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Introduction

Bipolar disorder is an illness which can require long-term treatment and skilled medical management. It is a biological condition with a strong genetic component, so effective management of bipolar disorder primarily involves the use of medications. Psychological therapies by themselves are ineffective, but they can be a useful adjunct to the physical treatment.

The management of bipolar disorder usually involves two parts:

- treating the current episode of mania or depression, and
- preventing the long-term recurrence of mania and depression.

Different medications for mania and depression

Since bipolar disorder involves episodes of *depression* and episodes of *mania* or *hypomania*, medications for bipolar disorder have two underlying strategies:

1. Medications that treat or prevent mania by stabilising the mood:
 - those commonly used include lithium and valproate (called 'Epilim' in Australia); others are carbamazepine, or lamotrigine, and (increasingly) the atypical antipsychotic drugs.
2. Medications that treat the depression:
 - there are different classes of these: some common ones used for bipolar disorder are the SSRIs and the Dual Action Antidepressants. These are less likely to 'switch' the depressed individual to a 'high' (an elevated mood). For people with bipolar II disorder, an SSRI may act as a stabiliser in a longer timeframe.

'Rapid cycling disorder' or 'mixed episodes' may need different medications.



Whether or not to treat mild mania and hypomania will depend upon the person's mood and the consequences (both positive and negative) of their 'highs'. Charting a person's moods by using a Daily Mood Graph (see 'Where to get more information') can help this decision.

Treatments also distinguish between managing an acute episode and 'maintenance' treatment. For example, a person with mania might require an atypical antipsychotic medication plus a mood stabiliser during an acute episode but, when settled, only require the mood stabiliser by itself to prevent further episodes. Similarly, someone with bipolar depression may only require an antidepressant at that time and then can rely solely on the mood stabiliser when the depression has resolved.

Electroconvulsive Therapy (ECT)

ECT plays an important role in treating both acute mania (and psychosis) and, on occasions, severe depression. Those occasions can include times when:

- medications can't be taken because of side-effects
- concurrent medical conditions (including pregnancy) make the use of medications too risky
- other treatments have proven to be ineffective
- the person is extremely disruptive (e.g. banging head on wall, not sleeping)
- the person is severely medically unwell (e.g. dehydrated or starved) as a consequence of the mood state.

Psychological therapies

Psychological therapies such as counselling, psychotherapy, cognitive behavioural therapy (CBT), family focused therapy, interpersonal therapy and social rhythm therapy are important adjuncts to physical treatments for bipolar disorder, but when used by themselves, i.e. without medication, they are ineffective and inappropriate.

Combining physical treatments and psychological therapies has been clearly demonstrated to be better than using physical treatments alone. It has been shown that this is not merely due to improved compliance or better adherence to the medication regimen.

Compliance

Poorly controlled bipolar disorder indicates either the inherent severity of the condition and/or poor compliance with medication.

It is hard for most people to accept a diagnosis of bipolar disorder and, for younger people, the prospect of taking preventative medication for long periods is very unappealing.



Other people fail to take medication either because they find the experience of mania seductive, or because of the unpleasant side-effects of the medication. Side-effects are often easily remediable, although lowering the dose too far can result in a loss of treatment efficacy.

It is important to recognise that, without ongoing treatment, bipolar disorder is unlikely to be controlled, and relapse is likely to occur. Most people who have had one manic episode will go on to have further episodes of the illness.

The benefits of ongoing treatment include a reduction in the severity and frequency of illness. For most people the benefits of long-term stability outweigh the drawbacks of being on medication.

Recurring mania

Non-compliance with mood stabilisers is a common cause of recurrence. Fifty per cent of people who suddenly cease lithium will relapse into a manic episode within five months, and many within a few weeks. A blood test can confirm whether levels of medication are in the effective range. If blood levels of the mood stabiliser are shown to be low, then the dose can be lifted into the 'therapeutic' range.

If mania recurs, the treating practitioner would normally ask two questions: either, why has the person stopped taking the medication; or, why is the medication no longer working?

If the person with bipolar disorder has ceased their medication because of unpleasant side-effects, it is possible to reduce the dosage, or another mood stabiliser could be used.

If mania recurs despite good compliance and acceptable tolerance of the medication, changing or combining medications might be the solution. For example, valproate (known as 'Epilim' in Australia) or carbamazepine could be added to lithium in cases where mania recurs despite maintenance of adequate blood levels and satisfactory compliance with lithium.

Hospitalisation

If someone with bipolar disorder has become psychotic, highly excited, aggressive or involved in clearly destructive behaviour, the issue of hospitalisation often arises. While some people may be manageable outside the hospital setting (perhaps with the assistance of community mental health resources), admission may be necessary. The use of other medications (such as antipsychotics or benzodiazepines) may be required while waiting for the antimanic effect of lithium to occur.



Drug treatment during pregnancy

Drug treatment for mania and depression during pregnancy is an extremely important issue in terms of the health of the baby.

The general principles are that if a woman is on antidepressant and mood stabilising medication, consultation with an expert should be undertaken and drug-free conception attempted.

In the first three months of pregnancy certain medications should be avoided, but this is not always achievable. In such circumstances, the mother, her partner and her doctor need to work together to address the cost-benefit issues.

Will I have to stay on medication forever?

Bipolar disorder is an illness which usually requires long-term medication. Most people who have had one manic episode will go on to have further illness. Without medication, relapse is likely. Long-term stability is usually a key objective for people with bipolar disorder, and correct medication is central to long-term stability.

Treatment for bipolar depression

'Bipolar depression' is the term used to describe depression in those with bipolar disorder. For most, the depression is of a *melancholic* or *psychotic* sub-type.

Depression in people who suffer from bipolar disorder is not always a natural part of the disorder itself. It can also be a sign of poor treatment compliance, or inappropriate treatment.

The first steps a treating doctor will usually take are to re-establish adequate blood levels of mood stabiliser and commence antidepressant treatment.

The difficulty in treating bipolar depression is the tendency of some people to 'switch' to mania. Once the depressed episode has been under control for a month or two, the antidepressant is usually gradually withdrawn, leaving the person on the mood stabiliser alone.

If you have bipolar depression it's best to consult your treating doctor. It may be a sign that your diagnosis needs reassessment or that your medication needs revision.



Effective management of bipolar disorder

To help with effective management of bipolar disorder, consider the following:

1. **Education** – is important for both the person with bipolar disorder and their supporters. Essential topics include the causes of bipolar disorder (genetic and environmental), medications and their possible side-effects, psychological treatments, lifestyle factors, triggers and early warning signs of relapse.
1. **Medication** – Individuals with bipolar disorder need to work in partnership with their doctor to find a combination of medications and dosages that minimise side-effects and help them to control the condition. Charting their moods with a Daily Mood Graph (see ‘Where to get more information’) will help with these decisions. They should also use memory aids or use links with daily routines to ensure that they remember to take their medications.
2. **Wellbeing Plans** are designed to help people to stay well in the short- and long-term and are unique to each person. They include identifying triggers and stresses that may cause problems, developing strategies for coping with at-risk or stressful situations, pinpointing early warning signs of both highs and lows and making lifestyle changes (e.g. reducing caffeine intake, getting adequate amounts of sleep). Wellbeing plans also include a section which outlines what will happen if you become ill – who do you want to help you, what will they do and which doctor do you want to see.

The Black Dog Institute’s online Bipolar Education Program covers all of the above areas (and more), with detailed information from experts and advice from well-known people with bipolar disorder.



Key points to remember

- Bipolar disorder is an illness which can require long-term treatment.
- Everyone is different and therefore the appropriate treatment for a particular individual is a matter for a skilled medical practitioner to decide in consultation with the patient.
- Physical (medication) treatments are necessary for bipolar disorder. Psychological approaches are, by themselves, insufficient, but serve a valuable complementary role alongside medication.
- Different medications are used to treat acute episodes of mania and of depression, and other medications ('mood stabilisers') are used to keep episodes at bay or to augment acute treatments.
- Some psychotropic medications (e.g. antidepressant drugs) can cause a 'switch' into mania.
- Recurring mania is usually due to poor compliance with medication, or the particular medication not working properly and needs readjusting or changing.
- The use of medications during pregnancy is an extremely important issue and requires consultation with an expert.

Where to get more information

- Watch our online Bipolar Disorder Education Program www.blackdoginstitute.org.au
- A *Daily Mood Graph* can be downloaded from our website at: www.blackdoginstitute.org.au/factsheets
- National Institute of Mental Health (US) www.nimh.nih.gov

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