The management of bipolar disorder in general practice

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ABSTRACT

- General practitioners have a key role in managing patients with bipolar disorder, a condition which affects at least one in 200 Australians each year and is the sixth leading cause of disability in the population.
- Although diagnosis and treatment of the illness is complex, effective treatment can lead to good outcomes for many patients.
- GPs can contribute significantly to early recognition of bipolar disorder, avoiding the long delays in accurate diagnosis that have been reported. As in other complex recurrent or persistent illnesses, GPs are well placed to coordinate multidisciplinary "shared care" with specialists and other health care professionals.
- GPs also provide continuing general medical care for patients with bipolar disorder, and are in a unique position to understand patients' life circumstances and to monitor their progress over time.
- The last decade has seen many advances in medication for bipolar disorder, including the introduction of new therapies and the refinement of treatment protocols using older medications. There has also been increasing recognition of the contribution of psychological therapies to symptom relief, relapse prevention, optimal function, and quality of life.

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It has been estimated that 1 in 200 Australians experiences an episode of bipolar disorder in any 12-month period,[1] and that lifetime prevalence is between 1% and 4%.[2]

The Australian National Study of Low Prevalence (Psychotic) Disorders included an analysis of 112 people meeting the criteria for bipolar disorder of the International classification of diseases, 10th revision (ICD-10).[3] Most were already in treatment, and might therefore reflect the more severe or acute segment within the continuum of severity.

The mean age of onset was 25 years for men and 26 years for women. In addition to episodes of mania, 79% had experienced at least one clinically significant episode of depression. A large proportion (86%) reported experiencing delusions at some time in their lives.

Difficulty with relationships was common. Just over half the men and a quarter of the women were single and had never been in a long-term relationship, and 64% of the men and 42% of the women did not have children. Half the men and a third of the women lived alone. Many had achieved well educationally, but their work performance was impaired: only 30% of both men and women with bipolar disorder had no formal secondary school qualifications, but 79% were receiving a pension or benefit, and 67% of those seeking work were unemployed at the time of interview; 9.8% were classified as severely disabled.

Nature and course of illness

- Bipolar I disorder is characterised by the occurrence of at least one lifetime episode of mania and, usually, episodes of depression.
- Bipolar II disorder is characterised by episodes of both hypomania and depression, but no manic episodes.
- Recognised patterns of illness also include mixed states and rapid cycling between depression and mania.

Depression is often the predominant mood and has been associated with the greatest burden of disability. One study found that patients with bipolar I disorder experienced 32% of their weeks of follow-up in depression and 9% in mania or hypomania. For those with bipolar II disorder, 50% of their follow-up period occurred in depression but only 1% in hypomania.[4]

Suboptimal function between discrete bipolar episodes, characterised by symptoms such as mild anxiety or depression, is common and tends to be unrecognised. The suicide rate in people with bipolar disorder is about 15 times that of the general population, and 80% of suicides occur during episodes of depression. At least 25% of patients will attempt suicide and 10%–20% will complete suicide. Comorbid conditions including anxiety disorders (52% of patients in one Australian study) and substance misuse (39%) are prevalent.[1]

Role of general practitioners

GPs are well placed to coordinate the care of patients with bipolar disorder as they continue to provide other aspects of general medical care and develop an understanding of the patient's circumstances and progress.

There is increasing interest in shared care between the primary and secondary care sectors for patients with mental illness.[5] It is appropriate for a psychiatrist to assess patients with bipolar disorder early in the illness, to make or confirm the diagnosis and establish a plan for medication and psychological management. Most GPs treat relatively few patients with bipolar disorder, and continuing care for those with severe or frequently recurring illness might best be directed by specialist services. Those with less severe illness, or illness that is responsive to treatment, might best be managed primarily by GPs.

Issues in diagnosis

Patients with bipolar disorder report that delays in diagnosis and incorrect diagnosis are common. A study of participants in a bipolar disorder support group revealed that more than a third sought professional help within a year of the onset of symptoms, but 69% were misdiagnosed, most frequently with unipolar depression.[6] Other frequently reported misdiagnoses included anxiety disorder, schizophrenia, borderline or antisocial personality disorder, alcohol or substance misuse and/or dependence, and schizoaffective disorder.[6] Over a third waited 10 years or more before receiving an accurate diagnosis. Notably, respondents rarely reported all their manic symptoms to a doctor. For example, fewer

Background and evidence base for recommendations

The original concept for these recommendations arose out of discussions between one of us (P B M) and Eli Lilly Australia. They were prepared by an expert working group with expertise in the diagnosis and management of bipolar disorder in both the general practice and psychiatric settings. The disciplines represented include general practice, psychiatry, psychology and medical education. This outline for the management of bipolar disorder in general practice has been formally endorsed by the Royal Australian College of General Practitioners.

Most of the pharmacological and psychological treatments recommended are supported by National Health and Medical Research Council (NHMRC) levels of evidence I or II; that is, there is evidence from a systematic review of all relevant randomised controlled trials (level I) or from at least one correctly designed randomised controlled trial (level II). The evidence is derived from patients with bipolar I disorder in inpatient or outpatient psychiatric treatment settings. Currently, there are no controlled trials of treatments for bipolar disorder in primary care. ◆

than a third admitted symptoms such as reckless behaviour, spending excessively and increased sexual interest or activity.[6]

The age of the patient influences the differential diagnosis. In younger patients, conditions such as attention deficit hyperactivity disorder and conduct disorder need to be considered. In patients older than 40 years — an age when initial presentation in the manic phase of bipolar disorder is relatively uncommon — possible organic causes should be addressed.

Some "clues" to the presence of bipolar disorder are summarised in Box 1. Note that longitudinal monitoring is often necessary to make or refine the diagnosis.

1 Clues to bipolar disorder

Symptoms and signs of mania and hypomania can include the following types of behaviour which are *out of character* for the individual:

- feeling energised and "wired"
- excessively seeking stimulation
- overly driven in pursuit of goals
- needing less sleep
- irritable if stopped from carrying out ideas
- disinhibited and flirtatious
- offensive or insensitive to the needs of others
- spending money in an unusual manner or inappropriately
- indiscreet and disregarding social boundaries
- having poor self-regulation
- making excessively creative and grandiose plans
- having difficulty discussing issues rationally or maturely
- reporting enhanced sensory experiences

Duration of symptoms

The criteria of the *Diagnostic and statistical manual of mental disorders* (DSM-IV) require that symptoms of hypomania are present for at least 4 days and symptoms of mania are present for 7 days before a diagnosis is made. However, these thresholds are somewhat arbitrary. ◆

Management of bipolar disorder

Medication

The main tasks for GPs in managing medication for patients with bipolar disorders are:

- monitoring the efficacy and side effects of maintenance therapy;
- in consultation with a psychiatrist, implementing treatment during acute episodes of mania or depression; and
- supporting medication adherence.

Clinical practice guidelines released by the Royal Australian and New Zealand College of Psychiatrists in 2004 provide an authoritative guide to treatment.[7] Some principles of treatment for bipolar disorder are listed in Box 2, and recommendations for laboratory monitoring during maintenance therapy are summarised in Box 3. Most research has been conducted in bipolar I disorder and extrapolated to bipolar II disorder when required: there is relatively little direct evidence on medications for bipolar II disorder.

While several guidelines on bipolar disorder have been published internationally, there is considerable unanimity between these. The major distinctions appear to be stronger recommendations for use of lithium in the Australian and European guidelines, with more emphasis on valproate in the United States.[8] Furthermore, US guidelines strongly support the use of mood stabilisers alone at an early stage in the treatment of bipolar depression.

The term "mood stabiliser" is used to describe medications that are effective in both acute and maintenance phases of therapy. "Traditional" mood stabilisers are lithium, valproate and carbamazepine, but there is evidence that atypical antipsychotics and the newer anticonvulsants are also effective in at least some phases of bipolar disorder.

2 Principles of medication for bipolar disorder*

Acute manic episodes

- Use a mood stabiliser (lithium, valproate, carbamazepine or an atypical antipsychotic, such as olanzapine, aripiprazole, quetiapine or risperidone) for elevated mood
- Also use an antipsychotic (if not already chosen as a mood stabiliser), a benzodiazepine, or a combination of an antipsychotic and a benzodiazepine, to calm or sedate the mood until the mood stabiliser takes effect (about 1 week)

Acute bipolar depression

- In de novo depression, in the absence of pre-existing mood stabiliser therapy, use a mood stabiliser either alone or in combination with an antidepressant. Mood stabilisers with proven antidepressant effects in bipolar depression include lithium, lamotrigine, quetiapine and olanzapine
- In breakthrough depression during mood stabiliser therapy, optimise the mood stabiliser by ensuring compliance and checking serum levels. If this fails, add an antidepressant or a second mood stabiliser. Selective serotonin reuptake inhibitors and venlafaxine are generally preferred, although monoamine oxidase inhibitors and tricyclic antidepressants are sometimes necessary

Prophylaxis

- Consider lithium, valproate, olanzapine, lamotrigine (the latter agent is most effective for prevention of bipolar depressive episodes) or carbamazepine

* Adapted from the clinical practice guidelines of the Royal Australian and New Zealand College of Psychiatrists, 2004.[7] ◆

Antidepressants in bipolar disorder

The role of antidepressants in bipolar disorder is controversial. A systematic review concluded that antidepressants were effective in

3 Laboratory monitoring of maintenance medication*

Lithium	
Every 3 months	Serum lithium concentration (aim for 0.6–0.8 mmol/L)
Every 6–12 months	Thyroid-stimulating hormone and electrolytes, urea and creatinine levels, to exclude hypothyroidism or declining renal function
Carbamazepine	
Every 3 months	Serum carbamazepine concentration (aim for 17–50 µmol/L)
Every 6–12 months	Liver function tests to exclude hepatotoxicity
	Full blood count to exclude aplastic anaemia and other haematological dyscrasias
	Electrolytes to exclude hyponatraemia
Sodium valproate	
Every 3–6 months	Serum valproate concentration (aim for 300–700 µmol/L)
	Liver function tests to exclude hepatotoxicity
	Full blood count to exclude thrombocytopenia
Lamotrigine	
	No regular testing necessary — there is no utility in serum level monitoring
Atypical antipsychotic drugs	
Every 6 months	Blood sugar and serum lipid concentrations to exclude diabetes and hyperlipidaemias

* Adapted from Mitchell and Gould, 2004.[5] ◆

the short-term treatment of bipolar depression and that switching to mania was not a common early complication of treatment.[9] However, another recent study reported the common occurrence of switching to mania, which was observed in 19% of acute and 37% of long-term antidepressant courses,[10] but the study was limited by the lack of a placebo control group.

Patients who stopped taking antidepressants within 6 months of remission from bipolar depression were more likely to relapse within the following year than those who continued treatment.[11] This suggests that for many patients continuation of antidepressants beyond the usual 2–3 months recommended in bipolar depression may be preferable.

Initiating therapy

Ideally, patients should be reviewed by a psychiatrist before a diagnosis of bipolar disorder is confirmed and therapy commenced. However, access to specialist services may be delayed, particularly when the patient's symptoms are not severe. Telephone advice from specialist services can assist GPs in these situations, and guide the initiation of appropriate treatment. More frequent review of the patient can also assist in monitoring progress and checking that symptoms, risks and disability are not progressing more rapidly than anticipated.

Medication adherence

Poor treatment adherence in patients with bipolar disorder is common. GPs can provide verbal and written information on the advantages and disadvantages of prescribed medications, and encourage patients to give their own views and discuss their experiences. Symptom history can be used to review the effects of medication, identifying the costs and benefits of adherence, and highlighting the active role of the patient in the analysis. Patients should feel confident about discussing the pros and cons of medication and their own concerns.

Psychological therapies

There is growing evidence for the benefits of psychological therapies in bipolar disorder.[12-15] Psychological therapies include:

- education about the condition and its treatment;
- basic cognitive behavioural techniques (eg, identifying triggers and planning how to minimise or avoid them; accurately labelling emotions; identifying thoughts and reframing them into more positive rational responses; and dealing with adjustment/self-esteem issues and long-term vulnerabilities);
- interpersonal and social rhythms therapy teaches patients to be more effective in handling relationships and make graded lifestyle changes to increase stability, and highlights the importance of routine and sleep;
- supportive psychotherapy is particularly useful in identifying interpersonal triggers that affect the patient's mood. It is most useful in the maintenance stage of treatment, once the skills of cognitive behavioural therapy have been learned; and
- exercise, yoga, relaxation therapy and similar "mind–body" interventions, individualised to the needs and lifestyle of the patient, may also be beneficial in the maintenance stage.

Indications for referral

Indications for referral to specialist services are given in Box 4.

Relapse and emergency care

Acute episodes

An episode of acute mania is a medical emergency. Patients have the capacity to destroy their reputations, relationships and finances within hours or days. Insight and judgement are usually impaired early, even in the absence of delusions, and involuntary hospitalisation is frequently required to protect the patient. However, the decision to admit may be traumatic for the patient and family members, all of whom will need support.

If outpatient treatment occurs, it is essential to monitor risky behaviour, such as financial indiscretion or potential harm to others from, for example, hazardous driving. A financial power of attorney may be necessary. Outpatient attendance is often erratic, and a legally enforceable community treatment order may be required.

It has been said that patients with acute mania are "always worse than they seem". An apparently reasonable level of function during a brief assessment may mask more serious dysfunction. Reports from family and friends should be taken seriously, but interpreted with an understanding of the patient's normal function and the nature of these relationships.

Similarly, active depression is associated with a high risk of suicide and self-harm. Risk management, particularly the recognition of suicidality, is a crucial responsibility of the treating doctor.

Relapse profile

It may be possible to develop a "relapse profile" for individual patients and list how the patient should respond. Common triggers for hypomanic or manic episodes are changes to everyday rhythms (eg, sleeping and eating), and stressful life events.

Possible early warning signs include destructive or impulsive behaviour after being sleepless or irritable, looking haggard, speaking in a caustic manner, telephoning friends indiscriminately regardless of the time, stopping medications, and impulsive, self-destructive threats and gestures.

Strategies to offer the patient when early warning signs of mania occur include the following:

- establish a regular routine for eating and sleeping;
- spend nights in your bedroom even if you are not sleeping — lie down and rest as much as you can;
- prioritise and reduce the number of tasks you are involved in;
- modify excessive behaviour — slow down;
- engage in calming activities and be aware of how you are thinking, feeling and behaving;
- carefully follow through the consequences of your actions — consider the costs and benefits;
- delay impulsive actions — if it is still a good idea in a few days time, it might *really* be a good idea;
- spend time on your own to reduce stimulation, for example by avoiding crowds, busy shops, intense movies and parties;
- find a quiet, restful place to spend your time;
- keep a diary of your moods and reactions;
- reframe your overly inflated thoughts as symptoms;
- recognise if you are getting into destructive situations;
- talk to someone you can trust;
- avoid drinking tea, coffee, cola or other drinks that contain caffeine;
- avoid alcohol, marijuana or other drugs; and
- see a doctor to review your medications and current state.

Possible medical and psychological responses to signs of relapse include:

- intensify psychological therapies, including stress reduction, normalising sleep patterns;
- adjust medication, for example adding a benzodiazepine or antipsychotic; and
- advise patients to minimise sleep disruption and other stressors and triggers.

The family

Bipolar disorder can be extremely taxing for the family and carers of the patient. Families need and want information and education about the illness, as well as continuing support during times of crisis. They can become active participants in elements of treatment such as encouraging appropriate medication, regulating lifestyle and monitoring the patient for signs of relapse (Box 5).

Insight, consent and confidentiality

Loss of insight during acute episodes of bipolar illness poses particular problems for families and carers, as patients may deny their illness and resist treatment. Treating doctors must balance the need to respect patients' privacy, while fulfilling their obligation to provide adequate care.

4 Indications for referral to psychological services

Clinical psychologist

- Patient is having difficulty understanding or accepting the diagnosis
- Medication adherence is less than optimal
- Relapses occur, suggesting the need for symptom management skills to supplement medication
- The patient has unresolved issues or trauma resulting from the phase of the illness or hospitalisation
- Patient has difficulty in adjusting to relationships or work
- Cognitive distortions act to destabilise mood
- Patient has difficulty identifying stressors or triggers leading to relapse
- Patient has sustained feelings of loss of direction or meaning
- Personality difficulties hinder recovery

Couples or family therapist

- Patient feels misunderstood or unsupported by family despite general practitioner's interventions
- Family dynamics trigger relapse
- Family members are overly involved or over-reacting to patient's illness, affecting independent functioning and recovery

Drug and alcohol services

- Continuing substance misuse ◆

5 Checklist for families

- Alert the general practitioner or other clinicians when you notice the person is experiencing early warning signs of hypomania or depression
- See the person's disturbed behaviour as a symptom of his or her illness. If frustrated, express frustration about the illness rather than the person
- Help develop an action plan to get the person through each day
- Decide if the person should be working, and how the illness can be managed in the workplace
- Ensure that the family has its own support systems, and access to educational material
- Ensure children or dependants can be supervised adequately while the person is unwell
- When the person is well again, encourage the person to take an active role in managing his or her illness, and plan for dealing with the person's affairs should he or she become unwell again ◆

Decisions may need to be made about the legal competence of patients and the point at which action should be taken to declare them incompetent and a danger to themselves and others. "Dangers" are not always physical, and can include damage to reputation, income and relationships. Dependants normally under the care of the patient may also be at risk, and treating doctors should be aware of their legal and ethical responsibilities to protect children from harm.

Support for patients and families

Although there is not a single national bipolar disorder support organisation for patients and families, a range of state-based services and organisations exist (Box 6).

6 Resources for bipolar disorder

Services directory

http://www.mindbodylife.com.au/Common/Pdf/Services Directory.pdf

Treatment guidelines

Royal Australian and New Zealand College of Psychiatrists. Bipolar disorder. Australian treatment guide for consumers and carers. June 2005 — http://www.ranzcp.org/publicarea/cpg.asp#consumer

Books for patients, families and carers

Goodwin G, Sachs G. Bipolar disorder. Oxford: Health Press, 2004.

Jamison KR. Touched with fire: manic-depressive illness and the artistic temperament. New York: Free Press, 1993.

Jamison KR. An unquiet mind: a memoir of moods and madness. New York: Knopf, 1995.

Orum M. Fairytales in reality: my victory over manic depression. Sydney: Macmillan, 1996.

Kelly M. Life on a roller coaster. Living well with depression and manic depression. Sydney: Simon and Schuster, 2000.

Russell S. A lifelong journey. Staying well with manic depression/ bipolar disorder. Melbourne: Michelle Anderson Publishing, 2005.

Websites

beyondblue: the national depression initiative — http://www.beyondblue.org.au

Black Dog Institute — http://www.blackdoginstitute.org.au

SANE Australia — http://www.sane.org

ORYGEN Youth Health — http://www.orygen.org.au

National Institute of Mental Health (USA) — http://www.nimh.nih.gov

Mental Health Council of Australia — http://www.mhca.org.au ◆

Conclusions

Bipolar disorder is a challenging illness for patients, families and carers, as well as for health care professionals. Increased understanding of the disorder can facilitate early and accurate diagnosis, effective short-term and long-term pharmacological and psychological treatment, and the development of effective support mechanisms.

GPs have a central role in facilitating diagnosis, accessing specialist care, and providing continuing monitoring and support.

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