PRACTICE GUIDELINES FOR BIPOLAR DISORDER IN ADULTS

MHNet monitors practitioner’s adherence to the following elements in the treatment of Bipolar Disorder:

- Psychotherapy
- Medication Management
- Conjoint Therapy

Bipolar disorder is much less common than major depression, afflicting about one percent of the population. Over the past few years, there has been an increase in the diagnosis as clinicians are seeing signs of the condition in very young patients, patients with major depression who’ve had hypomanic episodes, and patients with schizophrenia who appear to have a cyclical mood disturbance. However, the formal diagnosis of bipolar disorder should be reserved for individuals who have experienced at least one episode, lasting at least one week, characterized by persistently elevated, expansive, or irritable mood along with at least three of the following:

- Marked decrease in sleep,
- Talkative/pressure speech,
- Flight of ideas,
- Distractibility,
- Increased goal-directed activity (becoming very involved with numerous projects), or
- Increased involvement in pleasurable projects that involve risk (spending money, promiscuity, etc.).

ASSESSMENT

Although a formal diagnosis can be readily made if a patient presents with classic mania, a comprehensive assessment is essential to identify any pattern to the illness, what treatments have been effective in the past, and to address the negative consequences of the disease. Patients’ manic symptoms may create major problems with the family, financial, social, or vocational areas. The patient may suffer from inordinate shame and guilt over his behavior. Since many patients with bipolar disorder are medication non-compliant, education and interventions to address this problem are usually necessary.

ACUTE PHASE, MANIC

If the patient has an intact support network, he can be treated with intensive outpatient therapy. Hospitalization should be reserved for individuals in need of involuntary treatment or those engaging in high-risk behavior. Regardless of the treatment setting, symptoms should be carefully monitored for possible escalation to severe (i.e., delirious) mania or, conversely, a switch to depression.

A 2004 review article demonstrates that only lithium has been shown to be effective for the treatment of mania and bipolar depression as well as prophylaxis. Other commonly used medications have clearly demonstrated efficacy for mania (valproate and olanzapine). Lamotrigine has demonstrated efficacy for prophylaxis. Therefore the clinician must weigh potential benefit against risks when using medications other than lithium for the comprehensive treatment of bipolar disorder. However, with increasing evidence that divalproex is as effective, many psychiatrists are using it as a first line drug because it has fewer side effects.

Olanzapine, ziprasidone, quetiapine and aripiprazole have recently received FDA approval for the treatment of acute mania. These newer generation antipsychotics, along with clozapine, and risperidone, have supplanted older generation antipsychotics as the drugs of choice because of a reduced risk of tardive dyskinesia. However there is increasing evidence that all newer generation, atypical antipsychotics can cause significant weight gain, elevations in: a) fasting blood sugar, b) cholesterol and c) triglycerides. Therefore every patient should undergo baseline laboratory testing when initiating treatment. In addition prolonged (greater than 1 month) treatment should involve periodic blood monitoring. ECT remains an effective treatment for acute mania, but is rarely used due to the efficacy of pharmacologic interventions.

Whether treated with lithium, divalproex or olanzapine, symptoms should abate within 10 days. A failure to respond to lithium or divalproex despite adequate blood levels or a failure to respond to olanzapine at a dose of 15 mg/day warrants switching to an alternative medication. Prior to initiating lithium therapy, renal, thyroid, and cardiac (baseline EKG) functioning should be assessed.

Supplementing treatment with a benzodiazepine can afford significant relief from agitation and insomnia. Lorazepam (Ativan®), because it is short acting and can be administered parenterally as well as orally, is the drug of choice. Whether antipsychotic medication is superior to lithium in alleviating the agitation or hastening the remission of mania is unclear. If a patient is not receiving an atypical antipsychotic, an antipsychotic should be instituted if psychotic symptoms (delusions or hallucinations) are present.

Acute delirious mania can be very difficult to manage due to the deleriogenic properties of most medications and the tendency of drug combinations (e.g., lithium and an antipsychotic) to cause delirium. Through medical evaluation for treatable causes of delirium followed by careful medication trials and/or ECT is essential in treating this potentially lethal condition.

ACUTE PHASE, DEPRESSED

Incapacitating depression can occur at any time, although it is frequently associated with the spring and fall (seasonal variation). It is indistinguishable from major depression. However, unlike major depression, the treatment of choice is a mood stabilizing medication (lithium or an anticonvulsant). If the patient is already taking a mood stabilizer when the depression develops, increasing the dose based upon blood levels may be sufficient to alleviate the condition.

Psychotherapeutic treatments should be initiated, depending on the nature of the depression. Hospitalization, partial hospitalization, intensive outpatient, or standard outpatient treatment can all be effective. Individual, group, or family counseling should be considered depending on the symptoms.

There must be ongoing monitoring of suicidal thoughts and intent, as well as severity of hopelessness. Family and friends should be educated to recognize symptoms of increasing despair.

The efficacy of antidepressant medication in bipolar depressed individuals is not as clear as for major depression. However, most psychiatrists prescribe an antidepressant in combination with a mood stabilizer. Although any antidepressant can be effective, there have been concerns that tricyclics are more likely to precipitate rapid cycling. Since all antidepressants can cause a switch to mania, the clinician should alert the patient and family to this possibility.

The use of antipsychotics may be necessary if the depression progresses. Delusions and hallucinations can occur with depression. Command hallucinations require careful monitoring and will frequently necessitate
hospitalization. As with acute mania, ECT is a highly effective treatment and should be considered for treatment refractory (i.e., two months without significant improvement) or severely depressed individuals.

**SUBACUTE PHASE**

Once the acute symptoms of mania or depression have been addressed, a rehabilitative treatment plan should be implemented. This plan should focus on two main areas:

a) Rectifying the problems that may have been created by the acute illness, and

b) Developing a long-term maintenance plan to keep the patient symptom-free.

During the initial assessment, the clinician frequently uncovers severe disruptions in work functioning, social functioning, and family and marital functioning, as well as legal problems. Individuals with acute mania may abuse drugs or alcohol and may engage in high-risk behaviors, such as promiscuity.

Despite the best therapeutic interventions, jobs may be lost, marriages may end, and bankruptcy may occur. The role of the therapist is to identify all of these problem areas, intervene and educate where possible, and support the patient through losses and transitions. Establishing a long-term trusting relationship can be helpful in the event of future episodes.

**MAINTENANCE**

Long-term maintenance addresses the need for compliance with medications and the early identification of symptoms by the patient and family, which permits prompt professional attention. There is debate as to how many episodes of mania and/or depression an individual should experience before maintenance medication is recommended. In general, the decision should be based on the severity of the symptoms, the ability of the patient to obtain help early in the illness, and the patient’s desire to be medication free. Most clinicians will recommend maintenance medication after two episodes of severe mania or depression. Some clinicians recommend maintenance medication after a single manic episode.

Maintenance medication usually involves lithium, divalproex or lamotrigine. Although atypical antipsychotics may be an effective maintenance medication, long term risks and benefits have yet to be delineated. If using an atypical antipsychotic for long term maintenance one must monitor for the possibility of weight gain, diabetes and elevated lipids. Failure to stabilize on lithium or divalproex despite adequate blood levels warrants trials of other anticonvulsants (carbamazepine, lamotrigine, topiramate, oxcarbazepine or gabapentin). Each of these drugs has unique prescribing requirements. The physician should be very familiar with these guidelines before initiating therapy. Periodic plasma drug level testing (every three to six months) should be performed to monitor changes in metabolism or compliance. Acute monitoring of liver function (divalproex) and hemotologic status (carbamazepine) should be done. Annual monitoring of thyroid and renal status for patients on lithium is essential. The patient and family should be instructed about the symptoms of toxicity (particularly for lithium) since they can occur very rapidly. Extra caution should be used in the elderly, individuals with renal impairment, or patients on diuretics when administering lithium.

For patients who required an antidepressant or an antipsychotic medication during an acute phase, it may be necessary to continue the drug during the maintenance period. However, since many individuals with bipolar disorder can be effectively maintained on a mood-stabilizing drug alone, periodic attempts should be made to wean the patient from all other medications.

**INTENT**

This practice guideline is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The practitioner, in light of the clinical data presented by the patient and the diagnostic and treatment options available, must make the ultimate judgment regarding a particular clinical procedure or treatment plan.

**REFERENCES**

These guidelines were adapted from the American Psychiatric Association’s practice guidelines [American Psychiatric Association: Practice Guidelines for the Treatment of Patients with Bipolar Disorder. Am J Psychiatry 1994; 151 (Dec suppl)] and subsequently modified by consensus among a stratified sample of MHNet providers and clients. The reader is referred to the original article for detailed references (258) as well as the work group that prepared the guidelines. Selected references include: