

## Bipolar Disorder

Bipolar disorder or manic–depressive illness is characterized by the serial occurrence of repeated episodes of depressed and elevated mood. There are two main forms of Bipolar Disorder. In Bipolar I disorder elevated mood episodes are severe (referred to as “mania”) in Bipolar II disorder elevated mood is less severe (called “hypomania”) and there are frequent depressions. Bipolar I disorder is the best characterized and its treatments are the best studied. Less is known about how best to treat bipolar II disorder. A range of psychotropic medicines are available that can effectively treat manic/hypomanic episodes and/or depression. In addition medications are available to help prevent episodes of illness. The BAP bipolar guideline, revised in 2009, provide a detailed review of evidence-based supporting these treatment options along with recommendations for their use ([www.bap.org.uk/pdfs/Bipolar\\_guidelines.pdf](http://www.bap.org.uk/pdfs/Bipolar_guidelines.pdf)).

Episodes of illness in bipolar disorder can occur with varying severity from both highs and lows ranging from severe psychotic symptoms (delusions and hallucinations) to more minor mood fluctuations that are often predominantly depressive in nature. Mania, which defines bipolar I disorder, includes symptoms such as elevated or irritable mood, increased activity, rapid and loosely connected thoughts. Such thoughts may crowd into a person’s mind faster than they can speak. Projects at work or at home get started in a whirlwind of enthusiasm but don’t get finished as the person’s attention gets diverted too easily onto other topics. At times, an increased importance and meaning may be given to quite ordinary thoughts or events in a somewhat grandiose way. Patients almost invariably show impaired judgment in manic states. For example, they may spend large amounts of money that they can’t afford, indulge in risky sexual activity or drive dangerously. Such activity can lead to financial hardship, loss of jobs and relationship break down. As a result while mania might superficially be viewed as a positive state to be in, it can easily ruin lives.

Hypomania is the term that describes states of elevated mood and overactivity short of mania, without major impact on a person's function in day to day life. As a result in itself it is rarely a reason for complaint. Indeed, hypomanic patients tend to feel unusually well and energetic. Unfortunately, hypomania, like mania, is also associated with depressive swings in mood. Depression often very predictably follows hypomania and so the patient may have to learn to avoid hypomania in order to prevent depression.

The depressive episodes of bipolar disorder are largely indistinguishable from those of a straight forward depression illness or "unipolar depression". However, there may be quite important differences within the brain underpinning these conditions and research is needed to clarify this and to help guide treatment. A difference between bipolar depression and unipolar depression is suggested by the clinical observation that antidepressants are often of limited benefit in bipolar disorder where it is thought that optimizing mood stabilizing treatments are a better choice.

More recently there has been interest in people who have mood swings which do not meet criteria for bipolar I or II disorder – the so-called bipolar spectrum. Such people have states of mood elevation that last for short periods of time (less than 4 days required for current diagnostic criteria) or milder episodes show with fewer symptoms than hypomania. The bipolar spectrum disorders require much more research and it is unwise to assume that the principles derived from bipolar patients will apply to them. There is currently no evidence on how to treat such problems. There are also difficulties with the diagnosis of bipolar disorder in children, particularly when irritability is used as evidence of elevated mood as is particularly common in some US centres. All of the issues around diagnosis of bipolar disorder are covered at length in the BAP guideline.

The foundation of successful management of all chronic conditions is a positive therapeutic alliance between doctor and patient. This is, if anything, even more true of bipolar disorder, where 'psychoeducation' (helping the patient understand about the nature of their illness, which factors help and hinder their condition and the

need for and appropriate use of medication) has been consistently shown to reduce the risk of relapse. The place of cognitive behaviour therapy ('talking' therapy) has yet to be established in bipolar disorder because evidence from controlled studies has been conflicting. Conversely, there is strong evidence that drug treatments can be helpful – they are usually given for two reasons. Firstly, as short-term treatments to help with acute episodes of mania or depression and secondly, as longer term therapy aimed at reducing mood instability. Medicines that can be helpful for episodes of mania include antipsychotics or valproate and for episodes of depression, modern antidepressants (selective serotonin reuptake inhibitors) can be effective. Benzodiazepines such as diazepam or lorazepam are sometimes recommended as they can promote a better sleep-waking cycle. In the longer term, individualised lithium therapy can help to achieve stability.

New evidence-based guidelines on the treatment and management of bipolar disorder have been published by the British Association for Psychopharmacology. The guidelines are intended to assist physicians in their clinical decisions, as well as offering a source of information to other health professionals, patients and carers.

Published in the *Journal of Psychopharmacology*<sup>1</sup> the guidelines were the product of a review undertaken by a consensus committee led by Guy Goodwin, Professor of Psychiatry, University of Oxford. The committee updated the previous guidelines last published in 2003 and the revised guidelines cover:

- Diagnosis
- Clinical management
- Strategies for the use of medicines in the treatment of episodes
- Relapse prevention
- Stopping treatment

Although the guidelines necessarily tend to target 'average' patients, they also take into account the special needs of treating children, women of childbearing age, and the elderly.

Commenting on the new guidelines, Professor Goodwin said, “The revised guidelines review the changes in diagnostic practice and the controversial extension of the diagnosis to younger age groups. In relation to treatment, there is further emphasis on the depressed phase of the disorder and the role of psychological interventions in keeping patients well.”

<sup>1</sup> Goodwin GM *et al* (2009) Evidence-based guidelines for treating bipolar disorder: revised second edition-recommendations from the British Association for Psychopharmacology. *Journal of Psychopharmacology* 23: 346-388