Adult Bipolar Disorders At A Glance*

The goals of psychiatric management include establishing and maintaining a therapeutic alliance, monitoring the psychiatric status of the person served, providing education about bipolar disorder, enhancing treatment adherence, promoting regular patterns of activity and of sleep, anticipating stressors, identifying new episodes early, and minimizing functional impairments. Because bipolar disorder is associated with functional impairments even during periods of euthymia, and the presence, type, and severity of dysfunction should be evaluated and addressed. A bracketed Roman numeral following a recommendation signifies the level of clinical confidence:

[I] Recommended with substantial clinical confidence
[II] Recommended with moderate clinical confidence
[III] May be recommended on the basis of individual circumstances

INITIAL TREATMENT

Assess the person's safety and level of functioning to determine the optimum treatment setting.

Manic or mixed episodes

Firstline pharmacological treatment for more severe manic or mixed episodes is the initiation of either lithium plus an antipsychotic or valproate plus an antipsychotic [I]. For less ill persons, monotherapy with lithium, valproate, or an antipsychotic such as olanzapine may be sufficient [I]. Short-term adjunctive treatment with a benzodiazepine may also be helpful [II]. For mixed episodes, valproate may be preferred over lithium [II]. Atypical antipsychotics are preferred over typical antipsychotics because of their more benign side effect profile [I], with most of the evidence supporting the use of olanzapine or risperidone [II]. Alternatives include carbamazepine or oxcarbazepine in lieu of lithium or valproate [II]. Antidepressants should be tapered and discontinued if possible [I]. Although psychiatric management and pharmacologic treatment are essential components of the treatment regimen, psychotherapeutic approaches are also critical additions to the overall treatment plan.

Failure to respond

For persons who, despite receiving maintenance medication treatment, experience a manic or mixed episode (i.e., a "breakthrough" episode), the firstline intervention should be to optimize the medication dose [I]. Introduction or resumption of an antipsychotic is sometimes necessary [II]. Severely ill or agitated persons may also require short-term adjunctive treatment with a benzodiazepine [I].

When firstline medication treatment at optimal doses fails to control symptoms, treatment options include addition of another firstline medication [I]. Alternative treatment options include adding carbamazepine or oxcarbazepine in lieu of an additional first-line medication [II], adding an antipsychotic if not already prescribed [I], or changing from one antipsychotic to another [III]. Clozapine may be particularly effective in the treatment of refractory illness [II]. ECT may also be considered for persons with severe or treatment-resistant mania or if preferred by the person served in consultation with the psychiatrist [I]. In addition, ECT is a potential treatment for persons experiencing mixed episodes or for persons experiencing severe mania during pregnancy [II]. Manic or mixed episodes with psychotic features usually require treatment with an antipsychotic medication [II].

Depressive episodes

Firstline pharmacological treatment for bipolar depression is the initiation of either lithium [I] or lamotrigine [II]. Antidepressant monotherapy is not recommended [I]. As an alternative, especially for more severely ill persons, some clinicians initiate simultaneous treatment with lithium and an antidepressant [III]. In persons with life-threatening inanition, suicidality, or psychosis, ECT is a reasonable alternative [I] and a potential treatment for severe depression during pregnancy [II].

Substantial evidence supports the efficacy of psychotherapy in the treatment of unipolar depression [I]. In bipolar depression, interpersonal therapy and cognitive behavior therapy may be useful when added to pharmacotherapy [II]. While psychodynamic psychotherapy has not been empirically studied in persons with bipolar depression, it is widely used in addition to medication [III].

Failure to respond

For persons served who, despite receiving maintenance medication treatment, suffer a breakthrough depressive episode, the first-line intervention should be to optimize the dose of maintenance medication [II]. When an acute depressive episode of bipolar disorder does not respond to first-line medication treatment at optimal doses, next steps include adding lamotrigine [I], bupropion [II], or paroxetine [II]. Alternative next steps include adding other newer antidepressants (e.g., a selective serotonin reuptake inhibitor [SSRI] or venlafaxine) [II] or a monoamine oxidase inhibitor (MAOI) [II]. For persons with severe or treatment-resistant depression or depression with psychotic or catatonic features, ECT should be considered [I].

The likelihood of antidepressant treatment precipitating a switch into a hypomanic episode is probably lower in persons with bipolar II depression than in persons with bipolar I depression. Therefore, clinicians may elect to recommend antidepressant treatment earlier in persons with bipolar II disorder [II].

Depressive episodes with psychotic features usually require adjunctive treatment with an antipsychotic medication [I]. ECT represents a reasonable alternative [I].

Rapid cycling

Rapid cycling refers to the occurrence of four or more mood disturbances within a single year that meet criteria for a major depressive, mixed, manic, or hypomanic episode. The initial intervention in persons who experience rapid cycling is to identify and treat medical conditions, such as hypothyroidism or drug or alcohol use, that may contribute to cycling [I]. Certain medications, particularly antidepressants, may also contribute to cycling and should be tapered if possible [II]. The initial treatment for persons who experience rapid cycling should include lithium or valproate [I]; an alternative treatment is lamotrigine [I]. Many persons served require combinations of medications. [II].

MAINTENANCE TREATMENT

Following remission of an acute episode, persons served may remain at high risk of relapse for a period of up to 6 months; this phase of treatment, sometimes referred to as continuation treatment, is considered in this guideline to be part of the maintenance phase. Maintenance regimens of medication are recommended following a manic episode [I]. Medications with the best empirical evidence to support their use in maintenance treatment include lithium [I] and valproate [I]; possible alternatives include lamotrigine [II] or carbamazepine or oxcarbazepine [II]. If one of these medications was used to achieve remission from the most recent depressive or manic episode, it generally should be continued [I]. Maintenance ECT may also be considered for persons whose acute episode responded to ECT [II].

For persons served treated with an antipsychotic medication during the preceding acute episode, the need for ongoing antipsychotic treatment should be reassessed upon entering maintenance treatment [I]; antipsychotics should be discontinued unless they are required for control of persistent psychosis [I] or prophylaxis against recurrence [III]. While maintenance therapy with atypical antipsychotics may be considered [III], there is no definitive evidence that their efficacy in maintenance treatment is comparable to that of agents such as lithium or valproate.

During maintenance treatment, persons with bipolar disorder are likely to benefit from a concomitant psychosocial intervention—including psychotherapy—that addresses illness management (i.e., adherence, lifestyle changes, and early detection of prodromal symptoms) and interpersonal difficulties [II].

Group psychotherapy may also help persons served address such issues as adherence to a treatment plan, adaptation to a chronic illness, regulation of selfesteem, and management of marital and other psychosocial issues [II]. Support groups provide useful information about bipolar disorder and its treatment [I].

Persons served who continue to experience subthreshold symptoms or breakthrough mood episodes may require the addition of another maintenance medication [II], an atypical antipsychotic [III], or an antidepressant [III]. There are currently insufficient data to support one combination over another. Maintenance ECT may also be considered for persons served whose acute episode responded to ECT [II].

Additional Considerations

Severely ill persons served who lack adequate social support outside of a hospital setting or demonstrate significantly impaired judgment should also be considered for admission to a hospital. Additionally, those persons served who have psychiatric or general medical complications or who have not responded adequately to outpatient treatment may need to be hospitalized.

Persons with bipolar disorder may benefit from regular patterns of daily activities, including sleeping, eating, physical activity, and social and emotional stimulation. The clinician should help the persons served determine the degree to which these factors affect mood states and develop methods to monitor and modulate daily activities. Many persons served find that if they establish regular patterns of sleeping, other important aspects of life will fall into regular patterns as well.

The clinician should help the person served, family members, and significant others recognize early signs and symptoms of manic or depressive episodes. Such identification can help the person served enhance mastery over his or her illness and can help ensure that adequate treatment is instituted as early as possible in the course of an episode

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