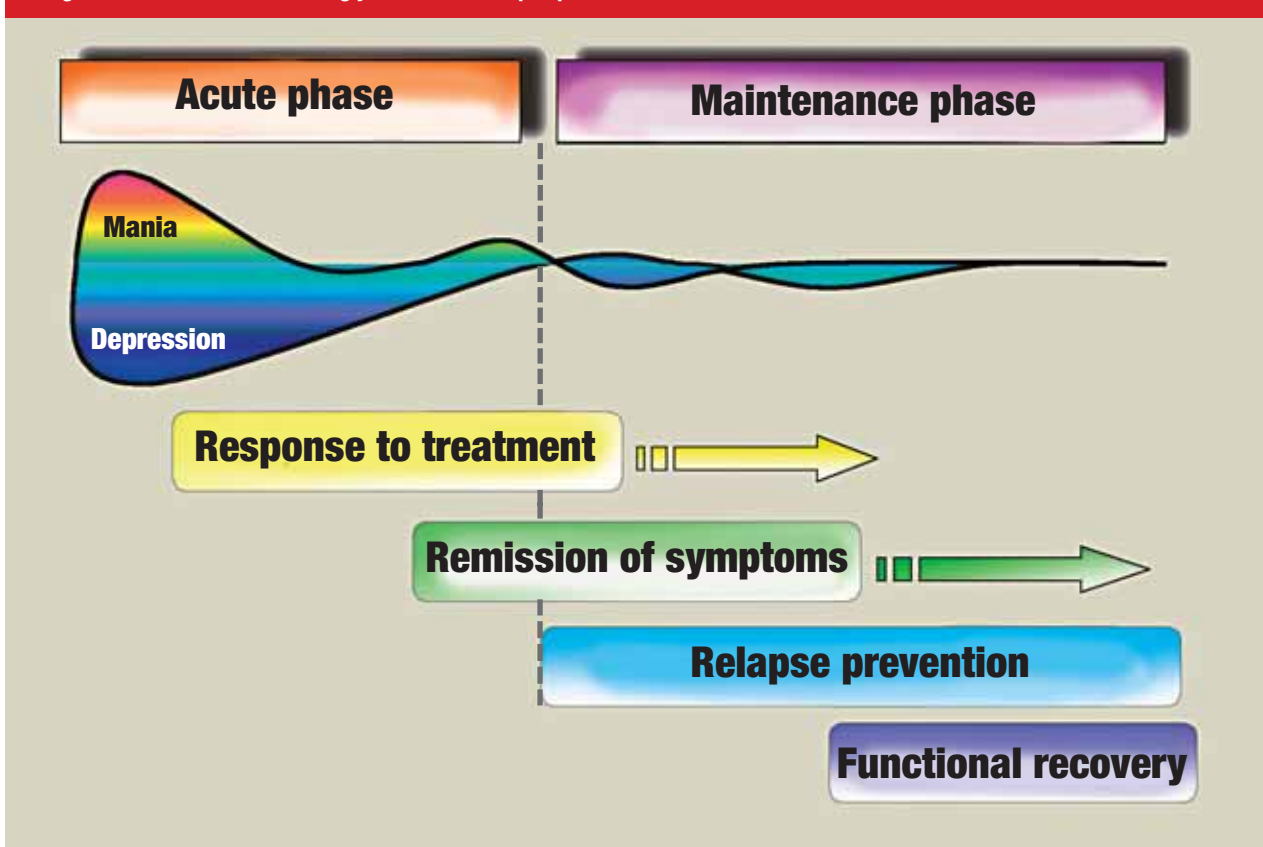
After the acute symptoms of depression or mania resolve, long-term treatment is necessary to prevent relapse either into depression or mania. This is a lifelong risk in patients with bipolar disorder.

Given the somewhat limited use of medications in this regard, psychotherapeutic interventions are important, both as adjuncts and as treatments in their own right. Indeed, there is emerging evidence that suggests combining pharmacological and psychological approaches provides the optimal remedy.

Adherence to treatment

In practice, selecting the appropriate treatments poses

Figure 2: Phases of treatment and stages of recovery. Management of bipolar disorder can be broken down broadly into acute-phase and maintenance-phase treatment. Recovery involves a number of overlapping stages, namely, response, remission and recovery, during which attention is increasingly focused on relapse prevention.



a significant challenge. When choosing suitable medications, efficacy and side-effect profile are important considerations. These vary from one individual to another, and tailoring treatment to the specific needs of a patient naturally enhances adherence and increases engagement.

In treating bipolar disorder this is a key issue, as the

rate of treatment non-adherence is high, with perhaps half of patients not taking medication as prescribed. Non-adherence in bipolar disorder principally occurs because of people's desire to control the illness themselves, and mistaken and negative beliefs about the illness and medications.

Tolerability is a further key consideration when planning

long-term maintenance treatment. The efficacy of pharmacological treatment is the main reason people adhere to treatment. It is in this context that psychosocial interventions and psychological treatments have been shown to enhance insight regarding the illness, which leads to an increase in medication adherence and the achievement of better outcomes.

Pharmacological treatment

Pharmacotherapy is a key ingredient in the management of bipolar disorder, and medications feature strongly both in the acute and long-term treatment of manic, mixed and depressed episodes.

In recent years a variety of clinical practice guidelines for bipolar disorder has been developed worldwide, including local Australian and New Zealand guidelines. However, because of ongoing advances and the emergence of new interventions, these guidelines are in a state of flux and are regularly revised and updated.

Interestingly, not all guidelines are in complete agreement as to the treatment of manic or mixed episodes and bipolar depression. In particular, the treatment of bipolar depression is more contentious than that of mania, and maintenance treatment is more difficult to prescribe than acute treatment.

In practice, some general principles need to be borne in mind in managing bipolar disorder; these are summarised in table 5 (page 29).

In the acute phases of bipolar disorder the focus of treatment is to achieve symptomatic remission and diminish any risk of self-harm.

When mood stability has

been achieved, the objective of maintenance treatment is to prevent relapse and sustain improvement so that, ultimately, normal psychosocial functioning is regained. The temptation to stop medication during the maintenance phase of treatment is high. However, both patients and clinicians need to be aware that if treatment stops the risk of relapse is extremely high, especially in the case of stopping lithium abruptly, and that this also increases the risk of self-harm.

To minimise the likelihood of stopping medication it is important to enhance adherence and increase tolerability. To this end monotherapy is the ideal, but in practice, combinations are often necessary, with up to 75% of patients with bipolar disorder taking more than one medication long term. The medications routinely used in the treatment of bipolar disorder are described in table 6.

Treatment of acute episodes

Mania

After an initial clinical assessment in which it is important to determine the symptom profile and gauge the severity of acute mania, management priorities are twofold. First, it is necessary to ensure the individual is safe and provide a calm and manageable environment.

Secondly, it is important to discontinue any medications promptly that promote mania, such as antidepressants, and initiate treatment with antimanic agents that also address any associated behavioural disturbance. At this point hospitalisation or referral to a specialist for the purposes of monitoring mental state and treatment should be considered.

In most cases mania can be treated with either mood stabilisers or atypical antipsychotics, as all have roughly equivalent efficacy. In an acute treatment setting, the need for rapidly achieving therapeutic serum levels favours sodium valproate, which along with the atypical antipsychotics is well tolerated at high doses.

In instances of psychosis and severe behavioural disturbance antipsychotic medications are almost always necessary and should be initiated promptly. About half of all people with mania will respond to monotherapy with any antimanic agent, and three-quarters to a combination of an atypical antipsychotic and either lithium or sodium valproate.

In less severe episodes of mania, or when there is no immediate risk to the individual, monotherapy is preferable, while in instances of more severe mania, cases

In the acute phases of bipolar disorder the focus of treatment is to achieve symptomatic remission and diminish any risk of self-harm.



Table 5: Some general principles for assessing and managing bipolar disorder

Consider a diagnosis of bipolar disorder

- Take a full and comprehensive history of mood symptoms; note also changes in behaviour and thinking
- Assess family history of mood disorders and attempt to obtain corroborative history from a family member, partner or friend of any mood episodes
- Seek a specialist opinion if possible before starting long-term treatment

Screen for possible differential diagnoses and comorbid illness

- Exclude the possibility of biological causes; examine and assess for medical illnesses such as hypo- and hyperthyroidism, head injury and steroid use
- Consider psychological comorbidity such as anxiety disorders and dual diagnosis, in particular, alcohol and drug misuse

Table 6: Therapeutic dosages of medications used in bipolar disorder

Generic name	Therapeutic dose range
Lithium	Acute mania: 400-1200mg/day Maintenance: reduce dose to maintain blood level within therapeutic range (0.6-0.8mmol/L)
Sodium valproate	Acute mania: can consider rapid titration Maintenance: usually 1000-2000mg/day, divided doses, titrated gradually
Lamotrigine*	Acute bipolar depression: 100-400mg/day titrated upwards slowly
Carbamazepine	Acute mania: 400-1200mg/day, titrated gradually Maintenance: 200-400mg/day
Olanzapine	Acute mania: 5-20mg/day Maintenance: continue at dose used for acute episode
Risperidone	Acute mania: usual dose 2-6mg/day
Quetiapine	Acute mania: usual dose 200-800mg/day Titrated to average of 600mg/day
Ziprasidone	Acute mania: 80-160mg/day
SSRIs/tricyclics	Acute bipolar depression: equivalent doses to those used in treating major depression

*Not included in the PBS

requiring hospitalisation or when the individual poses a risk to themselves or others, combination therapy is usually required.

In addition to antipsychotics and mood stabilisers, many patients hospitalised with mania may require benzodiazepines to assist with acute anxiety and agitation and to achieve quick sedation. These are usually tapered within a matter of days as the symptoms of mania subside, and ideally should be withdrawn after acute symptoms remit.

After initial titration of medications to therapeutic efficacy, the focus of management should shift to maintaining continuing clinical response. Therefore regular clinical monitoring is needed to allow refinement of ongoing treatment.

Bipolar depression

The treatment of bipolar depression is a more complex issue. Unlike in major depression the use of antidepressants in bipolar disorder is somewhat controversial, and there remains a lack of consensus regarding their place in therapy.

Apart from issues regarding their effectiveness, antidepressants have the potential to increase cycling and shorten inter-episode periods and provoke a switch into mania. All the antidepressants have this propensity to some degree, with tricyclics conferring the greatest risk.

Regarding efficacy, antidepressants may reduce symptoms in the short term, although the data are equivocal. However, there is little evidence to suggest significant benefit from continuing

long-term treatment, and the issue of discontinuing antidepressant treatment remains unresolved.

Therefore, if antidepressants are necessary they should not be prescribed in the absence of a concomitant mood stabiliser, and even in these circumstances their use should probably be limited to short-term treatment. In this regard SSRIs are preferable to tricyclics, as they are less likely to induce a switch to the opposite pole and are substantially safer in overdose.

There is substantive support for the use of monotherapy with a mood stabiliser such as lithium, sodium valproate or lamotrigine as first-line treatment of bipolar depression, and this course of action is advocated by several treatment guidelines. However, others suggest initiating treatment with a combination of a mood stabiliser and an antidepressant.

Recent research suggests that antidepressants are perhaps not as effective as initially thought, and several treatment guidelines suggest the addition of a second mood stabiliser as a second-line strategy.

What exactly constitutes a 'mood stabiliser' is also a matter of some debate. For example, atypical antipsychotics, in particular, quetiapine and olanzapine, have a growing evidence base that supports their use across the phases of bipolar disorder, including maintenance, whereas agents such as lamotrigine appear to have a more selective effect, in this case in bipolar depression.

If lumped together as 'mood stabilisers' the important differences in therapeutic profiles of the various agents could potentially be lost. In general, the term mood stabiliser has been reserved for lithium, sodium valproate, lamotrigine and carbamazepine.

Maintenance

After successfully managing an acute episode of bipolar illness it is usually necessary to consider maintenance treatment because in most patients the illness is recurrent. Maintenance treatment can also be useful if the acute illness is marked by high suicidality and severe psychotic symptoms. This phase of bipolar disorder more than any other benefits from adjunctive psychological and social interventions.

Key to the successful long-term management of bipolar disorder is the use of a pharmacological agent with prophylactic action. While it is clearly critical that remission be achieved quickly and safely, taking a longitudinal perspective it is perhaps more important to maintain recov-

ery and prevent relapse in this highly recurrent illness.

Lithium and sodium valproate are the principal mood stabilisers used in maintenance therapy, although lamotrigine along with olanzapine and quetiapine are also accepted as having reasonable efficacy (table 7, page 31).

Overall, most agents used in the maintenance phase of bipolar disorder have greater efficacy in preventing relapse into mania, with the exception of lamotrigine, which has greater potency in the prevention of relapse into depression.

In addition to lithium and the anticonvulsants, atypical antipsychotics are also accumulating an evidence base as useful maintenance treatments in bipolar disorder, with data now available for olanzapine and quetiapine (table 7, page 31). Quetiapine seems to have similar efficacy in preventing both poles of the disorder.

In practice, while some patients settle on monotherapy, a significant proportion will need combinations of accepted mood stabilisers for an adequate response. It is important to note that for many individuals the response to treatment is only partial, with either reduced frequency or amplitude of cycles, and that patients with bipolar disorder can often take months to settle on preventive pharmacotherapy.

Therefore in practice an 'adequate trial' of maintenance treatment may require up to a year before effectiveness or lack of efficacy can be determined.

After an acute episode of bipolar depression or mania it is important to gradually withdraw treatments that are perhaps no longer needed, such as benzodiazepines, antidepressants and antipsychotics.

With each of these it is important to balance the potential side effects of long-term therapy against the possible ongoing need for treatment and relapse prevention. Clear guidelines regarding such decisions in this stage of treatment are not available, so specialist management is perhaps best in this situation.

During the maintenance phase of bipolar disorder the most common reason for relapse is treatment non-adherence. It is therefore essential to promote strategies that enhance treatment compliance. This requires regularly assessing patient satisfaction and ideally should involve ongoing psycho-education with a particular focus on raising awareness of early warning signs. It is often helpful to involve family members in this process, and together a relapse-prevention plan can

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be developed and put in place.

Psychological interventions

Bipolar disorder has a substantial impact on relationships, occupational functioning and quality of life. Adherence to treatment and issues of chronic illness management are key issues in clinical practice. As a result, psychosocial treatments are important in this disorder, and include:

- Psycho-education.
- Cognitive therapy.
- Family-focused therapy.
- Interpersonal and social rhythm therapy.
- Programs of chronic illness management (table 8).

Adjunctive psychotherapy has been shown to reduce relapse rates into depression and mania, and to improve adherence to treatment. Most of the benefits have been observed during maintenance treatment and, although there are theoretical and practical differences between the various psychological approaches, they also have many commonalities. In essence, they all:

- Include bipolar disorder psycho-education.
- Promote individual adherence.
- Employ mood-monitoring and relapse-prevention strategies.

While recent Medicare initiatives have increased the availability of psychological therapies, the availability of these services in many parts of Australia is still limited.

The role of the GP and psychiatrist

GPs are essential in the diagnosis and management of mood disorders. The sheer prevalence of these problems means that the vast majority of patients will be managed in primary care. Also, it is usually only GPs who have the necessary long-term knowledge of patients that allows them to identify subtle changes in mood and behaviour over time.

A key issue in making a diagnosis of bipolar disorder is for patients who present with depression to be asked about any previous symptoms of mania or hypomania. Screening tools such as the Mood Disorder Questionnaire¹ are of value in this regard, but are no substitute for a careful history.

In managing bipolar disorder GPs can choose to be involved at various points in the course of the illness, and on each occasion to a varying extent. From the perspective of managing medication the main responsibilities include ensuring adherence to treatment, assessing efficacy and monitoring for potential side effects.

A stable long-term relationship that offers continuity of care is a key determi-

	Acute mania	Acute depression	Maintenance and prophylaxis
Lithium	✓	+	✓*
Anticonvulsants			
Sodium valproate	✓	+	✓
Carbamazepine	+	-	+
Lamotrigine	x	✓	✓*
Atypical antipsychotics			
Olanzapine	✓	+	✓
Quetiapine	✓	✓	✓
Ziprasidone	✓	-	-
Risperidone	✓	-	-
Antidepressants			
SSRIs	▲	-	-
Tricyclics	▲	-	-

✓ = proven efficacy
 + = likely efficacy
 x = ineffective
 - = inconclusive/insufficient evidence
 ▲ = contraindicated

*In terms of relapse prevention lithium is more effective in preventing mania than depression whereas lamotrigine is more effective in preventing bipolar depression than mania

Psychological intervention	Description
Cognitive behaviour therapy	Assumes that bipolar patients have disturbed cognitions and assumptions that precipitate negative mood states
Interpersonal and social rhythm therapy	Focus on the interpersonal context of depression and manic episodes Therapist identifies a recent problem to focus on, along with examining the regulation and stabilisation of sleep/wake rhythms Social routine and levels of arousal and stimulation are also identified Therapist then assists in developing routines and minimising events that disrupt mood The interpersonal focus is on resolving current problems and instituting strategies that prevent the development of similar problems in the future
Family-focused therapy	This is a manual-based intervention for the patient and their family that involves more than 20 sessions; it is applied after an acute episode. It involves four components: <ul style="list-style-type: none"> ■ An assessment phase ■ A psycho-education phase ■ A phase in which the focus is to enhance communication skills ■ A phase that deals with skills of problem solving



nant of outcome. GPs may choose to initiate treatment to manage an acute episode of illness, but in complex cases this should be done in consultation with a psychiatrist colleague.

Ideally, a diagnostic review should be sought from a psychiatrist before starting treatment, and in most cases a tailored management plan will be instituted. Further, referral to a

psychiatrist for 'flare-ups' and instances of high risk is perfectly appropriate and is best instituted early in the development of symptoms.

Long-term management

It is important to remember that bipolar disorder is a life-long illness with many recurrences of both depression and mania. Episodes of illness and hospital admissions punctuate patient's lives and

cumulatively confer significant functional impairment. GPs are therefore inevitably involved in gauging the broader impact of the illness on the individual, their family and their work.

Patients with highly unstable or unresponsive bipolar disorder can impose an enormous burden on a GP and in managing these cases it is important to have a close working relationship with

other professionals such as a psychiatrist and, ideally, also a psychologist. This assists in ensuring closer monitoring of the individual and also provides a basis for sharing the provision of care.

Bipolar disorder also impacts enormously on families and carers. Apart from education and involvement in the long-term management of an affected individual, families of patients with bipolar disorder need ongoing support.

They are also invaluable in actively contributing to care by reinforcing positive messages, encouraging treatment adherence and alerting both the patient and health professionals when the individual begins to relapse. In this regard psychological interventions can encompass the individual and their family. It is of note that psychological therapies are beneficial both in terms of their specific therapeutic effect and also because they involve psycho-education.

A focus on psychological aspects also allows the individual to embrace broader self-initiated therapies such as exercise, meditation and lifestyle interventions. Exercise is shown to reduce symptoms, particularly of depression. Smoking is associated with worse outcome, and attempts at smoking cessation should be routinely offered. Substance abuse similarly needs active and independent intervention. These additional 'supports and resources' should be sought as soon as the patient is capable of engaging in suitable programs.

Referral for structured psychological input is particularly apt when the individual or their family is having difficulty coming to terms with the diagnosis of bipolar disorder, and is also helpful if medication adherence is compromised. Psychological treatments are often necessary in addressing childhood issues and stressors, especially those involving loss or trauma.

In reality, patients with bipolar disorder are individuals with complicated psychosocial problems. They often have significant comorbid anxiety and difficulties with substance misuse. Consequently bipolar disorder is not straightforward to manage, and often requires the multidisciplinary skills of primary care physicians, allied health practitioners and specialists in a collaborative team.

Conclusion

In this article only the basics of bipolar disorder and the broad general principles of management have been addressed. The key message is to be aware of the possibility of bipolar illness when assessing patients with mood symptoms.

Reference

1. Hirschfeld RMA, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *American Journal of Psychiatry* 2000; 157:1873-75.

Further reading

- Available on request from
julian.mcallan@reedbusiness.com.au

Online resources

- Clinical Assessment and Diagnostic Evaluation (CADE): Clinic www.cadeclinic.com
- beyondblue — www.beyondblue.org.au/index.aspx
- depressionet: www.depressionet.com.au
- mental health association nsw inc: www.mentalhealth.asn.au
- BluePages: <http://bluepages.anu.edu.au>

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The authors would like to thank Vicki Campbell and Danielle Adams for their assistance and advice in preparing this manuscript.

GP's contribution



DR LINDA MANN
Inner west, Sydney

Case study

J was 30 when I first met her. She was under the care of a private psychiatrist for depression. She was a professional person who presented as a slim, somewhat brittle individual. Her marriage was coloured by her husband's excess alcohol use.

Immediately after the delivery of her first child, she became quite psychotic and was found wandering in another part of the city. She was admitted to the local

public mental health institution. She was discharged on antipsychotics and returned to the community.

The work situation deteriorated as her depression became more agitated, and she became unable to continue her professional work. I considered she needed to be in hospital and she was admitted and a diagnosis of bipolar disorder confirmed.

J has subsequently been able to return to her professional work, with decreased workplace responsibility. Many trials of different mood stabilisers have finally produced a good outcome for her. Her husband's alcohol use has decreased.

Questions for the authors

J's husband's excessive use of alcohol seemed to be another issue for her. I noted that his alcohol use settled



as her health improved, although he still misuses alcohol. What is your experience of carers' use of drugs and alcohol, and how does this change the treatment of the patient?

From a research perspective the association between a carer's substance misuse and bipolar disorder is not well established, but it is

often documented clinically. The impact of carers' substance misuse ranges from direct consequences such as financial hardship through to secondary considerations such as the degree of responsibility a carer can assume.

A supportive carer is a powerful therapeutic resource and can assist in the management of bipolar disorder on a variety of levels. For example, in diagnosing bipolar disorder and subsequent mood monitoring, the testimony of a carer is invaluable, and the non-judgmental support of an involved carer seems to be associated with improved outcomes. Not having this 'resource' can clearly complicate the management of bipolar disorder considerably.

This is particularly important if the carer is involved

in dispensing treatment or ensuring safety. These issues usually become apparent at the outset and should be addressed when formulating a suitable management plan.

J's eldest child is anxious and a little obsessive. What is the genetic burden of this disease?

Bipolar disorder does run in families and, although there is a risk of developing a mood disorder when one parent has bipolar disorder (about 15%), it is important to note that the likelihood of not developing bipolar disorder remains greater. However, as there is no diagnostic test as yet and environmental factors can play a significant role, the best advice is to simply be aware of this small risk.

More important is the need to attend to the child's

anxiety, which is likely to be associated with the family dynamics. The mother is periodically unwell and the father is drinking heavily, so the child may not be receiving the attention they need.

General questions for the authors

What medical monitoring, and how often, is appropriate for patients taking lithium (including thyroid function tests)?

Lithium requires regular monitoring of blood levels — this should be at least weekly when initiating treatment, then as the dose stabilises this can be gradually tapered to become less frequent, ranging from monthly to every three months. Similarly, thyroid function tests should also be monitored in patients on lithium, ideally every three months.



How to Treat Quiz

Bipolar disorder
— 13 June 2008

INSTRUCTIONS

Complete this quiz online and fill in the GP evaluation form to earn 2 CPD or PDP points. We no longer accept quizzes by post or fax.

The mark required to obtain points is 80%. Please note that some questions have more than one correct answer.

ONLINE ONLY

www.australiandoctor.com.au/cpd/ for immediate feedback

1. Which TWO statements about the epidemiology of bipolar disorder are correct?

- a) The lifetime prevalence of bipolar disorder is 1% to 4%
- b) In Australia there is an average delay of five years from symptom onset to diagnosis of bipolar disorder
- c) Women are twice as likely as men to develop bipolar I disorder
- d) The early onset of bipolar disorder is generally associated with a poorer outcome

2. Which TWO statements about the diagnostic criteria for bipolar disorder are correct?

- a) Bipolar I disorder requires the presence of at least one episode of mania lasting for at least one week
- b) Bipolar II disorder requires the presence of one or more episodes of mania accompanied by at least one episode of depression
- c) Rapid cycling requires the occurrence of at least three episodes of depression and at least three episodes of mania over 12 months
- d) Mixed episodes require the presence of mania plus at least two of six dysphoric symptoms

3. Cheryl, 28, presents with depression. Further history reveals that she has had episodic depression since age 18. Which TWO statements are correct?

- a) An abrupt, earlier age of onset is more likely in bipolar depression, compared with a more gradual onset and offset in unipolar depression
- b) In the natural evolution of bipolar disorder, an episode of mania or hypomania usually precedes any depressive episodes by several years
- c) A highly recurrent pattern of depression is

more suggestive of major depression, as opposed to bipolar depression

- d) A family history of bipolar disorder is suggestive of a bipolar episode, as opposed to major depression

4. On questioning, Cheryl admits to having had brief episodes of feeling highly energised for several days, while needing very little sleep. Which TWO statements about the symptoms of bipolar disorder are correct?

- a) It is essential to ask patients who present with depression about any previous symptoms of mania or hypomania
- b) People with bipolar disorder commonly present clinically with symptoms of hypomania
- c) In mania the predominant mood may be that of irritability
- d) Concurrent symptoms of depression and mania (mixed states) are quite rare

5. Which THREE statements about the characteristics of bipolar depression are correct?

- a) Like unipolar depression, bipolar depression is associated with an increased risk of suicide
- b) Psychomotor retardation and increased sleep and appetite are thought to be more common in unipolar depression than in bipolar depression
- c) Psychosis is thought to be more common in bipolar depression than in unipolar depression
- d) Mood lability is thought to be more common in bipolar depression than in unipolar depression

6. Which THREE statements about assessment of a patient with possible bipolar disorder are correct?

- a) Assessment should include taking a full history

of mood symptoms, and noting any changes in behaviour and thinking

- b) The diagnosis of bipolar disorder can be made on the history and mental status examination, therefore physical examination and investigations are not required
- c) It is important to consider psychological comorbidity such as anxiety disorders and substance abuse
- d) If possible, collateral history from a family member assists in diagnosis

7. Which THREE statements about treatment of acute mania are correct?

- a) It is essential to ensure the individual is safe and provide a calm and manageable environment
- b) Hospitalisation or referral to a specialist for the purposes of monitoring mental state and treatment should be considered
- c) About three-quarters of all people with mania will respond to monotherapy with any anti-manic agent
- d) About three-quarters of all people with mania will respond to a combination of an atypical antipsychotic and either lithium or sodium valproate

8. After completing your assessment, you suspect Cheryl may have bipolar rather than unipolar depression. You arrange for assessment by a local psychiatrist. Which TWO statements about the treatment of bipolar depression are correct?

- a) There is a clear consensus regarding the place of antidepressants in bipolar disorder
- b) The potential of antidepressants to increase cycling, shortening inter-episode periods and provoking a switch into mania, is greatest with the SSRIs

- c) There is substantive support for use of monotherapy with a mood stabiliser such as lithium, sodium valproate or lamotrigine as first-line treatment of bipolar depression
- d) If antidepressants are used in bipolar disorder, they should not be prescribed in the absence of a concomitant mood stabiliser

9. Which TWO statements about maintenance therapy in bipolar disorder are correct?

- a) During the maintenance phase of bipolar disorder the most common reason for relapse is lack of efficacy of the medication
- b) Overall, most agents used in the maintenance phase of bipolar disorder have greater efficacy in preventing relapse into mania, than into depression
- c) A significant proportion of patients with bipolar disorder will need combinations of mood stabilisers for an adequate response
- d) In practice, an 'adequate trial' of maintenance treatment may require up to six months before effectiveness or lack of efficacy can be determined

10. Which THREE statements about long-term management in bipolar disorder are correct?

- a) Psychotherapeutic interventions are useful in helping to prevent relapse in bipolar disorder
- b) Adjunctive psychotherapy has been shown to improve adherence to treatment in bipolar disorder
- c) There is no benefit in involving the family in the care of the patient with bipolar disorder
- d) In essence, psychological interventions all include psycho-education in bipolar disorder, promote individual adherence and employ mood-monitoring and relapse-prevention strategies

CPD QUIZ UPDATE

The RACGP now requires that a brief GP evaluation form be completed with every quiz to obtain category 2 CPD or PDP points for the 2008-10 triennium. You can complete this online along with the quiz at www.australiandoctor.com.au. Because this is a requirement, we are no longer able to accept the quiz by post and fax. However, we have included the quiz questions here for those who like to prepare the answers before completing the quiz online.

NEXT WEEK Type 2 diabetes is on the increase in both developed and developing nations, with more than 150 million people worldwide having the disease and this figure set to double by 2025. The next How to Treat focuses on current management guidelines for the treatment of type 2 diabetes, new treatments and recent controversies. The author is **Dr Neale Cohen**, endocrinologist, and director of clinical services, International Diabetes Institute, Victoria.

Australian Doctor
Education.

HOW TO TREAT Editor: **Dr Martine Walker**
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