

The Foundations of Effective Management of Bipolar Disorder

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Objectives: To understand the epidemiology and course of bipolar disorder; to outline the importance of accurate and reliable diagnosis of bipolar disorder both on a cross-sectional and longitudinal basis; and to emphasize the value of a collaborative therapeutic relationship, psychoeducation, and psychotherapy.

Methods: A brief review of relevant literature to deal with the issues of diagnosis and laying the foundations for effective treatment.

Results: Bipolar disorder may well be a heterogeneous group of conditions with varying forms of biphasic mood dysregulation and a changing course across a lifetime. A collaborative therapeutic relationship, psychoeducation, and psychotherapy can be the basis for effective management.

Conclusions: As the concept of bipolar disorder has broadened, the condition is being identified with increasing frequency in many clinical settings. It is a relapsing and recurring condition. It is now recognized that in addition to rational pharmacotherapy, there is a need to encourage a high level of treatment adherence while providing a holistic package of interventions.

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As the concept of bipolar disorder has broadened, the condition is being identified with increasing frequency in many clinical settings. Although many available treatments are effective in both acute states and prophylaxis, the efficacy of interventions is far from satisfactory, with patients with bipolar disorder experiencing significant relapses and recurrences (1–4). The guidelines we propose focus on biological and psychotherapeutic treatments used for patients with bipolar type I disorder as defined previously in DSM-III-R and currently in DSM-IV. These treatment options and guidelines may be relevant for some other conditions with significant biphasic mood dysregulation, including bipolar type II disorder and schizoaffective illness.

The authors recognize that the recommendations provided are not comprehensive. They are intended to build upon rather than replace good clinical skill and sound clinical experience. The suggested approach is based upon a synthesis of the best external evidence and expert opinion. This should be integrated with individual clinical expertise, as well as patients' needs and choices, to provide optimal care.

The evidence in support of these guideline proposals was derived from the results of studies which, in many instances,

have limited generalizability. The characteristics of a general patient population may differ significantly from those of patients included in research studies and clinical trials. Physicians and other clinicians should identify how much their patients are like those in the studies that have been cited and recognize that individual patient needs are variable and require skilful judgement not only about treatment choices but also about the timing of interventions. Further, because comorbid disorders are not uncommon (5) but are more often than not excluded from clinical trials, the treating clinician should feel free to go beyond the scope of these recommendations whenever required.

Every effort should be made to identify and treat biphasic mood dysregulation precipitated, caused, or exacerbated by alcohol, substance abuse, or a variety of general medical as well as neurological conditions (6–10).

Epidemiology, Clinical Presentations, and Course

Weissman has reported that bipolar type I disorder affects between 0.4% and 1.6% of the population, whereas bipolar II disorder may be relatively more common than previously recognized (11). There are no gender or racial differences in the prevalence of bipolar I disorder, although bipolar II disorder is reportedly more common in women.

The average age of onset for bipolar disorder is in the early to mid-20s. The concept of the mean age of onset, however, does not highlight the fact that the largest peak age of onset of first symptoms is likely between the ages of 15 and 19 years (12–14). The condition is commonly undetected, untreated, or undertreated. Often there is a 3- to 10-year time lag between the age of onset of the illness and the age at which the first treatment or hospitalization occurs. Further, bipolar types I and II are commonly preceded by chaotic fluctuation of mood and behaviour for months to years prior to the condition being recognized as meeting major mood disorder criteria (14,15).

Although the initial episode of mood dysregulation is commonly depression in females and mania in males, any patient may experience several episodes of depression before the onset of a manic episode. Early-onset bipolar disorder is more commonly associated with depression as the first mood disorder episode (14–17). In patients with an onset of bipolar disorder after the age of 60 (18,19), the disorder is more likely to be associated with identifiable general medical and neurological conditions, higher morbidity and mortality rates, and the absence of significant association with a positive family history for the illness.

Diagnostic assessment should include not only determination about the presence of depressive and/or hypomanic and manic features but also whether the patient has a mixed or rapid-cycling state (20); psychotic features; suicidality; risk of significant harm to others; alcohol and/or other substance abuse; social, financial, and sexual risk-taking behaviours; a

childbearing status or plans; and the presence of cognitive or functional impairment. It is also important to chart the course and chronology of subthreshold symptoms and mood disorder episodes (21). All of this diagnostic information can be vital in selecting the most appropriate specific treatment for a given patient at a given time in the course of the illness.

Bipolar disorder is an episodic, long-term illness. Inadequately treated patients often have more than 10 episodes of biphasic mood disorder during their lifetime, with interepisode intervals narrowing as age advances (22). There is an increased risk of suicide, reported to be between 17% and 19% (23,24), and there is significant disruption in psychosocial functioning, with severe impairment of quality of life for the sufferer and his or her family (25). Bipolar disorder is the most likely of Axis I disorders to cooccur with alcohol or substance abuse (5). Recent evidence suggests that bipolar patients who abuse drugs or alcohol have an earlier onset and more severe course of illness compared with those who do not (26).

There is evidence to support the use of pharmacotherapy in the acute and prophylactic phases of bipolar disorder. Pharmacotherapy may substantially reduce the risk of suicide in these patients (27,28). In addition to pharmacotherapy, there is increasing interest in the role of psychotherapy in bipolar disorder and its relationship to improving treatment adherence, which can itself affect prognosis (29–31).

Assessment and Reassessment

Careful assessment, monitoring, and rapid reassessment as necessary are essential in making an accurate diagnosis of bipolar disorder. This approach is also required to understand the cross-sectional and longitudinal characteristics of a condition that can fluctuate, often abruptly, in its presentation. The use of a simple mood diary and course of illness chart can be valuable diagnostically and provide a longitudinal view of the patient's symptoms and course. Readers should be aware that biphasic mood dysregulation, whether it meets the full threshold criteria for a bipolar disorder as per DSM-IV or not, can coexist with a variety of other Axes I, II, or III conditions and may benefit from mood stabilizer treatment in conjunction with other treatments. Clinicians should monitor their own tendencies to underdiagnose or overdiagnose biphasic mood dysregulation. Thus a thorough and valid multiaxial assessment and diagnostic formulation must form the cornerstone of practice before one can examine any treatment options and guidelines. Of course, there will always be patients who do not fit neatly into any category or whose primary diagnosis is unclear. This is commonly the case with patients who have biphasic mood dysregulation with comorbid alcohol or substance abuse. Such patients may benefit from individualized treatment algorithms that will allow for systematic testing of diagnostic or treatment hypotheses.

A positive family history of bipolar disorder increases the probability of a patient with a major depressive episode developing biphasic mood disorder (32). In children, adolescents, or young adults, the presence of psychotic depression or recurrent bouts of atypical depression or depression with obsessive-compulsive features should raise a strong suspicion of the future advent of bipolar disorder (13). This progression to bipolar illness is of particular concern in the presence of a family history of the disorder. A careful history from the patient, key informants, and, if necessary, a longitudinal monitoring of mood using a mood diary, can help establish if the patient suffers from or has suffered from episodes of mania or hypomania. Even if a diagnosis of bipolar disorder cannot be confidently established, the risk factors for the future development of bipolar disorder described above should influence the clinician to plan or use interventions that have a lower risk of switching the patient into manic, rapid-cycling, or mixed states.

Careful monitoring and rapid reassessment of a patient's clinical presentation (that is, severity of mood disorder or presence of rapid-cycling, mixed state, or psychotic features) not only influence immediate and possibly long-term prognosis but also may guide the clinician toward the use of specific treatments for particular clinical presentations (33–37).

Establishing Treatment Alliance and the Role of Psychoeducation and Psychotherapy

Whereas rational pharmacotherapy is effective and often central in the management of bipolar disorder, establishing a sound therapeutic alliance with a patient with bipolar disorder is the foundation of effective treatment. The acute bipolar, subsyndromal mood fluctuation, and prolonged remission phases are often found to be the most taxing on the therapeutic relationship and on treatment adherence. An understanding of the patient, his or her family, and his or her key friends' attitudes, understanding, and responses to psychiatric illness can help the clinical team develop particular strategies for support, monitoring, and therapeutic interventions.

While instilling hope, the clinician and team also need to help the patient, family, and friends understand the recurrent and fluctuating nature of the illness, the associated morbidity and mortality, and the opportunities for the implementation of effective treatment. The effective and empathic management of feelings of denial, guilt, self-blame, and hostility in the setting of appropriate psychoeducation can significantly improve the potential for a healthy therapeutic alliance and development of a collaborative, individualized treatment plan, thus improving the potential for treatment adherence. Having optimum treatment adherence can significantly reduce the risk of relapse and its associated problems, including increased morbidity and mortality (31,32,38,39).

One must not underestimate the possibility of nonadherence to a treatment regimen by patients, families, and treatment systems. Patients often use denial or minimalization in understanding their condition and its effects on themselves and those around them. A significant number of patients are also very reluctant to give up the pleasurable aspects of increased drive and energy, inflated self-confidence, and the feeling of a "high" that goes with hypomania and mania. If they perceive treatment as reducing their productivity and creativity, or perceive hypomania and mania as an effective counter to miserable and hopeless depression, compliance with treatment is often diminished (39–42). Adverse effects, plans for pregnancy, teratogenic risks, and negative views about medications in the patient, family, friends, and health care professionals also affect treatment adherence (43).

Very early in the management of the patient with bipolar disorder, there is a need to establish healthy social and biological rhythms. It is well established that sleep deprivation can provoke hypomania and mania and that substance abuse can induce or maintain a mood disorder. Having healthy patterns of sleep, nutrition, social interaction, physical activity, and involvement in tasks, school, or a job that is socially, emotionally, and/or financially rewarding can all be significantly beneficial in the treatment of mood disorder (31,44–46).

Although bipolar disorder is not a curable condition, it can be effectively managed with a combination of psychoeducational, pharmacotherapeutic, psychotherapeutic, and social interventions. Hence the prevention of recurrences and relapses deserves great attention. These recurrences or relapses can have a cumulative deteriorative effect on functioning and treatment response. Early diagnosis and optimal treatment, therefore, can significantly improve the chances of recovery, remission, improved functioning, and a better quality of life (3).

It is very useful to assist the patient and family to identify a supportive network of people who will, in an effective yet nonstigmatizing manner, help the patient to seek early intervention in a newly developing episode of mood disorder. Patients benefit significantly from making plans that instill hope while being directed toward realistic, tangible, and attainable goals. Patients often require active assistance to maintain and not jeopardize key relationships, employment, or financial status during the prodrome or actual acute major mood disorder episode. Concerns that patients may have about the risk of bipolar disorder in siblings or progeny should be taken seriously and addressed through genetic counselling or timely assessments of at-risk family members who may demonstrate subthreshold symptoms of mood disorder (32).

Helping the patient and his or her support network to identify the early warning signs of impending mood disorder (for example, sleep disturbance, changing patterns of alcohol

use, interpersonal relationship problems, and dysfunctional academic or work behaviour) allows for timely changes in the intensity or type of treatment intervention. Such a plan of action can improve the patient's sense of hope, promote a feeling of mastery, and foster a collaborative approach to management. A graphic and concrete view of paradigms of chronic physical illness and its treatment, for example, diabetes mellitus, can help patients and families work through the issues of a long-term disorder and the necessity for extended treatment and monitoring.

Clinical Implications

- Bipolar illness is a common clinical problem.
- Bipolar disorder can be effectively treated with a combination of medications and psychosocial interventions.
- Noncompliance with medications is common in patients with bipolar disorder.

Limitation

- Many factors have to be taken into account in devising a treatment plan for bipolar disorder.

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Résumé

Objectifs : *Comprendre l'épidémiologie et l'évolution du trouble bipolaire; souligner l'importance d'un diagnostic précis et fiable du trouble bipolaire à la fois sur le plan de son évolution transversale et de son évolution longitudinale; et faire ressortir l'importance d'une relation thérapeutique, d'une psychopédagogie et d'une psychothérapie axées sur la collaboration.*

Méthodes : *Un bref examen de la littérature pertinente pour traiter des questions liées au diagnostic et pour jeter les bases d'un traitement efficace.*

Résultats : *Le trouble bipolaire pourrait bien constituer un groupe hétérogène de pathologies comportant divers types de dérèglement biphasique de l'humeur et une évolution qui se transforme au cours de la vie. Une relation thérapeutique axée sur la collaboration, la psychopédagogie et la psychothérapie peut être à l'origine d'un traitement efficace.*

Conclusions : *À mesure que s'élargit le concept de trouble bipolaire, on identifie cet état pathologique de plus en plus fréquemment dans de nombreux contextes cliniques. Il s'agit d'une pathologie récidivante et récurrente. En plus d'une pharmacothérapie rationnelle, on reconnaît maintenant qu'il faut favoriser un niveau élevé de respect du traitement, tout en offrant un éventail d'interventions holistiques.*