

mindovermatter

by Professor Gordon Parker

Getting back in control

Once there was manic depressive illness, requiring hospitalisation and lithium clinic follow-up. Now there are several bipolar disorder subtypes, and management is more pluralistic.

HISTORY

Yvette, a 28-year-old unemployed hairdresser who lived in a small country town, was brought for assessment by her parents.

Yvette described “mood swings” since adolescence. During depressive episodes – which could last days to months – she felt “in a black hole”, becoming unmotivated and asocial, and lacking energy.

Intermittent ‘highs’ would last days, and were marked by irritability and loudness, while she would be disinhibited, drinking to excess and initiating one-night stands. Absenteeism during mood swings had lost her employment. Married briefly, she had recently returned to her parents’ home.

Her parents, Bob and Rose, had responded with increasing anger to her behaviour over the years. Her father judged her lying in bed for much of the day when depressed as “bone laziness” and she needed a “kick up the bum to get a job”.

Episodic panic attacks were mood related

Bob’s sister contacted him to say she’d listened to an interview of a sportsman with bipolar disorder and wondered if Yvette might have the same condition. Bob and Rose accompanied Yvette to Sydney for assessment.

Yvette was interviewed first. She had a clear history of bipolar II disorder, with only rare euthymic periods. Episodic panic attacks and alcohol excess were mood related, and not independent problems. While she was unaware of any family history,

when her parents joined the interview, Bob remembered his father having episodes of severe depression (which he never talked about) and his maternal grandmother having died in a psychiatric institution.

Informed about the diagnosis and its likely management, Yvette cried while both parents apologised to her for missing the mood disorder.

MANAGEMENT

The four key components to managing bipolar disorders – education, mood charting (recording the impact of stressors and medication), medication, and developing a ‘wellbeing’ plan – were put to the family.

All three were concerned about no available rural psychiatrist to manage medication. It was suggested that the referral letter from their GP indicated keen interest in managing psychological problems, and that a detailed plan would be sent to him.

While encouraging the view that medication would assist, it was noted that it was generally difficult to predict if the first, second or third medication would have the greatest cost benefit. Thus, sequencing medication options were detailed to the family and managing practitioner.

Education and developing a skeletal ‘wellbeing’ plan were provided initially by a web-based program.

ONLINE EDUCATION

Online education programs offer many advantages, including:

- Availability – information and resources are available at any time of the day or week)
- Privacy – users can access sensitive information in

private

- Flexibility – users can determine the pace of the program and review material as often as desired
 - Accessibility – information and self-help is not limited by geographical or financial barriers
 - Tracking – online questionnaires can allow users to track their progress and provide feedback to their clinicians, and
 - Anonymity.
- Thus, both education and the skeletal components of a wellbeing plan (in essence, identifying triggers and early warning signs, and then designing pre-emptive and episode-based personal and family responses) can be provided by such programs.

FOLLOW-UP

Six months later, Yvette sent the following email:

“The second medication really helped. Until getting the diagnosis, I thought the moods

were me. To see them as an illness has helped me accept some of the consequences. I have to say with surprise that the program was very beneficial. It kind of snuck up on me.

“We set up a strict budget and cancelled all my credit cards. I make a point of saying no to people more often – nothing new is added to my to-do list now until it is empty. I get out of bed as soon as the alarm goes and go for a fast walk around the town. And, I’ve got a part-time job. I really feel more in control.”

KEY ISSUES

Yvette’s diagnosis was assisted by community awareness and destigmatisation of mood disorders, by web-based ‘bottom up’ information and screening, by having her family involved in the history taking and in the development of a management plan.

And by linking general practice management with

a patient-directed education and wellbeing plan that moved Yvette from being ‘out of control’ with a disorder to begin to control it, she avoided being defined by it. ☺

Professor Parker is Scientia Professor at the University of NSW and Executive Director of the Black Dog Institute.

Web-based trial

The Black Dog Institute is undertaking a controlled trial of three Web-based educational programs for those who have received a diagnosis of bipolar disorder in the last six months. All those taking part receive educational material, with the study testing comparative educational programs and the impact of an optional counsellor. GPs might encourage recently diagnosed patients or those who are interested to send an email to bipolareducation@unsw.edu.au.