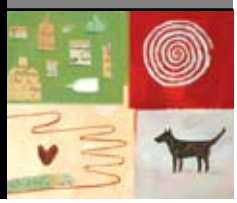

Bipolar disorder

Assessment and management

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BACKGROUND
General practitioners are increasingly aware of the bipolar disorders and of being required to adopt a management role.

OBJECTIVE
This article provides the GP with efficient strategies to assist detection and diagnosis of bipolar I and bipolar II disorders and defines management principles.

DISCUSSION
Bipolar disorders benefit from a mix of medication and nonmedication components, with complementary clinical management and patient self management reducing the high morbidity and suicide risk associated with these disorders.

Until recently, the lifetime prevalence of bipolar disorder was estimated at 0.5–1%.[1] This probably remains correct for bipolar I (BP-I) (formerly known as 'manic depressive illness'). In the past decade there has been increasing recognition of a so called milder condition, bipolar II (BP-II), where the lifetime prevalence may be up to 5%.[2] Numerous USA and Australian studies of bipolar disorder find the average duration from onset to diagnosis is 10–20 years,[3] indicating difficulties in awareness and recognition of this disorder. Written guidelines for managing bipolar disorder are restricted to BP-I, and as such, may not best fit the management of BP-II. Commonalities and differences in the conditions and their management are therefore overviewed.

What is bipolar disorder?

Bipolar disorder subsumes impaired mood conditions where the individual has 'highs' as well as depressive episodes over many years.

- BP-I is distinguished from BP-II by the intensity of its manic highs – which may include psychotic features – and which tend to last longer and/or necessitate hospitalisation
- In BP-II, the individual has 'hypomanic' highs – less severe, not associated with psychotic features, and not necessarily distinctly impairing, sometimes even enjoyable
- During bipolar depression, those with BP-I can develop psychotic depression. Most individuals with BP-I or BP-II experience severe, impairing melancholic depression
- BP-I mood oscillation tends to be slower, with longer episodes and longer periods of interepisode relief; BP-II mood oscillation occurs more frequently
- The length of a true bipolar high may be briefer – lasting hours to a couple of days – than the duration specified by DSM-IV (7 days for a manic episode and 4 days for a hypomanic episode)[4]
- Studies suggest that BP-I and BP-II impairment, and consequences such as suicide rates, are comparable in that individuals with both disorders probably spend equivalent periods of time in the 'at risk' depressive phase
- Bipolar III is the term used to refer to a 'high' induced by an antidepressant drug in individuals who may or may not intrinsically have bipolar disorder.

Clinical features

Bipolar highs are usually high energy states, although some people will more describe irritability or anger. The depressive phases are usually marked by the biological features that underpin melancholic and psychotic depression: no energy, to the extent of finding self care difficult; a nonreactive and anhedonic mood; and diurnal variation with mood and energy worse in the morning. While individuals may also report two characteristic 'endogeneity' symptoms – early morning wakening and appetite and weight loss – younger patients (especially adolescents) are more likely to report the opposite – increased sleeping and food cravings.

Diagnosing bipolar disorder

As a given, individuals should have experienced episodes of clinical depression, with a weighting to melancholic or psychotic features. As patients do not present complaining of their 'highs', all individuals presenting with clinical depression should be screened for previous 'highs'.

To establish the possibility of bipolar disorder (as opposed to unipolar conditions which manifests solely by depressive

episodes), the author finds it useful to ask the following: 'Do you have times when you are neither depressed nor feeling normal, that you feel more energised and wired?' This is a sensitive probe, as asking individuals whether they have highs can evoke defensiveness. If the individual admits to such periods, I then ask whether at such times they feel creative ('one with the world'), excessively confident or grandiose ('can tackle anything') and whether they become expansive or even 'loud'. A range of subsidiary questions is useful, including whether the individual at such times is:

- more talkative
- talks 'over' people
- needs less sleep and is not tired
- has increased libido
- becomes verbally or behaviourally indiscreet
- buys things that are not really needed.

The Black Dog Institute website (www.blackdoginstitute.org.au) has a 27 item bipolar self assessment test with high sensitivity (74%) and specificity (98%), which differentiates bipolar or unipolar disorder accurately in about 90% of cases.

Clinical clarification

Further clarification can come from exploring the following:

- Is there a 'trend break' – or a distinct change from not having mood swings to experiencing them? This generally commences in adolescence for those with BP-II, and possibly later for those with BP-I
- During a true manic or hypomanic episode, the individual will note that any anxiety they generally experience disappears
- About 50% of individuals with bipolar disorder will have a first degree relative with a mood disorder[5]
- The highs will often be observable to others, and the biological depression almost invariably observable (sometimes described as the loss of 'light in the eyes').

The presence of manic or hypomanic episodes, respectively, then determines whether the individual has BP-I or BP-II disorder.

The importance of diagnosis

Patients with bipolar disorder have the highest suicide rate of all the psychiatric conditions. Undiagnosed, individuals are at risk of a suicide attempt when they feel themselves sinking into a 'black hole' of depression. The higher the mood swing, the greater the chance of a more severe depression. Further, there is considerable collateral damage associated with the highs. Judgment and insight are rapidly impaired and individuals display uncharacteristic behaviours and are mortified when they are 'back to themselves'. 'One night stands', visits to prostitutes, [later] unwanted tattoos, excessive credit card spending, telling people off – all place the individual's reputation at risk. It is also very difficult to sustain an ongoing relationship or avoid a chequered work history.

Management

The Black Dog Institute website also has a modular bipolar educational program with presentations from 10 professionals (five with bipolar disorder themselves), advancing understanding and managing bipolar disorder. It is presented with general practitioners in mind for their own education or for referring patients.

Bipolar patients benefit from a 'stay well plan'. Components are described on the website, where there is also a downloadable daily mood chart. A 'stay well plan' is fundamental to managing both the highs and lows in ensuring that the individual has practical pre-emptive and episode related strategies.

Settling of any sleep disruption can curtail a developing bipolar episode.

Commonalities to managing BP-I and BP-II

A daily mood chart

Individuals with bipolar disorder find this strategy very useful. It helps identify triggers (eg. overseas travel, excessive coffee, recreational drugs, life events), early warning signs (eg. disrupted sleep patterns) and the effects of medication, which can be estimated over time (usually months or years). All assist the development of the 'stay well' plan.

Education

Education of both the individual with bipolar disorder and their family members is central to good management. A written relapse prevention strategy plan is essential for many. A copy can be given to the GP and to the closest relative and/or friend, often sanctioning timely intervention.

Support networks and journaling can be of use for solace, education and for encouraging medication adherence. The Mental Health Association provides a list of support groups (www.mentalhealth.asn.au).

Medication

The author's personal observation suggests that about one-third of bipolar patients will respond to a single mood stabiliser, one-third will have a good response to multiple mood stabilisers (with or without a combination antidepressant if depressive episodes are common) and one-third will continue to have a problematic course with multiple medications. The priorities for medication are:

- to obtain mood stabilisation: for BP-I, current recommended strategies include the formal mood stabilisers (eg. lithium, valproate, carbamazepine, lamotrigine) and the atypical antipsychotic drugs.[6] For BP-II, recent evidence suggests that selective serotonin reuptake inhibitors (SSRIs) may also have mood stabilising properties. Therefore, this may be a possible first strategy before trialling a formal mood stabiliser[6]
- for bipolar depression: it is usually recommended that the individual be started on a mood stabiliser before initiating an antidepressant drug. This is not always necessary in managing patients with BP-II, where the initiation of an antidepressant only may be sufficient to relieve the depression but not risk (apart from the tricyclic antidepressants) inducing a high or more rapid cycling[7]
- for 'highs': a manic episode may require hospitalisation and either a mood stabiliser, atypical antipsychotic or a combination of both.

Hypomanic episodes may be insufficiently severe or persistent as to require medication to bring the individual down, but instead require adjustment to the mood stabiliser (eg. adjusting drugs such as lithium).

Omega-3 fatty acids

The emerging story about omega-3 fatty acids suggests that omega-3 deficiency or an excess in the omega-6:omega-3 ratio may both explain the seeming increase in BP-II, and that fish oil supplementation may be beneficial for managing the bipolar conditions.[8] Of the published studies, only about one half are positive, and these tend to indicate that if there is any benefit at all, it is more in settling the depression rather than the highs. The Black Dog Institute website education program provides details on medication, including fish oil supplementation.

Conclusion

As for many other conditions in medicine and psychiatry, bipolar disorders cannot be cured but can be managed. It is essential to ensure a mix of professional management (detailing the responsibilities of the differing health practitioners) and self management. For many individuals, receiving a diagnosis of bipolar disorder has a major impact and can be very destabilising – they can feel totally controlled by 'it'. Education, stay well planning and other self management strategies enhance the individual's capacity to move forward, and complement medication and advice from health professionals, so that individuals progressively feel that they are in control. While more difficult than managing unipolar depressive disorders, the treatment matrix (ie. education, stay well planning, medication adjustments) allow many people with these conditions to be managed by GPs, while referral to a psychiatrist is usually relevant for diagnostic clarification or review of management plans.

Conflict of interest: none declared.

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